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Knowledge on Types of Treatment Pressure. A Cross-sectional Study Among Mental Health Professionals

Dominik Schori[a,*], Matthias Jaeger[b], Timon Elmer[c,d], Susanne Jaeger[e], Candelaria Mahlke[f], Kolja Heumann[f], Anastasia Theodoridou[b], Gianfranco Zuaboni[g], Bernd Kozel[h], Franziska Rabenschlag[c]

[a] Directorate of Nursing, Therapies and Social Work, University Hospital of Psychiatry Zurich, Lenggstrasse 31, P.O. Box 363, 8032 Zurich, Switzerland
[b] Department of Psychiatry, Psychotherapy and Psychosomatics, Centre for Acute Psychiatric Disorders, University Hospital of Psychiatry Zurich, Lenggstrasse 31, P.O. Box 363, 8032 Zurich, Switzerland
[c] Department of Development and Research in Nursing, Therapies and Social Work, Psychiatric Hospitals of the University of Basel, Wilhelm Klein-Strasse 27, 4002 Basel, Switzerland
[d] Chair of Social Networks, Department of Humanities, Social and Political Sciences, ETH Zurich, Weinbergstrasse 109, 8092 Zürich, Switzerland
[e] Centers for Psychiatry Suedwuerttemberg, Clinic for Psychiatry and Psychotherapy I, University of Ulm, Weingartshofer Strasse 2, 88214 Ravensburg-Weißenau, Germany
[f] Department of Psychiatry and Psychotherapy, University Medical Centre Hamburg-Eppendorf, Martinistrasse 52, 20246 Hamburg, Germany
[g] Department of Nursing Development, Private Clinic for Psychiatry and Psychotherapy Kilchberg, Alte Landstrasse 70, 8802 Kilchberg, Switzerland
[h] Nursing and Social Education Research Unit, University of Berne, Psychiatric Services Berne, Bolligenstrasse 111, 3000 Bern 60, Switzerland

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ABSTRACT

Treatment pressure restricts patients' voluntary and autonomous decisions. Yet interventions involving treatment pressure are widely used in mental health and psychosocial services. This cross-sectional study explored whether mental health professionals' knowledge on five types of treatment pressure (no coercion, persuasion or conviction, leverage, threat, and formal coercion) was associated with sociodemographic, professional and contextual factors. A more positive attitude towards interventions involving treatment pressure was associated with underrating the level of those interventions compared with a predefined default value. The treatment setting and professional group played a minor role in 'leverage' and 'formal coercion' types of treatment pressure, respectively.

Introduction

Interventions involving treatment pressures are widely used in mental health and psychosocial services (Burns et al., 2011; Hotzy & Jaeger, 2016; Jaeger & Roessler, 2010; Monahan et al., 2005; Yeeles, 2016). Two literature reviews found that 29 to 59% of patients using mental health and psychosocial services reported that they experienced treatment pressures at least once in their life (Hotzy & Jaeger, 2016; Yeeles, 2016). Treatment pressures comprise a wide range of interventions that mental health professionals usually apply with the intent to foster treatment adherence or to avoid statutory coercion, such as detention, seclusion or forced medication (Dunn et al., 2012; Hotzy & Jaeger, 2016; Jaeger, Ketteler, Rabenschlag, & Theodoridou, 2014; Jaeger & Roessler, 2010; Theodoridou, Schlatter, Ajdacic, Roessler, & Jaeger, 2012; Yeeles, 2016).

Formal (statutory) coercion is the strongest type among various types of treatment pressures. Unlike formal coercion, however, the other types of treatment pressure are not regulated by the law. Therefore, *informal coercion* is used in the literature to denote non-regulated treatment pressures (Hotzy & Jaeger, 2016; Jaeger et al., 2014; Jaeger & Roessler, 2010; Monahan et al., 2005; Theodoridou et al., 2012; Valenti et al., 2015; Yeeles, 2016).

Treatment pressures can be examined from the perspective of patient experience or from the perspective of mental health professionals. From the perspective of patient experience, treatment pressures carry the potential to be perceived as incisive as, or even more incisive than formal coercive measures (Yeeles, 2016): Treatment pressures may restrict patients' voluntary and autonomous decisions. Also, treatment

* Corresponding author.
E-mail addresses: mail@dschori.net (D. Schori), matthias.jaeger@puk.zh.ch (M. Jaeger), timon.elmer@gess.ethz.ch (T. Elmer), susanne.jaeger@zfp-zentrum.de (S. Jaeger), c.mahlke@uke.de (C. Mahlke), k.heumann@uke.de (K. Heumann), anastasia.theodoridou@puk.zh.ch (A. Theodoridou), g.zuaboni@sanatorium-kilchberg.ch (G. Zuaboni), bernd.kozel@upd.ch (B. Kozel), franziska.rabenschlag@upkbs.ch (F. Rabenschlag).

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pressures might be perceived as coercive and potentially provoke mistrust and feelings of being treated unfairly among the patients, which might negatively affect the therapeutic relationship (Jaeger & Roessler, 2010; Sheehan & Burns, 2011; Theodoridou et al., 2012; Valenti et al., 2015; Zugai, Stein-Parbury, & Roche, 2015). An impaired therapeutic relationship, in turn, might hamper the further course of treatment (Valenti et al., 2015). Yet, from the perspective of mental health professionals, there might be a therapeutic need to use treatment pressures (Valenti et al., 2015). Therefore, mental health professionals should be very cautious and judicious when they consider exerting any type of treatment pressure, especially when it comes to stronger types of treatment pressure (e.g. leverage, threat or formal coercion; Jaeger & Roessler, 2010; Yeeles, 2016). This study deals with treatment pressures from the perspective of mental health professionals.

In order to ensure a cautious and judicious use of treatment pressures, mental health professionals must be aware of the different levels of coercion that are inherent in interventions involving treatment pressure. According to Szmukler and Appelbaum (2008), the notion of treatment pressure refers to the 'range of interventions aimed at inducing reluctant patients to accept treatment' (p. 234). The authors proposed a continuum of treatment pressures ranging from persuasion (appealing to reason), interpersonal leverage (leveraging the emotional dependency of a patient), inducements (offering benefits to patients), through to threats (refusing or withholding entitlements), and formal coercion (exercising formal coercive measures). According to the classification of Szmukler and Appelbaum (2008), persuasion and interpersonal leverage are non-coercive treatment pressures while inducements and threats are coercive treatment pressures. Hence, the level of coercion inherent in interventions involving treatment pressure increases towards the end of the continuum where formal coercive measures are located. Szmukler and Appelbaum argued that mental health professionals should not exert more than the minimum degree of pressure necessary and that their justification of treatment pressures 'should be stronger the more one moves along the spectrum from persuasion to direct force' (Szmukler & Appelbaum, 2008, p. 242).

Previous research suggested that mental health professionals might not be aware of the level of coercion inherent in some types of treatment pressure (Elmer et al., 2017; Hotzy & Jaeger, 2016; Jaeger et al., 2014). This poses a problem to the requirement that Szmukler and Appelbaum (2008) proposed: if a mental health professional is not aware of the level of coercion inherent in an intervention, then he or she is not able to make a judicious decision that leads to a minimum of treatment pressure (Elmer et al., 2017; Jaeger et al., 2014). This, in turn, might pose a risk for establishing and maintaining a viable therapeutic relationship between mental health professionals and patients (Jaeger & Roessler, 2010; Sheehan & Burns, 2011; Theodoridou et al., 2012; Valenti et al., 2015; Zugai et al., 2015).

Most of the studies that have been conducted on treatment pressures considered patients in outpatient-settings (Hotzy & Jaeger, 2016). We are aware of three studies that were conducted among mental health professionals working in inpatient settings, namely the studies by Valenti et al. (2015), Jaeger et al. (2014), and Elmer et al. (2017). Valenti et al. (2015) conducted a qualitative research project to explore mental health professionals' attitudes towards and experiences with informal coercion in ten different countries, applying Szmukler and Appelbaums (2008) continuum of treatment pressure. They found that mental health professionals experienced the application of informal coercion as being effective. However, the mental health professionals reported an unease regarding informal coercion and explicitly formulated a 'dissonance between attitude and practice' (Valenti et al., 2015, p. 1302). The authors of the study showed that this dissonance is also implicitly present in the statements of the mental health professionals and that the discussions were infused with the underlying values of paternalism and responsibility vs. autonomy in mental health care. A quantitative pilot study by Jaeger et al. (2014) explored the knowledge of mental health professionals on informal coercion using the Knowledge on Coercion Scale (KCS). The authors assessed by means of vignettes whether mental health professionals adequately rated the level of coercion in interventions involving treatment pressures. The study compared the ratings of mental health professionals with a score that the authors assigned to the interventions described in the vignettes (the *KCS-assigned level* of coercion). The results showed that mental health professionals did underrate the level of coercion inherent in interventions, particularly in interventions that involved severe coercion (i.e. threat and formal coercion). Also, the authors showed for some of the tested interventions that those who had a positive attitude towards an intervention did underrate the level of coercion, while those who had a negative attitude towards an intervention did overrate the level of coercion. Jaeger et al.'s (2014) tentative results were corroborated by a follow-up study by Elmer et al. (2017), which was authored by the same group as the present study. We found that the above-mentioned association between a positive attitude towards coercion and underrating the level of coercion was present in each of the tested interventions. Also, we found that older mental health professionals were more likely than their younger colleagues to underrate the actual level of coercion. The results of our previous study (Elmer et al., 2017) suggested that an underestimation of coercion might be associated with one's professional group. We did not, however, analyse the knowledge of particular types of treatment pressure but combined all into one sum score. An analysis of particular types of treatment pressure is necessary if we want to explore whether the knowledge on the types of treatment pressure proposed by Szmukler and Appelbaum (2008) is associated with sociodemographic, professional and contextual factors.

The aim of this study was to explore whether mental health professionals' knowledge on five types of treatment pressure (no coercion, persuasion or conviction, leverage, threat, and formal coercion) was associated with sociodemographic, professional and contextual factors. Mental health professionals' attitude towards those types of coercion must be controlled for statistically, because previous results suggested that having a positive attitude towards an intervention is associated with underrating the level of coercion (Elmer et al., 2017; Jaeger et al., 2014). We are not aware of previous studies that have analysed whether health professionals' knowledge on types of treatment pressure was associated with sociodemographic, professional and contextual factors, controlling for the attitude towards different types of treatment pressure. The present study used the same data set that we used for a previous publication (Elmer et al., 2017). Expanding upon the previous study, however, the present study focuses on the single types of treatment pressure (i.e. 'leverage', 'threat', and 'formal coercion') instead of a sum-score of all types of treatment pressures. Based on previous evidence (Elmer et al., 2017; Wynn, Kvalvik, & Hynnekleiv, 2011), we expected that mental health professionals who were older, had a lower professional grade and those belonging to the group of psychologists were more likely to underrate the level of coercion than their counterparts. Also, we assumed that mental health professionals who had few years of professional experience were more likely to underrate the level of coercion than their colleagues who had many years of professional experience. We did not specify any hypotheses concerning the contextual factors such as site of the clinic and whether the mental health professionals worked in open-door or closed-door settings.

Methods

Design

We conducted a cross-sectional survey among mental health professionals of six psychiatric clinics in the German-speaking part of Switzerland and Germany in 2015.

Setting and sample

The participating clinics were selected by leveraging the