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Creators	Gadsby, Jonathan and Mckeown, Michael

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Mental Health Nursing and Conscientious Objection to Forced Pharmaceutical Intervention

Jonathan Gadsby & Mick McKeown

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Abstract

This paper attempts a critical discussion of the possibilities for mental health nurses to claim a particular right of conscientious objection to their involvement in enforced pharmaceutical interventions. We nest this within a more general critique of perceived shortcomings of psychiatric services, and injustices therein. Our intention is to consider philosophical and practical complexities of making demands for this conscientious objection before arriving at a speculative appraisal of the potential this may hold for broader aspirations for a transformed or alternative mental health care system, more grounded in consent than coercion. We consider a range of ethical and practical dimensions of how to realise this right to conscientious objection. We also rely upon an abolition democracy lens to move beyond individual ethical frameworks to consider a broader politics for framing these arguments.

Introduction

Forced treatment using drugs is arguably the most ethically suspect and least defensible of a range of coercive practices deployed within psychiatric services. It is often accompanied by other use of force, such as physical restraint, adding to its objectionable status. These practices can be seen to cause distress and trauma for both service users and mental health nurses. As such, we contend this enforcement of pharmacological treatment represents an affront to a progressive and positive nursing identity and recognition of this opens up the possibility to object as a matter of conscience.

In this paper we make the case for mental health nurses to have recourse to a conscientious objection to such forced treatment and frame this within an argument informed by theorising and activism relating to abolition democracy. In a general sense, a conscientious objection is a formally recognised right, grounded in conscience, to not be involved in a practice or activity felt to be morally objectionable. In history, the most obvious example is when citizens express a conscientious objection to involvement in warfare, typically under conscription. Nurses do have conscientious objection rights in different international jurisdictions, most usually concerning faith-based objections to involvement in interventions to terminate pregnancy. Interestingly, at times of conscientious objection to militarism conscientious objectors have been both compelled to work in psychiatric hospitals and on occasion been psychiatrised themselves.

Abolition democracy refers to a panoply of ideas and activist interventions for progressive improvements to society which have their roots in the movements to abolish slavery and provide for a more just post-abolition settlement. Coined by W. E. B. Du Bois, taken up by Angela Y. Davis in the context of critique of the US prison-industrial complex and re-energised in the Black Lives Matter movement, abolition democracy offers a radical lens through which objectionable and unjust social systems, relations and practices can be criticised and potentially transformed. It is our contention that forced pharmacological treatment of the mentally distressed is one such objectionable practice and that abolition democracy ideas represent a useful tool for considering the value of a right to conscientious objection. Both abolition democracy ideas and conscientious objection can be seen as deeply compatible concepts grounded in a morality of social justice. In the context of a desire to be an evidenced-based profession, evidence alone is unable to untangle the difficulties that many mental health nurses have with forced pharmaceutical intervention. An intolerable inner conflict may be the inevitable consequence for nurses attempting to uphold the values of their codes of conduct and of the demands of degree-level education to engage practices in a critical manner.

Background

Possession of a conscience can be an asset for nurses, driving attention to positive practice or sensitivity to patient needs and key moral, ethical and social concerns (Jensen & Lidell, 2009). The fact that matters of conscience exist for nurses is reflected in generic professional literature, acknowledging psychological stresses arising from conflicts of conscience occurring in practice (Glasberg et al., 2006; Juthberg et al., 2007, 2008) that may be resolved by claiming a conscientious objection (Cleary & Lees, 2019). The notion of conscientious objection, however, is much less visible in the literature, despite many international regulatory jurisdictions allowing for nurses to raise a conscientious objection (Dobrowolska et al., 2020; Lamb et al., 2019). Commentary and scholarship on conscientious objection rights exercised by nurses has focused on matters of conceptualisation/definition, ethics, and the practical circumstances within which nurses wishing to act on a matter of conscience can be supported by nursing leadership and organisations (see Catlin et al., 2008; Davis et al., 2012; Dickens & Cook, 2000; Ford et al., 2010; Lachman, 2014; Lamb et al., 2019). Nurses in the UK currently possess such a right regarding abortion and fertility issues only; with criticism of the tension between rights of nurses to object and patients to choose (Fiala & Arthur, 2014; Kane, 2009; McHale, 2009). In the mental health context, the stress of conscience has been found to be a key element of overall occupational stress (Hanna & Mona, 2014). Furthermore,

of all forms of coercive practice, forced pharmacy is viewed by a substantial proportion of nurses as the most ethically problematic (Jarrett et al., 2008). However, despite substantial attention to the moral, ethical and practical dilemmas of forced psychiatric treatment and the extent to which this troubles practitioners, seldom is this linked to demands for conscientious objection.

In mid-October 2018 the UK based Critical Mental Health Nurses' Network (CMHNN) hosted a three-day open online discussion about conscientious objection to forced treatment¹. Despite potential for the subject matter to be viewed as somehow rebellious it was striking that participants expressed attitudes and language steeped in nursing traditions, referring to the UK Nursing and Midwifery Council Code of Conduct, ethical consideration of rights, evidence and scholarship, professional and personal reflections, nursing duties and person-centred care. The saliency of notions of 'values-based practice' (Morgan et al., 2016) or trauma informed approaches (Sweeney et al., 2018) were noted amidst moving testimony from service users and nurses. It seems right to say the conversation reflected a situation in which *aspiring to be a good nurse* was driving problems of conscience for mental health nurses, rather than a feeling they were turning away from, or were unsuited to, nursing. This is an important theme in all that follows.

A number of important questions require attention. These include whether:

1. enforcing pharmaceutical interventions is a matter that may be described as 'of conscience' and not simply 'of evidence';
2. in a service including a spectrum of coercive and custodial elements, it is possible to single out this particular use of force for attention;
3. conscientious objection should be conceived as an identity or as an act, contingent on circumstances;
4. existing mechanisms to support nurses reporting concerns about enforced pharmaceutical interventions are sufficient, rendering a separate right of conscientious objection unnecessary;
5. exercising this potential right could work practically, especially considering employment protection and changed relationships within teams;
6. within a profession subject to various demands for reform, the issue of a possible conscientious objection to enforced pharmaceutical interventions should be prioritised;
7. this issue is specific to mental health nurses.

¹ The discussion is available to read and for people to continue at <https://criticalmhnursing.org/>.

A matter of conscience and not merely of evidence?

Radical nurses have long argued matters of conscience should be at the heart of any nursing interest in emancipation and social justice (Kagan et al., 2010). Moreover, nurses recognise a complex blend of evidence-based *and* moral or value-based questions concerning the issue of forced pharmaceutical interventions. This is entirely consistent with both the nursing profession more generally and ways in which issues of conscience are typically framed. For example, Paterson and Duxbury (2007) have written about the ethics of physically restraining distressed, disturbed and aggressive individuals.

Appeals to ethics may or may not delimit consideration of politics – both having a moral dimension – but we do need to be alert to such limitations. McKeown et al. (2019a) note the pitfalls of nurses framing use of coercion as a ‘last resort’ or ‘necessary evil’ only in terms of ethical frameworks or ethics informed clinical guidelines (e.g. Luciano et al., 2018). This risks neglecting consideration of a politics of legitimacy: specifically, how shibboleths like ‘last resort’ can blind us to routine applications of force and epistemic forms of violence, and can be used to socialise ‘good’ nurses into accommodating themselves into a system they feel uncomfortable in. Interestingly, notions of legitimacy can also be predicated on appeals to evidence, raising the same dilemmas concerning the somewhat equivocal nature of the evidence-base for various interventions.

The idea of evidence in this context ought to encompass more than just the supposed efficacy of medication and extend to inquiry into the short and long-term impact of forced treatment (and alternatives). That said, here we focus on the contested field of evidence for psychotropic medication. Writers such as Robert Whitaker (2010) lead nurses to question the reported efficacy of these interventions and Peter Gøtzsche (2013) and Ben Goldacre (2009; 2012) prompt disquiet about the influence of pharmaceutical industries in development, testing and dissemination. Critics such as Joanna Moncrieff (2009, 2020) further contest the evidential justifications for medications – that they are a ‘treatment’ at all; raising serious questions about the harms associated with long-term use. Moncrieff argues persuasively that practitioners should be more honest about the actual effects of drugs, rather than become distracted, and perhaps deluded, by supposed models of action. Then nurses might be in a better position to support service users in choices to take drugs or not.

Extensive philosophical work in recent years, such as brought together in the recently-published ‘Power Threat Meaning Framework’, suggests the very models on which mental health services and

mental health professions rely are contentious and not politically neutral (Johnstone & Boyle, 2018). Although the politics and over-simplifications of Thomas Szasz have been repeatedly exploded, fundamental questions about the failure of diagnostic categories to 'self-vindicate' remain. This is only important for this issue in the extent that diagnoses may provide an argument for a 'known' future deterioration of mental state linked to decisions surrounding enforced interventions and a background acceptability of the notion of such interventions being regarded as 'treatments'. Criticism issued by the UN Special Rapporteur leaves mental health nurses with some very serious questions about collisions between human rights, disability rights and mental health law (United Nations, 2017). Together with additional scholarship from authors such as Kate Pickett and Richard Wilkinson (2015) this suggests mental health services are missing important data, perspectives and approaches for public health, which, again, invites uncomfortable questions about political neutrality.

There is also disquieting evidence, especially in light of Black Lives Matters activism, of longstanding international anomalies in the detainment and treatment of ethnic minorities and indigenous peoples, including being disproportionately subject to higher doses and forced medication and extension of obvious harms up to and including death in custody (Aiken, 2011; Anthony, 2016; Gone, 2007; Gudjonsson et al., 2004; Keating & Robertson, 2004; Prins, 1993; Razack, 2015; Sivanandan, 1991).

To sustain the case for a conscientious objection, it is not necessary to attempt to resolve evidential contestation. Indeed, it is in part the inability of *anyone* to satisfactorily settle these contests and incommensurate ideas that makes this an issue of conscience. 'Evidence' does not necessarily win debates so infused with ideology, leading authors interested in the importance of both values and evidence in mental health to describe a preferable 'dissensus' of views (Morgan et al., 2016). It is therefore enough to notice that such contests are serious and wide-ranging and quite reasonably can be considered grounds for a degree of personal and professional crisis for individual mental health nurses. They may leave a nurse with a sense that core paradigmatic understandings of mental health services may be overturned, especially, perhaps, the supporting evidential and ethical frameworks of pharmaceutical interventions. We note that a recent response from the English Hearing Voices Network to proposed reforms of mental health law (Hart & Waddingham, 2018) argues for an end to enforced pharmaceutical intervention without arguing for an end to all detention. In line with the aforementioned UN Report, this would see a wedge driven between detention, viewed as legitimate, and enforced pharmaceutical interventions, viewed as unsupportable. For our purposes, the key understanding is that 'the evidence' does not resolve itself into a clear legitimization of pharmaceutical interventions and that connection to these areas of

contestation may be found through professional education and pursuit of the critical thinking and reflective practice required of registered nurses (Grant & Gadsby, 2018).

However, there are further factors that may make it reasonable that mental health nurses find the issue of forced pharmaceutical interventions a matter of conscience. A range of critical thought undermines reliance upon widely used justifications of 'last resort', 'best interests' and 'no alternative'. To these are added programmes such as Open Dialogue (Seikkula & Olson, 2003), Soteria (Mosher 1999), Trauma Informed Approaches (Sweeney et al., 2018), the insights of the Hearing Voices Movement (Romme & Escher, 1993) and more general forms and ideals of co-production (Dzur 2019); all very much concerned with democratisation of service provision. If we leave aside questions of co-option and adulteration of these ideas, then we might also pose questions of compatibility with coercion; coercive care seemingly the ultimate oxymoron. Ultimately, from this perspective, forced treatment is the factor that will derail efforts towards democratised therapeutic relations.

Such differing ideas may lead a mental health nurse to view the lack of alternatives to be a service-driven feature and not a service-user-driven feature (not integral to the mental or behavioural state of service users). Given the physical realities and well-established non-therapeutic effects involved with pharmaceutical interventions, anything undermining the credibility of 'last resort', 'best interests' and 'no alternative' justifications may reasonably be predicted to generate intolerable difficulties of conscience for some nurses in regard to enforcing pharmaceutical interventions.

One further related problem concerns the notion of psychiatric 'insight'. 'Lack of insight' is a phrase used to suggest that, due to illness, a person does not have the capacity to consent to or refuse pharmaceutical interventions: a capacity that they would have were they to accept pharmaceutical interventions, perhaps. This has always been a difficult and somewhat circular argument, along with concerns about professional power. Additionally, it certainly stands on a large degree of confidence in the 'treatment' model of psychotropic substances that many now view as problematic.

First person accounts of being subject to forced treatment, even in a context of cooperation with services in every regard other than a refusal to take medication, undermine ethical justifications (McKeown et al., 2019a). The establishment of 'drug free' beds in some Norwegian psychiatric hospitals (Whitaker, 2017) and the development of alternatives such as Philadelphia Houses or Soteria using minimal or no medication compare favourably with the mainstream. Despite variations in the methods and extent of implementation, such examples serve to highlight two points. Firstly, mental health professionals in other places are already seeking to divide involuntary hospitalisation

and involuntary pharmaceutical interventions. Secondly, the 'there is no alternative' mantra has geographical boundaries.

A mental health nurse does not need to argue that alternative interventions would be effective for every recipient of mental health services to find that they cannot always say they are acting in the 'last resort'. There is some evidence in the study of physical restraint that these interventions are applied more to certain (misunderstood) groups, such as people diagnosed with personality disorder or who practice self-harm (McKeown et al., 2020). The untruth of last resort is also obvious in the practice of planned restraint associated with administration of forced medication (McKeown et al., 2019a). Research studies and practice development initiatives focused on minimising the use of physical restraint have also remarked upon the propensity for levels of coercive practices to correlate with resource and funding cuts, with specific attention to safe staffing complements; staffing shortfalls are also implicated in undermining efficacy of the very initiatives introduced as remedies (McKeown et al., 2019b).

Is an objection to enforcing pharmaceutical interventions simply a signal that a person is not suited to the realities of the profession?

Crucially, in no way does critical consciousness of any of the above difficulties suggest that mental health nurses lack a clear vocation for the care of people with mental health problems, including that given in acute services. Such concerns do not make them less committed and skilled; in fact, we contend that they are likely to be motivated, professional and caring. The notion of professional identity does, however, offer scope for deepening the case for considering forced treatment a matter of conscience. Arguably, aspects of nursing's professionalization journey are intensely problematic; being bound up with an archaic notion of professionalism and riding the coattails of bio-medicine. This is especially true of the advancement of mental health nursing from roots in the occupation of asylum attendants in the 19th Century. Feminist nursing scholars blazed a trail in suggesting possibilities for deconstructing and reconstructing notions of nursing professionalism (Davies, 1995). A new model professionalism could be more person-centred and less attached to violence (opening up critical reflections on epistemic enmeshment of psychiatric power with for example, colonialism, neo-colonialism, free-market capitalism and toxic masculinity).

For several decades mental health nursing has aspired to be a profession 'in our own right'. It may be that a right to conscientiously object from enforcing pharmaceutical interventions adds a new and initially uncomfortable boundary to our close relationships with medical colleagues. As a

profession 'in our own right' this is to be carefully and sensitively welcomed. This request for an extended and revised right of conscientious objection need not be an explicitly 'anti-psychiatric' initiative. Indeed, many psychiatrists share grave concerns about the evidential and ethical context of their work and some key relevant texts are written by critically minded psychiatrists (e.g. Middleton and Moncrieff, 2019; Bracken and Thomas, 2010). To be mature professionals in our own right is to belong to an educated occupational group that prizes critical thinking rather than a potentially oppressive culture that student nurses are socialised to dutifully perpetuate. We see this issue of conscience as a predictable consequence of our professionalisation trajectory.

Is enforced pharmaceutical intervention something distinct from other forms of force, coercion or detention?

Mental health nurses provide many services existing on a spectrum of force, coercion and detention. Indeed, separating out forced pharmacological treatment for particular objections may raise some challenges to the apparent selectivity. These may have implications for building alliances with radical service user/survivor groups or other activists – who may struggle to see the point of separating out one set of coercions over others. Similarly, resistant or indifferent staff may use the same argument. Hence, a closely argued case needs to be made. Nurses seeking to claim a particular conscientious objection need to establish whether enforcing pharmaceutical interventions is a meaningfully separable element.

We contend that for an individual nurse to have a conscientious objection to enforcing pharmaceutical interventions it is not necessary to enter the many arguments about the morality and use of mental health law more generally (e.g. Pilgrim & Thomasini, 2012; Sidley, 2015). Given the difficulties already described, it is possible to conceive of circumstances in which a nurse could argue for a person's detention under mental health law while conscientiously objecting to them receiving enforced pharmaceutical interventions; preventing life-threatening self-harm for example.

Therefore, a nurse who conscientiously objects to enforcement of pharmaceutical interventions may yet be required (and choose) to take part in the trained application of force; these situations themselves may not be viewed as a difficult matter of conscience (and this is not duplicitous behaviour). To put this another way, one could imagine a conscientious objection to enforced pharmaceutical intervention in which the nurse remains wholly within the values and principles of the mental health nursing profession while objecting to all uses of force, or to mental health law more generally, has wider and more problematic implications. It is likely that a mental health nurse

who objects to enforcing treatment will have views on wider use of mental health law around, for example, utility of diagnostic categories, forced feeding of a person with anorexia, or enforced seclusion. We would want to encourage well-informed and frank discussion about all those issues. However, while we may be concerned about many of these when they are non-consensual, it is not clear to us that a mental health nurse can or should be afforded a right to conscientiously object to any of these at this time. Arguably, there are already opportunities to think about (and work towards) the possibilities for more consensual alternatives and preventative approaches.

The mechanisms allowing for appeal against applications of mental health law already provide nurses and nursing teams some opportunity to present the contested nature of detention for individuals in their care. Nurses can already contribute their views about these issues and we believe it is right to say that there has long been widespread, tacit and under-discussed informal support for mental health nurses conscientiously objecting to assisting with Electro-Convulsive Therapy². If a service user, having had an open and informed discussion about the therapeutic and non-therapeutic effects of pharmaceutical interventions, chooses to take them as prescribed, it seems then that the same issues of conscience do not apply; mental health nurses already have a role (indeed, it is specifically required by our Code of Conduct) in monitoring and discussing non-therapeutic effects of pharmaceutical interventions and are able to influence their prescription in this way.

An identity (i.e. 'I am a conscientious objector') or a case-by-case decision?

This is an important area of debate for conscientious objection more generally, but within the CMHNN discussion there was a consensus: if such a right were to exist it should be exercised on a case-by-case basis. Conscientious objection was recognised as less of a personal attribute or general moral stance and more of a thoughtful response to individual service-user circumstances, which may be highly nuanced. Perhaps this lack of contention was more likely because of the network being committed to criticality; critical thinkers are generally sceptical towards 'blanket' positions. Other mental health nurses may feel that the form of their own conscientious objection is more intrinsic to them as a person, but they would still be served by an extension to the existing provision for conscientious objection on a case-by-case basis.

² For the purposes of our argument it seems sensible to treat ECT as a sort of pharmaceutical intervention; despite its very different nature, it suffers from some similar issues of evidence and ethics.

Is conscientious objection an individual focus to problems that might be better discussed at a team-based or wider systems level?

In addition to questions about whether a focus on enforced pharmaceutical interventions is meaningfully distinct from a spectrum of coercive practices and legal frameworks, conscientious objection can be queried as a meaningful idea when those involved do not work alone but with many colleagues within a complex of interlocking professions and systems. Certainly, it seems that some parts of those teams and systems may be failing when the collective work may cause an individual member such difficulty. However, the idea of collective refusal is equally difficult. As already stated, part of the reason for thinking that this is an issue of conscience is precisely because evidences are so complex and incommensurate; finding whole-team or whole-system agreement is unlikely (and, arguably, risks replacing one universal solution with another). For us it is correct to view this as an issue of individual conscience *and also* as a matter that should become a team or systems problem. We wish to avoid the pitfall that, if conscientious objection is viewed as a 'symptom' of a system that sometimes requires nurses to act against their individual understandings and values, then that same system is capable of viewing conscientious objection as an individualised problem rather than a voicing of the trouble inherent within overarching systems of thought and practice. This means that great thought will be required to protect individual nurses who choose to conscientiously object. It may need to encompass staff training, employment law and possibly more. *If a right of conscientious objection were allowed, it would need to be introduced within a context supporting more robust discussion, more team work, a greater sense of nursing cohesion and mutual support, less individual anxiety and trauma and, ultimately, a more person-centred and thoughtful experience for service-users.*

One further question raised is how such change might appear to service-users and survivor groups. It would be wrong to attempt to guess their views, but it seems fair to note that while potential exists for teams or systems to vilify or sanction an objecting individual, it is very possible that service-users may sanctify her or him. This understandable response may be unhelpful for the objecting nurse; and it may cause non-objecting colleagues to be described as immoral (by comparison). If this becomes the case, then the trauma of the controversy over enforced pharmaceutical interventions will have effectively created further harm to a nursing team and individual nurses in ways unlikely to be viewed as an improvement (even where the existing situation is understood to be problematic).

Arguably, no initiative is adequate without taking into account views of people with lived-experience of mental health difficulties. Yet we also recognise conscientious objection is also in many ways an issue for discussion within the mental health nursing profession, concerning our personal

experiences and issues of conscience and how these can translate to collective demands. Just as with the views of our multi-disciplinary colleagues, we are keenly interested and yet feel there is something important here about mental health nurses primarily addressing our own practices.

An extension of existing provision for conscientious objection, or a revision?

The current UK provisions (NMC, accessed 2021) make for interesting reading. Two significant elements raise questions about whether provision can be merely extended, or whether it must be revised.

Firstly, the relevant portion of the NMC website states there is 'a currently statutory right of conscientious objection for nurses, midwives and nursing associates in two areas' before detailing the basis for both, in abortion and human fertilisation legislation respectively. As mental health nurses have become more educated and increasingly employed as autonomous practitioners, able and required to consider complex and contested ideas in their decision-making, it should be understood that in a contested field there will be legitimate and significant diversity of opinion. Under these circumstances it is inevitable the question of further provision for conscientious objection will arise. The current regulatory stance is difficult to defend from accusations it is less about enabling objection and more designed to prevent it.

Secondly, our mental health nursing values, our commitment to critical thinking and reflective practices such as clinical supervision lead us to the view that the emotions and deliberations of a colleague should be expressed, supported, explored and form part of team decision-making; and yet the stated requirement for the conscientious objector to find a replacement suggests that the team should remain untouched by the thoughts of their colleague and the issue seen as merely idiosyncratic, or as a resource-management issue. Conversely, conceiving alternate (perhaps more democratic) work processes, wherein teams are perpetually engaged in learning and reflection, ideally inclusive of service users would seem preferable.

The requirement to arrange for a substitute is certainly not a condition of the legal right to conscientiously object from military service and, indeed, within the field of conscientious objection more generally it is questionable whether sending another in one's stead is a meaningful objection. Once again, the suggestion seems to be that the current provision for conscientious objection must not be allowed to interfere with the smooth provision of the service's status-quo. Perhaps this is understandable in the complex interplay of rights found in fertility and termination issues where opposing views tend to be driven more by personal and religious conviction than debate over

incommensurate evidence. Objections to forced treatment may also reflect faith standpoints, and an interesting question might be why the religious conscientious objectors who oppose abortion do not dissent from the violence of psychiatry. Answers may cycle round into the powerful systems of socialisation and legitimation bound up in psychiatric systems.

Is this issue a priority?

Mental health nurses have to make complicated decisions every day that may involve compromise, for example due to constrained resources, resulting in a service that is less than their personal ideal. Many would argue for reform of services through reduction of coercion and minimising reliance upon medication, the introduction of alternative interventions such as those mentioned above, or describe their hopes to work in increasingly 'psychosocial' ways. What, then, makes the idea of a conscientious objection to enforced pharmaceutical interventions a priority?

Two main factors render this a priority. The first is the seriousness of the experience for all concerned. Enforcing pharmaceutical interventions is viewed by many service users as a physical assault and is variously described as shocking, degrading and humiliating; being frequently life-changing for service users (and nurses). Physical injury may occur. Post-traumatic symptoms for service users and for mental health nurses are not uncommon. Given that such force may be precipitated by service-user behaviour (taken as indicative of 'mental illness'), it is inevitable that themes of deviance and punishment may at times be prevalent, even if unintended. Service users may scream or shout and for both them and staff alike there may be a very uncomfortable sense of sexual assault, exacerbated by the unconsented exposure of a person's buttocks, together with penetration with a needle and an unwanted substance. Even the required training (a post-qualification separate training) impacts in some of these ways for mental health nurses. When student nurses talk about their first experiences of acute mental health wards, such experiences understandably preoccupy them. Nurses work hard to debrief themselves and each other following forced pharmaceutical interventions, but such processes can collapse into self-deception and justification (Chapman, 2014).

Given the extreme nature of these interventions, it seems right to describe them as unlike any other kinds of nursing procedures. In fact, they arguably challenge the very identity of 'nurse' for mental health nurses, tarnishing them in the eyes of service-users who may come to see them singularly as custodians, carrying the threat of conflict and force. These frequently voiced criticisms and mental health nurses' own troubled relationship with enforced pharmaceutical interventions may

contribute to estrange mental health nurses from a positive self-identity. Being a mental health nurse can feel like something for which to apologise, unlike other fields of nursing.

A second factor is the apparent absence of leadership about pharmaceutical interventions. One difficulty mental health nurses face is that, while controversies about pharmaceutical interventions are highly present in scholarly literature, these do not possess the same urgency within mental health services. Arguably, many nurses who feel they have a conscientious objection to enforced pharmacy would be less anxious if such debates were visibly present at the highest level of the profession with the intention of informing decisions about care. Instead, the justifying rhetoric often evokes the most simplistic acceptance of medical treatment narratives (e.g. 'It's like insulin for a diabetic' or evocative care narratives about amelioration of distress and preservation of dignity) that can make a nurse seem foolish or immoral for raising questions and concerns. New scholarly engagement in this area would likely alleviate concerns. Arguably, the strongest case for creation of this new right is that *the mental health service owes the people tasked with this most serious of procedures much more than the current level of debate*. Additionally, individual mental health nurses and nursing teams with skills in prevention of the perceived need for enforced pharmacy would be more clearly seen as examples of good practice. It is hard to imagine this being brought about with the appropriate urgency by other means.

Vote with your feet?

We recognise the argument that mental health nurses already have a means to excuse themselves from the enforcement of pharmaceutical interventions; they can leave acute wards and work in other roles. We believe that this has always been a key motivation for nurses to leave acute wards (and other places where forced pharmaceutical interventions occur, such as prisons and secure units, children's homes and other residential settings). However, we would argue that this is inadequate provision for conscientious objection.

Firstly, it implies that acute wards and other psychiatric spaces must necessarily involve enforced treatment as a status quo. In fact, as mentioned above, there is a large variation in its use, something that this proposed revision of the right of conscientious objection may make more visible and instructive.

Secondly, it locates the problems of evidence and ethics within the individual nurse who may be considered (or consider themselves) 'not cut out for acute settings'. This probably masks and delays the proper engagement by our profession of the evidential and ethical challenges already laid out.

Thirdly, it removes critically engaged nurses from acute wards where they might be influential, perhaps promoting service-user rights and more reflective practice. Moving the conversation about the use of force away from the clinical context probably has a negative impact on the quality of that conversation. It may also contribute to a divide between community and hospital nurses, and perhaps between academic nurses and nurses working in clinical areas. Despite our roles as nurse-academics, the CMHNN strongly recognises that such debate is poorer when not part of the pragmatism of practice focused nursing work.

Fourthly, a situation is possibly created wherein care of individuals most acutely in need is left to those holding a less diverse range of nursing views and moral instincts. While experienced nurses often have more autonomy and more ability to voice opinions, it is more difficult for newly qualified nurses to speak up. This proposed right might correct that problem a little, given the possibly greater proportion of more recently qualified nurses in acute settings.

Fifthly, when leaving is the mechanism of objection, refuseniks may find that enforced pharmacy remains an issue in new roles. Being a community mental health nurse does require consideration of hospitalisation at times and the mental health nurse who left the ward due to reasons of conscience may find this part of their new role no less difficult. The prospect of Compulsory Treatment Orders (CTOs) with medication administration in clinics, holds an implication that refusal returns one to compulsory admission.

While mental health nurses in general do not have the right to conscientiously object, there may be great inner conflict for the community nurse who feels they are 'handing over' service users at a time when they are vulnerable to a group of other nurses prepared to do the 'dirty work'. This situation does not serve any relationships well and still does not resolve the issue of conscience. However, the knowledge that they were recommending hospital admission for service-users under their care to a ward in which reflective nurses have the option to exercise a right to conscientiously object from enforcing pharmaceutical interventions might feel different; there would be the reasonable expectation that discussions take place about the issue of enforced pharmacy in an atmosphere in which the team have had to prioritise a skill set designed to prevent it.

Finally, community nurses have increasingly been required to give long-acting 'depots' to *detained* service-users in the community. Even consensual depot medication represents a strange hinterland of coercion and mistrust, complicated further by CTOs. Although this is not conducted under direct force (instead, facilitated by the legalised threat or memory of such force) it is a further example that changing roles and 'voting with your feet' is not a satisfactory way for mental health nurses to relieve issues of conscience about enforced pharmaceutical interventions.

How would conscientious objection to enforced pharmaceutical interventions work in practice?

If there are evidential, ethical, professional and personal grounds for this right, then its practical application will be a matter of employment law, policy, clinical supervision, team discussions, service-user information and nursing education. These highly important considerations would be a prerequisite of the establishment of that right. The CMHNN would wish to be involved in the very cautious consideration of all of the practical issues involved in taking this potential new right forwards. Survivor groups and nursing trade unions are likely to be valuable contributors.

Any future argument that agrees in principle with the view that mental health nurses should have the right to conscientious objection but then argues that it cannot be granted in practice is in effect saying that mental health services are not currently able to employ nurses ethically.

Is this issue specific to mental health nurses?

It may be case that other professions would wish to be part of this discussion and care will be needed to consider how, and to what extent, they may contribute. The enforcement of pharmaceutical interventions implicates a multi-disciplinary set of interactions, including hospital managers, even though it is nurses who are typically charged with carrying it out. It is occasionally the case that a medical professional is involved, but this is rare (and only extends to the administration of the pharmaceuticals and not the more obvious use of force). Medical professionals have their own registering body and their own provisions for conscientious objection. Further discussion will need to consider the rights of Health Care Assistants, who may also be trained in the use of force as part of a team with mental health nurses. Indeed, in the UK there are contemporary moves to formalise 'professional/occupational' regulation of HCAs.

Always, the question is not 'what do we know to be correct?' but 'is it reasonable that a mental health nurse could suffer unbearable issues of conscience in this context?'. This and other associated issues raise the possibility mental health nurses may experience post-traumatic symptoms if required to be involved enforced pharmaceutical interventions. The fact that nurses may also be traumatised may cut little ice with potential survivor allies, who undoubtedly bear the brunt of psychiatric harms. Acknowledgment of such possibilities allows for our arguments to connect with longstanding identification of alienation within nursing labour processes and, in turn, alienating technologies of care (Fromm, 1968). From this perspective, nursing involvement in coerced medication represents a profound existential threat to conceptions of 'being a nurse'. Hence, nurses

become estranged from a positive identity, and service users are appalled that nurses would act this way, associating nurses with custody, control, conflict and violence rather than care and compassion.

Action for change

Davis' (2005) espousal of abolition democracy identifies her as the consummate critically engaged academic, seamlessly connecting insightful scholarship with necessary activism; showing health care practitioners amongst other citizens paths to radical agency and praxis as alternatives to a more passive professionalism, complicit in social injustices by remaining on the sidelines (Roberts, 2006). Indeed, the provocation for Davis of the atrocities of Abu Ghraib is mirrored in the recognition that, however virtuous any clinical rationale, many people will experience forced psychiatric treatment as a traumatising violation (Jarrett et al., 2008). Of course, abolition democracy involves more sophisticated demands than simple root and branch dissolution of systems, rather it calls also for upstream action focused on underlying causes of systemic injustices, or the causes of the causes. Recent protests focused on police brutality and structural racism have resonated with radical healthcare practitioners. For example, Iwai et al (2020: 159) remark:

Abolition medicine is a practice of speculation, of dreaming of a more racially just future and acting to bring that vision to fruition. It is to recognise that the Hippocratic Oath to "first, do no harm" requires those working in health care to dream radically and act structurally. This is the possibility of abolition medicine: to renarrate and re-envision justice, healing, activism, and collectivity.

The history of critique and activism in and against psychiatric systems has reflected various tensions between outright abolitionist demands and more nuanced calls for reform or imaginative shaping of alternatives. The notion of a wild and fluid undercommons is helpful in pointing to a difference between calling for the end of an institution or social structure such as modern psychiatry, replete with restrictive practices, and the end of the standpoint from which such institutions and practices are seen as legitimate or make sense (Halberstam, 2013; Moten & Harney, 2004).

Inspired by such critique, radical nurses urge recasting nursing professionalism towards critical consciousness of shared history, the wider political context and politicised nursing action (Dillard-Wright et al., 2020; Dillard-Wright & Shields-Haas, 2021; McKeown 2019; Smith, 2020; Smith & Foth, 2021). A starting point might be radical influences upon nurse education, where a commitment to critical pedagogy engenders more critically thinking nurses. Such explicit connection to criticality and a critical/inquiring professionalism could be foregrounded in the necessary dialogue and debates to establish a conscientious objection principle and this, in turn, can open up the space for wider critical thinking about the role and function of psychiatric systems in the neoliberal state. In this way, agitation for a conscientious objection to forced treatment may be as much a means towards progressive change as an end in itself. We might consider this as one of many possible activist challenges to the power of psychiatry and, following Davis (2005: 125), consider ‘the best way to figure out what might work is simply to do it’.

The articulation in formal policies, or indeed in the current statement of principles for reforming the UK Mental Health Act, of commitments to ‘least restrictive practices’ and the more colloquially professional rhetoric of ‘last resort’ and ‘necessary evil’ can be seen to exemplify what Sara Ahmed (2006) has referred to as nonperformative speech acts. From this perspective, such language appeals to a morality of progressive change and action but blinds us to the actuality of nothing being done or nothing changing. By such means radical ideas and ideals can become neutralised or co-opted into the mainstream without effecting meaningful change.

Despite these ever present threats of incorporation or neutralisation of critical ideas and alternatives within contemporary psychiatric systems, there are some grounds for optimism regarding the fate of this call for a right to conscientious objection. The entrenched power of psychiatry and its broader functionality for neoliberal governance systems and social control (Rose, 2016) suggests a certain obduracy to revolutionary or abolitionist transformations. A more nuanced or tactical abolition democracy might, however, be advanced via a prefigurative politics (Springer, 2016). Following, Sedgwick’s (1982) seminal *PsychoPolitics*, we have argued elsewhere that, supported by cross-sectional activist alliances, prefigurative conceptions of alternative approaches to care may be achievable within the interstitial spaces of the psychiatric system; in effect operating in the places where a controlling, neoliberal gaze is not always looking (Spandler et al., 2016; Moth & McKeown, 2016). Arguably, activism for a right to conscientious objection might be catalytic in this regard, challenging the mainstream and raising the potential for alternative forms of care. Recognising that radical service users and survivors may be reluctant to enter into alliances with elements of the

mental health service workforce, we have also called for grass-roots processes to repair the hurt and harms presently and historically caused by psychiatry (Spandler & McKeown, 2017) and to sincerely apologise for these (Williams et al., 2018).

Notwithstanding our commitment to alliances, we feel that any campaign for conscientious objection should be led in the first instance by nurses themselves. This will serve a purpose of establishing an authenticity to nurse activist appeals to be considered in solidarity with service users, refusers and survivors of psychiatric care. It will also firmly locate the endeavour as part of taking control of our profession and reshaping professional identity along radical and progressive lines. Raised firstly as an internal issue between nurses and the regulatory body, the issue is reinforced as a matter of personal and collective conscience. Finally, lived experience of mental health problems has always been a possible motivating factor in people coming to the special vocation of mental health nursing, meaning uncritical and divisive 'us and them' binaries are also open to contestation. Eschewing binary positionings, on this or other contestable matters, represents a more constructive pathway for radical movement building (Spandler & Poursanidou, 2019).

Conclusion

The ultimate value of a campaign to enact this right to conscientious objection might be to open up the discursive space for a meaningful and constructive debate within the mental health professions regarding the detriment caused by forced treatment amongst other coercive practices and embolden moves to seek more consensual alternative forms of care provision. Moreover, such critical dialogue within services should signal to external critics, including survivor activists, a favourable basis for political alliances to further advance action for change. Following Moten and Harney (2004) this may be less about the complete abolition of psychiatry as we know it than abolition of the perspective from which an essentially coercive psychiatry makes sense: thus requiring a transformed society where forced psychiatric treatment can no longer be imagined.

Critical Mental Health Nurses' Network Draft Position Statement

The Critical Mental Health Nurses' Network believes that it is timely and proportionate to request that the United Kingdom Nursing and Midwifery Council extends and revises the current provision for conscientious objection to include the right for nurses to conscientiously object to enforcing pharmaceutical interventions and Electro Convulsive Therapy within mental health services. This reflects the changing relationship between those practices within mental health services and their

evidential and ethical context. We believe that this request is wholly consistent with our commitment to the values and principles of our Nursing and Midwifery Code of Conduct, the scholarship required by our degree-level education, the ongoing critical reflection required of us as a profession in our own right and our practice experiences.

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