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Brief report

Longer term outcomes of voluntarily admitted service users with high levels of perceived coercion

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ABSTRACT

Voluntarily admitted service users can report levels of perceived coercion comparable to those admitted involuntarily, yet little is known of this groups longer term outcome. The 'coerced voluntary' had a score of 4 or above on the MacArthur perceived coercion scale and one year after discharge, they had a better therapeutic relationship compared to involuntarily admitted service users. There was no difference between the coerced voluntary, uncoerced voluntary and involuntary groups in engagement, satisfaction and functioning.

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1. Introduction

The concept of perceived coercion is not restricted to involuntarily admitted service users, with previous studies reporting up to 48% of voluntarily admitted service users describing levels of perceived coercion comparable to that of involuntarily admitted service users (Prebble et al., 2014). Voluntary patients who are treated on locked wards and those with more severe symptoms are more likely to have higher levels of perceived coercion (O'Donoghue et al., 2014), while those who are more satisfied with their treatment feel less coerced (Katsakou et al., 2011). Overall, levels of perceived coercion tend to reduce over time and improvements in functioning and psychotic symptoms are associated with reduced perceived coercion (Fiorillo et al., 2012). However, the longer term outcomes for these voluntarily admitted service users with high levels of perceived coercion ('the coerced voluntary') is unknown (Luciano et al., 2014). It is a controversial issue, as if individuals who require admission are persuaded or pressured into accepting a voluntary hospital admission, it could mean being 'spared' an involuntary admission. Considering that involuntary admissions are associated with the use of physical coercion (Stewart et al., 2009) and poorer longer term outcomes (Priebe et al., 2011), the motivation of a clinician for avoiding an involuntary admission could be driven by the perception that they are acting in the best interests of the service user. Yet the individual is then not afforded the provisions and protections provided for under the mental health act legislation for involuntarily admitted service users (Kelly, 2002).

Hospital admissions tend to address the acute needs of the service user, however the majority of mental health service is delivered in the community. Therefore, while it is necessary to ensure that the appropriate acute treatment is delivered during hospital admission, it also needs to be ensured that the therapeutic relationship is maintained to facilitate longer term engagement and recovery. The longer term outcomes for this coerced voluntary group in regards to engagement and functional recovery is unknown. Therefore, in this study, we aimed to determine the level of engagement, the therapeutic relationship, satisfaction with services and functioning at one year following discharge for a coerced voluntary group, and to compare these outcomes with (i) voluntarily admitted service users who did not feel coerced and (ii) involuntarily admitted service users. It was hypothesized that the 'coerced voluntary' group would have a similar outcome to involuntarily admitted service users.

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2. Methods

2.1. Sites

This study was undertaken in three psychiatry hospitals attached to three community mental health services in Ireland and one of these hospitals was also an independent psychiatric hospital that received private referrals from across Ireland. The three catchment areas covered a combined catchment area population of approximately 390,000.

2.2. Participants

Individuals admitted involuntarily to the three hospitals over a fourteen month period were invited to participate in the study. To have a comparable number of voluntarily admitted participants, after each involuntary admission, the next voluntarily admitted service user was invited to participate in the study. In Ireland, under the mental health legislation, individuals with a sole diagnosis of a personality disorder or substance abuse disorder cannot be admitted involuntarily, therefore this exclusion criteria was also applied to the voluntarily admitted service users.

2.3. Instruments

The MacArthur Admission Interview was used to determine the level of perceived coercion (Gardner et al., 1993) and a score of 4 or greater was taken to be representative of levels of perceived coercion comparable to those admitted involuntarily. In a previously published study from the baseline data from this cohort, a score of 4 or greater on the MacArthur Admission Interview was found to be the equivalent level of coercion experienced by the majority of involuntarily admitted service users, therefore this level of perceived coercion was used to define the 'coerced voluntary' group (O'Donoghue et al., 2014). The 'uncoerced voluntary' group were those participants who were admitted voluntarily and had scores of 3 or less on the MacArthur Admission Interview and the 'involuntary' group included all of the participants admitted involuntarily.

Information pertaining to the level of the perceived coercion was obtained from the baseline interview (conducted prior to discharge) and the following instruments that evaluated engagement, the therapeutic alliance, satisfaction, functioning and insight were all administered at one year follow-up.

Engagement was measured using the Service Engagement Scale (SES) which was completed by the participants keyworker and it has four subscales measuring whether the client is available for arranged appointments (availability), whether the client actively participates in the management of their illness (collaboration), whether they seek help when needed (help-seeking) and whether they were adherent with treatment (adherence) (Tait et al., 2002). The scores of the SES range from 0 to 42 with higher scores representing worse engagement. The Working Alliance Inventory-Short Revised (WAI-SR) was used to measure therapeutic relationship and this is a 12 item self-report questionnaire with scores ranging from 12 to 84, with higher scores representing a good therapeutic relationship (Munder et al., 2010). The WAI-SR measures three key aspects of the therapeutic alliance, agreement on the tasks of therapy (tasks), agreement on the goals of therapy (goals) and development of an affective bond with the therapist (bond).

The level of satisfaction with services was measured using the self-report Client Satisfaction Questionaire (CSQ8) and this scale has scores ranging from 8 to 32, with higher scores representing a higher level of satisfaction (Attkisson and Greenfield, 2004). The level of functioning was measured by a clinician in the research team using the Global Assessment of Functioning (GAF) Scale, which measures social, occupational and psychological functioning on a numeric scale from 1 to 100, with higher scores representing higher functioning (American Psychiatric Association,1994).

2.4. Statistical analysis

Data were entered into a MS Access database and exported to PASW version 18 for analysis. One-way ANOVA tests were performed to determine if the means varied between the three groups. If a difference was identified between the three groups, further explorative analysis was performed, specifically using t-tests to determine if the coerced voluntary group differed significantly to the uncoerced voluntary and the involuntarily admitted groups. Chi-square tests were performed to determine if categorical variables differed. One way ANOVA was used to test whether the means between the three groups differed and when a difference was observed, further exploratory analysis using t-tests was used to determine which two groups differed. For the one way ANOVA analysis, the degrees of freedom are presented in brackets as (numerator/denominator).

3. Results

3.1. Characteristics of participants

A total of 231 service users were eligible to participate and of these 37 were not approached and 31 declined to participate. Therefore, 69.7% ($N=161$) of those eligible were interviewed at baseline. At one year following discharge, of those interviewed, 58.4% ($N=94$) were followed-up, 5.0% ($N=8$) declined, 1.9% ($N=3$) were deceased and 34.8% ($N=56$) were lost to follow-up. Of those interviewed at one year, 17% ($N=16$) were 'coerced voluntary', 39.4% ($N=37$) were 'uncoerced voluntary' and 43.6% ($N=41$) were involuntarily admitted. The demographic and clinical characteristics of the participants are presented in Table 1. 88.9% of the coerced voluntary group was followed up compared to 56.9% of the uncoerced voluntary and 51.9% of the involuntary group. There were no other differences in the demographic and clinical characteristics of participants who were followed up and those not followed up, as displayed in a Supplementary Table.

3.2. Engagement

The total mean engagement score was 14.5 (SD ± 9.3) and there was no difference in the level of engagement with services in the year following discharge between the coerced voluntary group, uncoerced voluntary group and those admitted involuntarily.

3.3. Therapeutic alliance

The total mean score for the therapeutic alliance was 62.0 (SD ± 13.6). As displayed in Table 1, there was a difference in the sub total regarding 'shared goals' between the groups and a trend for a difference in total therapeutic alliance scores. There was no difference between the coerced voluntary group and the uncoerced voluntary group in regards to the therapeutic alliance at one year following discharge. The coerced voluntary group had a better therapeutic alliance compared to involuntarily admitted service users in terms of overall therapeutic alliance (67.6 vs 58.5, $t=2.20$, $df=42$, $p=0.04$), shared tasks (22.7 vs 19.3, $t=2.10$, $df=42$, $p=0.045$) and shared goals (22.4 vs 18.6, $t=3.02$, $df=43$, $p=0.007$).

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