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Perceived coercion in voluntary hospital admission

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ABSTRACT

The legal status of service users admitted to psychiatric wards is not synonymous with the level of coercion that they can perceive during the admission. This study aimed to identify and describe the proportion of individuals who were admitted voluntarily but experienced levels of perceived coercion comparable to those admitted involuntarily. Individuals admitted voluntarily and involuntarily to three psychiatric hospitals were interviewed using the MacArthur Admission Experience Interview and the Structured Clinical Interview for DSM-IV diagnoses. One hundered sixty-one individuals were interviewed and 22% of the voluntarily admitted service users had levels of perceived coercion similar to that of the majority of involuntarily admitted service users. Voluntarily admitted service users who experienced high levels of perceived coercion were more likely to have more severe psychotic symptoms, have experienced more negative pressures and less procedural justices on admission. Individuals brought to hospital under mental health legislation but who subsequently agreed to be admitted voluntarily and those treated on a secure ward also reported higher levels of perceived coercion. It needs to be ensured that if any service user, whether voluntary or involuntary, experiences treatment pressures or coercion that there is sufficient oversight of the practice, to ensure that individual's rights are respected.

1. Introduction

In the last decade, our understanding of individual's perspectives towards the use of involuntary admission and physical coercion has grown substantially (Priebe et al., 2009, 2010; O'Donoghue et al., 2011). Some individuals admitted involuntarily reflect that the use of coercion can be necessary, while others reflect that it can infringes upon their autonomy and feel that less coercive interventions should be used (Katsakou et al., 2011b). However, less is known about voluntarily admitted service users who experience high levels of perceived coercion on admission to hospital despite it being described nearly half a century ago (Breggin, 1964). It is now well established that an individual's legal status upon admission is not synonymous with the level of coercion they experience upon admission (Monahan et al., 1995). Approximately one quarter of individuals admitted voluntarily to hospital perceive that they were coerced into hospital and half of those individuals continue to feel coerced throughout their admission (Newton-Howes and Stanley, 2012; Katsakou et al., 2011a). In addition to the ethical reasons for reducing perceived coercion, it could actually have benefits in treatment outcome and the perspectives of service users. Voluntarily admitted service users with high levels of perceived coercion are more likely to perceive their treatment as ineffective and conversely, those who experience an improvement in symptoms and functioning are more likely to report a reduction in the level of perceived coercion (Katsakou et al., 2011a; Fiorillo et al., 2012).

Clinicians are at times faced with a dilemma, in that they could use persuasion or pressures to admit a service user voluntarily and prevent an individual having an involuntary admission, which has traditionally been viewed to have a worse outcome, due to the higher risk of readmissions and of suicide (Kallert et al., 2008). Although clinicians may believe that they are acting in the individual's best interest by avoiding an involuntary admission, the 'coerced voluntary' service user is not afforded the provisions from mental health legislation, such as a review board or independent legal support and service users could perceive this practice as coercive and an infringement of their autonomy.

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In addition, voluntary service users who perceive high levels of coercion often think that if they do not agree to a voluntary admission they will be admitted involuntarily anyway (Katsakou et al., 2011a). Worryingly, it is possible that this action by clinicians could actually have the opposite effect to that intended, as more recent evidence suggests that individuals who experience coerced voluntary treatment have worse outcomes compared to involuntarily admitted service users (Kallert et al., 2011). It has been proposed that treatment pressures should be structured within a hierarchy and that as a coercive practice ascends this hierarchy, the justification and oversight of this practice must be stronger (Szmukler and Appelbaum, 2008). There is also a concern that coercive practices may result in service users being 'pushed away from the service' (Hoge et al., 1997). In support of this, higher levels of perceived coercion during hospital admission are associated with a poorer therapeutic relationship, which in turn, is also associated with a poorer outcome (Sheehan and Burns, 2011; Theodoridou et al., 2012).

Therefore, in this study we aimed to quantify the proportion of voluntarily admitted service users with levels of perceived coercion equivalent to that of involuntarily admitted service users. Secondly, we aimed to identify demographic and clinical characteristics of voluntarily admitted service users who experienced high levels of perceived coercion.

2. Methodology

2.1. Setting

This study was undertaken in three psychiatry hospitals attached to three community mental health services in Ireland: the Cluain Mhuire mental health service, Dublin South East mental health service and the Newcastle mental health services, Co. Wicklow. These services cover a combined catchment area population of approximately 390,000. We also included individuals admitted to St. John of God Hospital, an independent psychiatric hospital, which receives referrals on a national basis. Service users from the Cluain Mhuire mental health service are also admitted to St. John of God Hospital. All three mental health services have community teams, day hospitals and day centres. The ward environments vary between the three approved centres, for example, the wards associated with the Dublin South East mental health service do not have seclusion facilities or a secure ward. If individuals from this approved centre require seclusion or a secure ward they are transferred to another approved centre, such as St. John of God Hospital.

2.2. Participants

Firstly, we acquired a representative cohort of individuals admitted involuntarily to hospital, so as to determine the level of perceived coercion associated with the majority of those admitted involuntarily. Therefore, for this cohort, we invited all individuals aged over 18 years involuntarily admitted to St. John of God Hospital between 01.05.10 and 30.06.11, St. Vincent's University Hospital between 01.08.10 and 30.06.11 and Newcastle Hospital between 01.11.10 and 30.06.11. We excluded individuals with a diagnosis of dementia or a learning disability.

To acquire the cohort of voluntarily admitted service users, after each involuntary admission, we invited the next voluntarily admitted service user to participate in the study. A stipulation of the Mental Health Act 2001 is that individuals with a sole diagnosis of a personality disorder or substance use disorder cannot be admitted involuntarily (Department of Health Ireland, 2006). Therefore, we did not include service users with either a sole diagnosis of personality disorder or substance misuse in the cohort of individuals admitted voluntarily, to ensure the two groups were comparable. We were also unable to include individuals with first episode of psychosis due to their participation in a separate clinical study.

2.3. Ethics approval

Written informed consent was obtained from all study participants, and ethical approval was granted from the St. John of God Hospitaller Service provincial ethics committee, St. Vincents University medical ethics and medical research committee and the Newcastle mental health service ethics committee.

2.4. Study design

The study design was an observational cohort study. The study has another component in which individuals were randomly assigned to have a part of their interview conducted by either a service user researcher or a clinician and these results have been published elsewhere (O'Donoghue et al., 2013). The MacArthur Admission Interview was part of this interview however there was no difference in the level of perceived coercion, perceived pressures or procedural justice reported to service user researcher or clinicians (O'Donoghue et al., 2013). Participants were interviewed prior to discharge from hospital.

2.5. Instruments

We used the MacArthur Admission Experience Interview to determine the level of perceived coercion, perceived pressures and procedural justice experienced by an individual on admission to hospital. Perceived coercion (MPCS) is measured on a scale from 0 to 5, with higher scores indicating higher levels of perceived coercion. The level of perceived pressures contains four questions with dichotomous 'yes' or 'no' answers, and it is scored from 0 to 4, with higher scores indicating higher levels of perceived pressures. In the study by Lidz et al., the forms of pressures of persuasion and inducements were grouped together as positive pressures and threats and forces were grouped together as negative pressures (Lidz et al., 1995). Procedural justice encapsulates a persons' belief that others are acting out of genuine concern for them, that they are being listened to and being treated respectfully and fairly. This is measured on a scale from 1 to 4, with higher scores indicating higher levels of experienced procedural justice (Lidz et al., 1995).

All individuals underwent a Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders IV (SCID) conducted by a trained clinician (American Psychiatric Association, 1994). The SCID has good inter-rater reliability, ranging from 0.60 to 0.83 for all of major mental disorders (Lobbestael et al., 2011). This included measurement of Global Assessment of Functioning (GAF), which ranges from 0 to 100 with 100 being the highest level of functioning (First and Spitzer, 1995). Positive and negative symptom severity was measured using the scale for assessment of positive symptoms (SAPS) and the scale for assessment of negative symptoms (SANS) respectively (Andreasen, 1983a, 1983b). We measured depressive symptoms using the Beck Depression Inventory and insight using the Birchwood Insight Scale (Beck and Beck, 1972; Birchwood et al., 1994).

2.6. Clinical information

Information relating to the use of restraint and seclusion was recorded in the register for restraint and seclusion and the administration of medication without consent was obtained from the clinical notes and drug chart. In the jurisdiction in which the study took place, it is possible for voluntarily admitted service users to experience physical coercion, however in this circumstance they would typically be transferred to involuntary legal status.

2.7. Statistical analysis

Data were entered into a MS Access database and exported to PASW version 18 for analysis. We used Chi-square tests to determine associations for dichotomous variables and we used Fisher's Exact test when there was an expected count of less than 5 in any of the groups. We used *t*-tests to compare continuous variable means between the two groups. Binary logistic regression was performed with high levels of perceived coercion (score of 4 or greater on the MPCS) as the dependent dichotomous variable. Factors that were associated with a perception of coercion on bivariate analysis were entered into the regression model to control for any potential confounding that may occur between variables.

2.8. Power

Firstly, to identify a subgroup of voluntarily admitted service users with high perceived coercion with an estimated mean PCS score of 4.0 (S.D. 1) and uncoerced voluntary service users with a mean PCS score of 2.0 (S.D. 1) with 90% power at the 5% significance level would require a total of 20 participants. Secondly, to identify characteristics associated with being coerced and voluntary, to have 80% power at the 5% significance level to detect a difference of 20% in proportions between variables, would require 67 voluntary admitted service users with high perceived coercion and 267 voluntarily admitted service users with low perceived coercion.