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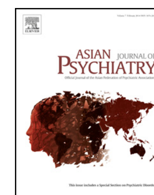

Original Article

Clinical correlates and predictors of perceived coercion among psychiatric inpatients: A prospective pilot study

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A R T I C L E I N F O

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A B S T R A C T

Background: The current Mental Health Care Bill (MHCB) –2013 in India advocates least restrictive alternatives (LRA) in psychiatric treatment. However, we have little evidence on patient's perspectives of coercion and LRA.

Methodology: This was a hospital-based prospective pilot study. 170 subjects chosen by computer-generated random number sampling were screened. In 83 eligible subjects, all assessments including coercion assessment were completed within 3 days of admission and in 75 subjects reassessment was done within 3 days of discharge.

Results: Perceived coercion as measured by the MacArthur Perceived Coercion Scale (MPCS) decreased significantly from 3.72 ± 1.98 at admission to 1.77 ± 1.8 (<0.001) at discharge. This was accompanied by significant increase in global functioning, insight score (from 1.5 ± 1.0 to 3.8 ± 1.1; $p < 0.001$) and as well as decrease in symptom severity (CGI-S) (from 5.9 ± 1.1 to 1.8 ± 1.9; $p < 0.001$). Coercion is predicted by family type, employment status, socio economic status, severity of illness and level of insight. 87% patients reported that their admission was justified even though many felt coerced during hospital stay.

Conclusion: Coercion is a dynamic state and changes with treatment and care. Clinical care may result in an improvement in global functioning, insight as well as in reduction in severity of illness consequently leading to less coercion. During the time of discharge, majority of patients reported that their admission was justified, even though they felt coerced during hospital stay and agreed for treatment against their will within a safe, standardised coercive practice.

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1. Introduction

Coercion is a subjective inner experience of a particular intervention performed against a person's will, either through force or through threat of force. Ideally, no person should be coerced into treatment (Fears and Hackman, 2009). Use of coercive practice in mental health care has to balance between four different ethical issues representing interests, which are often controversial such as respect of the autonomy of patient, beneficence, non-maleficence and justice.

Perceived coercion has been studied in many of developed countries. Studies have shown that perceived coercion may be influenced by several socio demographic and clinical variables, such as higher age, being single, female sex and ethnicity (Rain et al., 2003; Swartz and Swanson, 2004; Bindman et al., 2005; Anestis et al., 2013). In addition, diagnosis of psychotic illness, substance abuse problems, recent sexual abuse, poor insight, low scores on measures of functioning and more symptoms severity (eg. CGI –S) predicted a higher level of perceived coercion (Bindman et al., 2005; Kjellin et al., 2006; O'Donoghue et al., 2014). Contrary to these findings, some studies have shown no clear influence of patient related variables on perceived coercion (Poythress et al., 2002; Kjellin et al., 2006; Sheehan and Burns, 2011). Individuals with hostile-dominant interpersonal style were also known to have higher levels of perceived coercion (Anestis et al., 2013). Involuntarily admitted patients tended to perceive higher levels of coercion when compared with voluntarily admitted ones (Rain et al., 2003; O'Donoghue et al., 2014) though not exclusively as was shown by higher levels of coercion among those with severe psychotic symptoms (O'Donoghue et al., 2014).

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Social factors like being admitted under reception order or by legal force also appeared to be important predictors of coercive treatment (Lidz et al., 1998). Among prison populations, a higher perceived coercion was related to recent sexual abuse, having a drug charge, old age, males and higher symptoms severity (Cusack et al., 2010). Patient under voluntary admission who perceived coercion had poor prognosis when compared with those admitted involuntarily who perceived coercion (Steinert et al., 2010). Perceived coercion significantly decreased with improvement in global functioning and decrease in positive symptoms (Fiorillo et al., 2012; Anestis et al., 2013) and did not predict engagement with follow-up (Bindman et al., 2005). Among prison populations, a higher perceived coercion was related to recent sexual abuse, being charged by drug-related issue, old age, males and higher symptoms severity (Cusack et al., 2010).

In the Indian health context, society values medical and social paternalism than individual autonomy. The family structure like belonging to nuclear, extended or joint family plays an important role by treatment of mentally ill person. The head of family makes decisions about treatment of beloved ones suffering from mental illness. Majority numbers of family members are responsible of supporting the patients by providing economical and psychological support in addition to staying with them during hospitalisation. The Indian Mental Health Act 1987 under Chapter IV Part II: No.19 also supports the family to admit the mentally ill person, who does not, or is unable to, express his/her willingness for admission as a voluntary patient (MHA, 1987). These are important protective factor for In India to treat person with mental illness. As such, absence of family support is expected to be a factor negatively associated course and outcome of mental illness.

In short, perceived coercion was found to be influenced by various socio demographic, clinical and social factors. It tended to improve during inpatient care and was predicted by parallel changes in insight, symptom severity and global functioning. In contrast, this issue has received relatively less research attention in developing countries. This is especially important in the background of the Mental Health Care Bill – 2013[MHCB-2013] of India that seeks for psychiatric treatment in least restrictive settings with provision for the least restrictive alternatives. Culturally relevant information could emanate from such a study and inform clinicians, patients, families and policy makers alike [MHCB-2013]. With this in mind, we set out to assess the clinical correlates and predictors of perceived coercion among psychiatric inpatients at two points in time: soon after admission and just before discharge.

The study was carried out at the Department of Psychiatry at NIMHANS. This psychiatric hospital is one of the oldest and largest in South East Asia, providing mental health service for more than 60 years through Outpatient Clinics and Inpatient Services. The Department has a large inpatient set-up with 550 beds, a De-addiction Service, a Family Psychiatric Centre, legal aid service and a Psychiatric Rehabilitation Day Care Centre. It caters a majority of both urban and rural population of south India and other parts of India. The catchment area may be estimated above 15 million inhabitants. In our Inpatient Services, commonly a family member has to stay in the ward to take care of the patient, which implies double costs as they often miss an important provider of income. During ward stay, Family members were involved in persuasive and coercive treatment procedures like surreptitious treatment, involuntary medication and physical restraints. We report findings from a study investigating performed and perceived coercion. Main questions were:

1. Which coercive measures were taken?
2. What was the perceived coercion at admission and at discharge?
3. Which patient and contextual characteristics were related to perceived coercion at admission and discharge?

2. Methods and materials

This study was conducted from June 2013 to January 2014 at the Department of Psychiatry, National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore -29. The patients were selected through computer generated random numbers on all working days. Randomly selected inpatients (aged 18 and above) were approached with a request to participate in the study. Patients suffering from mental retardation, organic brain syndromes, delirium, dementia, developmental disorders and antisocial personality disorder were excluded from the study as some cognitive ability allowing reflection on one's own experience was required. After completely describing the study to the subjects and their relatives, written informed consent was obtained. When patients were not in a position to provide consent, their attendants/family members were requested to provide consent. The study was therefore performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki (Declaration of Helsinki 1964). All patients were interviewed within 3 days of admission and re-interviewed within 3 days before discharge.

170 patients were screened to enter the study. 83 patients satisfied study criteria and were assessed at baseline (Fig. 1: Flow Chart). 75 were re-interviewed at the time of discharge. The remaining eight patients either absconded or discharged against medical advice (DAMA).

2.1. Interview procedures

Apart from socio demographic details, data on the number of admission, the duration of illness and the duration of inpatient

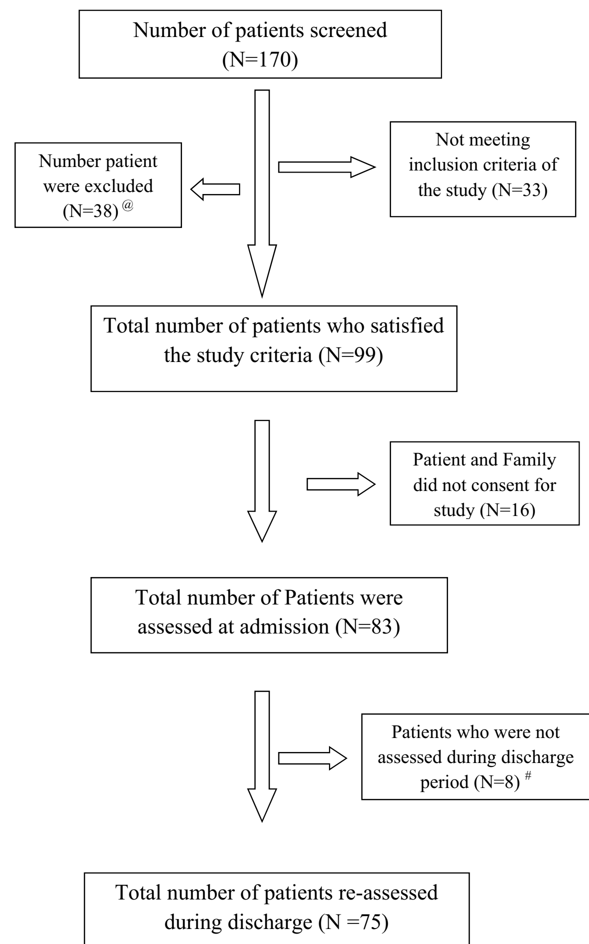

Fig. 1. Flow chart.

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