Perceived coercion in mental health care

A thesis submitted for the degree of

Doctor of Philosophy

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Christ Church

University of Oxford

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THESIS

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Abstract

While decreasing coercion is an important objective of mental health policy and clinical practice, empirical research investigating perceptions of coercion has been limited. This thesis investigated patients' and clinicians' perceptions of coercion in mental health care. It aimed to: determine the levels of perceived coercion experienced by patients and clinicians during psychiatric hospital admissions; investigate the perceptions of coercion in patients receiving care from community mental health teams; and use qualitative thematic analysis to gain a better understanding of patients' experiences during the hospitalization process.

The results indicated that there was great variation in the levels of coercion perceived by patients and clinicians. Perceptions of coercion were not associated with sociodemographic characteristics. Instead, they were most influenced by individuals' experiences during the process. In all of the situations studied, high levels of perceived coercion were associated with either the experience of negative pressure or with the experience of little procedural justice. Both patient and clinician perceptions of coercion may be reduced by improving communication during the psychiatric decision making process.

Further quantitative and qualitative research is required to aid in the development of interventions for reducing high levels of perceived coercion and to determine the consequences of feeling coerced into mental health care.

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With my sincere gratitude,

Katie Sheehan

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1 Background

1.1 Introduction

The use of coercion in mental health care has long been a controversial issue (Jones 1955; Scull 1979). For centuries it has sparked debate among health care professionals, legislators, lawyers, patients, their families and advocacy groups. As a more patient-centered approach to medical care has become the focus of legislation and clinical practice guidelines, there has been renewed interest in this issue (Monahan *et al.* 1995).

The treatment relationship between patient and clinician in all areas of medicine has traditionally been considered paternalistic. The clinician suggested a treatment plan based on expert medical knowledge and the patient was expected to agree with this course of action. More recently the doctor-patient relationship has been viewed as a partnership, with the clinician having professional expertise and the patient making an autonomous decision regarding treatment based on their own views, beliefs and preferences (Tuckett *et al.* 1985; Weston 2001).

Theoretically, the principle of patient autonomy applies to psychiatry as it does in other medical disciplines (World Health Organization 2001). Legislation and clinical guidelines indicate that psychiatric patients should be encouraged to make their own decision regarding care, in accordance with the canons of ethical medical treatment and good practice (Department of Health 1998; World Psychiatric Association 2002). It is unclear, however, whether patients receiving care for mental illness feel free to make treatment decisions. The historical link between psychiatric treatment and detention, the existence of legal mechanisms which allow mental health professionals to treat patients against their will, and an inherent power imbalance in the patient-clinician relationship, may lead patients to feel they are not fully autonomous in decision making. The impact this may have on the therapeutic relationship and treatment outcome is also unknown (Monahan *et al.* 1995). Decreasing the use of coercion in mental health care has become an important objective for policymakers, lawyers and clinicians alike (Department of Health 1998).

Despite the contentious nature of this debate, the current research literature on coercion has been limited in both its scope and conceptual framework (Susser & Roche 1996). Theoretical discussions of coercion tend to be too broad, debating deontological and utilitarian values or the competing principles of autonomy and paternalism. In contrast, much of the empirical research has used too narrow a definition of coercion to be useful in guiding service provision. Studies have often defined coercion as the use of legal mechanisms for involuntary hospitalization. These have failed to examine the experiences and perceptions of patients, although it is recognized that "patients' experience of coercion is an important empirical factor…in determining whether coercive hospitalization is justified" (National Center for State Courts 1986; Kaltiala-Heino 1995). Studies have also tended to ignore the use of coercion in community mental health services, the main locus of treatment for most psychiatric patients (Susser & Roche 1996; Monahan *et al.* 2003).

This thesis examines perceptions of coercion in hospital and community-based treatment settings. Using both quantitative and qualitative methods, a series of studies will investigate the experiences of patients and clinicians in mental health service provision. This chapter provides relevant background information for these studies.

1.2 Patient autonomy in medical decision making

In recent decades a shift in medical decision making, from paternalism to professional-patient partnership, has occurred (Etchells *et al.* 1996a; Etchells *et al.* 1996b; Etchells *et al.* 1996c; Beauchamp & Childress 2001; Jonsen *et al.* 2002). While the clinician has professional expertise, the patient is an expert on their own views, beliefs and preferences (Tuckett *et al.* 1985). Clinicians present medically indicated treatment options to the patient and the patient has "decisional authority" to choose the course of action which they feel best fits their needs and desires (Jonsen *et al.* 2002).

1.2.1 Law and patient autonomy

The right of the patient to choose their medical treatment is legally protected in most countries (United Nations General Assembly 1948; Council of Europe 1950; Home Office 1998; World Health Organization 2001; World Psychiatric Association 2002). A competent patient generally has the right to make decisions regarding their own medical care in the western world. This respect for patient preferences in medical decision making is based on the basic human rights of liberty and freedom. Some jurisdictions have legislation to this effect (US Congress 1991; Government of Ontario 1996). In the United Kingdom, this right is primarily protected by common law.

Human rights law

Human rights protect individuals from actions that interfere with fundamental freedoms and human dignity (World Health Organization 2002). They are legally guaranteed by human rights laws and are mainly concerned with the relationship between the individual and the state. A basic set of universal human rights was first adopted by the international community with the Universal Declaration of Human Rights in 1948 (United Nations General Assembly 1948). In 1950, the Council of Europe introduced their own Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe 1950). While the links between human rights and health are complex, it is possible to examine how these rights have become enshrined in law and affect health policy.

In the United Kingdom, the majority of substantive rights granted by the European Convention on Human Rights were incorporated into UK law with the adoption of the Human Rights Act in 1998 (Council of Europe 1950; Home Office 1998). According to the British Medical Association, the Human Rights Act did not "represent a major change in practice for health professionals" as the requirements of the Act reflected "existing good practice" (Committee on Medical Ethics 2000). They did note, however, that it was essential to "build into the decision making process consideration of how the decision could be justified from a human rights perspective" and highlighted several Articles within the Act that they felt were most relevant to medical decision making (Committee on Medical Ethics 2000; British Medical Association 2004).

With respect to the role of patient autonomy in the decision making process, they noted that "providing treatment contrary to the patient's expressed wish or his or her best interest" could violate Article 3 of the Act which protects an individual's absolute right to be free from inhuman treatment or punishment (Herczegfalvy v Austria 1992). Furthermore, providing treatment without valid consent could contravene Article 8, which protects an individual's qualified right for private and family life and the right to be "involved in decision making about their treatment or that of their relatives" (W v UK 1987).

Common law

In addition to human rights laws, a patient's right to choose or refuse medical treatment is also protected by common law in the United Kingdom. In the UK, patients are legally required to provide informed consent prior to any medical treatment being carried out (Re T *(Adult: refusal of treatment)* 1992; Re C *(Adult: refusal of treatment)* 1994). Treatment without consent is a civil wrong that constitutes the tort of battery and can result in civil action against the practicing clinician (Malette v Shulman 1990; Ciarlariello v Schacter 1993). Treating a patient on the basis of inadequately informed consent constitutes negligence (Reibl v Hughes 1980). The common law allows competent people to make choices regarding their own medical care, even in cases where the refusal of life-sustaining treatment may result in death (Malette v Shulman 1990; Re T *(Adult: refusal of treatment)* 1992).

Informed consent

Informed consent is the "practical application of respect for [a] patient's autonomy" (Jonsen *et al.* 2006) and is defined as the "autonomous authorization of a medical intervention" (Beauchamp & Faden 1995). It has three main components: disclosure, which is the provision of relevant information by the clinician and its comprehension by the patient; capacity, which is the patient's ability to understand the relevant information and to appreciate the foreseeable consequences of their decision; and voluntariness, which is the patient's right to come to a decision freely and without force, coercion or manipulation (Etchells *et al.* 1996c; Beauchamp & Childress 2001; British Medical Association 2004; Jonsen *et al.* 2006). Each of these components must be fulfilled for informed consent to be considered granted.

According to Jonsen *et al.* (2006), informed consent should not be considered a "mechanical recitation of facts or a proforma signature on a piece of paper"; instead it requires a dialogue between patient and clinician. Properly negotiated informed consent may help establish a therapeutic alliance between the patient and physician (Berg *et al.* 2001).

1.2.2 Ethics and patient autonomy

Medical ethics, also called bioethics, is a branch of philosophy (Audi 1991; Honderich 2005). It involves the "deployment of philosophical moral theories" to deal with ethical problems raised in medicine and create systems of norms for practice (World Health Organization 2002; Honderich 2005). In conjunction with the legal doctrine of informed consent, principles of medical ethics help to guide the decision making process at an individual level and are used to formulate codes of practice for health care professionals.

As in law, the fundamental issue in medical ethics is the relationship between healthcare professionals and patients, and the "appropriate role of each in decision making about patient care" (Audi 1999). In the western world, the ethical frameworks used in clinical decision making tend to focus on respect for patient autonomy and preferences. This is balanced by a fiduciary responsibility and duty of care requiring the physician to present the appropriately indicated treatment options and aid the patient in choosing an option which best fits their particular preferences.

Principlism

First introduced in 1979 by Beauchamp and Childress, principlism is a pluralistic approach that requires the balancing of four principles when addressing ethical issues in medicine: autonomy, beneficence, non-maleficence and justice. While Beauchamp and

Childress (2001) argue that ethical debate requires discussing all four principles, debate in western countries tends to focus on the balance between autonomy and beneficence.

According to Beauchamp and Childress (2001), fulfilling the principle of respect for autonomy requires that a "person's right to hold views, to make choices, and to take actions based on personal values and beliefs" be acknowledged. This requires that clinicians be respectful "in disclosing information and foster[ing] autonomous decision making" by patients (Beauchamp & Childress 2001). It also requires that a patient's "autonomous action…not be subjected to controlling constraints by others" (Beauchamp & Childress 2001).

The principle of beneficence is often presented in competition with autonomy (Beauchamp & Childress 2001). In the past, it has been used to justify paternalistic actions. It is now interpreted as being a clinician's obligation to present and encourage options that are in the patient's best interest. Beauchamp and Childress argue that the principles of beneficence and autonomy can be complementary, as "beneficence provides the primary goal and rationale of medicine and health care, whereas respect for autonomy…sets moral limits on the professional's actions in pursuit of this goal" (Beauchamp & Childress 2001).

Professional guidelines

Ethics also inform the development of codes of practice for health care professionals. The codes have supported an increased focus on patient autonomy.

In the United Kingdom, guidance for medical clinicians is issued by the General Medical Council (General Medical Council 2006) and the British Medical Association (British Medical Association 2004). The GMC has regulatory and statutory powers and failure to comply with their guidelines can result in sanctions for professional misconduct. The GMC states that doctors have a duty to "respect the rights of patients to be fully involved in decisions about their care" and that patients can "decide whether to consent to, or refuse medical intervention" (General Medical Council 2001). While the advice provided by the BMA on ethical issues is not binding, they offer similar guidance as the GMC with respect to patient autonomy (British Medical Association 2004).

1.2.3 Clinical practice and patient autonomy

Respecting patient autonomy has also been found to be a component of good clinical practice. Understanding patient preferences has been associated with many factors related to improved clinical outcomes (Frosch & Kaplan 1999). Research suggests that patients who believe that their choices and preferences are valued in the decision making process are more satisfied with health services (Lerman *et al.* 1990; Beach *et al.* 2005;

Mandelblatt *et al.* 2006), show better adherence with treatment interventions (Kahn *et al.* 2007) and demonstrate improved disease outcomes (Schulman & Swain 1980; Greenfield *et al.* 1988).

1.3 Patient autonomy in psychiatric decision making

Theoretically the principle of patient autonomy applies equally to psychiatric treatment for mental illness. In the United Kingdom, since the 1924 Macmillan Commission Report stated that "there is no clear line of demarcation between mental and physical illness" (Royal Commission 1926), there has been a call to treat those suffering from mental disorders in the same way as those suffering from physical diseases. The 1998 Department of Health report, Modernising Mental Health Services, set forth new standards that "patients, service users and carers should be informed, involved and empowered" in their care (Department of Health 1998). The British Medical Association (2004) has stated that "generally speaking, the same basic ethical principles that govern physical health care should also govern mental health care".

The Expert Committee, in their 1999 Review of the Mental Health Act 1983, indicated that "an emphasis on patient autonomy" was "fundamental to [their] approach" in examining the legislation and concluded that "as far as possible, those suffering from mental disorders should be treated in the same way as those suffering from physical disorders" (Richardson *et al.* 1999). The 2004 draft of the Mental Health Bill for England and Wales was designed to ensure that "patients are involved in the making of decisions" (Department of Health 2004).

Similarly, the World Health Organization (WHO) has stressed the importance of respecting patient preferences, stating that it is "vital that individuals [suffering from mental illness] are given the opportunity to exercise choice and make decisions about their own care and treatment" and that people with mental health problems should be offered "choice and involvement in their own care, sensitive to their needs and culture" (World Health Organization 2001). The World Psychiatric Association (WPA) also asserted that psychiatrists should "allow the patient to make free and informed decisions" and "empower the patient to come to a rational decision according to personal values and preferences" (World Psychiatric Association 2002).

While these statements suggest that decision making in psychiatry is the same as decision making in other branches of medicine, most acknowledge that the process is fundamentally different (Radden 2002). This is because, in contrast to almost all other medical disciplines, exceptions in legislation and ethical policies exist for individuals suffering from mental disorders.

1.3.1 Law and psychiatric decision making

Almost every western country has legislation that allows for the compulsory hospitalization and treatment of the mentally ill under certain conditions. Although the specific conditions vary among jurisdictions, it generally requires that an individual be suffering from a mental disorder and be considered a threat to themselves or others.

While some public health legislation also allows for the detention of those with highly communicable diseases to prevent the spread of infection (Department of Health 1984), these laws are invoked far more infrequently than those in mental health (Kaur & Bingham 1993) and they do not permit non-consensual treatment.

Human rights law

While human rights are guaranteed by universal human rights law, exceptions are made for those with mental disorders. For example, the United Nations state that "the treatment of every patient shall be directed towards preserving and enhancing personal autonomy" and that patients have "the right to refuse or stop treatment". However, this excludes those who are "held as an involuntary patient" and situations where the "patient unreasonably withholds" informed consent or "lacks the capacity to give...informed consent" (United Nations General Assembly 1991).

Similarly, in the United Kingdom, the right to be free from inhuman or degrading treatment, to liberty and security, to a fair trial, and to respect for family and private life are guaranteed by Articles 3, 5, 6 and 8 of the Human Rights Act 1998 respectively (Home Office 1998). However, provisions of the Mental Health Act can override these rights and freedoms if specific conditions are met (Department of Health 1983).

Mental Health Act

Prior to the early 1700s, there was limited legal recognition of the mentally ill. The first statute regarding confinement of the mad was enacted in the Vagrancy Act of 1714, which included a provision whereby the "furiously and dangerously mad" could be confined "in a secure place" on the orders of two magistrates as long as their madness continued (Jones 1993). Since that time there have been several major overhauls of mental health legislation in the United Kingdom. The enactment of the Mental Health Act 1959 had arguably the greatest effect on mental health practice. It redefined the term "mental disorder", established Mental Health Review Tribunals to function as a watchdog over individual cases of compulsory detention and revised the procedures for voluntary and compulsory admission (Department of Health 1930; Department of Health 1959; Jones 1993).

In England and Wales, the Mental Health Act 1983 (MHA) currently provides the legal structure for the psychiatric care of people suffering from mental disorders. The Act deals with "the reception, care and treatment of mentally disordered patients, the management of their property and other related matters" (Department of Health 1983). It allows for both informal (voluntary) and compulsory (involuntary) admission to hospital.

There are three forms of compulsory admission allowed, each governed by a different section of the Act. This is origin of the term "being sectioned" when someone is admitted to a psychiatric inpatient facility under compulsion. As summarized in Table 1, each section can be used in different circumstances and allows for provision of different types of treatment.

Section 2 provides the authority for someone to be detained in hospital for assessment and requires an application by an Approved Social Worker (ASW) or the patient's nearest relative (NR). This application must be based on medical recommendations by two doctors, one authorized under Section 12 of the Act and preferably the other by one who has previous experience with the patient. The individual must be suffering from a "mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment" and the detention must be in "the interests of [their] own health or safety or with a view to the protection of other persons" (Department of Health 1983). Section 2 can be used to detain a patient for up to 28 days, but cannot be extended or renewed. If continued detention is required Section 3 is used.

Section 3 provides the authority for someone to be detained in hospital for treatment and also requires an application, based on two medical recommendations, similar to Section 2. The detained individual "must be suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment" and the disorder must be "of a nature or degree which make it appropriate for him to receive medical treatment in a hospital" (Department of Health 1983). The treatment the individual receives in hospital must be "likely to alleviate or prevent a deterioration of [their] condition". In addition,

Table 1: Overview of Mental Health Act provisions for care in hospital and the community

Section	Provision	Requirements
2	- detention for assessment - up to 28 days - no extension or renewal	- application by ASW or NR - must be based on medical recommendations from two doctors, one approved under S.12 of the MHA and one with previous experience with the patient
3	- detention for treatment - up to six months in the first instance - renewal for a period of six months and then periods of one year	- application by ASW or NR - must be based on medical recommendations by two doctors, one approved under S.12 of the MHA and one with previous experience with the patient
4	- emergency detention for assessment - up to 72 hours - convert to S.2 if second medical recommendation obtained	- application by ASW or NR - must be based on one medical recommendation by a doctor - in cases of urgency when getting two recommendations would lead to an undesirable delay
5	- emergency detention for assessment of an individual already informally admitted - up to 72 hours - no extension or renewal	- application by doctor, S.5(2), or nurse, S.5(4) - report must be made to MHA managers indicating that admission under the Act is required - only by nurse if doctor not available
7	- allows for guardianship in the community - guardian can require an individual with a mental disorder to: live at a particular place; attend medical appointments, employment, education and training; give access to a doctor, ASW or other approved person (consenting to treatment cannot be required - up to six months in the first instance - renewal for a period of six months and then periods of one year	- application by ASW, NR or court to local social services authority - must be based on medical recommendations from two doctors

Section	Provision	Requirements
17	- leave from hospital for those detained in hospital under a MHA section - can be: for fixed or indefinite period; subject to specific conditions; in custody of hospital staff; and revoked at any time - can be extended by further leave, even in the patient's absence	- can be granted by the RMO
25	- those discharged from hospital following MHA detention can be subject to certain requirements - can require a patient to: live in a certain place; attend medical appointments, employment, education and training; give access to the supervisor specified in the application, any doctor, any ASW, any other person approved by the supervisor (consenting to treatment cannot be required) - up to six months in the first instance - renewal for a period of six months and then periods of one year	- applications can be made by the RMO to the health authority which has responsibility for the patient following discharge from hospital - must be based on two recommendations; one from the doctor responsible for the patient's care in the community (CRMO) and one from an ASW
135	- police can enter an individual's premises to search for a person with a mental disorder - person can be taken to a place of safety for up to 72 hours for assessment	- application by ASW to Justice of the Peace - police must be accompanied by an ASW and doctor when they enter the premises, unless the individual is already under a MHA section and absent without leave from the hospital
136	- police can remove someone from a public place - person can be taken to a place of safety for up to 72 hours for assessment	- police must believe the person suffers from a mental disorder - person must need immediate control or be considered a threat to themselves or others

ASW	approved social worker	MHA	Mental Health Act 1983
NR	nearest relative	(C)RMO	(community) responsible medical officer
S	section		

"the detention must be necessary for the provision of treatment" and "for the health or safety of the patient or for the protection of other persons" (Department of Health 1983). Section 3 can be used to detain a patient for up to six months in the first instance and can be renewed for a further six months and then in periods of one year.

Section 4 provides for admission in emergency situations. It is used in cases where Section 2 admission would be appropriate, but getting two medical recommendations would lead to an "undesirable delay" (Department of Health 1983). A Section 4 admission requires an application by an ASW or NR, but can be based on a single medical recommendation. Section 4 admissions can last for up to 72 hours and convert to a Section 2 admission if a second medical recommendation is obtained during that time.

Other sections of the Act pertain to those already hospitalized. Section 5 allows for the detention of individuals who are already informal patients in hospital. Section 17 pertains to the granting of planned and authorized leave away from hospital for those who are detained under the MHA. Sections 56 and 57 cover consent to treatment issues.

Some sections of the Act pertain to powers not involved in the hospital admissions process. Section 135 allows a Justice of the Peace to authorize the police to enter individual's premises, by force if necessary, to search for a person with a mental disorder. The Justice must have "reasonable cause to suspect" that the individual is "being (or has been) ill-treated, neglected, or not kept 'under proper control'" or is living alone and unable to care for themselves (Department of Health 1983). Section 136 allows for a mentally ill individual to be removed by police from a public place to a "place of safety" such as a police station or hospital.

Formal requirements related to people living with mental disorders in the community are also imposed by guardianship orders (Section 7 of the MHA) and Supervised Discharge Orders (SDOs; Section 25 of the MHA). These sections can require an individual to reside in a specific place, attend specified places for treatment or training and give access to members of the care team. Adherence to medication regimes cannot be required of patients living in the community.

Informed consent

As previously discussed, informed consent is the "autonomous authorization of treatment" by a patient. Informed consent requires that three components exist: disclosure, capacity and voluntariness (Etchells *et al.* 1996a; Etchells *et al.* 1996b; Etchells *et al.* 1996c; Jonsen *et al.* 2006). Complications arise in psychiatric decision making because individuals suffering from mental disorders are often assumed to lack capacity and because, in mental health, refusal of treatment can lead to use of the compulsory treatment under the Mental Health Act.

In the United Kingdom, individuals over the age of 16 are presumed to have the capacity to make health care decisions unless evidence to the contrary is demonstrated. Capacity is a legal, not medical, concept and the level of capacity required for a decision to be valid depends on the specific decision being made. If there is disagreement or doubt as to whether a patient has capacity to make a specific treatment decision, the courts decide. While doctors are involved in assessing capacity and need to be aware of the legal issues surrounding capacity, they do not make the final decision.

Mental disorder does not result in an assumption of diminished legal capacity (British Medical Association 2004). Even those hospitalized with severe psychiatric conditions can be competent to make health care decisions (Re C *(Adult: refusal of treatment)* 1994). The questioning of competency often only occurs when psychiatric patients refuse treatment. While competent patients can legally refuse treatment, patients are more likely to be viewed as lacking capacity when they refuse treatment than when they accept it (British Medical Association 2004). In these situations, when patients refuse treatment, clinicians may feel it is necessary to detain them under the Mental Health Act.

In contrast, capacity is often not called into question when a patient accepts treatment. The House of Lords has established that it is "lawful to treat people who lack capacity who agree to admission without recourse to mental health legislation" (British Medical Association 2004); although they acknowledge that these compliant, but incapacitated, patients are treated under common law provisions for informally admitted patients and are not protected by legislative safeguards for detained patients. These include access to external reviews of the need for compulsion, second opinions from approved doctors to authorize treatment plans and oversight from the independent Mental Health Commission. This is known as the Bournewood Gap following a case heard by the European Court of Human Rights which highlighted the issue (HL v UK 2004).

The Mental Capacity Act 2005 is expected to come into force in 2007 (Department of Health 2005). This Act "enshrines in statute current best practice and common law principles concerning those who lack mental capacity and those who make decisions on their behalf" (Department of Health 2005). It provides for new tests of assessing capacity, permits legally binding advance directives and gives new powers to substitute decision makers. It does not, however, tackle the lack of legal safeguards for those who fall into the Bournewood Gap. The government has announced its intention to incorporate these into law by amending the Mental Capacity Act in the future (Department of Health 2006a).

The legal controversy regarding patient autonomy in mental health care

Historically, the primary legal controversy in psychiatric decision making was the compulsory hospitalization of mentally ill patients. To some degree, this has been established as acceptable under certain conditions. Legislation has attempted to balance the right of the individual and the right of the state. However, recent attempts to reform the Mental Health Act of England and Wales have raised questions over the extent to which the state should be able to restrict personal freedoms (Moncrieff 2003). While decreasing the use of coercion in psychiatric care has been a goal of policymakers for over half a century, many feel that the proposed legislation marks a return to more coercive and stigmatizing practices. Furthermore, some argue that the presence of legislation allowing for compulsory hospitalization may limit the voluntariness of any decision a patient may make to enter hospital (Szasz 1997).

The move to reform the provisions of the 1983 Mental Health Act was made following publication of the Labour Government's manifesto in 1997. This included a pledge to review fully all current mental health law and introduce community treatment orders (CTO). It was motivated by a need to update the laws to reflect a new focus on patient autonomy and changing patterns of treatment, which encourage treatment in the community over treatment in hospital. Green Papers were published the following year by the Richardson and Fallon Committees respectively (Richardson *et al.* 1999; Fallon *et al.* 1999).

Richardson Report

The framework proposed by the Richardson Committee formalized the generally accepted principles of medical ethics and applied them to a mental health setting (Richardson *et al.* 1999). They suggested fundamental amendments to the Mental Health Act 1983 based on the: desirability of patient autonomy; preference for informal care over compulsory measures; preference for the least restrictive manner and environment for treatment; preference for care to reflect the wishes of the service user; participation of users in all aspects of treatment and care insofar as capacity allowed; and "reciprocity" wherein compulsory measures create a corresponding duty to provide a high standard of care. They also advocated increasing the power to mandate compulsory treatment in the community.

Fallon Report

The Fallon Committee was established in response to problems in treating criminals with personality disorders. Their aim was to determine how appropriate services could be made available to criminals with personality disorders following their sentence (Fallon *et al.* 1999). The committee's recommendations were more controversial than those of the Richardson Committee. They included proposals to allow for the confinement of persons with personality disorders indefinitely, regardless of whether they had previous contact with the criminal justice system or whether their disorder was considered to be treatable. Civil libertarians and mental health professionals both opposed the recommendations. While civil libertarians argued against detaining those who had not committed an offence indefinitely, mental health professionals objected to detaining those they could not treat.

The recommendations made by both Committees were merged into a White Paper, published by the Department of Health in 2000 (Department of Health 2000). A draft bill was subsequently circulated in 2002 (Department of Health 2002). Both documents were poorly received by almost all stakeholder groups (Moncrieff 2003). Service user advocates complained about the disappearance of rights-based protections and focus on autonomy. Clinicians objected to the removal of the treatability criterion, which provided that compulsory treatment could only be used if there was anticipated therapeutic benefit to the patient. Civil rights advocates and lawyers criticized the loss of due process and legal safeguards. The British Medical Association went so far as to suggest that the Bill threatened to turn "therapeutic legislation into a vehicle for social control" (British Medical Association 2004).

1.3.2 Ethics and psychiatric decision making

While psychiatry is governed by the overarching ethical principles of medicine, it is also unique. The World Psychiatric Association acknowledges that "psychiatrists must be aware of the ethical implications of being a physician, and of the specific ethical implications of the specialty of psychiatry" (World Psychiatric Association 2002). In psychiatry, the patient-clinician relationship tends to be longer than in other medical disciplines, the goal of treatment is not always to cure the disorder but often to control symptoms and the clinician holds the legal power to compel the patient into hospital if necessary.

Principlism

As noted, patient autonomy is the dominant ethical principle governing medical care. Whenever possible, patient preferences are respected over professional paternalism. However, the ethical principles of beneficence and non-maleficence may be of increased importance in psychiatric treatment compared to other medical disciplines (Burns 2000).

Beneficence is often used to justify the clinician's role in decision making when they override patients' known preferences regarding care. In this situation, overriding patient preference would be justified by suggesting that a clinician's primary obligation is to act in the patient's best medical interest, not to solely encourage autonomous decision making. Especially in mental health care where patients can lack insight into the nature of their illness, clinicians often believe it is their professional duty to ensure that patients follow recommendations regarding treatment. Clinicians may use various methods of informal pressure to ensure that patients comply with these recommendations. However, as these actions often involve "some form of interference with or refusal to conform to another person's preferences regarding his or her own good", they can sometimes be viewed as coercive (Beauchamp & Childress 2001).

Some also view mental illness as restricting a patient's autonomy, preventing them from fully participating as active members of society. By acting in the best interest of the patient and ensuring that they comply with effective treatment, some argue that clinicians can actually restore patients' autonomy (Group for the Advancement of Psychiatry 1994). This is supported by research investigating Stone's "thank you theory of paternalistic interventions" in mental health care (Stone 1975; Beck & Golowka 1988). This research suggests that patients are often grateful to clinicians for coercing or compelling them into treatment after they have recovered and revise their beliefs regarding the need for treatment (Gardner *et al.* 1999).

Non-maleficence, the principle of doing no harm, is also presented to justify paternalism. Some believe that if a patient's choice of treatment is harmful or ineffective, clinicians have a duty to act to prevent or minimize harm to the patient (Beauchamp & Childress 2001). In psychiatry, this may occur when a patient refuses treatment. Informal pressure may be used to encourage an unwilling patient to accept treatment or the MHA may be used to detain the patient if they are a danger to themselves or others. While some argue that these actions are part of patient-centered care (Monahan *et al.* 2003), others suggest that not allowing a patient to make their own decisions regarding treatment may be harmful and lead to poorer treatment outcomes or have a negative impact on the therapeutic relationship (Pinfold & Bindman 2001).

Professional guidelines

While professional guidelines support a focus on patient autonomy, they also acknowledge the role of clinicians in providing the appropriate treatment for individuals with mental health disorders (British Medical Association 2004; General Medical Council 2006). These guidelines are a practical translation of ethical principles. Clinicians are encouraged to use evidence-based approaches to ensure that the needs and preferences of patients are met. This requires clinicians to integrate their "clinical expertise with the best available external clinical evidence from systematic research" and requires clinicians to ensure that an "individual patients' predicaments, rights and preferences" are considered "in making clinical decisions about their care" (Sackett *et al.* 1996). Evidence-based practices are becoming increasingly prevalent in mental health care (Geddes & Harrison 1997; Beinecke 2005).

The ethical controversy regarding patient autonomy in mental health care

The primary ethical challenge in psychiatric decision making is determining whether the autonomy model applies to patients (Radden 2002). Some have suggested that psychiatry may require its own unique ethics, rather than be subsumed under the principles of biomedical ethics (Tannsjo 2004). According to Radden (2002), a psychiatric ethicist, while "stigmatizing attitudes towards mental disorder have undeniably exaggerated the extent to which the mentally ill are imperfectly rational and autonomous agents", it is still "morally necessary to violate the psychiatric patient's expressed wishes" under certain circumstances. This is because the state also has ethical obligations to protect its members; protecting the vulnerable ones under the doctrine of *parens patriae* and protecting society-at-large from dangerous individuals. Balancing patient autonomy with these ethical obligations is one of the great challenges in mental health care.

1.3.3 Clinical practice and psychiatric decision making

While there is a substantial literature investigating the association between patients' roles in decision making and clinical outcomes in physical illness (for review, see Frosch & Kaplan 1999), research on this association is more limited in mental health (Laugharne & Priebe 2006). Studies have demonstrated, however, that psychiatric patients wish to be included in the therapeutic decision making process and are capable of being so (Bunn *et al.* 1997). Medical communication researchers have observed associations between physicians' communicative skills and patients' satisfaction, their adherence to treatment recommendations and treatment outcomes (Cruz & Pincus 2002). Dissatisfaction with antipsychotic therapy has been associated with lack of involvement in treatment planning or decision making and lack of involvement of family members in the care plan (Chue 2006).

The clinical controversy regarding patient autonomy in mental health care

As noted, clinical practice is becoming increasingly evidence-based (Sackett *et al.* 1996). However, research investigating the outcomes of treatment where autonomy has been restricted is limited (for review see Katsakou & Priebe 2006; Salize & Dressing 2005).

Studies in this area have examined clinical outcomes and patients' attitudes. They indicate that hospitalization which is involuntary or perceived to be forced leads to improved symptomatology and functioning and is not associated with decreases in treatment adherence (Kjellin *et al.* 1993; Kjellin *et al.* 1997; Kaltiala-Heino *et al.* 1997; Rain *et al.* 2003a; Rain *et al.* 2003b; Bindman *et al.* 2005).

However, when patient attitudes are investigated the results are not as clear and significant proportions of patients subjected to coerced treatment continue to hold negative views about their experiences (Toews *et al.* 1981; Kane *et al.* 1983; Kjellin *et al.* 2004). Some suggest that patients who feel that their autonomy has been restricted may choose not to seek treatment for fear of loss of liberty (Campbell & Schraiber 1989). As the effect of limiting autonomy on patient views and how this may affect future engagement with services are not known, this remains a controversial topic in psychiatric care.

1.4 The role of coercion in psychiatric care

The attempt to promote patient autonomy within the legal and ethical framework of psychiatric decision making has made coercion a major issue in mental health care.

Historically, all psychiatric care was considered coercive. In the United Kingdom, from the early 1700s until 1930, all admissions to mental hospital required a judicial order and specific legal procedures before an individual could be hospitalized (Jones 1993). As patients could not seek to enter hospital for mental disorders on a voluntary basis, admission to hospital tended to reflect the wishes of medical and legal officials rather than those of the patient (Jones 1993).

The introduction of voluntary admission in the 1930 Mental Health Act enabled patients to be admitted to mental hospital voluntarily or under a section of the Mental Health Act. When patients sought voluntary admissions, no legal restrictions were placed on them and they could leave on their own volition. In contrast, if a patient refused an offer to enter hospital informally and fulfilled specific criteria, legislation could be invoked to detain the patient compulsorily for a period of time.

Since the establishment of voluntary (informal) and involuntary (compulsory) pathways for admission to psychiatric hospitals, there has been debate on the distinction between the two (Clausen & Yarrow 1955). Brakel *et al.* (1985) stated that "the voluntary-involuntary distinction is in application quite blurred. Compulsion varies…on a spectrum where most commitment decisions fall into a middle grey area while the more distinct extremes of either fully voluntary admission or unwilled, formally resisted commitment are rarely seen". It is argued that all patients entering psychiatric treatment may be affected by some form of coercion (Szasz 1972b; Pescosolido *et al.* 1998).

1.4.1 The controversy of coercion

The use of coercion is one of the most controversial issues in psychiatric care with an extensive literature (Szasz 1972b; Edelsohn & Hiday 1990; Hiday 1992; Monahan *et al.* 1995; Szasz 1997).

Opponents of coercion

Philosophical arguments against coercion

Many opponents of coercion argue that the value of liberty and freedom outweigh any potential therapeutic benefit from forced entry into psychiatric treatment (Szasz 1972a; Ennis & Emery 1978; Saks 2002). This opposition to coercion is not rooted in an empirical argument, but in philosophically libertarian values.

Dr. Thomas Szasz, arguably the most prominent libertarian in psychiatry, adheres to this view of coercion (Szasz 1972b). He "oppose[s] using the coercive apparatus of the state to impose psychiatric relations on persons against their will". In contrast, he supports "voluntary psychiatric interventions" not because they are good for patients, but because he opposes "using the power of the state to interfere with contractual relations between consenting adults" (Szasz 1972a). Szasz's adherence to the principle of liberty is clear. He believes that "if the persons called "patients" break no law, they have a right to liberty" but that "if they break the law, they ought to be adjudicated and punished in the criminal justice system". He believes that the use of coercion in mental health will be present as "long as conventional wisdom decrees that mental patients must be protected from themselves, that society must be protected from mental patients, and that both tasks rightfully belong to psychiatrists wielding powers appropriate to the performance of these duties" (Szasz 1997).

Therapeutic arguments against the use of coercion

Others oppose the use of coercion because they believe that it will have negative effects on treatment outcomes (Campbell & Schraiber 1989). Those who adhere to a therapeutic jurisprudence model believe that the loss of free will in the decision making process may decrease the effectiveness of treatment (Wexler 1992). They suggest that treatment will have better results if patients are willing participants in the decision making process (Winick 1997).

Some also believe that forcing a patient to enter treatment may lead them to feel dissatisfied with mental health services. These feelings may lead patients to become non-compliant with treatment as soon as the coercion is removed (National Center for State Courts 1986). Moreover, the threat of coerced treatment may discourage other patients from seeking voluntary treatment for fear that they will be treated compulsorily (Campbell & Schraiber 1989).

Proponents of coercion

Philosophical arguments in favor of coercion

Proponents argue that mental disorders restrict a patient's ability to be autonomous in the decision making process. They suggest that coercive treatment may actually restore this autonomy and enable patients to make informed decisions regarding their treatment in the future (Chodoff 1984).

The Group for the Advancement of Psychiatry, one of the most vocal advocacy groups in supporting coercion, argue that coercive treatment "can be effective and can lead to freedom from the constraints of illness" (Group for the Advancement of Psychiatry 1994). They state that "the idea that forced treatment not only can be successful, but also can sometimes be more successful than voluntary treatment...contradicts the conventional wisdom that psychiatric treatment must be voluntary to succeed". Moreover, they suggest that "situations that can be described as coercive can also be viewed as containing external pressures that strengthen the patient's motivation for treatment" (Group for the Advancement of Psychiatry 1994).

Therapeutic arguments in favor of coercion

Other proponents of coercion in psychiatric care believe that coercion can be justified because it leads to better health outcomes, including decreased symptomatology and increased functioning (Kjellin *et al.* 1993; Kjellin *et al.* 1997; Zdanowicz 2006). They believe that the use of coercion assists in getting patients early treatment for their condition and aids in getting relapsing patients back into contact with services quickly.

Proponents of coerced treatment cite research that indicates that patients believe that some forms of coerced treatment are fair and effective (Swartz *et al.* 2004) and that the possibility of compulsory treatment does not cause patients to fear seeking treatment (Swartz *et al.* 2003). They also frequently call upon Stone's "thank you theory of paternalistic intervention" to justify the use of these practices (Stone 1975). This theory suggests that, following their recovery, individuals who were coerced into treatment will retrospectively be grateful for the forced intervention (Meichenbaum & Turk 1987) or believe it was justified (for review, see Katsakou & Priebe 2006).

Furthermore, they support their view with research that indicates that patient attitudes toward forced treatment change over time, with decreases in symptomatology being coupled with more positive attitudes toward care at discharge (Kane *et al.* 1983; Beck &

Golowka 1988; Edelsohn & Hiday 1990). A one-year follow-up study by Gove and Fain (1977) indicated that although the involuntary patients were hospitalized for longer and suffered from more severe disorders, their responses to whether they felt their hospitalization was beneficial were very similar to those of voluntary patients. 75% of them stated that they felt their hospitalization did them good, compared with 80% of voluntary patients; and 9.5% felt that their stay in hospital harmed them, compared with 5.5% of voluntary patients.

Justifying the use coercion

The legal and ethical controversies surrounding the use of coercion are complex and the empirical question of whether coerced treatment is effective is even more complicated. However, "these empirical issues are extraordinarily difficult to study" and the opponents and proponents of the use of coercion in mental health care have had little empirical research to draw on to support their arguments (Monahan *et al.* 1999). A major limitation to research in this area has been the lack of a consistent conceptualization and definition of coercion.

1.4.2 Theoretical conceptualizations of coercion

There is much controversy, both theoretical and operational, over what constitutes coercion. Theoretical conceptualizations are used primarily in legal, philosophical and ethical debates over whether the use of coercion is right or wrong. In contrast, operational definitions of coercion are generally used in empirical investigations of coercion which examine the determinants of coercion and its effect on clinical outcomes.

Coercion as the use of force

The Oxford English Dictionary defines coercion as "…the application of force to control the action of a voluntary agent" (Oxford English Dictionary 2006). In the psychiatric nursing literature, several others also use this narrow conceptualization of coercion. Zerwekh (1992) has referred to coercion as the "use of force by social authority" and Olofsson *et al.* (1998) stated that coercion was "an action imposed upon a person against that person's expressed wishes".

Coercion as a threat

Broader conceptualizations of coercion are found in the ethical and medical literature. Perhaps most influential is Beauchamp and Childress' definition of coercion as a "credible and severe threat of harm to force or control another" (Beauchamp & Childress 2001). This definition separates coercion from manipulation and persuasion which are deemed as not coercive. Similarly, Lakeman (2000) states that coercion is the "threat of force or bodily harm" and notes that it is "conceptually distinct from other forms of influence". Legal definitions also include the threat of force as coercion (Frankfurt 1973).

Wertheimer's (1987; 1993) philosophical account of coercion similarly distinguishes between threats and other forms of power like persuasion, inducement and authority. In the case of mental health, he argues that coercion is actually constrained volition. Coercion does not occur because the patient has no choice, but because the patient is forced to choose from a limited range of options. Those options which will result in the individual being worse off than a specified baseline are considered threats. Options which result in the individual being better off than the baseline are considered offers and are not coercive. However, Wertheimer does not prescribe how to set that baseline. Szmukler also adheres to this distinction between threats and offers (Szmukler 1999).

Coercion as a moral concept

Wertheimer and Rosenbaum, another philosopher, view coercion as a moralized concept. Applied to mental health, Rosenbaum's account suggests that different levels of coercion may be acceptable depending upon the outcome expected (Rosenbaum 1986). For example, it may be considered acceptable to coerce an individual to hospital if they are depressed and express suicidal ideation, but this level of coercion cannot be used if they are just depressed and not suicidal. Similarly, Wertheimer calls for an examination of coercion in terms of what justifies its use (Wertheimer 1993).

Coercion as a continuum

Others believe that coercion should not be considered as a dichotomous variable, where it either is present or absent, but as a variable which occurs along a continuum. For example, Weisner (1990) believes that there is a "rough continuum of coercion, ranging from those that are legally mandated to those that are less explicit [and]...there is variation within each category at the level of coerciveness and the range of practices used". Rosenbaum also believes that coercion "is graded along different degrees depending on the means used to influence or control" (Rosenbaum 1986).

Hiday (1992) and Rogers (1993) conclude that their research indicates that coercion is a continuum. Hiday (1992) notes that various social pressures are brought to bear on mentally ill individuals to accept hospitalization. These come from family, friends and mental health professionals and involve requests, persuasion, enticement, manipulation, threats and physical force. She believes that "they constitute a continuum to greater amounts of volition on one end and greater amounts of coercion to the other". Rogers states that "an implication from [her] study is that coercion should be viewed as a continuum that cuts across the legal and administrative boundaries of voluntary and involuntary status categories" (Rogers 1993).

Szmukler and Appelbaum (2001) use the term "treatment pressures" in their discussion of coercion. This "covers a range of interventions aimed at inducing the patient to accept treatment which they initially declined or seem likely to decline" (Szmukler & Appelbaum 2001). The continuum of pressures ranges from persuasion to leverage/interpersonal pressure to inducement/offer to threats to compulsion/backed by force supported by legal statute.

1.4.3 Empirical studies of coercion

The application of these theoretical concepts of coercion to empirical research is limited. Empirical research requires an operational definition of coercion; meaning that the definition of coercion must be effective in separating those individuals who experienced coercion from those who did not. As in theoretical discussions of coercion, a variety of definitions have been used.

Nearly every study which has tackled the issue of coercion has noted that the lack of a definition and clear conceptual framework has been a major barrier to understanding the basis of coercion and its effect on outcome. Hoyer *et al.* (2002) recognized that "one of the reasons we lack empirical knowledge about the impact of coercion is that the concept of coercion is poorly defined" and Weisner (1990) noted that "in the literature, what is meant by coercion is often unclear…varying terms and conceptions [are] used". Similarly, O'Brien and Golding (2003) indicated that "studies of coercion do not provide the conceptual definition of coercion that informs the research". As "no operational definition of coercion has been proposed, let alone uniformly adopted" (Marlowe *et al.*

1996), it has proved difficult to draw conclusions from the coercion studies. Even more than a decade after the coercion research renaissance, definitions of coercion used in studies range from “a crude idea of ‘force’ to undue personal influence” (Lidz *et al.*1997).

Legal status as an indicator of coercion

Research examining coercion has often used legal status at admission as an operational definition of coercion (Monahan *et al.* 1995). Under this definition, involuntarily hospitalized patients are believed to have been coerced into treatment, while voluntarily admitted patients are thought to have entered treatment under their own volition. These types of studies typically examine the prevalence of legal coercion, investigate its correlates and look for outcome factors that may be associated with the different legal categories (Kaltiala-Heino 1995; Kaltiala-Heino 1996; Kaltiala-Heino *et al.* 1997).

Limitations of legal status as an indicator of coercion

Many problems arise when legal status is used as a proxy for the experience of coercion.

Firstly, gathering data is complicated by the way that legal status is defined in different jurisdictions (Kallert *et al.* 2005). The criteria which must be met before involuntary hospitalization or involuntary community treatment processes can be initiated differ among countries, leading to different rates of admission. Several studies have found great variation in involuntary admission rates in Europe (Riecher-Rossler & Rossler 1993; Salize & Dressing 2004). Riecher-Rossler & Rossler (1993) found that the percentage of patients involuntarily hospitalized across Europe ranged from 1% in Spain to 93% in regions of Switzerland. This result was supported by a more recent study of involuntary hospitalization that found great variation in admission rates across the European Union (Salize & Dressing 2004). Moreover, involuntary hospitalization rates may even vary within countries (Kjellin 1997). A study in the UK found that compulsory admission was much more common in London than in other areas of England (Ford *et al.* 1988).

Many states also have different compulsory admission procedures for emergency, assessment and treatment admissions. Some jurisdictions even have more than one category of patient within voluntary and involuntary categories. This can make international comparisons difficult. For example, in England and Wales, patients can be admitted involuntary under Sections 2 (Assessment Orders), 3 (Treatment Orders), and 4 (Emergency Orders) of the 1983 Mental Health Act (Department of Health 1983).

Some jurisdictions also allow for legally compulsory treatment in the community, in addition to legally mandated treatment in hospital (Dawson 2005). Several European countries, as well as states and provinces within the USA, Canada, Australia and New Zealand have legislation which requires patients to adhere to treatment in the community. England and Wales do not currently have legislation to this effect, although it is likely to be incorporated in the current reform of mental health laws (Department of Health 2004; Department of Health 2006b). Again, this makes drawing comparisons of coerced community treatment among jurisdictions difficult.

Secondly, a patient's legal status may change during their time in hospital. Legal status at admission may not reflect this (Cuffel 1992). For example, Hotopf *et al.* (2000) report that in 1995-96 over 15000 patients admitted informally to hospital in UK were detained under a section of the MHA at some point during their stay in hospital. This included over 10000 cases where informally admitted patient were prevented from leaving the hospital under doctors' or nurses' holding order in Section 5 of the MHA and over 5000 cases where the patient was detained for assessment or treatment under Section 2 or Section 3 of the Act respectively (Department of Health 1983).

Finally, recorded legal status may not fully reflect whether the process of decision making was coercive or autonomous. Jurisdictions may characterize a patient's admission as voluntary, even if the patient has not explicitly consented to treatment. In the UK, patients who lack capacity but do not object to treatment can be admitted to hospital and would be classified as an informal or voluntary patient (Eastman & Peay 1998). Substitute decision-makers may also be able to accept treatment on a patient's behalf (Department of Health 2005). Conversely, a series of studies suggests that patients may be explicitly encouraged to accept voluntary treatment or risk being admitted to hospital involuntarily (Gilboy & Schmidt 1971; Lewis *et al.*1984; Lurigio & Lewis 1989; Reed & Lewis 1990).

Objective events as an indicator of coercion

With recognition of the limitations of legal status as a measure of experienced coercion, researchers have attempted to define coercive practices as observable events which may leave the patient feeling that they cannot refuse to accept treatment. A variety of these events have been investigated in studies. They range from the threat of involuntary hospitalization during the admissions process to the use of seclusion, restraint and forced medication in hospital.

As previously mentioned, Gilboy and Schmidt's (1971) seminal study was the first to note that legal status may not truly reflect a patient's experience of coercion. Using an observational methodology, they documented cases in which legally voluntary patients had been told, by those with the power to compulsorily hospitalize them, that they would be committed if they did not agree to enter hospital voluntarily. In addition, many of the patients were already being held in official custody (i.e. police custody) at the time of the admission process which may have also left them feeling that they were not free to refuse hospitalization.

The results of this study were supported by later research also conducted in Chicago. This study observed the interactions between patients and lawyers during the proceedings of mental health courts. Lewis *et al.* (1984) found that over one-quarter of the patients who initially refused hospitalization and were scheduled to appear in a mental health court later agreed to be admitted to hospital voluntarily. Knowing that they may be involuntarily hospitalized if they went to court, patients were reminded of the advantages of voluntary admission by "hospital staff, the social worker, and even, sometimes the public defender" (Lewis *et al.* 1984). Similar findings have been reported in the United Kingdom. Barnes *et al.* (1990) reported that patients who are assessed for admission to hospital under the Mental Health Act often agree to enter informally as a result of social workers' "persuasive powers".

Seclusion, restraint and forced medication once patients are admitted to hospital have also been used as a proxy measure for the experience of coercion (Kaltiala-Heino 1999). A study in Sweden found that 44% of hospital personnel surveyed had witnessed coercive measures against voluntary patients (Kjellin *et al.* 1993). The most frequently used measures were restriction of liberty and forced medication.

Limitations of objective events as an indicator of coercion

There are several limitations in using these types of objective events as proxy measures of coercion.

Firstly, in considering the use of threatened compulsory admission as an indicator, there is difficulty in distinguishing between what is considered a threat and what is persuasion.

As noted in the discussion of theoretical definitions of coercion, threats are often viewed as coercive while persuasion is not. Instead, persuasion is seen as an appeal to the patient. As Rogers (1993) notes "it is generally considered legitimate practice to use persuasion in gaining patient's compliance to enter hospital". Another observational study suggested that it is persuasion, not threats of involuntary hospitalization, which is most prevalent in the interactions between mental health care professionals and patients (Lidz *et al.* 1993). They also note, however, that "while the interactions that are coded as persuasions seem benign outside of the meaning context, in the context of the Emergency Room, patients may see them as more threatening".

Secondly, it is difficult to observe the many different types of pressures to which patients are subjected. These pressures may come from mental health care professionals including doctors, nurses and social workers (Lidz *et al.* 1993). They may also come from family members, friends and employers. Moreover, some people believe that "what is coercive is not an isolated case or a particular interactive detail but the system as a whole" (Lidz *et al.* 1993). Similarly, the presence of police or security officers may result in an atmosphere that suggests free choice may be constrained. These types of factors cannot easily be detected in observational studies.

Thirdly, while "coercion is something that is…done to someone", it is also "experienced by someone" (Hoge *et al.* 1993). Thus, it may be viewed as both "an objectively observable set of actions and a subjectively experienced result of particular actions".

Merely measuring what can be observed does not take into account patients' subjective experiences of different actions (Kjellin & Westrin 1998). Moreover, as mental disorders affect cognition, making assumptions about how people may react or feel about certain events may result in subjective experiences of coercion being overlooked.

Fourthly, in examining the use of seclusion, restraint and forced medication, it is difficult to separate the effect that each of these forces may have. For example, patients may act in a certain way to avoid been subjected to them. Just like a patient may accept voluntary admission to avoid involuntary admission, a patient may agree to accept medication because they know they will be forced to take it if they do not.

Finally, there are problems in collecting data about seclusion, restraint and forced medication. As with involuntary admission procedures, statutes and regulations vary among jurisdictions. Moreover, their use may not always be recorded making this an imperfect measure of coercion (Kjellin & Westrin 1998; Poulsen & Engberg 2001).

Subjective experience as an indicator of coercion

As previously noted, neither legal status nor observed events are perfect measures of the experience of coercion. As the major limitation of these methodologies is the inability to capture the patient's perceptions of the admission process, "the best existing source of information on the role of coercion in mental hospital admission may be those studies that have sought the views of patients themselves on the experience of their hospital admission" (Monahan *et al.* 1995). As Hiday (1992) states, "for a subjective definition...coercion is any action the individual says it is...coerced hospitalization, thus, occurs when an individual feels forced to accept hospitalization". Many researchers and studies acknowledge the distinction between objective and subjective coercion (Szmukler & Appelbaum 2001).

A series of Canadian studies, conducted in the early 1980s, first suggested that legal status may not be good indicator of subjective coercion because many patients are not even aware that they have been admitted involuntarily. Toews *et al.* (1981; 1984; 1986) examined patients' reactions toward compulsory admission in Manitoba. In the first study, a group of patients who had been involuntarily admitted to hospital responded to a questionnaire approximately one year after discharge (Toews *et al.* 1981). In the second study, 105 inpatients (75 who were involuntarily hospitalized and 30 were voluntarily admitted) took part in an interview during the first nine days of their admission to hospital (Toews *et al.* 1984). In both studies, approximately half of the involuntarily admitted patients were unaware of their legal status and nearly two-thirds reported that they had been denied the opportunity to be admitted voluntarily. Over half of these patients stated that they would have liked the opportunity to do so (Toews *et al.* 1984).

Two years later, a study conducted at an Ontario hospital supported these initial findings (Bradford *et al.* 1986). In this study, 39% of involuntarily admitted patients reported that they were not aware of their legal status. Approximately half stated that they had been denied the opportunity to be admitted voluntarily and 31% of these patients said that they would have voluntarily admitted themselves if they had had the chance to do so.

In Australia, Shannon (1976) conducted one of the earliest studies of patient perceptions of coercion in psychiatric hospital admissions. He interviewed 100 patients admitted to a psychiatric hospital in Melbourne. 56 patients were admitted voluntarily and 44 were legally involuntary (or "recommended" under the mental health legislation of Victoria). 48 patients reported feeling coerced into hospital. Shannon analyzed patient's views of their treatment based on both their legal status and perception of coercion. Those who were coerced and those were legally involuntary had significantly more negative feelings about their treatment and hospitalization than those who did not feel coerced or were admitted voluntarily. However, data investigating the relationship between legal status and feeling coerced were not presented and Shannon did not state how he established which patients felt coerced into hospital.

In the United States, Beck and Golowka (1988) interviewed voluntarily and involuntarily admitted patients within one day of their admission to hospital. Over half of the legally voluntary patients reported that there was "a major element of coercion" in their hospitalization and nearly one-quarter of the involuntary patients stated that their hospitalization was "largely a voluntary choice", indicating a discrepancy between legal status and patients' perceptions of coercion.

A study by Kjellin *et al.* (1993) demonstrated that 65% of involuntarily admitted patients and 28% of voluntarily admitted patients in two Swedish hospitals felt that "they had been exposed to measures against their own will". They did not specify which measures patients found coercive. This finding was supported by a later Swedish study using the same question which found that 65% of involuntary and 29% of the voluntary patients had reported such coercion (Westrin & Nilstun 2000).

In the United Kingdom, Rogers (1993) analyzed 412 questionnaires sent to patients who had previously been admitted to psychiatric hospitals. Again, almost half of patients who had previously been admitted to hospital informally reported that they "did not regard their status as being genuinely informal".

Limitations of subjective experience as an indicator of coercion

While most researchers agree that measuring subjective experiences of coercion was the best method of examining this phenomenon in mental health services, these studies also have major methodological limitations (Hiday 1992; Gardner *et al.* 1993; Monahan *et al.* 1995).

Firstly, there was difficulty in comparing the different studies. While most consistently demonstrated little correlation between legal status or observed coercive events and subjectively experienced coercion, there was no standard method of measuring perceptions of coercion. Each study used a different interview or questionnaire to examine whether patients felt coerced. Similarly, the language used in each study differed. Some patients were asked whether they felt "fully voluntary", others whether they were "genuinely informal", and yet others whether there was an "element of coercion" during their admission.

Secondly, early studies suggested that a wide range of events during the admissions process may be experienced as coercive but were limited in their ability to specify what these events or experiences were. As Monahan *et al.* (1995) noted, there was "little work isolating the specific aspects of hospital admission that [were] perceived as coercion, how staff behavior affect[ed] patients' perceptions, or discussing non-hospital factors (e.g. family pressures) that lead to admission".

Finally, it was not clear whether these experiences of coercion were stable or changed over time. While studies indicated that there were changes in whether patients felt that hospitalization was necessary or helpful over time, it was not clear whether patients' experiences of coercion would change retrospectively.

To tackle these limitations in research of subjective experiences of coercion, it was necessary to develop a standardized instrument for quantifying experiences of coercion. While developing quantitative measures of subjective experiences is a challenging area of research, it was felt that this would allow future research to tackle the methodological limitations noted above. The development of such tools marked a new chapter in "perceived coercion" research (Gardner *et al.* 1993; Monahan *et al.* 1995).

1.4.4 Empirical studies of perceived coercion

In the last decade, important progress has been made in the development of instruments for investigating perceived coercion and its impact on mental health care. These have enabled the examination of associations between sociodemographic and clinical characteristics and perceived coercion, and they are now being used to investigate the effect of perceived coercion on treatment outcomes.

Development of instruments to measure perceived coercion

Recognizing the need for a standardized instrument to measure perceived coercion, several groups undertook the task of developing such a tool during the 1990s. Three instruments have explicitly been designed for this purpose: the MacArthur Perceived Coercion Scale (MPCS; Gardner *et al.* 1993), the Coercion Ladder (Hoyer *et al.* 2002) and the Coercion/Non-Coercion Matrix (Marlowe *et al.* 1996). Only the MacArthur Perceived Coercion Scale and the Coercion Ladder were developed for use in investigating coercive processes in psychiatric hospital admissions and have been used in multiple studies. The Coercion/Non-Coercion Matrix has been used to examine the experience of coercion to enter drug treatment. Some reviews of instruments designed to measure perceived coercion include the Circumstances, Motivation, Readiness, and Suitability Scales (CMRS; De Leon *et al.* 1994). However, this scale was developed to investigate the factors that contribute to patients entering and remaining in treatment. As it is not limited to those pressures which are perceived as coercive, the CMRS will not be discussed.

The Coercion/Non-Coercion Matrix (Marlowe *et al.* 1996)

The Coercion/Non-Coercion Matrix was developed by Marlowe *et al.* (1996). Their aim was to "devise a reliable interview procedure for the detection and characterization of coercion to treatment in multiple psychosocial functional domains" (Marlowe *et al.* 1996). It was used to investigate perceptions of coercion in patients receiving outpatient treatment for cocaine addiction.

The scale was generated based on interviews and surveys with patients during their initial counseling sessions. These were used to investigate what advantages the patient expected as a result of quitting cocaine, what disadvantages they anticipated if they continued using cocaine and what led them to seek treatment. Their responses were used to develop a two by two matrix that "crossed reinforcement schedules with social mediation". Those responses that included a socially-mediated avoidance reinforcement schedule were deemed to be coercive.

Marlowe *et al.*'s work suggested that coercion accounted for approximately one-third of the expressed reasons for entering treatment. Financial, social, familial and legal reasons were more likely to be coercive than psychological, medical, drug or religious factors. As in studies of coercion in psychiatric inpatient settings, "these data suggested that legal pressures may exert substantially less influence over drug treatment than do informal, extra-legal influences" (Marlowe *et al.* 1996).

***The Coercion Ladder* (Hoyer *et al.* 2002)**

The Coercion Ladder has been used primarily in European studies of coercion and in conjunction with the MPCS (Hoyer 1999; Hoyer *et al.* 2002; Kallert *et al.* 2005). It is a visual analogue scale, adopted from the Cantril Ladder (Cantril 1965).

The ladder is shown to the patient and they are asked to mark the degree of perceived coercion while the following instruction is read to the patient: "When a person is admitted to a mental hospital or ward, different things will be of importance in each case. In some cases, a lot of pressure and even physical force is used when a person is admitted, while in other cases patients come to the ward totally of their own will. If you think of your own admission to this hospital this time, try to consider if you were subjected to any kind of coercion, threats, pressure or inducements. Then try to figure out what step on the ladder below best corresponds with the amount of pressure from others that you experienced when you were admitted, and mark the step with an X. For instance, if you came entirely on your own initiative put an X on step 1, but if you were subjected to the maximum use of coercion, then you put the X on step 10" (Hoyer 1999; Hoyer *et al.* 2002).

The use of this global measure "was inspired by the experience from research on quality-of-life measures" which suggested that simple measures exclusively based on self-report may be the best way of measuring complex subjective dimensions like these (Gill & Feinstein 1994; Hoyer 1999). However, most instruments used to measure these subjective concepts provide an index score that describes the level based on multiple dimensions. As Hoyer *et al.* (2002) stated "it is generally believed that indexes constitute a better instrument".

***The MacArthur Perceived Coercion Scale (MPCS;* Gardner *et al.* 1993)**

The MacArthur Perceived Coercion Scale (MPCS) was devised by the MacArthur Research Network on Mental Health and the Law. Since its development it has been the most widely used measure of perceived coercion and the only one to be used internationally. It was generated from preliminary data gathered from "semi-structured interviews with patients, focus groups of patients, family members, and mental health professionals, and from a review of the philosophical and social scientific literature on coercion and the clinical literature on involuntary hospital admission" (Gardner *et al.* 1993; Bennett *et al.* 1993; Hoge *et al.* 1993; Monahan *et al.* 1995).

The scale requires patients to answer five "true or false" questions about their admission. Each question asks the patient to "judge the degree of influence, control, choice and freedom they had during their admission to hospital" (Gardner *et al.* 1993). These terms were chosen because they were found in the preliminary interviews to have "face validity as everyday synonyms for autonomy". The scale was found to have good psychometric properties and to be easily understood by patients (Gardner *et al.* 1993; Hoyer 1999).

The MPCS has been used in 25 published studies to date, which includes research conducted in nine countries. It has been used to examine perceived coercion in psychiatric inpatients (Hoge *et al.* 1997; Lidz *et al.* 1998; McKenna *et al.* 2001; Bindman *et al.* 2005; Kjellin *et al.* 2006), hospitalized patients receiving treatment for physical illnesses (Taborda *et al.* 2004), patients in hospital receiving treatment for eating disorders (Guarda *et al.* 2007), individuals starting drug treatment programs (Wild *et al.*1998) and for parolees and prisoners with mental illness (Fabaree *et al.* 1998; Rigg 2002). It has recently been adapted to measure perceived coercion in community mental health patients (Monahan *et al.* 2005; McKenna *et al.* 2006; Davidson & Campbell 2007). Studies using this measure indicate that patients' perceptions of coercion and recollection of events during the admissions process are accurate when compared to family members' and clinicians' experiences (Hoge *et al.* 1998) and that perceptions of coercion are stable over time (Gardner *et al.* 1999).

1.5 Summary

The use of coercion in mental health care is a controversial issue and decreasing coercion has become an important objective in mental health policy and practice internationally. Empirical research investigating patients' experiences of coercion has been limited, particularly outside of the USA and Nordic countries.

The four studies presented in this thesis use quantitative (Chapters 2-4) and qualitative (Chapter 5) methodologies to examine perceptions of coercion in mental health care in England:

- Chapter 2 describes an investigation of perceived coercion in patients recently admitted to hospital
- Chapter 3 describes an examination of clinicians' perceptions of coercion during the hospital admissions process and uses dyadic analysis to compare clinician perceptions with patient experiences
- Chapter 4 describes an investigation of levels of perceived coercion in patients receiving treatment from community mental health teams

- Chapter 5 describes a thematic analysis of patients' experiences of the hospital admission process in their own words and compares these accounts with current health policy and health services research

2 Patients' perceptions of coercion during the psychiatric hospital admissions process

2.1 Introduction

Compulsory hospitalization is a widely accepted, although controversial, practice in psychiatry. Its use has been debated legally, philosophically and ethically worldwide. As healthcare policy and practice has shifted in recent decades to incorporate a greater focus on patient preferences, many have questioned whether psychiatric patients perceive that they are autonomous in the decision-making process regarding inpatient hospitalization. An empirical understanding of patient perceptions of coercion is important to gain insight into which patients may feel that they are coerced into accepting hospitalization. The aim of this study was to examine the level of perceived coercion in patients hospitalized in the UK.

2.1.1 Psychiatric hospitalization in England and Wales

The pathways by which patients reach inpatient psychiatric care are known to be complex (Goldberg & Huxley 1980; Gater 1991a, 1991b; Pescosolido *et al.* 1998; Commander *et al.* 1999; Morgan *et al.* 2003). Once they are assessed as requiring admission to hospital, patients can be admitted either informally or compulsorily under the powers of the MHA. Chapter 1 and Table 1 outline the legal criteria for and consequences of admission in each category, which vary substantially (Department of Health 1983). The provision of "care, treatment and support…without recourse to compulsion" when possible is preferred (Department of Health 1999), so informal admission to hospital is encouraged.

However, little is known about patients' experiences of the hospitalization process in the UK.

Pathways to inpatient psychiatric care

Studies of pathways to inpatient psychiatric care have focussed on the differences in routes taken by various ethnic groups (Commander *et al.* 1999; Morgan *et al.* 2005a; Morgan *et al.* 2005b; Steel *et al.* 2006) and developed from the observation that UK minority groups have differential access to mental healthcare.

This research has also identified the various individuals involved in the pathways to care. While some patients self-refer for admission to hospital, the vast majority access inpatient mental health services through a number of routes including: medical professionals such as psychiatrists, general practitioners (GPs), community psychiatric nurses (CPNs) and accident and emergency departments; social services such as social workers and housing agencies; and the criminal justice system such as the police, courts and prison. The inpatient admissions process is also influenced by the involvement of patients' family and friends who often accompany them to hospital.

These studies have suggested that some pathways to inpatient care may be regarded as more "negative", "adversarial" (Morgan *et al.* 2003) and "aversive" (Commander *et al.* 1999) than others. Commander *et al.* (1999) indicated that "'aversive' pathways" were complex and sometimes followed "tortuous routes often involving the police". Similarly

Morgan *et al.* (2003) noted that "negative and adversarial routes" included those "involving the police and…compulsory admission to hospital". The potential outcome of these contacts with services "via less favourable routes" is believed to be a "vicious cycle of negative experiences, coercion, disengagement and relapse" (Morgan *et al.* 2003).

2.1.2 Patient experiences of the admissions process

Examining subjective experience has become an important objective in mental health research as it reflects an increased focus on patient preferences in medicine. In psychiatry, this research has examined patients' experiences of care in community and inpatient treatment. These studies have primarily investigated global factors important to all medical disciplines, such as patients' general attitudes toward care, their perceived quality of life, their satisfaction with healthcare services and their relationship with clinicians (Becker *et al.* 1993; Cooper-Patrick *et al.* 1997; Gaite *et al.* 2002; Rutter *et al.* 2004; McCabe & Priebe 2004; Priebe & McCabe 2006; Chue 2006). A specialized literature exploring patients' experiences of psychiatric treatment and mental health services has also developed. These take into account situations which are unique to psychiatry, such as the use of compulsion, coercion, seclusion and constraint (Hoge *et al.* 1993; Hoyer 1999; Canvin *et al.* 2002; Frueh *et al.* 2005).

Obtaining an understanding of patients' experiences specifically during the psychiatric hospitalization process is of particular importance. As patients' subjective views are often associated with treatment outcome, understanding how patients feel about the admissions process may provide the basis for investigating how perceptions at this time affect outcome and future engagement with services (Holcomb *et al.* 1998). Nearly all studies of the hospitalization process have noted that understanding patients' experiences of compulsory admission should be a priority of research. However, legal status does not fully reflect patients' experiences of coercion during the inpatient admissions process.

Perceived coercion during psychiatric hospital admission

As reviewed in Chapter 1, patient perceptions of coercion during psychiatric hospital admission have been investigated since the late 1970s (Shannon 1976). While legal status and the observation of objectively coercive events have often been used as proxy measures of coercion, there has been a move to systematically investigate patients' perceptions of coercion in recent years. The development of quantitative instruments for measuring perceived coercion has allowed for international comparison (Kallert *et al.* 2005).

These studies have been conducted primarily in the USA and Nordic countries (Gardner *et al.* 1993; Kjellin & Westrin 1998). They have examined the levels of coercion experienced by patients during the psychiatric hospital admissions process and investigated the association between perceived coercion and sociodemographic and clinical characteristics. To date, only one published study has been conducted in the UK.

This examined the levels of perceived coercion experienced by patients admitted to hospital in London and its association with engagement with services following discharge (Bindman *et al.* 2005).

2.1.3 Summary

Reducing the use of coercion has become a focus of mental healthcare policy and clinical practice. As research has traditionally focused on the use of compulsory measures, the empirical understanding of patient perceptions of coercion during the psychiatric hospital admissions process is limited. Previous research has noted that process variables, such as the involvement of other people in the admissions process and the patient-clinician relationship, may influence perceptions of coercion. However, to our knowledge, no study has examined their association with perceived coercion quantitatively. Our aim was to examine patients' perceptions of coercion during admission to hospital in the UK and to advance previous research by exploring the role of admission process variables.

2.1.4 Aims

This study had three aims:

- to investigate the level of perceived coercion experienced by patients admitted to acute adult psychiatric wards in Oxfordshire

- to identify sociodemographic, clinical and service use characteristics associated with perceptions of coercion
- to explore the role of admission experience variables in mediating perceptions of coercion during psychiatric hospitalization

2.2 *Methods*

2.2.1 Study design

The study was a cross-sectional cohort design. Patients at five acute adult psychiatric wards within the Oxfordshire Mental Healthcare NHS Trust were recruited to participate. Data were collected through an interview with the patient during the week following their admission to hospital and a review of case notes and computerized medical records. The study received ethical approval from the Mid and South Buckinghamshire Local Research Ethics Committee and the Oxfordshire Mental Healthcare NHS Trust Research and Development Committee.

2.2.2 Participants

Consecutively admitted patients during the periods between January-May 2005 and August-December 2005 were assessed for their eligibility to participate in the study. The inclusion criteria for the study were broad. To be approached to take part, patients needed to be:

- 18 to 65 years of age
- diagnosed with a mental illness
- admitted to a participating ward within the previous seven days
- able to provide written and informed consent

- adequately proficient in English to participate in an interview

Patients were excluded if they were:

- deemed by ward staff as too ill or dangerous to take part
- diagnosed with dementia (as this would prevent the provision of informed consent)

Recruitment

A member of ward staff introduced the researcher to eligible patients. The patient was given an information sheet and the study was described verbally. Those who were interested in participating were asked to provide written informed consent. If the patient did not want to take part in the study at that time, they were asked if they would mind being approached the next day. This continued for the week following their admission or until an interview was granted.

Consenting patients participated in an interview with the researcher who was independent of their care team. Interviews took place on the ward in a location that was private and amenable to the patient (e.g. an examination room or bedroom). Interviews took between 30 and 60 minutes to complete.

Patients were not compensated for their participation in the study. Those who were admitted multiple times during the study period were only interviewed following their first admission.

2.2.3 Data collected

The structured interview schedule was designed to collect data on sociodemographic and clinical characteristics and admission experience variables. These are listed in Table 2. Data collected during the interview was verified and supplemented by a review of case notes and computerized medical records.

Instrumentation

Several standardized instruments were used to collect data as noted above.

MacArthur Admission Experience Survey* (AES; Gardner *et al. 1993)

The MacArthur Admission Experience Survey (AES) is a validated psychometric measure of patients' perceptions during the admissions process (Gardner *et al.* 1993). It consists of 14 items which require a patient's true or false responses to statements about their admission to hospital. Statements answered as "true" are scored as zero and those answered as "false" are scored as one. From these items, ratings of perceived coercion, negative pressures and procedural justice can be derived.

Table 2: *Sociodemographic and clinical characteristics and admission experience variables collected through interview at admission*

Sociodemographic	**Clinical**	**Admission Experience**
- age	- diagnosis	- expectations
- sex	- co-morbid substance abuse	- involvement of others
- ethnicity	- legal status at admission	- perceived coercion[c]
- education	- change in legal status	- negative pressures[c]
- marital status	- prior admission	- procedural justice[c]
- living arrangements	- prior compulsory admission	- therapeutic alliance[d]
- IQ[a]	- functioning[b]	

[a] measured by the National Adult Reading Test (NART; Nelson & Willison 1991)

[b] measured by Global Assessment of Functioning (GAF; American Psychiatric Association 1994)

[c] measured by scale of MacArthur Admission Experience Survey (AES; Gardner *et al.* 1993)

[d] measured by the Helping Alliance Survey (HAS; Priebe & Gruyters 1993)

The perceived coercion scale consists of five statements concerning the degree of influence, control, choice and freedom the patient had in the decision to enter treatment. Scores range from 0 to 5, with a high score reflecting a high degree of perceived coercion. The negative pressures scale consists of six items looking at the patient's experience of threat, force and deception during the admission. Scores range from 0 to 6, with a low score reflecting high levels of negative pressure. The procedural justice scale consists of three items and examines the patient's experience of voice during the admissions process. Scores range from 0 to 3, with a high score reflecting low levels of procedural justice.

***Helping Alliance Scale (HAS;* Priebe & Gruyters 1993)**

The Helping Alliance Scale (HAS) was developed to measure the therapeutic relationship in patients with psychotic illness (Priebe & Gruyters 1993). It consists of five items that examine the extent to which the patient feels that they are understood by their clinician and how much their treatment reflects mutually agreeable goals. The first four items are marked on a 100-mm long visual analogue scale, from a rating of "not at all" (0 mm) to a rating of "entirely" (100 mm). The fifth question is categorical and examines whether patients felt "better, worse or unchanged" following their interaction with the clinician. The scale was adapted for use in an inpatient setting. It has been previously been modified for use in different settings and patient groups (McCabe & Priebe 2003). The HAS has been found to be a simple, brief and reliable measure of therapeutic alliance and is acceptable to patients with acute psychiatric illness (McCabe & Priebe 2003; Bale *et al.* 2006)

Global Assessment of Functioning (GAF; **American Psychiatric Association 1994)**

The Global Assessment of Functioning (GAF) is a 100-point numeric scale (American Psychiatric Association 1994). The rating takes into consideration the patient's psychological, social and occupational functioning on a continuum of mental health to mental illness. The GAF is a modified version of the Global Assessment Scale (GAS) developed by Endicott *et al.* (1976) and was first included in DSM-III-R as a measure of global functioning (American Psychiatric Association 1980).

National Adult Reading Test (NART; **Nelson & Willison 1991*)***

The National Adult Reading Test (NART) is a list of 50 words, presented in order of increasing difficulty, which are read aloud (Nelson & Willison 1991). The words are irregular with respect to common rules of pronunciation and this reduces the likelihood that the patients is using phonemic decoding, rather than word recognition, during the task. Studies have found that word-reading ability is unaffected in depression and chronic schizophrenia (Crawford *et al.* 1987; Nelson *et al.* 1990). The NART has been used extensively in psychiatric research and is effective in measuring the IQ of acutely ill and psychotic patients (O'Carroll *et al.* 1992). It has also been standardized against the Wechsler Adult Intelligence Scales-Revised (WAIS-R) (Nelson & Willison 1991).

2.2.4 Data analysis

Data were entered into a database and analyzed using the Statistical Package for Social Sciences (SPSS 14.0; SPSS, Chicago).

Descriptive statistical analyses were performed on baseline sociodemographic and clinical characteristics.

Univariate analyses were conducted to examine the association between perceived coercion score (zero to five) and sociodemographic, clinical and admission experience variables. Spearman's rank order correlation was used to test the relationship between continuous variables and perceived coercion scores. Associations between categorical variables and perceived coercion score were examined using Mann-Whitney U Tests (comparison of two categories) and Kruskal-Wallis Tests (comparison of three or more categories) as appropriate. Post-hoc analyses of significant associations between categorical variables (with three or more groups) and perceived coercion score were carried out using Mann-Whitney U Tests. Statistical significance of post-hoc analyses was determined using a Bonferroni correction. Differences were considered significantly different at $p<0.017$ (for three groups).

Univariate analyses were also conducted to investigate the association of perceived coercion level (low, score: 0-2, or high, score: 3-5) and sociodemographic, clinical and admission experience variables. Associations between categorical variables and perceived coercion level were examined using chi-square tests. Post-hoc analyses of significant associations between variables with three or more categories and perceived coercion level were carried out using chi-square test. Statistical significance of post-hoc analyses was determined using a Bonferroni correction. Differences were considered significantly different at $p<0.017$ (for three groups).

Multiple variable logistic regression analysis was also conducted to investigate the relationship between variables that were significantly associated with perceived coercion in univariate analysis and perceived coercion level (low, score: 0-2, or high, score: 3-5). Both forced entry and stepwise (backwards and forwards) procedures were used. In addition, hierarchical logistic regression analyses were used to evaluate the relative contributions of sociodemographic and clinical characteristics and admission experience variables to the prediction of perceived coercion level (Cascardi & Polythress 1997; Bindman *et al.* 2005). Collinearity diagnostic tests were run to examine multicollinearity between variables and standardized residuals and Cook's distance values were inspected to assess the influence of individual cases on the model.

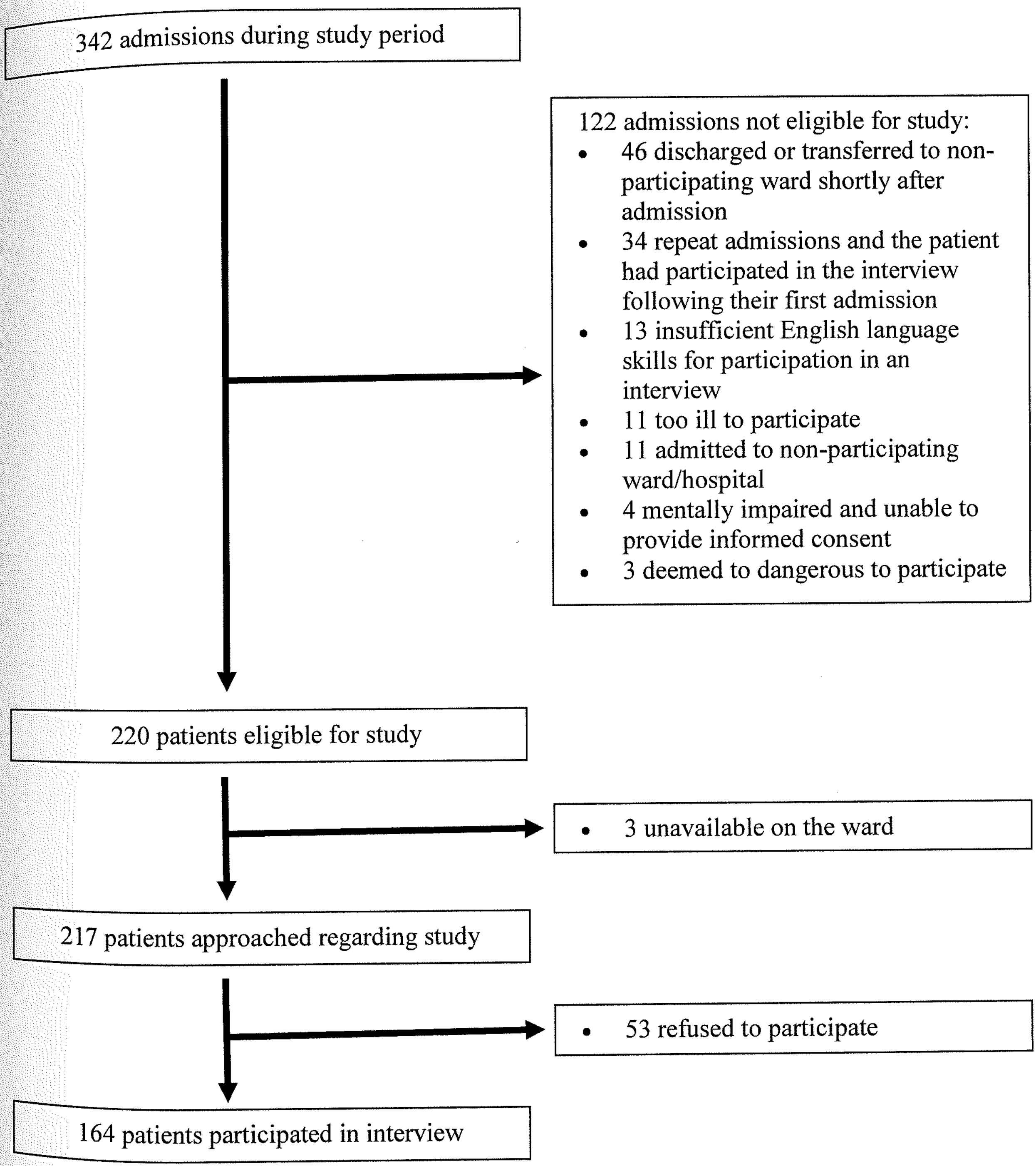
2.3 Results

2.3.1 Responders and non-responders

As shown in Figure 1, there were 342 admissions during the study period. Of these, 122 admissions were not eligible for participation (see Section 2.2.2 for inclusion and exclusion criteria): 46 patients were discharged or transferred to non-participating wards or hospitals shortly following admission; 34 patients were admitted multiple times during the study period and participated in the interview during the first admission; 13 patients did not have sufficient English language skills for participation; 11 patients had originally been admitted to non-participating wards or hospitals; and ward staff deemed that 11 patients were too ill to provide informed consent, four patients were mentally impaired and three patients were too dangerous to approach.

Of the 220 admissions that were eligible for the study, 217 were approached to take part. The remaining three patients were not available on the ward during the week following their admission. Interviews were obtained from 164 patients, a response rate of 75%. Fifty patients refused to participate because they did not feel like talking or were too tired, while three agreed to take part but were unwilling to sign the consent form.

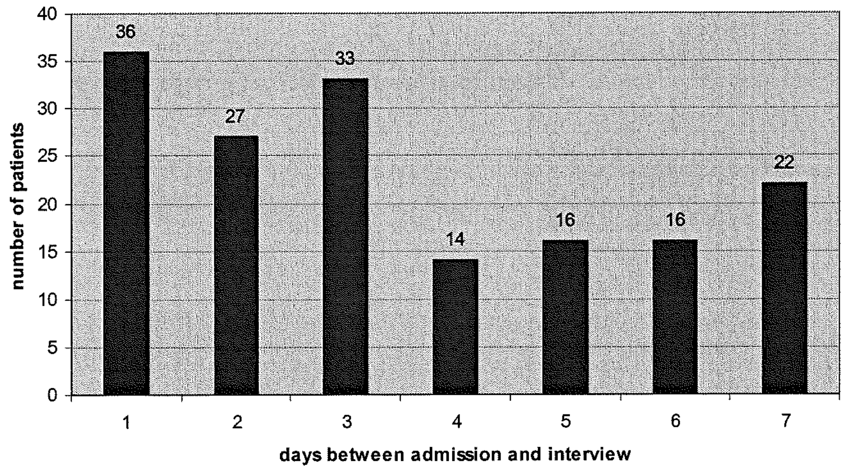
Figure 1: **Selection process for patients interviewed in study**


342 admissions during study period
122 admissions not eligible for study:
• 46 discharged or transferred to non-participating ward shortly after admission
• 34 repeat admissions and the patient had participated in the interview following their first admission
• 13 insufficient English language skills for participation in an interview
• 11 too ill to participate
• 11 admitted to non-participating ward/hospital
• 4 mentally impaired and unable to provide informed consent
• 3 deemed to dangerous to participate
220 patients eligible for study
• 3 unavailable on the ward
217 patients approached regarding study
• 53 refused to participate
164 patients participated in interview

2.3.2 Baseline characteristics of sample

All interviews with participating patients were conducted within one week of admission to hospital, as per the study protocol. As shown in Figure 2, over one-half of patients (58.6%) were interviewed within three days of their admission.

Figure 2: Length of time between index admission and interview



Collection of sociodemographic and clinical and service use data

Baseline sociodemographic and clinical characteristic data were collected by interview and a review of medical notes and computerized records. The sociodemographic and clinical/service use characteristics of the participating sample are shown in Tables 3 and 4 respectively.

Summary of baseline sociodemographic characteristics

The mean age of the sample was 38.8 years (*SD*=12.0). The majority of the sample was male (*N*=94, 57.3%), white (*N*=145, 88.4%), single (*N*=89, 54.3%) and living independently (*N*=131, 79.9%). Over half of the sample had completed A-levels or some post-secondary education (*N*=98, 59.7%). The mean IQ score of participants, as measured by the National Adult Reading Test (NART), was 108.6 (*SD*=11.9).

Summary of baseline clinical and service use characteristics

Almost half of the sample had an affective disorder (*N*=75, 45.1%) and approximately one-third had co-morbid substance abuse (*N*=56, 34.1%). The mean Global Assessment of Functioning (GAF) score was 35.3 (*SD*=14.1). 82 patients (50.0%) reported that they had previous contact with their admitting clinician.

The majority (*N*=113, 70.2%) of patients had been previously admitted to hospital, although less than one-third (*N*=50, 29.8%) had ever been detained under the Mental Health Act. Over three-quarters (*N*=128, 78.0%) of the sample were admitted to the hospital informally, with 22.0% (*N*=36) being admitted under a section of the Mental Health Act (MHA).

Table 3: Baseline sociodemographic characteristics

Characteristic	Sample (*N*=164)	
	***N* or mean**	**(%) or (*SD*)**
Age [mean (*SD*)]	38.8	(12.0)
Sex		
male	94	(57.3)
female	70	(42.7)
Ethnicity		
white	145	(88.4)
black	5	(3.0)
other	14	(8.5)
Marital status		
single	89	(54.3)
divorced/separated/widowed	30	(18.3)
married/cohabiting	42	(25.6)
widowed	3	(1.8)
Living arrangement		
independent	131	(79.9)
supported housing	22	(13.4)
homeless	9	(5.5)
prison	2	(1.2)
Education		
no qualifications	21	(12.8)
GCSE	45	(27.4)
A levels	23	(14.0)
some post-secondary	75	(45.7)
IQ (measured by NART)~ [mean (*SD*)]	108.6	(11.9)

~14 missing values, *N*=150

Table 4: Baseline clinical characteristics

Characteristic	Sample (*N*=164)	
	***N* or mean**	**(%) or (*SD*)**
Diagnosis		
affective disorder	74	(45.1)
schizophrenia	64	(39.0)
other	26	(15.9)
Co-morbid substance abuse		
yes	56	(34.1)
no	108	(65.9)
Previous admission to hospital+		
yes	113	(70.2)
no	48	(29.8)
Previous MHA admission^		
yes	50	(31.8)
no	107	(68.2)
Previous contact with admitting clinician		
yes	82	(50.0)
no	82	(50.0)
Global assessment of functioning~ [mean (*SD*)]	35.3	(14.1)
Legal status of admission		
informal	128	(78.0)
MHA	36	(22.0)

+3 missing values in dataset, *N*=161, ^7 missing values, *N*=157, ~14 missing values, *N*=150

2.3.3 Patients' experiences during the hospitalization process

Patients' experiences during the psychiatric hospitalization process were investigated in a series of interview items and standardized scales. Table 5 provides a summary of the admission experiences of the sample.

Expectations prior to admission

Almost 60% (*N*=98, 59.8%) of patients reported that they did not expect to be admitted when they came into contact with mental health services. However, nearly half (*N*=81, 49.4%) reported that they had wanted to be admitted.

Involvement of others in the hospitalization process

Patients were asked about who had first suggested hospitalization as a treatment option and asked to identify up to three individuals who were involved in this process. As shown in Figure 4, a minority of patients (*N*=18, 11.0%) stated that they had suggested hospitalization. More than half of patients (*N*=94, 57.3%) said that they were not involved in suggesting admission to hospital as a treatment option, while 52 patients (31.7%) indicated that it was suggested jointly by themselves and others.

Table 5: Admission experiences of the sample

Variable	**Sample (*N*=164)** ***N* or mean**	 **(%) or (*SD*)**
Expected admission		
yes	66	(40.2)
no	98	(59.8)
Wanted admission		
yes	81	(49.4)
no	83	(50.6)
Suggestion of admission		
own	18	(11.0)
myself and others	52	(31.7)
others	94	(57.3)
Agree with admission^{+}		
yes	119	(73.0)
no	44	(27.0)
Most influence in decision		
self	54	(32.9)
others	110	(67.1)
Voluntariness of admission		
voluntary	63	(38.2)
involuntary	25	(15.2)
neither	76	(46.1)
Freedom to leave		
yes	85	(51.8)
no	58	(35.4)
unsure	21	(12.7)
Affective response to hospital		
relieved	45	(27.4)
sad	28	(17.1)
confused	27	(16.5)
angry	25	(15.1)
frightened	22	(13.4)
pleased	11	(6.7)
safe	6	(2.4)
Therapeutic alliance score [mean (*SD*)]	278.6	(99.5)
Negative pressure score [mean (*SD*)]	4.3	(2.0)
Procedural justice score [mean (*SD*)]	1.1	(1.1)
Perceived coercion score [mean (*SD*)]	2.8	(1.8)

$^{+}$ one missing value in dataset, *N*=163

Figure 3: **Suggestion of admission**

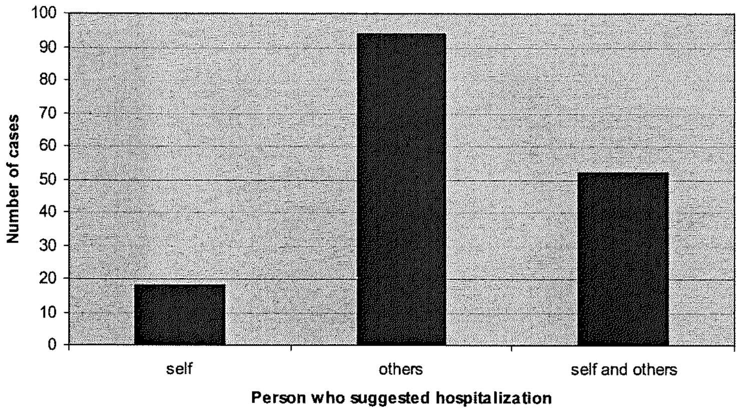


Figure 4: **Primary source of influence during the admission process**

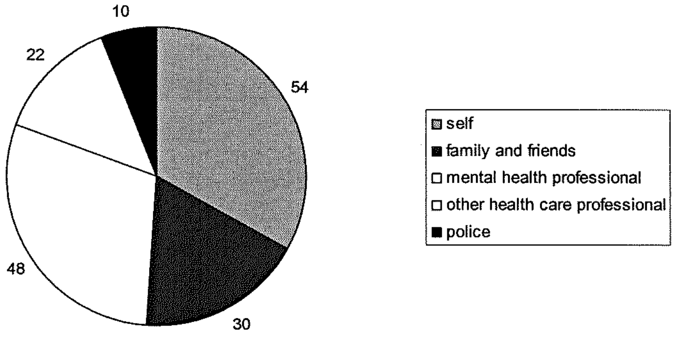


Figure 4 shows that, when asked who had the most influence over their hospitalization, approximately one-third (*N*=54, 32.9%) said that they, themselves, had the most influence. The remaining 110 patients (67.1%) reported various individuals as having the most influence in the admissions process. These included: mental health professionals in 48 (29.3%) cases, family and friends in 30 (18.3%), other health care professionals in 22 (13.4%) and the police in 10 (6.1%) of cases

Agreement with admission to hospital

Patients were asked whether they agreed that hospitalization was appropriate in their case. The majority of patients (*N*=119, 73.0%) reported that they agreed with the decision to enter hospital, while 44 (27.0%) stated that they did not agree with hospitalization.

Voluntariness of admission to hospital

Patients were asked whether their admission experience could be described as voluntary or involuntary. Nearly half of the patients, (*N*=76, 46.1%) stated that it was "neutral" and was neither voluntary nor involuntary. Over one-third of the sample (*N*=63, 38.2%) reported that their admission was voluntary and 25 patients (15.2%) stated that it was involuntary.

Freedom to leave hospital

Over half of the patients (*N*=85, 51.8%) reported that they were free to leave the hospital at the time of the interview. Of the remaining 79 patients, 58 (35.4%) believed that they were not free to leave and 21 (12.7%) were unsure of whether they were free to go.

Response to hospitalization

Over one-quarter of patients (*N*=45, 27.4%) felt relieved immediately following their admission to hospital. The affective responses of the remaining three-quarters varied: 28 (17.1%) felt sad, 27 (16.5%) felt confused, 25 (15.2%) felt angry, 22 (13.4%) felt frightened, 11 (6.7%) felt pleased and six (2.4%) felt safe following hospitalization. When collapsed into positive (relieved, pleased, safe) and negative responses (angry, confused, sad, frightened), most patients (*N*=102, 62.2%) had negative responses to hospitalization.

Therapeutic alliance with admitting clinician

Patient ratings of the therapeutic alliance were made using the Helping Alliance Scale (HAS) (Priebe & Gruyters 1991). Responses to each of the five questions are shown in Table 6. Total scores on the HAS ranged from 0 to 450. The mean HAS score was 278.6 (*SD*=99.5; *MDN*=280.0; range: 0-450)

Table 6: *Scores on Helping Alliance Scale (HAS)*

Question	**mean**	***SD***	**min**	**max**
Did you feel understood by the clinician who admitted you?	64.66	33.03	0	100
Did you feel criticized by the clinician who admitted you?	50.17	42.07	0	100
Was your admitted clinician committed to you and involved in your admission?	67.69	32.99	0	100
Is hospitalization right for you?	58.94	37.39	0	100
How did you feel immediately following admission?	37.12	21.94	0	50
TOTAL	278.58	99.47	0	450

Admission Experience Survey

Negative pressure

As shown in Figure 5, negative pressure scores ranged from the minimum of zero to the maximum of six (high scores indicated less negative pressure). The mean negative pressure score was 4.3 (*SD*=2.0) with a median of 5.0. The distribution was negatively skewed with almost half of patients (*N*=76, 46.3%) reporting no negative pressure. Individual subscale items are shown in Table 7. The scale had high internal consistency with a Cronbach α coefficient of 0.85.

Figure 5: Negative pressure scores

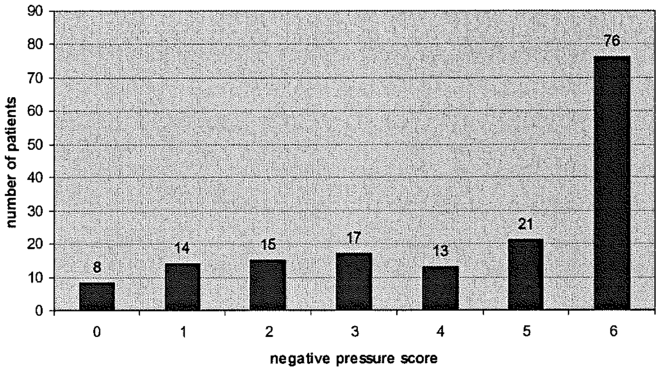


Table 7: Responses to individual items of the negative pressure scale

Item	*N*		%	
	true	**false**	**true**	**false**
People tried to force me into hospital	52	112	31.7	68.3
Someone threatened me to get me to come into the hospital	23	141	14.0	86.0
Someone physically tried to make me come into the hospital	27	137	16.5	83.5
I was threatened with sectioning	49	115	29.9	70.1
They said they would make me come into the hospital	54	110	32.9	67.1
No one tried to force me to come into the hospital*	93	71	56.7	43.3

* reverse scored

Procedural justice

Procedural justice scores (Figure 6) ranged from the minimum of zero to the maximum of four. The mean procedural justice score was 1.1 (*SD*=1.1) with a median of 1.0. The distribution of was positively skewed with 66 (40.2%) patients experiencing the greatest "voice" score. The responses to individual questions in the scale are shown in Table 8. The scale had good internal reliability with a Cronbach α coefficient of 0.65.

Figure 6: Procedural justice scores

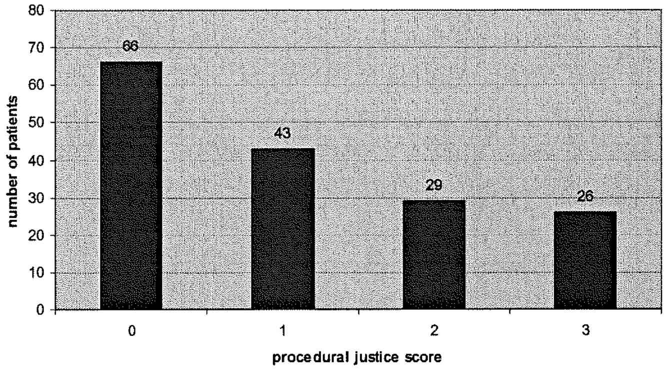


Table 8: Responses to individual items of the negative pressure scale

Item	*N*		%	
	true	**false**	**true**	**false**
I had enough of a chance to say whether I wanted to come into the hospital	115	49	70.1	29.9
I got to say what I wanted about coming into the hospital	107	57	65.2	34.8
My opinion about coming into the hospital didn't matter*	73	91	44.5	55.5

* reverse scored

Perceived coercion

As shown in Figure 7, perceived coercion scores ranged from the possible minimum of zero to the possible maximum of five. The distribution was relatively even across the range of scores, although the majority experienced high levels of coercion. The mean score was 2.8 (*SD*=1.8) with a median of 3.0. The responses to individual questions in the scale are shown in Table 9. The scale was highly internally reliable with a Cronbach α coefficient of 0.78.

Figure 7: Perceived coercion score

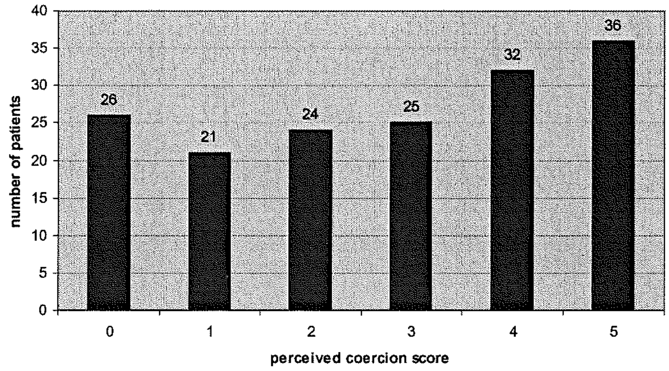


Table 9: Responses to perceived coercion scale items

Item	*N*		%	
	true	**false**	**true**	**false**
I felt free to do what I wanted about coming into the hospital	86	78	52.4	47.6
I chose to come into the hospital	105	59	64.0	36.0
It was my idea to come into the hospital	53	111	32.3	67.7
I have a lot of control over whether I came into the hospital	70	94	42.7	57.3
I had more influence than anyone else over whether I came into the hospital	54	110	32.9	67.1

2.3.4 Associations of baseline data and perceived coercion

Univariate analyses were used to test the association between perceived coercion and baseline characteristics. Perceived coercion was investigated as both a continuous and dichotomized variable.

Analyses with perceived coercion as a continuous variable

As perceived coercion scores were not normally distributed, non-parametric statistical tests were used. Spearman's rank order correlation was used to test the relationship between continuous variables and perceived coercion scores. Associations between categorical variables and perceived coercion score were examined using Mann-Whitney U Tests (comparison of two groups) and Kruskal-Wallis Tests (comparison of three or more groups) as appropriate. Post-hoc analyses of significant associations between categorical variables (with three or more groups) and perceived coercion score were carried out using Mann-Whitney U Tests. Statistical significance of post-hoc analyses was determined using a Bonferroni correction. Differences were considered significantly different at $p<0.017$.

Sociodemographic characteristics and continuous perceived coercion score

As shown in Table 10, there were no significant associations between any sociodemographic characteristics and perceived coercion score.

Clinical/service use characteristics and continuous perceived coercion score

As shown in Table 11, legal status was the only clinical/service use characteristic significantly associated with perceived coercion score. The perceived coercion scores of patients detained under the MHA at admission (*MDN*=4.5, range=1-5) were significantly higher than those who were hospitalized informally (*MDN*=2.0, range=0-5; $Z=-5.33$, $p<0.001$).

Table 10: Associations between perceived coercion score and sociodemographic characteristics

Characteristic		**Perceived Coercion Score**					
	N	**mean**	***SD***	***MDN***	**min**	**max**	**Significance of Difference**
Age	164						*rho*=-.04, *p*=.63
Sex							*Z*=-1.18, *p*=0.24
male	94	2.9	1.8	3.0	0	5	
female	70	2.6	1.7	3.0	0	5	
Ethnicity							*H*(2)=0.26, *p*=0.88
white	145	2.8	1.8	3.0	0	5	
black	5	3.2	0.4	3.0	3	4	
other	14	2.6	1.8	2.5	0	5	
Marital status							*H*(2)=5.53, *p*=0.06
single	89	2.9	1.7	3.0	0	5	
divorced/separated/widowed	33	2.1	2.0	1.0	0	5	
married/cohabiting	42	2.9	1.6	3.0	0	5	
Living arrangement							*H*(2)=0.63, *p*=0.73
independent	131	2.8	1.7	3.0	0	5	
supported housing	22	2.5	2.0	2.0	0	5	
homeless/prison	11	3.1	1.6	3.0	0	5	
Education							*H*(3)=0.47, *p*=0.93
no qualifications	21	3.0	1.6	4.0	0	5	
GCSE	45	2.6	1.8	3.0	0	5	
A level	23	2.8	1.8	3.0	0	5	
post-secondary	75	2.8	1.8	3.0	0	5	
IQ	164						*rho*=.004, *p*=.96

Table 11: Associations between perceived coercion score and clinical and service use characteristics

Characteristic		**Perceived Coercion Score**					
	N	**mean**	***SD***	***MDN***	**min**	**max**	**Significance of Difference**
Diagnosis							$H(2)=2.64$, $p=0.27$
affective disorder	64	3.0	1.7	2.5	0	5	
schizophrenia	74	2.6	1.7	3.0	0	5	
other	26	2.6	2.0	3.0	0	5	
Co-morbid substance abuse							$Z=-1.36$, $p=0.17$
yes	56	2.5	1.8	3.0	0	5	
no	108	2.9	1.8	3.0	0	5	
GAF score$^{\sim}$							$rho=-.14$, $p=.08$
Prev admission to hospital^{+}							$Z=-0.26$, $p=0.80$
yes	113	2.7	1.8	3.0	0	5	
no	48	2.8	1.6	3.0	0	5	
Prev contact with clinician							$Z=-0.51$, $p=0.61$
yes	82	2.7	1.8	3.0	0	5	
no	82	2.8	1.7	3.0	0	5	
Previous MHA admission$^{\wedge}$							$Z=-1.18$, $p=0.24$
yes	50	3.0	1.7	3.5	0	5	
no	107	2.6	1.7	3.0	0	5	
Legal status of admission							$Z=-5.33$, $p<0.001$
informal	128	2.4	1.7	2.0	0	5	
MHA section	36	4.1	1.1	4.5	1	5	

$^{\sim}$14 missing values, $N=150$; $^{+}$three missing values in dataset, $N=161$; $^{\wedge}$seven missing values, $N=157$

Analyses with dichotomized perceived coercion score

Univariate associations between perceived coercion level (low or high) and sociodemographic and clinical/service use characteristics were also tested. An *a priori* decision was made to dichotomize perceived coercion score at the midpoint of the scale (Gardner *et al.* 1993). Perceived coercion scores between zero and two were categorized as low perceived coercion and scores between three and five were categorized as high perceived coercion. Associations between categorical variables and perceived coercion level were examined using chi-square tests. Post-hoc analyses of significant associations between variables with three or more categories and perceived coercion level were carried out using chi-square test. Statistical significance of post-hoc analyses was determined using a Bonferroni correction. Differences were considered significantly different at $p<0.017$ (three groups).

Sociodemographic characteristics and perceived coercion level

As shown in Table 12, there were no significant associations between any sociodemographic characteristics and perceived coercion level.

Table 12: Associations between dichotomized perceived coercion score and sociodemographic characteristics

Characteristic	**Low Perceived Coercion (*N*=71)**		**High Perceived Coercion (*N*=93)**		**Significance of Difference**
	***N* or mean**	**(%) or (*SD*)**	***N* or mean**	**(%) or (*SD*)**	
Age [mean (*SD*)]	39.7	(12.0)	38.2	(12.1)	$t(162)=0.79$, p=0.43
Sex					$\chi^2(1)=0.54$, $p=0.46$
male	43	(60.6)	51	(54.8)	
female	28	(39.4)	42	(45.2)	
Ethnicity					$\chi^2(1)=0.36$, $p=0.55$
white	64	(90.1)	81	(87.1)	
non-white	7	(9.9)	12	(12.9)	
Marital status					$\chi^2(2)=3.5$, $p=0.17$
single	36	(50.7)	53	(57.0)	
married	16	(22.5)	26	(28.0)	
divorced	19	(26.8)	14	(15.0)	
Living arrangement					$\chi^2(2)=1.44$, $p=0.49$
independent	55	(77.5)	76	(81.7)	
supported	12	(17.0)	10	(10.8)	
prison/rough	4	(5.6)	7	(7.5)	
Education					$\chi^2(1)=0.03$, $p=0.85$
up to 16	28	(39.4)	38	(40.8)	
16 and over	43	(60.6)	55	(59.1)	
IQ$^+$ [mean (*SD*)]	109.4	(14.2)	108.1	(10.0)	$t(148)=0.64$, $p=0.52$

$^+$ 14 missing values, *N*=150

Clinical/service use characteristics and perceived coercion level

As shown in Table 13, legal status was significantly associated with perceived coercion level with a significantly higher proportion of detained patients (88.9%) experiencing high perceived coercion than those who were informally admitted (47.7%) ($\chi^2(1)=19.46$, $p<0.001$). This was the only clinical/service use variable association with perceived coercion. Patients who were compulsorily detained were 8.6 times more likely to experience high levels of perceived coercion.

2.3.5 Associations of admission experiences and perceived coercion

Univariate analyses were used to test the association between admission experiences and perceived coercion. As with associations between baseline characteristics and perceived coercion, analyses with perceived coercion as a continuous and dichotomized variable were carried out. The statistical analysis plan is outlined in Section 2.1.4.

Analyses with perceived coercion as a continuous variable

As shown in Table 14, all of the admission experience variables investigated were significantly associated with perceived coercion score.

Table 13: Associations between dichotomized perceived coercion score and clinical and service use characteristics

Characteristic	**Low Perceived Coercion (*N*=71)**		**High Perceived Coercion (*N*=93)**		**Significance of Difference**
	***N* or mean**	**(%) or (*SD*)**	***N* or mean**	**(%) or (*SD*)**	
Diagnosis					$\chi^2(2)=2.62, p=0.27$
affective disorder	37	(52.1)	37	(39.8)	
schizophrenia	25	(35.2)	39	(42.0)	
other	9	(12.7)	17	(18.2)	
Diagnosis					$\chi^2(1)=0.76, p=0.38$
schizophrenia	25	(35.2)	39	(41.9)	
other	46	(64.8)	54	(58.1)	
Co-morbid substance abuse					$\chi^2(1)=0.84, p=0.36$
yes	27	(38.0)	29	(31.2)	
no	44	(62.0)	64	(68.8)	
GAF score~ [mean (*SD*)]	37.5	(13.8)	33.6	(14.2)	$t(148)=1.71$, p=0.09
Previous contact with clinician					$\chi^2(1)=1.22, p=0.27$
yes	39	(55.0)	43	(46.2)	
no	32	(45.0)	50	(53.8)	
Previous admission to hospital+					$\chi^2(1)=0.57, p=0.45$
yes	52	(73.2)	61	(67.8)	
no	19	(26.8)	29	(32.2)	
Previous MHA admission^					$\chi^2(1)=0.01, p=0.90$
yes	22	(32.4)	28	(31.5)	
no	46	(67.6)	61	(68.5)	
Legal status of admission					$\chi^2(1)=19.46, p<0.001$
informal	67	(94.4)	61	(65.6)	
MHA section	4	(5.6)	32	(34.4)	

~14 missing values, *N*=150; +three missing values in dataset, *N*=161; ^seven missing values, *N*=157

Table 14: Associations between perceived coercion score and admission experience variables

Characteristic		Perceived Coercion Score					
	N	mean	*SD*	*MDN*	min	max	Significance of Difference
Expected admission							Z=-3.05, p=0.02
yes	66	2.3	1.7	2.0	0	5	
no	98	3.1	1.7	4.0	0	5	
Wanted admission							Z=-7.33, p<0.001
yes	81	1.7	1.5	2.0	0	5	
no	83	3.8	1.4	4.0	0	5	
Suggestion of admission							$H(2)$=46.57, p<0.001
own	18	1.0	1.1	1.0	0	3	
myself and others	52	1.9	1.4	2.0	0	5	
others	94	3.5	1.6	4.0	0	5	
Most influence							Z=-9.10, p<0.001
self	54	0.89	1.1	1.0	0	4	
others	110	3.65	1.2	4.0	0	5	
Agree with admission^{+}							Z=-7.48, p<0.001
yes	119	2.1	1.6	2.0	0	5	
no	44	4.4	1.1	5.0	0	5	
Voluntariness of admission							$H(2)$=67.74, p<0.001
voluntary	63	1.3	1.3	1.0	0	5	
involuntary	25	4.1	1.4	5.0	0	5	
neutral	76	3.5	1.4	4.0	0	5	
Freedom to leave							$H(2)$=13.47, p<0.001
yes	85	2.3	1.7	2.0	0	5	
no	58	3.4	1.6	4.0	0	5	
unsure	21	2.7	1.8	3.0	0	5	

Characteristic		**Perceived Coercion Score**					
	N	**mean**	***SD***	***MDN***	**min**	**max**	**Significance of Difference**
Affective response to hospital							*Z*=-3.24, *p*=0.001
negative	102	3.1	1.7	3.5	0	5	
positive	62	2.2	1.7	2.0	0	5	
Therapeutic alliance score	164						*rho*=-.37, *p*<.01
Negative pressure	164						*rho*=-.64, *p*<.01
Procedural justice	164						*rho*= .56, *p*<.01

[+]one missing value in dataset, *N*=163

Expectations prior to admission

Patients who expected admission to hospital had significantly lower perceived coercion scores (*MDN*=2.0, range=0-5) than those who did not expect to be admitted (*MDN*=4.0, range=0-5; $Z=-3.05$, $p=0.02$). Similarly, patients who wanted admission to hospital had significantly lower perceived coercion scores (*MDN*=2.0, range=0-5) than those who did not want to be admitted (*MDN*=4.0, range=0-5; $Z=-7.33$, $p<0.001$).

Involvement of others in the hospitalization process

There was a significant relationship between whose suggestion hospitalization was and perceived coercion score ($H(2)=46.57$, $p<0.001$). Patients who said that hospitalization was first suggested by others had significantly higher perceived coercion scores (*MDN*=4.0, range=0-5) than those who said that it was their own idea (*MDN*=1.0, range=0-3; $Z=-5.00$, $p<0.001$) and those who said it was both their and others' idea (*MDN*=2.0, range=0-5; $Z=-5.57$, $p<0.001$). There was no significant difference in perceived coercion score between patients who said that hospitalization was their own idea and those who said that it was a joint suggestion from themselves and others ($U=11.04.0$, $z=-2.24$, $p=0.03$).

There was a significant association between who the patient reported as having the most influence over the hospitalization decision and perceived coercion score ($Z=-9.10$, $p<0.001$). Patients who felt that they had the most influence had significantly lower perceived coercion score (*MDN*=1.0, range=0-4) than those who reported others (family and friends, health care professionals or the police) having the most influence (*MDN*=4.0, range=0-5; Z=-9.10, $p<0.001$)

Agreement with admission to hospital

The perceived coercion scores of patients who agreed with their admission to hospital were significantly lower (*MDN*=2.0, range=0-5) than those who did not agree with their admission (*MDN*=5.0, range=0-5; Z=-7.48, $p<0.001$).

Voluntariness of admission to hospital

There was a significant relationship between voluntariness of admission and perceived coercion score ($H(2)$=67.74, $p<0.001$). Post-hoc analysis determined that patients who felt that their admission was voluntary had significantly lower perceived coercion scores (*MDN*=1.0, range=0-5) than those who felt that it was involuntary (*MDN*=5.0, range=0-5; Z=-5.97, $p<0.001$) or "neutral" (*MDN*=4.0, range=0-5; Z=-7.37, $p<0.001$). There was no significant difference in perceived coercion between those who felt that their admission was involuntary and those who felt it was "neutral" (Z=-2.29, p=0.02).

Freedom to leave hospital

There was a significant relationship between beliefs about freedom to leave hospital and perceived coercion score (*H*(2)=13.47, *p*<0.001). Those who believed they were free to leave hospital at the time of interview had significantly lower perceived coercion scores (*MDN*=2.0, range=0-5) than those who felt they were not free to leave (*MDN*=4.0, range=0-5; *Z*=-3.68, *p*<0.001). There was no significant difference between those who felt they were free and those who did not know whether they were free to leave (*MDN*=3.0, range=0-5; *Z*=-0.92, *p*=3.53) and between those who did not believe they were free to leave and those who did not know (*Z*=-1.53, *p*=0.51).

Response to hospitalization

Patients' affective response to hospitalization was also associated with perceived coercion score with positive responses being significantly associated with lower scores (*MDN*=2.0, range=0-5) than negative responses (*MDN*=3.5, range=0-5; *Z*=-3.24, *p*=0.001).

Therapeutic alliance with admitting clinician

There was a significant negative relationship between therapeutic alliance score and perceived coercion score (*rho*=-.37, *p*<.01). Higher therapeutic alliance scores were associated with lower perceived coercion scores. Therapeutic alliance score can account for 13.7% of the variance in perceived coercion score.

Negative pressure

There was a significant negative correlation between negative pressure and perceived coercion score (*rho*=-.64, *p*<.01). Experiences of negative pressure were associated with high perceived coercion scores. Negative pressure can account for 41.0% of the variance in perceived coercion score.

Procedural justice

There was a strong positive association between procedural justice and perceived coercion (*rho*=.56, *p*<.01). Experiences of procedural justice were associated with low perceived coercion scores. Procedural justice can account for 31.4% of the variance in perceived coercion score.

Analyses with dichotomized perceived coercion level

As shown in Tables 15, all of the admission experience variables investigated were significantly associated with dichotomized perceived coercion level (high or low).

Table 15: Associations between dichotomized perceived coercion score and admission experience variables

Characteristic	**Low Perceived Coercion (*N*=71)**		**High Perceived Coercion (*N*=93)**		**Significance of Difference**
	N* or *MDN	**(%) or range**	***N* or *MDN***	**(%) or range**	
Expected admission					$\chi^2(1)=4.27, p<0.04$
yes	35	(49.3)	31	(33.3)	
no	36	(50.7)	62	(66.7)	
Wanted admission					$\chi^2(1)=35.62, p<0.001$
yes	54	(76.0)	27	(29.0)	
no	17	(24.0)	66	(71.0)	
Suggestion of admission					$\chi^2(2)=34.94, p<0.001$
own	15	(21.1)	3	(3.2)	
myself and others	33	(46.5)	19	(20.4)	
others	23	(32.4)	71	(76.3)	
Most influence					$\chi^2(1)=61.69, p<0.001$
self	48	(67.6)	5	(5.4)	
others	23	(32.4)	88	(94.6)	
Agree with admission$^+$					$\chi^2(1)=29.12, p<0.001$
yes	67	(94.4)	52	(56.5)	
no	4	(5.6)	40	(43.5)	
Voluntariness of admission					$\chi^2(2)=64.81, p<0.001$
voluntary	52	(71.2)	11	(11.8)	
involuntary	3	(4.2)	22	(23.6)	
neutral	16	(22.5)	60	(64.5)	
Freedom to leave					$\chi^2(2)=12.17, p<0.001$
yes	47	(66.2)	38	(40.9)	
no	15	(21.1)	43	(46.2)	
unsure	9	(12.7)	12	(12.9)	

Characteristic	Low Perceived Coercion (*N*=71)		High Perceived Coercion (*N*=93)		Significance of Difference
	N or *MDN*	(%) or range	*N* or *MDN*	(%) or range	
Affective response to hospital					$\chi^2(1)=4.01$, $p=0.04$
negative	38	(53.5)	64	(68.8)	
positive	33	(46.5)	29	(31.2)	
Helping Alliance Scale [*MDN* (range)]	315.0	(0-450)	245.0	(50-450)	$Z=-3.90$, $p<0.001$
Negative pressure [*MDN* (range)]	6.0	(1-6)	3.0	(0-6)	$Z=-7.00$, $p<0.001$
Procedural justice [*MDN* (range)]	0.0	(0-3)	2.0	(0-3)	$Z=-6.08$, $p<0.001$

$^{+}$ one missing value in dataset, $N=163$

Expectations prior to admission

There was a significant association between perceived coercion level and expectation of admission ($\chi^2(1)=4.27$, $p=0.04$). Patients who expected admission were significantly more likely to experience low levels of perceived coercion than those who did not expect admission.

Wanting to be admitted to the hospital and perceived coercion level were also associated. Patients who wanted to be admitted to hospital were significantly more likely to experience low levels of perceived coercion than those who did not want admission to hospital (χ^2 (1)=35.62, $p<0.001$).

Involvement of others in the hospitalization process

There was a significant association between suggestion of hospitalization and perceived coercion level ($\chi^2(2)=34.94$, $p<0.001$). Patients who reported that hospitalization was others' suggestion were significantly more likely to experience high levels of perceived coercion than those who indicated it was their own suggestion ($\chi^2(1)=24.34$, $p<0.001$) or a joint suggestion ($\chi^2(1)=21.53$, $p<0.001$). There was no significant difference in perceived coercion level between those who reported that it was solely their suggestion or a joint suggestion ($\chi^2(1)=3.31$, $p=0.07$).

Patients who reported that others had the most influence over the hospitalization decision were also significantly more likely to experience high levels of perceived coercion ($\chi^2(1)=61.69, p<0.001$).

Agreement with admission to hospital

Those who agreed that hospitalization was the appropriate course of action were significantly more likely to experience low levels of perceived coercion compared to those who did not agree with hospitalization ($\chi^2(1)=29.12, p<0.001$).

Voluntariness of admission to hospital

Beliefs about the voluntariness of admission were also significantly associated with perceived coercion level ($\chi^2(2)=64.81$, $p<0.001$). Patients who believed that their admission was not voluntary were more likely to experience high levels of perceived coercion than those who felt their admission was voluntary ($\chi^2(1)=39.0$, $p<0.001$) and those who felt their admission was "neutral" ($\chi^2(1)=52.12, p<0.001$).

Freedom to leave hospital

The belief that one was free to leave the hospital was associated with perceived coercion level ($\chi^2(2)=12.17$, $p<0.001$). Patients who believed they were free to leave were significantly more likely to experience low levels of perceived coercion than those who did not think they were allowed to go ($\chi^2(1)=12.17$, $p<0.001$).

Response to hospitalization

Patients who had negative affective responses to hospitalization were significantly more likely to experience high levels of perceived coercion than those who had positive affective responses ($\chi^2(1)=4.01$, $p=0.04$)

Therapeutic alliance with admitting clinician

There was a significant association between score on the Helping Alliance Scale (HAS) and level of perceived coercion ($Z=-3.90$, $p<0.001$). Patients experiencing low levels of perceived coercion had higher therapeutic alliance scores as measured with the HAS (*MDN*=315.0, range: 0-450 vs. *MDN*=245.0, range: 50-450).

Negative pressure

Score on the negative pressure subscale of the AES was significantly associated with perceived coercion level. Patients perceiving low levels of coercion experienced more negative pressures (*MDN*=6.0, range: 1-6) than those perceiving high levels of coercion (*MDN*=3.0, range: 0-6; $Z=-6.08$, $p<0.001$)

Procedural justice

There was a significant association between procedural justice score, as measured by the AES, and perceived coercion level. Patients who perceived low levels of coercion experienced significantly more procedural justice (*MDN*=0.0, range: 0-3) than those who perceived high levels of coercion (*MDN*=2.0; range: 0-3; *Z*=-6.08, *p*<0.001).

2.3.6 Logistic regression models of patient perceived coercion

Multiple variable analyses of variables significantly associated with perceived coercion were conducted. Logistic regression analysis was used to investigate the relationship between these variables and perceived coercion. For this analysis, perceived coercion scores were dichotomized at the midpoint of the scale to divide the sample into low (score zero to two) and high (score of three to five) perceived coercion groups (Gardner *et al.* 1993).

Ten variables were entered into the logistic regression model. Table 16 presents their associations with perceived coercion level. The logistic regression model (forced entry; Table 17) demonstrated that, when all variables were controlled for, high perceived coercion was significantly associated with: not wanting to be admitted to hospital and experiences of negative pressure and low sense of procedural justice during the

Table 16: *Associations between variables entered in the logistic regression and high perceived coercion*

				95% CI for exp *b*		
Factor	***B***	**SE**	p	**lower**	**exp *b***	**upper**
detention under MHA at admission	2.17	0.56	0.01	2.94	8.79	26.28
did not expect admission	0.66	0.32	0.04	10.03	1.94	3.67
did not want admission	2.05	0.36	0.01	3.84	7.76	15.72
did not agree with admission	2.56	0.56	0.01	4.33	12.88	38.31
felt admission was involuntary	2.34	0.76	0.01	2.35	10.38	45.85
believes not free to leave hospital	1.17	0.36	0.01	1.59	3.21	6.47
negative affective response to hospital	0.65	0.33	0.05	1.01	1.92	3.64
high score on Helping Alliance Score	-0.01	0.002	0.01	0.99	0.99	1.00
experience of little negative pressure	-0.78	0.14	0.01	0.35	0.46	0.60
experience of low procedural justice	1.15	0.21	0.01	2.11	3.16	4.74

Table 17: *Forced entry logistic regression model of factors associated with high perceived coercion*

				95% CI for exp *b*		
Factor	***B***	**SE**	p	**lower**	**exp *b***	**upper**
detention under MHA at admission	-2.04	0.83	0.81	0.16	0.82	4.17
did not expect admission	-0.57	0.47	0.23	0.22	0.56	1.43
did not want admission *	1.67	0.60	0.01	1.64	5.30	17.18
did not agree with admission	0.76	0.78	0.33	0.46	2.14	9.90
felt admission was involuntary	0.70	0.93	0.45	0.32	2.01	12.41
believes not free to leave hospital	0.16	0.54	0.76	0.41	1.71	3.36
negative affective response to hospital	0.92	0.54	0.09	0.88	2.51	7.17
high score on Helping Alliance Score	0.002	0.003	0.39	1.00	1.00	1.01
experience of low negative pressure *	-0.52	0.18	0.01	0.42	0.59	0.84
experience of low procedural justice *	0.83	0.26	0.01	1.38	2.30	3.83
constant *	3.51	1.73	0.04		33.33	
R^2=.36 (Hosmer & Lemeshow), .39 (Cox & Snell), .53 (Nagelkerke); Model $X^2(10)$=81.13, N=164, *$p<0.05$						

admissions process. The model described with these ten variables can account for approximately 43% of the variance in perceived coercion.

Stepwise logistic regression (forwards and backwards) was also used to investigate the relationship between variables. A significance level of 10% was used to retain variables in the model and a significance level of 5% was used to exclude them. Tables 18 and 19 show the final models in the forward and backward stepwise logistic regression analyses respectively. Both of these methods produced similar results. Significant associations were found between high perceived coercion score and not wanting to be admitted to hospital and experiences of negative pressure and low sense of procedural justice.

Hierarchical logistic regression analyses were then used to evaluate the relative contributions of sociodemographic, clinical, and admission experience variables to the prediction of perceived coercion level. The inclusion of different variables was based on previous studies of perceived coercion (Lidz *et al.* 1995; Cascardi & Polythress 1997; Bindman *et al.* 2005). Table 20 shows the block-wise decomposition of this model.

In the first block, sociodemographic characteristics (gender, age, ethnicity [white/non-white], education [below age 16/ age 16 and above] were entered. These variables did not significantly improve the prediction of perceived coercion and explained approximately 2% of the variance in perceived coercion level. Clinical characteristics

Table 18: *Forward stepwise logistic regression model of factors associated with high perceived coercion (final model)*

				95% CI for exp *b*		
Factor	***B***	**SE**	***p***	**lower**	**exp *b***	**upper**
did not want admission *	1.06	0.43	0.01	1.25	2.89	6.68
experience of low negative pressure *	0.54	0.15	0.01	0.43	0.58	0.78
experience of low procedural justice *	0.74	0.23	0.01	1.32	2.09	3.30
constant	1.66	0.88	0.06		5.25	

R^2=.33 (Hosmer & Lemeshow), .37 (Cox & Snell), .49 (Nagelkerke); Model $X^2(3)=74.18$, $N=164$, *$p<0.01$

Table 19: *Backward stepwise logistic regression model of factors associated with high perceived coercion (final model)*

				95% CI for exp *b*		
Factor	***B***	**SE**	***p***	**lower**	**exp *b***	**upper**
did not want admission *	1.50	0.52	0.01	1.62	4.47	12.31
negative affective response to hospital	0.83	0.52	0.10	0.83	2.30	6.33
experience of low negative pressure *	-0.58	0.16	0.01	0.42	0.56	0.76
experience of low procedural justice *	0.72	0.24	0.01	1.30	2.06	3.27
constant	1.27	0.91	0.16		3.56	

R^2=.35 (Hosmer & Lemeshow), .38 (Cox & Snell), .51 (Nagelkerke); Model $X^2(4)=76.94$, $N=164$, *$p<0.01$

Table 20: *Relative contributions of sociodemographic, clinical and admission experience variables to predicting high perceived coercion level*

				95% CI for exp *b*		
Factor	***B***	**SE**	***p***	**lower**	**exp *b***	**upper**
Block One (sociodemographic)						
gender [male/female]	-0.32	0.35	0.36	0.37	0.73	1.44
age	-0.02	0.02	0.22	0.96	0.98	1.01
ethnicity [white/non-white]	0.26	0.52	0.62	0.47	1.30	3.62
education	0.10	0.34	0.77	0.56	1.11	2.16
R^2=.01 (Hosmer & Lemeshow), .02(Cox & Snell), .02 (Nagelkerke); Model X^2(4)=2.50, N=149, *p=0.64						
Block Two (clinical)						
diagnosis [affective/SZ or other]	0.44	0.34	0.20	0.79	1.56	3.06
GAF	-.02	0.01	0.07	0.96	0.98	1.00
R^2=.04 (Hosmer & Lemeshow), .05 (Cox & Snell), .07 (Nagelkerke); Model X^2(6)=7.55, N=149, *p=0.27						
Block Three (legal status)						
legal status [informal/sectioned]	2.07	0.58	0.00	2.53	7.95	24.97
R^2=.12 (Hosmer & Lemeshow), .15 (Cox & Snell), .20 (Nagelkerke); Model X^2(7)=24.65, N=149, *p=0.0.001						
Block Four (therapeutic alliance)						
HAS score	-0.01	0.00	0.01	0.99	1.00	1.00
R^2=.16 (Hosmer & Lemeshow), .20 (Cox & Snell), .26 (Nagelkerke); Model X^2(8)=32.25, N=149, *p<0.0.001						
Block Five (negative pressure)						
experience of low negative pressure	-0.68	1.37	0.00	0.37	0.50	0.69
R^2=.28 (Hosmer & Lemeshow), .32 (Cox & Snell), .42 (Nagelkerke); Model X^2(9)=56.78, N=149, *p<0.0.001						
Block Six (procedural justice)						
experience of low procedural justice	0.80	0.26	0.00	1.33	2.22	3.71
R^2=.33 (Hosmer & Lemeshow), .36 (Cox & Snell), .49 (Nagelkerke); Model X^2(10)=67.37, N=149, *p<0.0.001						

(diagnosis [affective/other] and GAF score) were added to the model in the second block. Again, these variables did not significantly improve the prediction of perceived coercion. They explained approximately 5% of the variance in perceived coercion level. In the third block, legal status [informal/compulsory] was entered into the model. This significantly improved the prediction of perceived coercion. The amount of variance explained by the model was increased to approximately 16%. Score on the Helping Alliance Scale (HAS) was added in the fourth block. This partially confounded the effect of legal status. The inclusion of HAS score increased the amount of variance explained to approximately 21% and significantly improved the prediction of perceived coercion level. In the fifth and sixth block, negative pressure and procedural justice were added respectively. The addition of these variables confounded the effects of legal status and HAS score. The inclusion of both these variables to the model significantly improved the prediction of perceived coercion. The addition of negative pressure increased the amount of variance explained to approximately 34% and this was further increased by the addition of procedural justice in the model to approximately 39%. Although the addition of procedural justice slightly confounded the effect of negative pressure, both the variables were independently associated with perceived coercion level.

2.4 Discussion

In this study, perceptions of coercion in a sample of patients admitted to acute adult psychiatric wards in Oxford were investigated. We examined the association of perceived coercion with sociodemographic, clinical and service use characteristics. We also explored the association between admission experience variables and perceptions of coercion. To our knowledge, this is the first such study to include a patient rating of therapeutic relationship with their admitting clinician. Only one other study of patients' perceptions of coercion during the inpatient admission process has been published in the United Kingdom (Bindman *et al.* 2005).

2.4.1 Principal findings

Levels of perceived coercion

The results of this study indicate that there is considerable variation in patients' perceptions of coercion. While a substantial number of patients experienced little or no coercion, the majority of patients experienced high levels of perceived coercion. These results support previous studies conducted internationally which have found similar variation in perceptions of coercion (Hiday *et al.* 1997; Hoge *et al.* 1997; Hoge *et al.* 1998; Gardner *et al.* 1999; McKenna *et al.* 1999; Poulsen *et al.* 1999; Rain *et al.* 2003; Bindman *et al.* 2005; Kjellin *et al.* 2006).

The distribution of perceived coercion scores in this study differed from those in previous studies (Gardner *et al.* 1993; Hiday *et al.* 1997). While most of those studies noted the bimodal distribution of scores on the MacArthur Perceived Coercion Scale (MPCS), this study found a relatively even distribution across the range of scores. Researchers have suggested that the bimodal distribution found previously indicated that feeling coerced may reflect a fundamental "violation of integrity" that is either present or absent (Hoyer 1999; Iversen *et al.* 2002). However, our results support conceptualizations of coercion as a continuum (Rosenbaum 1986; Hiday 1992; Rogers 1993). The notion of coercion as a continuum is also supported by patients' feelings of voluntariness during the admissions process in this study. While patients were legally either informally or compulsorily admitted to hospital, nearly half of patients reported that they would describe their admission as neither voluntary nor involuntary and that it fell between those two extremes.

The levels of perceived coercion in this sample were high compared to previous studies, both in terms of mean perceived coercion score and the proportion of patients who were highly coerced. This high level of perceived coercion may reflect differences at an individual or systems level. Firstly, previous studies have found that perceived coercion levels are often higher in individuals of "higher status" (Hiday *et al.* 1997; Lidz *et al.* 1998). Hiday *et al.* (1997) suggested that these higher status individuals may have more "resources, autonomy and control in their daily work and family roles" and so have a heightened awareness of any restriction of this liberty and autonomy. Although we found no significant associations between these sociodemographic variables and perceived coercion level, overall our sample was highly educated. This may have resulted in the sample having overall high levels of perceived coercion.

Secondly, the increased level of perceived coercion found in this study is particularly apparent when our results are compared to studies conducted in the USA. Of all previous MPCS studies, our results are most similar to Bindman *et al.* (2005) which was also conducted in England. This result could indicate that the mental health care system in England is actually more coercive than in the United States. However, as previously noted, individuals' expectations may influence perceptions of coercion. Patients in the public mental health system in the United States may be less autonomous in their day-to-day life than those in the mental health care system in England and therefore feel less coerced during admission. As legislation allowing for mandated community treatment exists in most states in the USA, hospitalization may not seem as coercive as in the United Kingdom. Previous studies have noted that levels of perceived coercion vary across jurisdictions (Lidz *et al.* 1995; Nicholson *et al.* 1996).

Legal status and perceived coercion

As in previous studies, univariate analyses found that perceptions of coercion and legal status were significantly associated. Nearly all patients who were admitted involuntarily under a section of the Mental Health Act perceived that they were highly coerced during the admissions process. Patients who were compulsorily admitted had significantly higher perceived coercion scores than those who were admitted informally. However, legal status and subjective feelings of coercion were not equivalent. Nearly half of informally admitted patients experienced high levels of perceived coercion and one-tenth of compulsorily admitted patients experienced low levels of perceived coercion.

The proportion of compulsorily admitted patients experiencing low levels of perceived coercion was low compared to previous research, while the proportion of informally admitted patients experiencing high levels of perceived coercion was high. This means that there were fewer "uncoerced involuntary" and more "coerced voluntary" patients compared to other studies (Hoge *et al.* 1997). While cases of "coerced voluntary" patients have often been described in the literature (Gilboy & Schmidt 1971; Lewis *et al.* 1984; Beck & Golowka 1988), the reasons why patients who report that they wanted admission to hospital would be admitted involuntarily are not well understood. In some cases, cognitive impairments and deficits in communication may result in a patient being admitted involuntarily and then retrospectively reporting that they wanted to be admitted (Hoge *et al.* 1997). Researchers have also suggested that "uncoerced involuntary" patients may reflect situations where mental health professionals have "use[d] the law in an opportunistic way in order to get patients admitted" (Miller 1980; Iversen *et al.* 2002). Involuntary procedures are reportedly used to make admission easier when there is a shortage of hospital beds in Norway (Iversen *et al.* 2002). In the United States, where a two-tier health care system exists, mental health legislation may be invoked to ensure that patients without insurance are transported and admitted for treatment (Miller 1980; Hoge *et al.* 1997).

In England, the Mental Health Act requires that a patient refuse to accept treatment informally before they can be compulsorily detained, decreasing the likelihood of "uncoerced involuntary" patients. Moreover, because of the provision of universal health care through the National Health Service and good inpatient bed coverage in Oxford, it may not be necessary to resort to using mental health legislation to ensure that patients are admitted.

Other factors associated with perceived coercion

As previously noted, univariate analyses indicated that legal status was significantly associated with perceived coercion. No other sociodemographic, clinical or service use characteristics were significantly associated with perceived coercion. Logistic regression analyses also demonstrated that these variables explained very little of the variance in perceived coercion score. This finding was similar to previous studies that found no or few associations between perceived coercion and sociodemographic and clinical characteristics (Lidz *et al.* 1995; Cascardi & Polythress 1997).

Most admission experience variables were associated with perceived coercion in univariate analysis. Perhaps unsurprisingly, patients were less likely to feel coerced if they expected and wanted to be admitted, if they were involved in suggesting hospitalization, if they agreed with hospitalization, and if they had a positive affective reaction to admission (Monahan *et al.* 1999). Similar to previous studies, patients were more likely to feel coerced if they felt forced or threatened into entering hospital (experience of negative pressure) or if they felt they had little "voice" in the admissions process (little procedural justice) (Gardner *et al.* 1993; Hiday *et al.* 1997; Hoge *et al.* 1998; McKenna *et al.* 1999; Iversen *et al.* 2002; Sorgaard 2004; Bindman *et al.* 2005). After controlling for negative pressure and procedural justice, legal status was not significantly associated with perceived coercion.

One of the main arguments against the use of coercion in psychiatric care is that it may damage the patient-clinician relationship (Meichenbaum & Turk 1987; Rogers 1993). This study of perceived coercion was the first, to our knowledge, to include a measure of therapeutic relationship. A significant association between therapeutic relationship and perceived coercion was found in univariate analysis. Patients who had lower therapeutic alliance scores were more likely to perceive high levels of coercion. This association was confounded in multiple variable analyses by the addition of negative pressure and procedural justice to the logistic regression model. This suggests that the therapeutic alliance scale (HAS) may be measuring similar dimensions of the admissions process as the negative pressure and procedural justice scales. This makes sense intuitively, as positive therapeutic relationships are likely to be non-threatening (low negative pressure) and involve the patient feeling that they are respected and listened to (procedural justice).

Improving patient-clinician communication and the therapeutic relationship may mediate experiences of procedural justice and negative pressure (Hoyer 1999).

The cross-sectional nature of this study means that it is not possible to determine causality. Patients may have had negative views of their relationship with the admitting clinician because they felt they had been coerced into hospital, or they may have perceived that they were coerced because their relationship with the admitting clinician was poor. Regardless of the causal nature of this association, this result highlights the link between perceived coercion and therapeutic relationship and indicates that it should be an area of focus for future research (McGuire *et al.* 2001; McCabe & Priebe 2004).

2.4.2 Limitations of study

Several methodological constraints should be taken into consideration when assessing the results of this study. Firstly, a substantial number of patients admitted to the hospital were either excluded from the study or refused to participate. Approximately 20% were excluded because they were discharged or transferred from the ward before they could be approached by the researcher or because they were deemed too ill to participate by ward staff. A further 15% of patients who were approached refused to participate. This non-participation rate is similar to those reported in other studies of perceived coercion (Nicholson *et al.* 1996; Poulsen 1999). As some of these were excluded because they were dangerous or particularly impaired, the data collected from the sample may not reflect their views (Hoyer 1999). Similarly, patients who refused to participate may have different attitudes toward the hospitalization process. This may limit the ability to generalise our findings.

Secondly, the study was limited in terms of geographical area. All participants were recruited from acute adult wards in Oxford and most lived in surrounding areas of Oxfordshire. The patients included in this sample may not be representative of those in other countries or other areas of England. Research has found that thresholds for hospitalization and use of mental health legislation vary greatly within England and Wales (Ford *et al.* 1998). In terms of sociodemographic and clinical characteristics, this study included a greater proportion of informally admitted patients, as well as more white and higher educated patients, compared to the only published study of perceived coercion in the UK (Bindman *et al.* 2005). This reflects differences in the general population characteristics of the two areas in which the studies were conducted. Despite these differences, compared to studies of perceived coercion internationally, the results are most similar to that in Bindman *et al.* (2005) indicating that the results may be generalised to England and Wales.

Thirdly, as previously mentioned, the cross-sectional nature of the study makes it difficult to determine causality. For example, there was a significant association between negative affective reaction following admission and high perceived coercion. However, it is not clear whether patients had negative responses to hospitalization because they felt coerced or whether patients felt they were coerced during admission because they had negative views of hospitalization. Longitudinal studies are needed to address the issue of causality and also to investigate changes in patients' experiences of and attitudes toward mental health care over time.

Finally, a number of patients who were admitted informally in this study were then detained under the MHA following their admission to hospital. It was not possible in this study to analyze perceived coercion separately for this group. However, this group may be of interest in future studies of perceived coercion as their change in legal status may more accurately reflect their experiences of coercion during the admissions process (Poulsen 1999).

2.4.3 Summary

This study supports previous findings suggesting that perceptions of coercion are not associated with sociodemographic and clinical characteristics, but reflect patients' beliefs and experiences during the admissions process. Patients feel more coerced during the hospital admissions process when they feel forced or threatened to accept hospitalization and when they feel that they have not had the opportunity to voice their opinions about hospitalizations. Patients' perceptions of coercion tend to reflect their feelings about the justice of the admissions process; these are decreased when the patient feels they have been given the opportunity to tell their side of the story and treated respectfully.

3 Clinicians' perceptions of coercion during the psychiatric hospital admissions process

3.1 Introduction

The increased focus on patient autonomy has often resulted in the role of the clinician being overlooked in psychiatric decision making. However, clinicians are the gatekeepers to mental health services, both in community and inpatient care. The decision to admit a patient to hospital, informally or compulsorily, is complex and requires the consideration of many factors. While studies have examined clinicians' decisions to admit patients to hospital, there is a lack of research investigating clinicians' experiences during the admissions process. The aim of this study was to collect data from patient-clinician dyads to explore how each party experienced the admissions process.

3.1.1 Clinicians' role in the psychiatric hospitalization process

Clinicians in all medical disciplines often act as gatekeepers to more specialized services (National Institute for Clinical Excellence 2000; Forrest *et al.* 2000; Forrest 2003). They "collaborate with patients to identify their healthcare needs and choose services that effectively meet those needs" (Forrest 2003). However, as healthcare resources are limited, clinicians play an important role in determining how these resources are rationed.

Clinicians as gatekeepers to inpatient psychiatric services

In mental healthcare, treatment in the community is the preferred option over hospitalization for several reasons. Community treatment has been found to be associated with improved adherence with treatment and engagement with services (for review, see Burns 2001), preferred by patients and their carers (Swartz *et al.* 2003) and cost effective compared to inpatient care (Knapp *et al.* 1994). With the closure of many psychiatric hospitals and wards in recent decades, available psychiatric beds in hospital are a scarce resource (see Ford *et al.* 1998).

Inpatient care remains an essential part of good psychiatric services (Burns & Kent 1994; Thornicroft & Tansella 2004; Joy *et al.* 2006) and, while the number of psychiatric hospital beds has decreased, admission rates over the same period have increased (see Ford *et al.* 1998). This has resulted in high rates of bed occupancy and difficulties in finding beds for patients who require admission (Powell *et al.* 1995; Fulop *et al.* 1996; Ford *et al.* 1998). Consequently clinicians use hospital admission only in situations when it is essential.

Psychiatric hospitalization is a complex and unique process in healthcare; and medical, ethical and legal factors must all be taken into consideration. Medically, the patients' need for inpatient treatment must be assessed and the clinician must believe that their mental illness cannot be treated in a less restrictive environment. Ethically, the clinician must consider the opinion and choices of the patient. They must ensure that the patients' views concerning care are respected, but also act in the patient's best interest. Legally, the clinician must assess whether the patient is a risk to themselves or others. If they are, they can invoke legal procedures under the Mental Health Act to ensure that the patient receives care in hospital. Issues of risk and liability are increasingly important in clinicians' decisions to admit patients to hospital (Harrison 1997).

3.1.2 Factors influencing clinicians' decisions to admit patients

Despite the important role of clinicians as gatekeepers to psychiatric services and the complexity of the assessment process, research in this area has been limited. Most of the studies have investigated factors associated with compulsory hospitalization (Appelbaum & Hamm 1982; Schwartz *et al.* 1984; Lidz *et al.* 1989; Bagby *et al.* 1991; Engleman *et al.* 1998), the sociodemographic and clinical characteristics that predict psychiatric hospital admission following assessment at an emergency ward (Friedman *et al.* 1983; Apsler & Bassuk 1983; Zohar *et al.* 1987; Marson *et al.* 1988; Gillig *et al.* 1990; Way & Banks 2001) or the reasons that clinicians admit patients (Flannigan *et al.* 1994; Abas *et al.* 2003; Fitzpatrick *et al.* 2003).

Clinicians' decision to admit patients compulsorily

The majority of studies examining clinicians' decision to admit patients to hospital compulsorily have investigated whether the decision to admit met the legal criteria for compulsory hospitalization legislation. Some studies have investigated the association between symptoms, clinician characteristics and situational variables and the decision to admit (for review, see Engleman *et al.* 1998). This research indicates that the extent to which the decision to admit compulsorily is consistent with legislation varies. Moreover, as Engleman *et al.* (1998) noted, "even when clinicians' judgments are consistent with the law, unexplained variations in decision making exist". These studies have suggested that patient and clinician characteristics have an effect on the decision to admit. Patient factors included: their diagnosis, the treatability of their condition, their level of dangerousness, education level, age, negative attitude, residential status and level of support available. Clinician factors included: their professional status and their previous experience.

Clinicians' decisions to admit from emergency wards

Studies which examined factors associated with admission following presentation to an emergency ward found that the decision to admit is based on a combination of medical, social and clinician factors (Meyerson *et al.* 1979; Friedman *et al.* 1983; Apsler & Bassuk 1983; Zohar *et al.* 1987; Marson *et al.* 1988; Gillig *et al.* 1990; Anderson & Eppard 1995; Way & Banks 2001). Medical factors included: diagnosis, degree of psychopathology, clinical history and dangerousness to self or others. Social factors included: lack of social support, opinion of family and friends and coping style. Clinician factors included: the personal and emotional characteristics of the physician, intuitive reasoning, connection with client and the prior experience of the clinician.

Clinicians' reasons for admission

Studies investigating the reasons why patients are admitted to hospital have used varying methodologies. Some have asked keyworkers to give feedback on the decision making process (Flannigan *et al.* 1994), while others have used case note reviews (Abas *et al.* 2003). These studies have examined both the major and contributory reasons for admission to hospital. Abas *et al.*'s (2003) study in New Zealand looked at the major reasons for admission. These were mainly illness related and the most common were admission for the reinstatement of medication (46%), intensive observation (43%) and non-compliance with medication (35%). Flannigan *et al.* (1994) investigated both major and contributory reasons for admission in two health districts in London. While the reasons for admission varied between the two sites, the most common major reason for admission overall was relief of carers (29%) and the most common contributory reason was patient's request (34%).

3.1.3 Role of perceived pressure in clinician decisions

With an increased focus on patient autonomy in healthcare, it has been suggested that clinicians can feel forced to comply with patient demands for treatment even when they feel these are inappropriate or ineffective (Gallagher *et al.* 1997). This has been well documented in antibiotic prescribing (Scott *et al.* 2001). More recently, Little *et al.* (2004) investigated the role of perceived pressure on clinicians' decision to prescribe or refer patients for further investigation.

Perceived pressure in psychiatric hospital admissions

As previously mentioned, there is much variation in clinicians' decision to admit patients to psychiatric hospital. Research suggests that non-clinical reasons may contribute to this decision. Studies indicate that factors like "intuitive reasoning", "connection with client" and the "influence of others" may play a role (Anderson & Eppard 1995). Moreover, many researchers have suggested that clinicians may feel pressured to admit patients to hospital (Tischler 1966; Rose 1977; Friedman *et al.* 1983; Zohar *et al.* 1987; Gillig *et al.* 1990; Anderson & Eppard 1995; Fitzpatrick *et al.* 2003). Zohar *et al.* (1987) and Friedman *et al.* (1983) have noted this most explicitly. Zohar *et al.* (1987) stated that "the role of pressures by family members in the admission process cannot be disregarded" as "the clinician in charge can be taken advantage of by a shrewd patient or by the patient's family". In commenting on their finding that "patients who come to our ER with a family member have a higher admission rate than patients who come to our ER alone", Friedman *et al.* (1983) concluded that "this seems to indicate some agenda, sometimes hidden, on the part of the family to help hospitalize the patient".

3.1.4 Summary

Although clinicians are gatekeepers to psychiatric services, limited research has examined the decision making process in psychiatric hospitalization. These studies have mainly focused on the reasons clinicians admit patients to hospital, either compulsorily or voluntarily. Most note that there is great variation in the criteria used for admission and suggest clinician factors. However, to our knowledge, no study has identified these clinician factors. As part of this investigation of perceived coercion in patients, we wanted to investigate clinicians' perceptions of pressure and choice during the process.

3.1.5 Aims

This study had three aims:

- examine the extent to which clinicians felt pressure, beyond simple medical need, to admit patients to hospital
- to investigate the relationship between clinician and patient perceptions of coercion
- to explore the role of admission experience variables in mediating perceptions of coercion during psychiatric hospitalization

3.2 *Methods*

3.2.1 Study design

The study was a cross-sectional dyad study, with data collected from patients admitted to acute adult psychiatric wards and the clinician responsible for their admission.

Patients at five acute adult psychiatric wards within the Oxfordshire Mental Healthcare NHS Trust were recruited to participate. Data were collected by interviews during the week following their admission to hospital and verified by a review of case notes and computerized medical records. All patients consented to the clinician responsible for their admission to be contacted. These clinicians were identified by either the patient or review of case notes. Admitting clinicians were sent a questionnaire in the week following the patient interview.

3.2.2 Patient participants

Patient recruitment is detailed in Section 2.1.2. In summary, consecutively admitted patients to five acute adult psychiatric wards were assessed for their eligibility to participate in the study. Of the 342 admitted during this period, 220 were eligible for the study and 164 consented and participated in an interview during the week following their admission.

3.2.3 Patient data collected

The structured interview schedule was designed to collect data on sociodemographic and clinical characteristics and admission process variables. These are listed in Table 2. Data collected during the interview was verified and supplemented by a review of case notes and computerized medical records.

Instrumentation

Several standardized instruments were used to collect data as noted above. These are described in Section 2.1.3.

3.2.4 Clinician participants

The clinician who was most responsible for the patient's admission to hospital, referred to as the "admitting clinician" in this study, was also recruited to take part. Admitting clinicians were identified by the patient during their interview or, in cases where the patient could not identify an individual, by a review of the case notes. When the patient could not name their admitting clinician, they were asked to describe the person they felt was most responsible for their admission to hospital. This information was then used to guide the case note review.

Clinicians identified through this process were sent a letter and questionnaire. These noted the patient's name and the date of their admission and requested that the clinician respond to the questionnaire with reference to that one specific event. Clinicians were asked to complete the questionnaire and return it promptly. If the questionnaire was not returned, up to three reminder letters and questionnaires were mailed out.

3.2.5 Clinician data collected

The questionnaire was designed to collect data on demographic and professional characteristics and admission experience variables. These are shown in Table 21. Clinicians who were involved in the admission of more than one patient during the study period were only required to complete the section of the questionnaire regarding admission process variables for subsequent admissions.

Instrumentation

The questionnaire used in this study was comprised of purpose-designed items and two standardized instruments as noted below.

MacArthur Admission Experience Survey (modified; C-**AES; Gardner *****et al. 1993)***

The MacArthur Admission Experience Survey (AES) is a validated psychometric measure of patients' perceptions during the admissions process (Gardner *et al.* 1993).

Table 21: Sociodemographic and professional characteristics and admission experience variables collected through clinician questionnaire

Sociodemographic	**Professional**	**Admission experience**
- age	- professional designation	- expectations
- sex	- years in mental health field	- involvement of others
- ethnicity	- experienced burnout [a]	- affective reaction to admission
		- perceived coercion [b]
		- negative pressures [b]
		- procedural justice [b]
		- pressure to admit

[a] measured by the Maslach Burnout Inventory (MBI; Maslach & Jackson 1981)

[b] measured by scale of modified MacArthur Admission Experience Survey (C-AES; Gardner *et al.* 1993)

For this study, we modified the scale to examine clinician experiences during the admissions process. The modified scale, the Clinician Admission Experience Survey (C-AES), was presented at the European Network for Mental Health Services Research (ENMESH) conference in London in September 2005. Feedback on the modified scale was gathered from clinicians and researchers. This was generally positive and clinicians felt that a study of their experiences during the admissions process was an important and valid exercise.

Like the original AES, the C-AES consists of 14 items which require true or false responses to statements about clinicians' experiences when admitting a patient to hospital. Statements answered as "true" are scored as zero and those answered as "false" are scored as one. From these items, ratings of perceived coercion, negative pressures and procedural justice can be derived.

The perceived coercion scale consists of five statements concerning the degree of influence, control, choice and freedom in the decision to admit the patient to hospital. Scores range from zero to five, with a high score reflecting a high degree of perceived coercion. The negative pressures scale consists of six items looking at the clinician's experience of threat, force and deception during the admission. Scores range from zero to six, with a low score reflecting high levels of negative pressure. The procedural justice scale consists of three items and examines the clinician's experience of voice during the admissions process. Scores range from zero to three, with a high score reflecting low levels of procedural justice.

***Maslach Burnout Inventory* (MBI; Maslach & Jackson 1981)**

The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) is validated psychometric measure of experience of burnout for those working in human services and institutions (Maslach & Jackson 1981). It consists of 22 items and each is scored according to the frequency with which it occurs. The scale ranges from never (score of zero) to everyday (score of six). The survey contains three subscales that assess different aspects of experienced burden: emotional exhaustion (EE), depersonalization (DP) and reduced personal accomplishment (PA). Burnout is viewed as a continuous variable, ranging from low to high degrees of experienced feeling. A low degree of burnout is associated with low scores on the EE and DP subscales and high scores on the PA subscale, while a high degree of burnout is reflected in high scores on the EE and DP subscales and low scores on the PA subscale. A moderate degree of burnout is reflected in average scores on all three subscales.

3.2.6 Data analysis

Data were entered into a database and analyzed using the Statistical Package for Social Sciences (SPSS V. 14.0; SPSS, Chicago).

Descriptive statistical analyses were performed on baseline sociodemographic and clinical characteristics.

Univariate analyses were conducted to examine the association between perceived coercion score (zero to five) and sociodemographic, clinical and admission experience variables. Spearman's rank order correlation was used to test the relationship between continuous variables and perceived coercion scores. Associations between categorical variables and perceived coercion score were examined using Mann-Whitney U Tests (comparison of two groups) and Kruskal-Wallis Tests (comparison of three or more groups) as appropriate. Post-hoc analyses of significant associations between categorical variables (with three or more groups) and perceived coercion score were carried out using Mann-Whitney U Tests. Statistical significance of post-hoc analyses was determined using a Bonferroni correction. Differences were considered significantly different at $p<0.017$ (for three groups).

Multiple variable logistic regression analysis was also conducted. This was used to investigate the relationship between variables that were significantly associated with perceived coercion in univariate analysis and perceived coercion level (low, score: zero to one, or high, score: two to five). Collinearity diagnostic tests were run to examine multicollinearity between variables and standardized residuals and Cook's distance values were inspected to assess the influence of individual cases on the model.

3.3 *Results*

3.3.1 Responding clinicians

As shown in Figure 8, questionnaires were sent to the 87 clinicians identified in 164 cases from the patient study (see Section 2.2). Responses to the questionnaire were received in approximately half of the cases (*N*=83, 50.6%). Dyadic datasets, with information collected from both patient and clinician, were acquired for 69 of 164 (42.1%) cases. Of the remaining 95 cases: clinicians failed to respond to the questionnaires in 81 cases; clinician returned incomplete questionnaires in six cases; five clinicians had moved; two clinicians reported they could not remember the particular admission as they were duty doctors; and one clinician refused to participate on principle, disagreeing with the negative connotation he believes is associated with the word "coercion" in the medical literature.

As shown in Figure 9, 69 questionnaires were returned from 41 clinicians. The number of questionnaires returned per clinician ranged from one to six, with the majority of clinicians returned only one questionnaire.

Figure 8: **Response process for dyadic study**

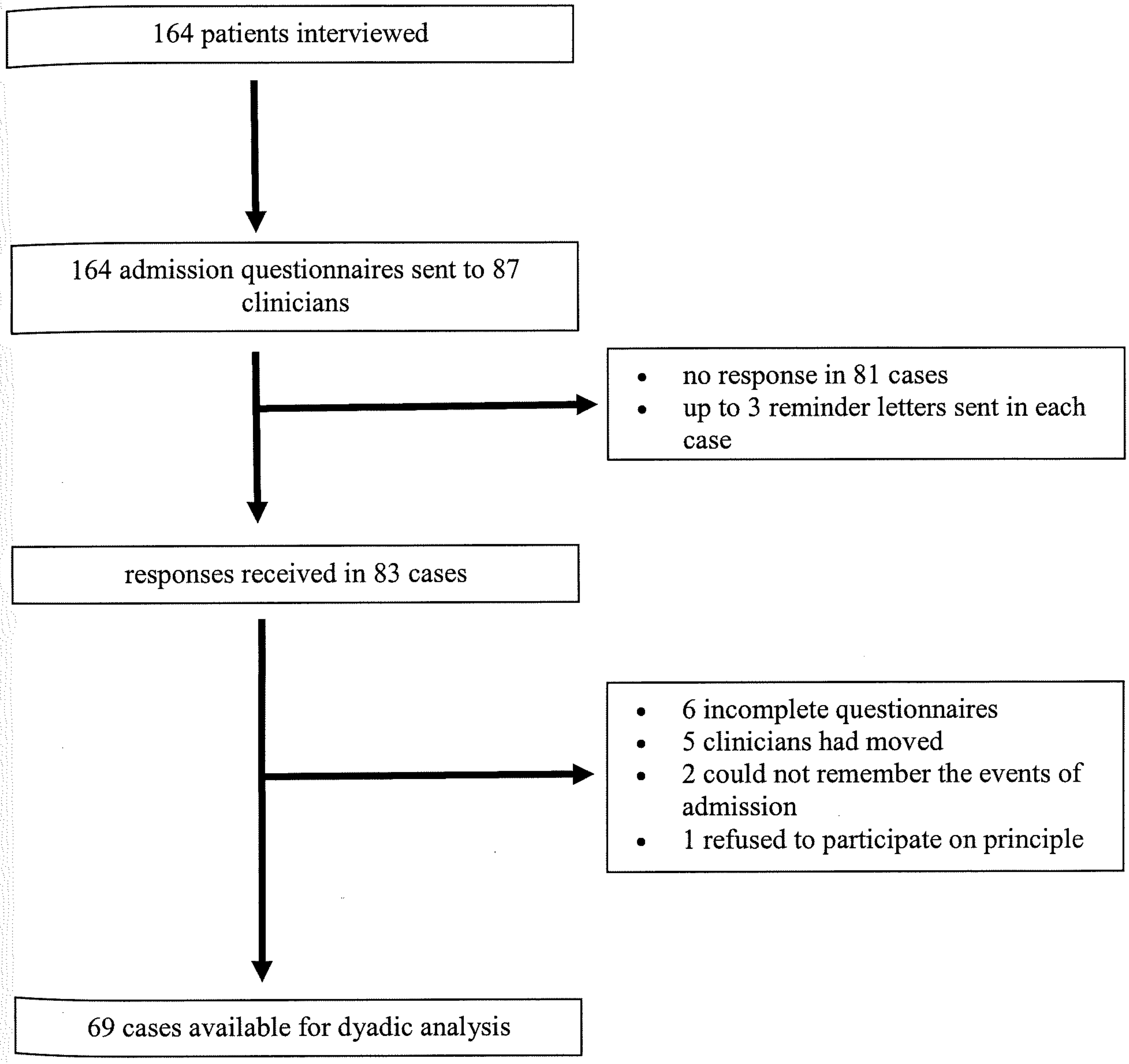
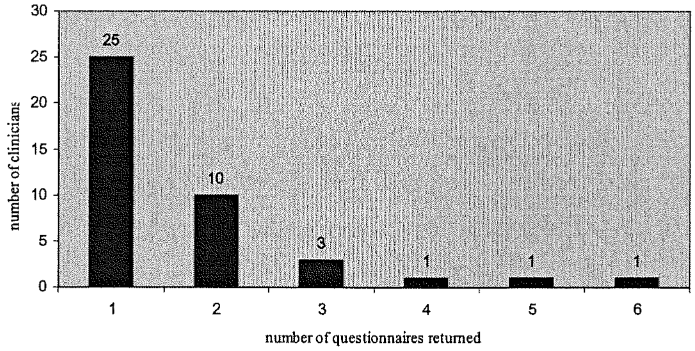

164 patients interviewed
164 admission questionnaires sent to 87 clinicians
no response in 81 cases
up to 3 reminder letters sent in each case
responses received in 83 cases
6 incomplete questionnaires
5 clinicians had moved
2 could not remember the events of admission
1 refused to participate on principle
69 cases available for dyadic analysis

Figure 9: Number of questionnaires returned by each clinician



The sociodemographic and professional characteristics of participating clinicians are shown in Table 22. The majority of clinicians returning questionnaires were male (*N*=23, 56.1%), white (*N*=36, 87.8%), psychiatrists (*N*=28, 68.3%) and had been working in mental health care an average of 15 years. Compared to other mental health professionals, they experienced average levels of emotional exhaustion and depersonalization and high levels of personal accomplishment (Maslach *et al.* 1996).

Data on gender and professional designation was collected for the 87 clinicians who did not return questionnaires. A chi-square test showed that there was no significant difference between clinicians who returned and did not return questionnaires on either of these variables (gender (male or female): $\chi^2(1)=1.17$, $p=0.28$; professional designation (psychiatrist or other): $\chi^2\ (1)=0.01, p=0.93$).

Table 22: Sociodemographic and professional characteristics of participating clinicians

Characteristic	**Sample (N=41)**	
	***N* or mean**	**(%) or (*SD*)**
Age [mean (*SD*)]	42.2	(9.6)
Sex		
male	23	(56.1)
female	18	(43.9)
Ethnicity		
white	36	(87.8)
non-white	5	(12.2)
Professional designation		
psychiatrist	28	(68.3)
social worker	5	(12.2)
psychiatric/mental health nurse	4	(9.8)
general practitioner	3	(7.3)
crisis care coordinator	1	(2.4)
Years in mental health care [mean (*SD*)]	15.2	(12.0)
Maslach Burnout Inventory score$^+$		
emotional exhaustion [mean (*SD*)]	15.6	(10.0)
depersonalization [mean (*SD*)]	5.3	(4.3)
personal accomplishments [mean (*SD*)]	38.8	(6.8)

$^+$ one dataset missing, N=40

3.3.2 Baseline characteristics of patients in dyadic analysis

The sociodemographic and clinical/service use characteristics, and admission experiences of patients included and excluded from the dyadic analysis are shown in Tables 23, 24 and 25 respectively. Differences between participating and non-responding eligible patients were tested using t-tests, chi-square tests and Mann-Whitney U tests, as appropriate depending on the distribution and nature of the data.

There were no significant differences in sociodemographic characteristics between the patients from the original sample who were included and excluded in the dyadic analysis. They only significant differences in clinical/service use characteristics were co-morbid substance abuse and previous contact with the clinician. Patients included in the dyadic analysis were significantly more likely to have co-morbid substance abuse than those who were excluded from the analysis ($\chi^2(1)=8.89$, $p<0.01$) and to have had previous contact with the admitting clinician ($\chi^2(1)=5.63$, $p=0.02$).

Table 23: Sociodemographic characteristics of patients included and excluded from the dyadic analysis

Characteristic	**Included** (*N*=69)		**Excluded** (*N*=95)		**Significance of Difference**
	***N* or mean**	**(%) or (*SD*)**	***N* or mean**	**(%) or (*SD*)**	
Age [mean (*SD*)]	39.3	(11.4)	38.5	(12.5)	$t(162)=0.41, p=0.68$
Sex					$\chi^2(1)=0.11, p=0.74$
male	38	(55.1)	56	(58.9)	
female	31	(44.9)	39	(41.0)	
Ethnicity					$\chi^2(1)=0.55, p=0.46$
white	59	(85.5)	86	(90.5)	
non-white	10	(14.5)	9	(9.5)	
Marital status					$\chi^2(2)=0.84, p=0.66$
single	35	(50.7)	54	(56.8)	
married/cohabit.	18	(26.1)	24	(25.3)	
divorced/sep/wid	16	(23.2)	17	(17.9)	
Living arrangement					$\chi^2(2)=2.51, p=0.29$
independent	52	(75.4)	79	(83.2)	
supported	10	(14.5)	12	(12.6)	
homeless/prison	7	(10.1)	4	(4.2)	
Education					$\chi^2(3)=5.83, p=0.12$
no qualifications	10	(14.5)	11	(11.6)	
GCSE	14	(20.3)	31	(32.6)	
A level	14	(20.3)	9	(9.5)	
post-secondary	31	(44.9)	44	(46.3)	
IQ$^+$ [mean (*SD*)]	108.6	(10.3)	108.6	(12.9)	$t(148)=0.01, p=0.99$

$^+$ 14 missing values, *N*=150

Table 24: *Clinical/service use characteristics of patients included and excluded from the dyadic analysis*

Characteristic	**Included** (*N*=69)		**Excluded** (*N*=95)		**Significance of Difference**
	***N* or mean**	**(%) or (*SD*)**	***N* or mean**	**(%) or (*SD*)**	
Diagnosis					$\chi^2(2)=3.22$, $p=0.20$
affective disorder	29	(42.0)	35	(36.8)	
schizophrenia	26	(37.7)	48	(50.5)	
other	14	(20.3)	12	(12.6)	
Substance abuse					$\chi^2(1)=8.89$, $p=0.003$
yes	33	(47.8)	23	(24.2)	
no	36	(52.2)	72	(75.8)	
GAF$^{\sim}$ [mean (*SD*)]	35.7	(13.0)	35.0	(15.1)	$t(148)=0.31$, $p=0.75$
Previous admission$^+$					$\chi^2(1)=1.73$, $p=0.19$
yes	52	(76.5)	61	(65.5)	
no	16	(23.5)	32	(34.4)	
Previous MHA admission$^\wedge$					$\chi^2(1)=1.32$, $p=0.25$
yes	24	(36.9)	26	(28.3)	
no	41	(63.1)	66	(71.7)	
Prev contact with clinician					$\chi^2(1)=5.63$, $p=0.02$
yes	42	(60.8)	40	(42.1)	
no	27	(39.1)	55	(57.9)	
Legal status of admission					$\chi^2(1)=0.06$, $p=0.80$
informal	55	(79.7)	73	(76.8)	
MHA	14	(20.3)	22	(23.2)	

$^+$three missing values in dataset, $N=161$; $^\wedge$seven missing values, $N=157$; $^{\sim}$14 missing values, $N=150$

Table 25: Admission experiences of patients included and excluded from dyadic analysis

Characteristic	**Included** (*N*=69)		**Excluded** (*N*=95)		**Significance of Difference**
	N or *MDN*	(%) or range	*N* or *MDN*	(%) or range	
Expected admission					$\chi^2(1)=3.12, p=0.58$
yes	30	(43.5)	36	(37.9)	
no	39	(56.5)	59	(62.1)	
Wanted admission					$\chi^2(1)=1.54, p=0.22$
yes	38	(55.1)	43	(45.3)	
no	31	(44.9)	52	(54.7)	
Suggestion of admission					$\chi^2(2)=0.11, p=0.94$
own	7	(10.1)	11	(11.6)	
others	39	(56.5)	55	(57.9)	
myself and others	23	(33.3)	29	(30.5)	
Agreed with admission^{+}					$\chi^2(1)=0.88, p=0.35$
yes	53	(76.8)	66	(70.2)	
no	16	(23.2)	28	(29.8)	
Voluntariness					$\chi^2(2)=2.54, p=0.28$
voluntary	27	(39.1)	36	(37.9)	
involuntary	7	(10.1)	18	(18.9)	
neutral	35	(50.7)	41	(43.2)	
Freedom to leave					$\chi^2(2)=0.02, p=0.99$
yes	36	(52.2)	49	(51.6)	
no	24	(34.8)	34	(35.8)	
unsure	9	(13.0)	12	(12.6)	
HAS score [*MDN* (range)]	280.0	(0-450)	281.5	(20-450)	$Z=-0.05, p=0.96$
Negative pressure [*MDN* (range)]	5.0	(0-6)	5.0	(0-6)	$Z=-1.05, p=0.29$
Procedural justice [*MDN* (range)]	1.0	(0-3)	1.0	(0-3)	$Z=-2.12, p=0.83$
Perceived coercion [*MDN* (range)]	3.0	(0-5)	3.0	(0-5)	$Z=-0.59, p=0.56$

$^{+}$one missing value in dataset, *N*=163

3.3.3 Clinicians' experiences during the admissions process

Clinicians' experiences during the psychiatric hospitalization process were investigated through a series of questionnaire items and standardized scales.

Pressure to admit patient beyond medical need

Clinicians responded that they felt pressure, beyond simple medical need, to admit patients in 20 of 69 cases (29.0%). This pressure came from several sources: the patient's family, the patient, other health care professionals and concerns of risk and liability. Examples of responses from clinicians are shown in Table 26 and demonstrate overlap across sources.

Perceptions of patients' expectations

Clinicians believed that patients expected to be admitted to hospital in over half of cases (*N*=36, 52.2%) and that patients wanted to be admitted in nearly two-thirds of cases (*N*=44, 63.8%). The clinician wanted the patient be admitted in 57 cases (83.8%).

Clinicians correctly assessed patients' expectations in 36 cases (52.2%) and correctly assessed whether patients wanted to be admitted to hospital in 45 cases (65.2%). When the clinician incorrectly assessed patients' expectations or desire to be admitted, they tended to overestimate that the patient expected or wanted to be in hospital. Clinicians

Table 26: Examples of responses from clinicians about pressure beyond medical need

Source of pressure	Examples
Family	"The husband felt at risk from the patient" "Mother"
Patient	"Pressure to admit from the patient…I did not think she was mentally ill and knew she was homeless" "The patient threatened to take an overdose if I did not admit him. I felt this threat was more related to his personality than to any dysfunction and so initially did not admit him. He overdosed that night and the following day rejected all help except admission and threatened to kill himself that night. He left a suicide note blaming us for his attempt on his life"
Health care professional	"GP, was concerned spouse was at risk" "Other psychiatrists were not prepared to take case through and do the right thing because they were risk averse and lazy"
Risk/liability/legal	"The absence of a 'safe house' meant that hospital admission was the only viable method" "The patient had been remanded in custody and was keen to be admitted to the hospital and maintain treatment contact. As informal admission to a day hospital setting would have been okay, indeed preferred, but the needs of the criminal justice system demanded MHA and inpatient admission"

believed that patients expected to be admitted when they did not in 20 of 33 cases (60.6%) and that patients wanted to be admitted when they did not in 15 of 24 cases (62.5%).

Negative pressure

As shown in Figure 10a, negative pressure scores ranged from one to the possible maximum of six. Low scores reflected the experience of high levels of negative pressure, while high scores indicated low levels of negative pressure. The mean negative pressure score was 5.1 (*SD*=1.0) with a median of 5.0 (range: 1-6). The responses to individual items in the scale are shown in Table 27. However, the scale had low internal consistency, with a Cronbach's α coefficient of 0.50. With the deletion of the item, "I would have sectioned the patient to get them into hospital", the Cronbach's α coefficient increased to 0.74 indicating good internal consistency.

With this item removed, negative pressure scores ranged from the minimum of zero to the maximum of five. The mean negative pressure score was 4.5 (*SD*=1.0) with a median of 5.0 (range: 0-5). This is shown in Figure 10b.

Figure 10a: Negative pressure scores including item "I would have sectioned the patient to get them into hospital"

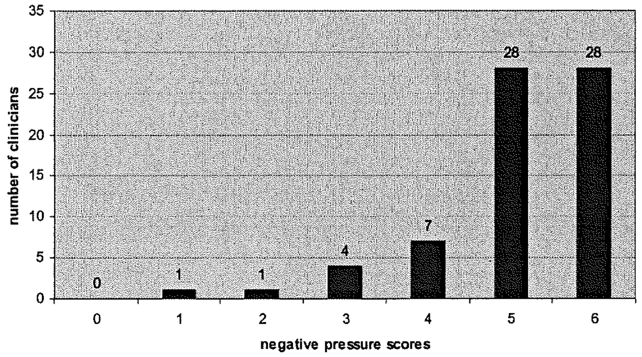


Figure 10b: Negative pressure scores with sectioning question removed

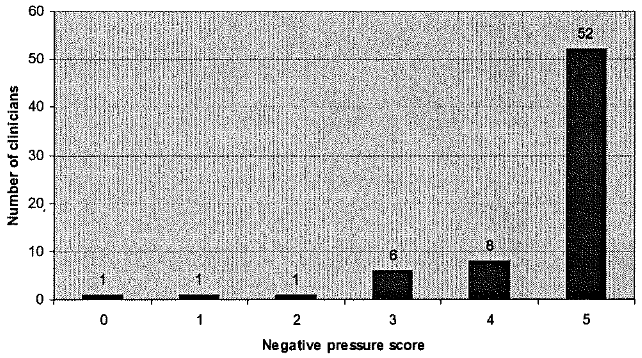


Table 27: Responses to individual items of the negative pressure scale

Item	*N*		%	
	true	**false**	**true**	**false**
People forced to admit the patient into hospital	10	59	14.5	85.5
Someone threatened me to get the patient into hospital	4	65	5.8	94.2
Someone physically tried to make me bring the patient into hospital	2	67	2.9	97.1
I would have sectioned the patient to get them into hospital^{+}	33	36	44.9	55.1
They said they would make bring the patient into hospital	2	67	2.9	97.1
No one tried to force you to bring the patient to hospital*	14	55	20.3	79.7

* reverse scored, $^{+}$ dropped from analysis

Procedural justice

As shown in Figure 11, procedural justice scores from the possible minimum of zero to the maximum of four. Low scores indicated the experience of high levels of procedural justice and high scores indicated low levels of procedural justice. The mean procedural justice score was 0.3 (*SD*=0.7) with a median of 0.0 (range: 0-3). The responses to individual questions in the scale are shown in Table 28. The scale had good internally consistency, with a Cronbach's α of 0.72.

Figure 11: Procedural justice scores

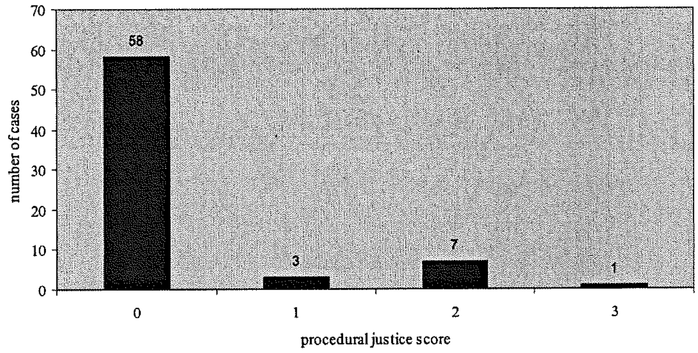


Table 28: Responses to procedural justice scale items

Item	*N*		%	
	true	false	true	false
I had enough of a chance to say whether I wanted the patient to come into hospital.	61	8	88.4	11.6
I got to say what I wanted about the patient coming into hospital	60	9	87.0	13.0
My opinion about the patient coming into hospital didn't matter*	66	3	95.7	4.3

* reverse scored

Perceived coercion

As shown in Figure 12, perceived coercion scores ranged from the possible minimum of zero to the possible maximum of five. Low scores reflected low levels of perceived coercion and high scores indicated high levels of perceived coercion. The mean score was 1.7 (*SD*=1.6; *MDN*=1.0; range: 0-5). The responses to individual questions in the scale are shown in Table 29. The scale had good internal consistency, with a Cronbach's α of 0.77.

Figure 12: Perceived coercion scores

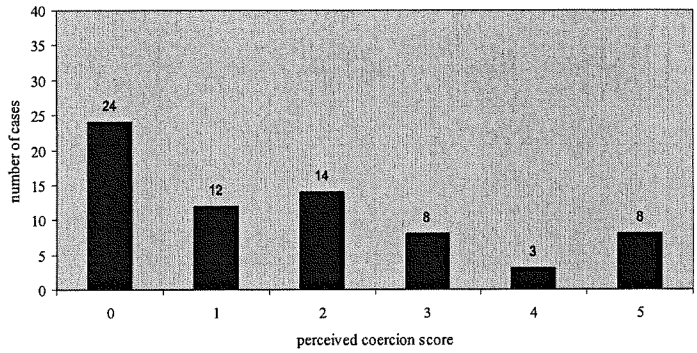


Table 29: Responses to perceived coercion scale items

Item	*N*		%	
	true	**false**	**true**	**false**
I felt free to do what I wanted about the patient coming into hospital	46	23	66.7	33.3
I chose for the patient to come into hospital	53	16	76.8	23.2
It was my idea for the patient to come into hospital	39	30	56.5	43.5
I had a lot of control over whether the patient came into hospital	52	17	75.4	24.6
I had more influence than anyone else over whether the patient came into hospital	39	30	56.5	43.5

3.3.4 Associations of baseline data and perceived coercion

Univariate analyses were used to test the association between perceived coercion and baseline clinician and patient characteristics. Perceived coercion was investigated as a continuous variable.

As perceived coercion scores were not normally distributed, non-parametric statistical tests were used. Spearman's rank order correlation was used to test the relationship between continuous variables and perceived coercion scores. Associations between categorical variables and perceived coercion score were examined using Mann-Whitney U Tests (comparisons between two groups) and Kruskal-Wallis Tests (comparisons between three or more groups). Post-hoc analyses of significant associations between categorical variables (with three or more groups) and perceived coercion score were carried out using Mann-Whitney U Tests. Statistical significance of post-hoc analyses was determined using a Bonferroni correction. Differences were considered significantly different at $p<0.017$.

Clinician characteristics and perceived coercion score

As some clinicians returned more than one questionnaire (see Figure 9), an average perceived coercion score was calculated for each clinician. Table 30 shows that no clinician sociodemographic or professional characteristic was associated with perceived coercion score.

Table 30: Associations between perceived coercion score and clinician characteristics

Characteristic	Perceived Coercion Score						
	N	**mean**	***SD***	***MDN***	**min**	**max**	**Significance of Difference**
Age							*rho*=.041, *p*=.80
Sex							*Z*=-0.63, *p*=0.53
male	18	1.6	1.7	1.0	0	5.0	
female	23	1.6	1.3	2.0	0	3.5	
Ethnicity							*Z*=-1.03, *p*=0.30
white	36	1.7	1.4	1.8	0	5	
other	5	1.0	1.5	1.0	0	3	
Professional designation							*Z*=-0.14, *p*=0.90
psychiatrist	28	1.6	1.4	1.8	0	5	
other	13	1.6	1.5	1.5	0	5	
Years in mental health							*rho*=.41, *p*=.80
Maslach burnout inventory							
emotional exhaustion	41						*rho*=.02, *p*=.88
depersonalization	41						*rho*=.21, *p*=.19
personal accomplishment	41						*rho*=.30, *p*=.06

Patient characteristics and perceived coercion score

Associations between patient characteristics and perceived coercion score were calculated for each admission event. Table 31 shows that patient diagnosis was significantly associated with clinician perceived coercion score (*H*(2)=6.27, *p*=0.04). Post-hoc analyses demonstrated that clinician perceived coercion scores were significantly lower when the patient was diagnosed with an affective disorder (*MDN*=0.5, range 0-3) than when they were diagnosed with schizophrenia (*MDN*=2.0, range 0-5) (*Z*=-1.91, *p*=0.05) or had other diagnoses (*MDN*=2.0, range 0-5) (*Z*=-2.34, *p*=0.02). There was no significant difference in clinician perceived coercion score for patients with schizophrenia and other diagnoses (*Z*=-.65, *p*=0.52).

Patient perceived coercion level (low or high) was associated with clinician perceived coercion score. Clinician perceived coercion scores were significantly higher when patients had low perceived coercion levels (*MDN*=2.0, range 0-5) than when patients had high perceived coercion levels (*MDN*=1.0, range 0-5; *Z*=-2.30, *p*=0.02)

Clinician perceptions of coercion were also significantly associated with patient education level. They were significantly higher when patients had some post-secondary education (*MDN*=0.5, range 0-5) compared to when they did not have any education at this level (*MDN*=2.0, range 0-5; *Z*=-2.79, *p*=0.01).

Table 31: Associations between perceived coercion score and patient characteristics

Characteristic		Perceived Coercion Score					
	N	mean	*SD*	*MDN*	min	max	Significance of Difference
Age	69						$rho=.15$ $p=.22$
Gender							$Z=-0.42$, $p=0.67$
male	31	1.7	1.9	1.0	0	5	
female	38	1.7	1.5	1.5	0	5	
Ethnicity							$Z=-0.56$, $p=0.57$
white	59	1.7	1.7	1.0	0	5	
other	10	1.4	1.6	1.0	0	5	
Education							$Z=-2.79$, $p=0.01$
up to 16 years of age	24	1.0	1.4	0.5	0	5	
over age 16	45	2.1	1.7	2.0	0	5	
IQ	62						$rho=.11$ $p=.35$
Diagnosis							$H(2)= 6.27$, $p=0.04$
schizophrenia	29	2.0	1.9	2.0	0	5	
affective disorder	26	1.0	1.8	0.5	0	3	
other	14	2.3	1.1	2.0	0	5	
Co-morbid substance abuse							$Z=-0.12$, $p=0.90$
yes	33	1.7	1.8	1.0	0	5	
no	36	1.7	1.6	1.5	0	5	
GAF score$^+$	69						$rho=-.22$, $p=.07$
Prev contact with clinician							$Z=-0.50$, $p=0.62$
yes	42	1.7	1.6	2.0	0	5	
no	27	1.6	1.8	1.0	0	5	
HAS	69						$rho=.14$ $p=.24$
Prev admission to hospital$^+$							$Z=-1.33$, $p=0.26$
yes	52	1.8	1.6	1.5	0	5	
no	16	1.4	2.0	0.0	0	5	

Characteristic		**Perceived Coercion Score**					
	N	**mean**	***SD***	***MDN***	**min**	**max**	**Significance of Difference**
Previous MHA admission$^{\wedge}$							*Z*=-1.53, *p*=0.18
yes	24	1.9	1.6	1.6	0	5	
no	41	1.3	1.6	1.0	0	5	
Legal status of admission							*Z*=-0.84, *p*=0.90
informal	55	1.7	1.8	1.0	0	5	
MHA section	14	1.4	1.6	1.0	0	5	
Perceived coercion							
low	30	2.2	1.8	2.0	0	5	Z=-2.30, *p*=0.02
high	39	1.3	1.4	1.0	0	5	
Therapeutic alliance score	69						*rho*=-.26 *p*<.05

$^{+}$one missing value in dataset, *N*=68; $^{\wedge}$four missing values in dataset, *N*=65

3.3.5 Association of clinician admission experiences and perceived coercion score

Associations between clinician admission experiences and perceived coercion score were calculated for each admission event. As shown in Table 32, three variables were associated with perceived coercion score: clinician perception of the patient's expectation of admission; whether the clinician wanted the patient to be admitted; and whether the clinician felt pressure beyond medical need to admit the patient.

Clinicians perceived coercion scores were significantly higher when the clinician felt that the patient expected to be admitted to hospital (*MDN*=2.0 vs. *MDN*=0.5) (*Z*=-1.99, p=0.05), when the clinician did not want the patient to be admitted (*MDN*=5.0 vs. *MDN*=1.0) (*Z*=-4.20, *p*<0.001), and when the clinician felt pressure beyond medical need to admit the patient (*MDN*=2.5 vs. *MDN*=1.0) (*Z*=-3.00, *p*<0.01).

Negative pressure and procedural justice scores were also significantly associated with clinician perceived coercion scores. There was a strong negative correlation between negative pressure and perceived coercion score (*rho*=-.38, *p*<.001) and a strong positive correlation between perceived coercion and procedural justice score (*rho*=.52, *p*<.01).

Table 32: Associations between perceived coercion score and clinician admission experiences

Characteristic		Perceived Coercion Score					
	N	mean	*SD*	*MDN*	min	max	Significance of Difference
Clinician perceived that patient expected admission							*Z*=-1.99, p=0.05
yes	37	2.0	1.6	2.0	0	5	
no	32	1.3	1.8	0.5	0	5	
Clinician perceived that patient wanted admission							*Z*=-0.69, *p*=0.50
yes	44	1.7	1.5	1.5	0	5	
no	25	1.6	2.0	1.0	0	5	
Clinician wanted patient to be admitted							*Z*=-4.20, *p*<0.001
yes	57	1.2	1.3	1.0	0	5	
no	12	3.8	1.6	5.0	1	5	
Clinician felt pressure, beyond medical need, to admit patient							*Z*=-3.00, *p*<0.01
yes	20	2.7	1.9	2.5	0	5	
no	49	1.3	1.4	1.0	0	5	
Negative pressure	69						*rho*=-.38 *p*<.01
Procedural justice	69						*rho*= .52 *p*<.01

3.3.6 Logistic regression model of clinician perceived coercion

Multiple variable analysis of variables significantly associated with perceived coercion was conducted. Logistic regression analysis was used to investigate the relationship between these variables and perceived coercion. For this analysis, perceived coercion scores were dichotomized around the mean of 1.7 (Bindman *et al.* 2005) to divide the sample into low (score zero to one) and high (score of two or higher) perceived coercion groups.

Seven factors were entered into the logistic regression model (Table 33). As shown in Table 33, logistic regression analysis (forced entry) demonstrated that, when all variables were controlled for, high perceived coercion in clinicians was significantly associated with the: patient having post-secondary education; clinician perceiving that the patient expected admission; and clinician experiencing high levels of negative pressure and low levels of procedural justice during the admissions process. The model described with these variables can account for 35%-51% of the variance in perceived coercion.

Table 33: *Forced entry logistic regression model of factors associated with high perceived coercion in clinicians*

				95% CI for exp *b*		
Factor	***B***	**SE**	***p***	**lower**	**exp *b***	**upper**
patient diagnosis of schizophrenia or other	0.01	0.68	0.23	0.27	1.01	3.85
patient educated after age 16 *	1.85	0.75	0.01	1.46	6.39	28.01
patient perceived high level of coercion	0.25	0.65	0.20	0.36	1.28	4.57
clinician perceived pt expected admission	1.39	0.68	0.11	1.06	4.03	15.34
clinician felt pressure beyond medical need to admit the patient to hospital *	0.70	0.99	0.02	0.28	2.00	14.11
clinician – low negative pressure *	-1.03	0.61	0.01	0.11	0.36	1.18
clinician – low procedural justice *	1.86	0.95	0.01	1.0	6.43	41.44
constant	2.04	3.0	0.50		7.69	

R^2=.35 (Hosmer & Lemeshow), .38 (Cox & Snell), .51 (Nagelkerke); Model $X^2(7)=33.24$, $N=69$, $*p<0.05$

3.3.7 Investigation of patients who would have been sectioned

Clinicians either sectioned the patient or responded positively to the item "I would have sectioned this patient to get them into hospital" in 33 cases. However, only 14 patients in this sample were sectioned. The remaining 19 patients who "would have been sectioned" were admitted informally. This allows for the exploration of characteristics associated with informal admission when the clinician felt the patient met the criteria for compulsory admission. These are shown in Table 34.

Patients were more likely to be admitted informally, even when the clinician said that they would have sectioned the patient under the MHA, if they were: female, white, living independently, well educated and suffering from an affective disorder. Those who accepted informal admission in this case were less likely to feel coerced into hospital compared to those patients who were sectioned.

Table 34: Characteristics of patients sectioned and "would have been" sectioned

Characteristic	**Would have** (*N*=19)		**Sectioned** (*N*=14)	
	N **or mean**	**(%) or (*SD*)**	***N*** **or mean**	**(%) or (*SD*)**
Age [mean (*SD*)]	40.1	(12.3)	37.6	(12.8)
Sex				
male	9	(47.4)	9	(64.3)
female	10	(52.6)	5	(35.7)
Ethnicity				
white	17	(89.5)	9	(64.3)
non-white	2	(10.5)	5	(35.7)
Marital status				
single	10	(52.6)	8	(57.1)
married/cohabiting	6	(31.6)	3	(21.4)
divorced/separated/widowed	3	(15.8)	3	(21.4)
Living arrangement				
independent	17	(89.5)	8	(57.1)
supported	2	(10.5)	5	(35.7)
prison	0	(0.0)	1	(7.1)
Education				
up to age 16	5	(26.3)	9	(64.3)
over age 16	14	(73.7)	5	(35.7)
Diagnosis				
schizophrenia	6	(31.6)	9	(64.3)
affective	10	(52.6)	4	(28.5)
other	3	(15.8)	3	(7.1)
Substance abuse				
yes	6	(31.6)	7	(50.0)
no	13	(68.4)	7	(50.0)
GAF [mean (*SD*)]	37.6	(11.2)	32.9	(9.1)
Prev contact with clinician				
yes	13	(68.4)	9	(64.3)
no	6	(31.6)	4	(35.7)
HAS score [mean (*SD*)]	304.4	(35.7)	196.4	(137.9)
Expect admission				
yes	8	(42.1)	3	(21.4)
no	11	(57.9)	11	(78.6)
Want admission				
yes	8	(42.1)	5	(35.7)
no	11	(57.9)	9	(64.3)
Perceived coercion				
low	8	(80.0)	2	(14.3)
high	11	(47.8)	12	(85.7)

3.4 Discussion

The aims of this study were to examine the extent to which clinicians felt pressure beyond medical need to admit the patient to hospital, investigate levels of perceived coercion in clinicians and explore the role of various factors in mediating these perceptions. To our knowledge, this is the first study of clinicians' perceptions of pressures and coercion during the psychiatric hospitalization process.

3.4.1 Principal findings

Pressure beyond medical need to admit

A small, but substantial, proportion of clinicians felt pressure beyond simple medical need to admit patients to hospital. This pressure came from various sources including the patient, the patient's family, other health care services and concerns of risk and liability. These results support previous research of factors or reasons associated with psychiatric hospital admission decision which suggested that clinicians' perceptions of pressure are involved (Anderson & Eppard 1995). This study confirms that clinicians' decisions may be influenced by the opinions of family (Tischler 1966; Rose *et al.* 1977; Friedman *et al.* 1983; Gillig *et al.* 1990), patient requests (Zohar *et al.* 1987; Flannigan *et al.* 1994), the responses of other health care professionals (Engleman *et al.* 1998) and issues of risk and liability (Harrison 1997).

Clinicians were asked whether they experienced "pressure beyond medical need" to admit the patient. It was hoped that by wording the question like this, we would be able to control for pressure that reflected medical need (Cockburn & Pit 1997; Little *et al.* 2004). Responses to this question in the negative with explanations suggested that this wording was effective. Clinicians interpreted clinically appropriate pressure from patients, carers and other health care professionals as not being beyond medical need. For example, when clinicians did not feel pressure beyond medical need to admit the patient, they responded:

> *"There was strong pressure from the rest of the Assertive Outreach Team to admit this man. I entirely agreed, however, and it seemed entirely appropriate for him to be admitted under the MHA against his will (entirely clinically appropriate). I had plenty of time to put forward my views and express my opinion to other members of the team"*

> *"The only pressure was from the patient. I felt it was appropriate to respond to this positively and admit the patient"*

> *"I did not feel pressure to admit this patient. Patient came to see me as a referral as an outpatient accompanied with her husband. I discussed this with one of the other consultants and talked with herself and her husband. We all agreed that it would be better for her to be admitted..."*

Clinicians' experiences during the admissions process

Single-questionnaire items and a modified version of the Admission Experience Survey (AES) were used to investigate clinicians' experiences during the psychiatric hospitalization process. We examined responses to the three subscales: perceived coercion, negative pressure and procedural justice. Items were altered so that we could investigate: the amount of choice, control and influence the clinician had in the decision making process (perceived coercion); the extent to which they felt threatened or forced to admit the patient (negative pressure); and whether they had the opportunity to voice their opinions during the process (procedural justice).

The Admission Experience Survey has, to our knowledge, not been used to examine clinicians' experiences. Our results suggest that it may be a simple way to measure the experiences of clinicians in a standardized way. All three subscales showed good internal consistency (see comment about the negative pressure subscale below). Total subscale scores ranged from the minimum to maximum, suggesting that the scales differentiated between clinicians' experiences. The pattern of distribution of scores on the three clinician subscales was similar to that in patient samples.

Negative pressure

In the questionnaire, the negative pressure scale consisted of six items. When the internal consistency of the scale was assessed, we found that it was low. The deletion of a single item, "I would have sectioned the patient to get them into hospital" increased the consistency of the scale substantially. In the patient version of the scale, this item examines whether a patient believes they have been sectioned and fits into the broader negative pressure concept of feeling that one has been forced or threatened to accept hospitalization. We feel that, for clinicians, believing that you would have used mental health legislation to ensure that the patient is admitted may not be viewed the same as being threatened or feeling forced into hospital. Instead, the Mental Health Act provides the clinician with additional power during the decision making process and may assist the clinician in acting in the best interest of the patient.

Associations with perceptions of coercion

We examined the associations of perceived coercion with clinician and patient characteristics and clinicians' admission experiences. In univariate analyses, there were no significant associations between clinician sociodemographic or professional characteristics and perceived coercion. As some clinicians returned questionnaires for more than one patient, composite perceived coercion scores were calculated for each clinician. The composite score was the average perceived coercion score of all cases for that clinician. We relied on the assumption that each questionnaire was independent of the others returned by that clinician (i.e. that a fundamental clinician factor would not influence all of the questionnaires returned by that clinician). Clinicians were instructed to respond to questionnaires with respect to that single admission event and inspection of the scores for clinicians submitting more than one questionnaire suggested that the perceived coercion scores did reflect separate events and not the clinician. However, in a larger sample, clustered analysis may be appropriate.

Several patient characteristics were significantly associated with clinicians' perceptions of coercion in univariate analysis. Clinicians perceived that they were highly coerced if the patient had a diagnosis of a non-affective disorder (i.e. schizophrenia or other) or had completed at least some post-secondary education. Previous research suggests that clinicians are more likely to admit patients suffering from psychosis (Zohar *et al.* 1987), and some of the factors that influence these decisions may result in clinicians feeling that they have less choice when deciding whether to hospitalize these patients. For example, patients with schizophrenia may be viewed as being more dangerous or in need of treatment than those with affective disorders (Flannigan *et al.* 1994; Abas *et al.* 2002).

There was an inverse relationship between patient and clinician perceptions of coercion. When patients had low levels of perceived coercion, clinicians tended to have high levels of perceived coercion and vice versa. Although it is not possible to determine causality with this data, it suggests that when patients feel free to make their own choices about entering hospital then clinicians may feel that they are not free to do what they want about the patient coming into hospital.

There is limited research examining the relationship between education and socioeconomic status and mental health service use. However, studies of general practice have suggested clinician decision making may be associated with socioeconomic status (Scott *et al.* 1996). Studies indicate that patients who are highly educated are more likely to be referred to specialist services than those with low educational status (Fylkesne *et al.*1992). Individuals of low socioeconomic status have been found to be more passive recipients of health care and less active in seeking information from doctors (Pendleton & Bochner 1980). In this study, clinicians may have felt that they have less influence during decision making when patients have higher levels of education.

Clinician admission experiences were also significantly associated with perceptions of coercion. Clinicians felt higher levels of perceived coercion when they felt the patient expected admission, when they felt pressure beyond medical need to hospitalize the patient, and when they experienced more negative pressure and less procedural justice. The role of clinicians' perceptions of patient expectation in this case is similar to that found in general practice. Little *et al.* (2004) found that clinicians' perceptions of patient expectations were a strong independent predictor, after controlling for medical need, of clinicians behaviour. Clinicians were more likely to prescribe medication or refer patients for investigation when they felt it was what the patient expected. In this study, the results indicate that clinicians feel that they are more coerced in the decision making process when the patient expects to be admitted. Interestingly, our data also demonstrates that clinicians are poor at perceiving patients' expectations accurately. Clinicians correctly assessed patients' expectations in about half of the cases and they were more likely to overestimate that patients expected to be admitted. Similar results have also been found in the general practice literature (Cartwright 1983; Britten 1997).

Clinicians also perceived higher levels of coercion when they felt pressure beyond medical need to admit the patient. Like studies of perceived coercion in patients, this suggests that clinicians may view coercion as a moralized concept. When the pressure is clinically appropriate, then it is not coercive. For example, if a patient or family member believes that a patient needs to be admitted to the hospital for valid reasons and advocates for this then a clinician may not find this coercive, if is medically warranted. Pressure beyond medical need may also be conceptualized as the lack of suitable alternatives. A clinician may feel that the patient should attend day hospital instead of inpatient care, but if the patient refuses that treatment they may feel that hospitalization is the only acceptable alternative.

Like patients' perceptions of coercion, high levels of perceived coercion in clinicians were associated with high levels of negative pressure and low levels of procedural justice. This suggests that clinicians feel coerced to admit patients to hospital when they feel forced or threatened or when they are not given the opportunity to give their opinions about the situation.

When all factors were controlled for in multiple variable analysis, patient education, pressure beyond medical need, negative pressure and procedural justice remained significantly associated with perceptions of coercion. However, this model can only account for about 40% of the variance in perceived coercion. There are likely to be other variables, such as service delivery or situational factors, which may also influence clinicians' perceptions of coercion.

The conceptualization of clinician perceived coercion

The concept of perceived coercion was developed with patients in mind, not clinicians. However, we feel that understanding clinicians' experiences of pressure and coercion is an important issue in mental health service delivery. Decision making in psychiatry is becoming more complex, as clinicians and patients have a greater range of care and treatment options. There is no longer just the dichotomous decision of whether to admit the patient to hospital or not. Patients can be admitted informally or under the MHA. Clinicians may soon be able to legally require patients to comply with treatment in the community. Depending on their needs, a patient's care can be managed by a community mental health, assertive outreach, complex needs, or crisis resolution team. Clinicians have social and political pressure to help patients be autonomous and cared for in the least restrictive environment, but also face increased risk and liability issues if a patient does not get treatment and harms themselves or someone else.

It is not known whether the concept of coercion is the same in patients and clinicians. Wertheimer (1993) suggests that coercion in mental health care is constrained volition, when the patient is forced to make a decision that puts them in a situation or state that is worse than a set baseline. The assumption in the concept of patient perceived coercion is that the patient determines where that baseline is set. However, in clinician perceived coercion, various players in the decision making process may be taken into consideration.

For example, when a patient is assessed for admission to hospital, the clinician is ultimately the gatekeeper to inpatient care. If they decide not to admit: the patient may end up at a worse baseline if they end up deteriorating without inpatient care; the family may end up at a worse baseline if they feel burdened or overwhelmed at having to care for the patient; the clinician may end up at a worse baseline if their decision results in other clinicians being upset with them. This baseline may be different in each case. For example, clinicians may feel more reluctant to admit a well off person to an inpatient ward than someone living rough (Quirk *et al.* 2003). Understanding more about the hospitalization process should be a priority for mental health services research.

Would have sectioned

While the aim of this study was to investigate clinicians' perceptions of coercion during the psychiatric admissions process, in the analysis of the negative pressure scale we noticed that more clinicians had reported that they would have sectioned the patient to hospital compared to the number of patients actually sectioned. This allowed for a description of patients who met the criteria for compulsory admission (as clinicians stated that they would have sectioned them), but who accept informal admission. We have found no data describing this group in the published literature.

Patients who were actually sectioned, compared to those who met criteria for being sectioned but were admitted informally, were more likely to be: non-white, male, living in supported housing, less educated, diagnosed with a non-affective disorder and perceive that they were highly coerced to hospital.

Many studies have commented on higher levels of compulsion in male, black, psychotic patients in the United Kingdom and a variety of reasons have been suggested for this higher rate of compulsory admission (Moodley & Perkins 1991). These include more aversive pathways to mental health treatment, increased severity of disorder, and clinicians' view of minorities as more dangerous (Harrison *et al.* 1988; Bhugra *et al.* 1997; Commander *et al.* 1999). There is an inherent assumption that more of these patients meet the criteria for requiring compulsion. However, our results suggest that actual compulsion rates do not represent who meets the threshold for compulsory admission. Instead they indicate that a much broader sample of patients meet this threshold but accept informal admission for other reasons. Further research is required to examine whether the preliminary results of this study are indicative of a larger pattern in mental health services throughout the UK and to determine the reasons that some patients accept informal admission while others do not.

3.4.2 Limitations of study

This study was exploratory, both conceptually and methodologically. As it was a small study, it has limited statistical power to detect significant differences between groups. No power calculation was done as, to the best of our knowledge, it is the first study of its kind.

There was a low response rate from clinicians, with dyadic datasets being collected in just over 40% of cases. This is similar, however, to other studies involving clinicians and responding and non-responding clinicians did not differ in terms of gender or professional designation (Claassen 2007). Data was not collected from non-responders, however, so they may have differed on other factors. It is possible that the clinicians identified by the patient or medical note review were not the admitting clinician in the case. Clinicians were asked to return or forward the questionnaire in this case and only five were returned for this reason. These were resent to the appropriate individuals involved. In addition, the dyadic sub-sample was relatively representative of the patient sample in terms of sociodemographic and clinical/service use characteristics and admission experiences. Questionnaires were more likely to be returned if the patient had co-morbid substance abuse and if the clinician had previous contact with the patient. Clinicians may have been more willing or felt more able to respond to questionnaires when they had a history with the patient.

As previously noted, this study explored perceptions of coercion in clinicians using a modified version of a questionnaire developed for patients. It may be questioned whether clinician perceived coercion is a valid concept. We suggest that understanding the pressures on clinicians' judgment during decision making is of importance in mental health service delivery. The project emerged from discussions with clinicians and the modified scales were refined with clinicians and researchers through local and conference presentations. Further examination of this concept on philosophical, conceptual, and empirical levels is required.

We suggest that a qualitative systematic analysis of clinician views of coercion may be a next step. Given the complexity of medical decision making, this type of research may also shed light on other determinants of pressure and coercion which were not investigated in this study. This study relied solely on self-report of clinicians' views and experiences. An observational study would allow for the collection and triangulation of data from patients, clinicians and other players in the admissions process (Quirk *et al.* 2003). Furthermore, this was an admissions study and we have no data from situations when clinicians decided not to admit a patient to hospital.

3.4.3 Summary

Studies of the psychiatric hospitalization process have recognized the role of pressures from family, friends, other services and the issue of risk and liability in clinicians' decision to admit patients to hospital. However, to our knowledge, no study has examined whether these pressures are clinically appropriate or whether clinicians feel coerced or forced into admitting patients to hospital. Our results suggest that a substantial proportion of clinicians feel coerced to admit patients to hospital and that they experience pressures beyond medical need to admit patients.

Understanding why clinicians admit patients to hospital is important for mental health service delivery and has implications for resource allocation. Further research is needed to explore the pressures experienced by clinicians and to ensure that clinicians correctly assess the expectations and needs of their patients.

This study also highlights an important issue in mental health services research and policy. Most studies have focused on measuring which patients are subject to compulsory admission to hospital. Knowing which patients would have been sectioned had they not accepted informal admission is also of interest and may provide insights into how to reduce compulsory and coercive treatment.

4 Patients' perceptions of coercion during community mental health care

4.1 Introduction

The coercive imposition of mental health care services on patients has long been a controversial issue in psychiatry (Jones 1955; Jones 1972; Szasz 1975). Debates over whether those suffering from mental illness should be hospitalized against their will are centuries old. In recent years, however, the locus for treatment of mental illness has shifted from the hospital to the community (Bennett 1991; Jones 1993). With this change has come a host of new legal, ethical and clinical issues to be resolved. As in studies of perceived coercion during psychiatric hospital admissions, empirical research of coercion in community mental health treatment has been hampered by a limited definition of what constitutes coercive care (Monahan *et al.* 2001; Monahan *et al.* 2003).

4.1.1 Community mental health care in England and Wales

As previously discussed, there has been an increased focus on patient autonomy and attempts have been made to reduce the use of compulsory treatment within mental healthcare. Providing treatment for patients in the "least restrictive environment" has become a goal of legislation, policy and best practice guidelines (Department of Health 1999). In England and Wales, the provision of mental healthcare services for patients within the community has expanded over the last 50 years.

Since the process of deinstitutionalization gained momentum in 1955, the number of beds on psychiatric inpatient wards has decreased from over 150 000 to approximately 42 000 in 1994-95 (Health and Personal Social Services statistics, reported in Ford *et al.* 1998). Despite the reduction in psychiatric beds, the number of hospital admissions has risen to 237 000 in 1994-95 (Health and Personal Social Services statistics, reported in Ford *et al.* 1998). The presence of "revolving door" patients has led many to question whether community mental health services are effective (Leff 1997).

Changes in community care policy

In 1985, the House of Commons Social Services Committee published a highly critical report on problems in the coordination of health and social services. The Committee deemed community care to be a "virtually meaningless...slogan, with all the weakness that implies" (House of Commons Social Services Committee 1985). They criticized the government for how they organized and funded community care. Specifically, the Committee stated that community treatment was not to be used as a cost-cutting method "by getting people out of hospital or care by families and volunteers rather than statutory care" (House of Commons Social Services Committee 1985).

The Government's response was the report *Caring for People* in 1989, followed by the National Health Service and Community Care Act 1990 (Department of Health 1990a; Department of Health 1990b). This legislation aimed to promote the development of home-based care and day-care to enable vulnerable adults to live in their own homes. It also encouraged practical support for carers and allowed for respite care if needed. The Act required local authorities to assess those "who appear[ed] to need community care services" for social care and support. The assessment determined which services should be provided including accommodation, home help and social support. In situations where services were required, policy stated that a Care Management Approach should be taken to ensure that services were provided for that person. While the Act applied to all vulnerable adults living in the community, new policies concerning the care management of those with mental health problems living in the community soon followed.

The Care Programme Approach

The Care Programme Approach (CPA) was introduced in 1991 and provided a framework for the care of those with mental healthcare needs outside of hospital (Department of Health 1990c). It applied to "anyone in touch with secondary mental health services (health and social care)". Community mental healthcare teams (CMHTs) assessed the needs of those users living in the community, while hospitals usually used the CPA to outline discharge planning and aftercare when a patient was leaving inpatient care. The CMHT provided each patient a keyworker who was responsible for coordinating and managing their care in the community. Each keyworker would have a caseload of 20-30 patients with whom they would meet regularly. The Care Programme and Care Management Approaches were often coordinated to ensure that an individual's healthcare and social services needs were both met.

Patients in the Community Act

The Mental Health (Patients in the Community) Act 1995 amended the MHA 1983 and introduced a new power for the supervision of patients following discharge from compulsory inpatient psychiatric care (Department of Health 1995). Under this law, patients who had been detained in hospital under a Section of the MHA could be required to comply with certain conditions on discharge from hospital. While the provision of after-care in the community was already mandatory (under Section 117 of the MHA) for people discharged after compulsory admission, the new legislation allowed for the activities of the patient to be controlled to a greater extent. Under a Supervised Discharge Order (SDO), a patient could be required to live in a particular place, attend appointments and allow service providers access to their home. Although the amendments required that a patient attend appointments, it included no powers to require that the patient consent to treatment and stopped short of compulsory treatment.

The Act also strengthened the provisions of Sections 17 and 18 of the MHA. It extended the permitted period of authorized leave under Section 17 from six months to the end of the current period of detention, if this was longer than six months. It also lengthened the period of time during which a person could be taken into custody and returned to hospital when they were absent without leave.

These amendments were controversial. They were introduced following several high profile violent incidents instigated by patients in the community who were not receiving treatment. The language used in debating these new provisions was of risk rather than of rights, which had been the focus of mental healthcare policy in previous decades (Jones 1993). Jones (1993) noted that the amendments blurred the distinction between institution and community and marked an increase in the role of the state in mandating community mental healthcare.

Compulsory community treatment

Compulsory community treatment legislation is becoming increasingly common internationally, primarily in common law countries. Laws allowing for compulsory treatment in the community exist in the United States, New Zealand and in some states and provinces within Australia and Canada respectively (Dawson 2005). While the goal of compulsory community treatment legislation is similar among these jurisdictions, there are differences in its implementation, utilization and efficacy. The terminology used also differs and they are often called outpatient commitment laws (OPC) or community treatment orders (CTO).

In England and Wales, the possible introduction of legal compulsion in community mental healthcare has garnered much attention. Community Treatment Orders (CTOs) have been formally proposed on two occasions in the past 20 years. The proposals, reviewed by the Royal College of Psychiatrists in 1988 and 1993, met with considerable opposition from psychiatrists, nurses and social workers. In March 2006, a new amending bill to the MHA was proposed. According to the Government, this will "introduce supervised treatment in the community to ensure that patients who have been discharged from compulsory treatment in hospital continue to comply with treatment" (Department of Health 2006). They have argued that supervised community treatment "reflects modern service provision enabling patients to be treated according to their individual needs and circumstances" and "will benefit patients and improve public safety" (Department of Health 2006).

This change in legislation remains highly controversial in England and Wales and mandating adherence to community treatment has been identified as one of the "most contested issues in mental health law" worldwide (Monahan *et al.* 2001). Much of the debate over these new laws and policies has examined compulsory community treatment as an extension of compulsory inpatient treatment. However, this conceptual framework is limited because it fails to consider the array of other legal and non-legal tools that are used to ensure that patients adhere to treatment in the community (Monahan *et al.* 2001; Monahan *et al.* 2003).

4.1.2 Leveraged treatment in the community

While the discussion of coercive practices in community treatment has focused on the use of legislation to mandate compliance, it is clear in service provision that other forms of coercion are often used to engage patients (Burns & Firn 2002). The term "leverage" has been used to describe the pressure that may be applied to patients through the linking of social services, the criminal justice system and mental healthcare (Susser & Roche 1996).

Money as leverage

People with mental health problems are often viewed as not being able to manage their finances (Pescsolido *et al.* 1999). In some situations, mental health patients may have their money managed; either formally by a legally appointed individual, or informally by a family member or friend. Depending on their ability to manage their own affairs, this may be at their request or an arrangement made for them.

In the UK, nearly three-quarters of those with mental health problems as their main disability receive state benefits (Office for National Statistics 2004). People suffering from mental and behavioral disorders make up 35% of those on incapacity benefit and a significant proportion of those with mental health problems may also be eligible for a disability living allowance (Citizens Advice Bureau 2004).

If patients who receive benefits are unable to manage their finances, an appointee will manage the money provided through the welfare system. An appointee can be an individual or an institution that receives the patients' benefits. Appointees manage the spending of benefits to ensure that the individual's basic needs, like food and accommodation, are met. They can also deal with savings up to £1700. While appointees are not legally allowed to operate a bank account on the patient's behalf, banks may allow this to happen in practice (Citizens Advice Bureau 2004). Appointees are required to act reasonably and must account for the money spent and ensure that it is not misused.

When patients do not have appointees, their finances may still be controlled informally by others. Recipients of benefits who are deemed capable of handling their finances can choose a third-party to receive payments on their behalf. Similarly, those who are not in receipt of benefits may have family members, friends or organizations that assist with their financial management. When appointees are members of CMHTs, an informal link between medication compliance and finances will likely be formed.

While acceptance of benefits does not explicitly require a patient to be in treatment, money and financial management may be used informally as leverage to ensure that a patient engages with services. Research has demonstrated that money may be used to provide incentive for entering and staying in treatment (Elbogen *et al.* 2003; Appelbaum & Redlich 2006).

Housing as leverage

As individuals with mental health problems often have low incomes, housing options for this population may be limited. While some live well independently or with their family, supported housing may be the only option for others. Supported housing may be run by the local government authority, voluntary organizations or the private sector. There are different types of housing available depending on the particular needs of the individual. These include: residential care homes, assertive outreach support, hostels, group homes, sheltered accommodation and therapeutic communities.

Depending on the level of support provided, these housing options range from being primarily for lodging to being residential treatment facilities. Across this spectrum, continued access to housing may require adherence to some treatment program. Little research has investigated how often these types of requirements are imposed on individuals with mental health problems living in the community and how they are expressed to occupants. For example, to be considered for MIND housing in Oxfordshire one must be "eligible for services from a Community Mental Health Team" and "be in need of and willing to accept support" (MIND 2007). This suggests an implicit requirement to accept support from their CMHT.

Child custody as leverage

Parents with mental health problems can be threatened with or actually lose access to their children if they fail to adhere to treatment (Nicholson 2005). Children of parents with mental illness are often seen as being "at risk" and fear of custody loss is a significant deterrent to parents seeking psychiatric treatment (Nicholson *et al.* 1998). However, there are no data on "the prevalence of custody loss" and little research investigating how often "compliance with treatment recommendations" is used "as a condition for parents to maintain care-giving responsibility, to visit, or to reunite with children" (Nicholson 2005).

Criminal sanction as leverage

The high prevalence of individuals with mental illness in the criminal justice system in the UK has been well documented (Birmingham *et al.* 1996; Fazel & Danesh 2002). To alleviate this burden, court diversion programs have been developed. These programs shift individuals from the criminal justice system to the mental healthcare system when necessary (Blumenthal & Wessely 1992). In these programs, criminal charges are not laid against individuals if they accept some form of mental health treatment. Despite the prolific growth of such programs, there has been little research investigating the process by which they are implemented and how often this type of leverage is used (Redlich *et al.* 2006).

Hospitalization as leverage

As previously mentioned, compulsory community treatment is the most controversial form of leverage. While England and Wales do not yet have legislation to this effect, supervised discharge orders (SDOs, Section 25 of the MHA), extended community leave (Section 17 of the MHA) and guardianship (Section 7 of the MHA) have been used as *de facto* community treatment orders for many years in the UK (Pinfold *et al.* 2001; Hatfield *et al.* 2001).

These provisions allow patients to be released from the hospital, but still remain under a section of the Mental Health Act. They are often used as bargaining tools (Pinfold *et al.* 2001). Patients may be promised an early hospital discharge or extended community leave if they are compliant with treatment in hospital and agree to adhere while in the community. Those who fail to do so can be taken into custody and detained again in hospital if they do not adhere to treatment.

4.1.3 Perceived coercion in community mental health care

As compulsory community treatment legislation has become more common, there has been an increased interest in examining the use of coercion in the community and patients' perceptions of coercion in community mental health care. Most studies of perceived coercion in the community focused on patients' who had been mandated to receive compulsory community treatment (Steadman *et al.* 2001; Swartz *et al.* 2001;

Swartz *et al.* 2002). A randomized controlled trial of outpatient commitment in the USA found that patients receiving mandatory community treatment experienced higher levels of perceived coercion than those who were not (Swartz *et al*. 2002)

To our knowledge, only one study has examined the relationship between perceived coercion and other forms of leveraged community treatment (Monahan *et al.* 2005). This study found that the experience of leverage in community mental health care and perceptions of coercion were significantly associated (Appelbaum & Redlich 2006; Robbins *et al.* 2006)

4.1.4 Summary

An increasing number of mental health patients are being cared for in the community and compulsory community treatment laws have been introduced in the UK and many other common law countries. This has led to debate over the use of such legislation and the use of "leverage" to improve adherence to treatment in the community. In this study, we explored the use of these leverages in the UK and their association with patients' perceptions of coercion.

4.1.5 Aims

This study had three aims:

- to assess the prevalence and pattern of leverage use among patients under the care of community mental healthcare teams (CMHTs) in England
- to compare the prevalence and pattern of leverage use between patients in England and the United States
- to determine whether patients perceive the use of leverage as coercive

4.2 Methods

4.2.1 Study design

The study was a cross-sectional cohort study. Patients receiving treatment from Community Mental Health Teams (CMHT) within the Oxfordshire Mental Healthcare NHS Trust were recruited to participate. Data were collected by an interview with the patient following a regularly scheduled outpatient appointment. This information was verified by a review of computerized medical records.

4.2.2 Participants

Patients were recruited sequentially from the waiting room of an outpatient clinic which serves several Oxfordshire Community Mental Health Teams (CMHTs). Patients were asked whether they would like to participate in a research project about mental health services and assessed for their eligibility to participate in the study. The inclusion criteria for the study were broad. To be approached to take part, patients needed to be:

- 18 to 65 years of age
- under the care of mental health services for a minimum of six months
- have been in contact with mental health services at least once in the last six months

- able to provide written and informed consent
- adequately proficient in English to participate in an interview

Patients were excluded if they were:

- diagnosed with dementia (as this would prevent the provision of informed consent)

Those patients who expressed interest in participating were given an information sheet and a verbal overview of the study. Participating patients provided written informed consent and then took part in an interview with the researcher, who was independent of their care team. Interviews took place in a private room within the outpatient clinic complex and took approximately 30 minute to complete.

Patients were paid £5 for their participation in the study. Those who attended the outpatients' clinic multiple times during the study period were only interviewed once.

4.2.3 Data collected

The interview schedule was designed to collect data on sociodemographic and clinical characteristics and service experience variables. These are listed in Table 35. Data collected during the interview were supplemented by a review of computerized medical records.

Table 35: Sociodemographic and clinical characteristics and admission experience variables collected through patient interview

Sociodemographic	Clinical	Admission Experience
- age	- diagnosis	- experience of leverage
- sex	- co-morbid substance abuse[a]	- money
- ethnicity	- age of onset of symptoms	- housing
- education	- first contact with services	- criminal justice
- marital status	- prior admission	- hospitalization
- living arrangements	- prior compulsory admission	- child custody
- children	- functioning [b]	- general pressure to adhere
- employment		- perceived coercion[c]
		- negative pressures[c]
		- procedural justice[c]
		- therapeutic alliance[d]

[a] measured by CAGE (Allen *et al.* 1988)

[b] measured by Global Assessment of Functioning (GAF; American Psychiatric Association 1994)

[c] measured by scale of MacArthur Admission Experience Survey-Community Version (AES - Comm; Monahan *et al.* 2005)

[d] measured by the Helping Alliance Survey (HAS; Priebe & Gruyters 1993) and the Scale To Assess Therapeutic Relationships in Community Mental Health Care (McGuire-Snieckus *et al.* 2007)

Instrumentation

Several standardized instruments were used to collect data as noted below.

MacArthur Admission Experience Survey-Community Version **(Monahan *et al.* 2005)**

The MacArthur Experience Survey-Community Version (AES-Comm) is a measure of patients' perceptions of coercion. It was modified by its original authors for use in a community treatment setting (Monahan *et al.* 2005). The survey consists of 14 items from which ratings of perceived coercion, negative pressures and procedural justice can be derived. It requires patients to respond with true or false to statements about their admission to hospital. Statements answered as "true" are scored as zero and those answered as "false" are scored as one.

The perceived coercion scale consists of five statements concerning the degree of influence, control, choice and freedom the patient had in the decision to enter treatment. Scores range from zero to five, with a high score reflecting a high degree of perceived coercion. The negative pressures scale consists of six items examining the patient's experience of threat, force and deception during care. Scores range from zero to six, with a low score reflecting high levels of negative pressure. The procedural justice scale consists of three items and investigates the patient's experience of voice, fairness, motivation, validation, respect and information during community treatment. Scores range from zero to three, with a high score reflecting low levels of procedural justice.

Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR; McGuire-Snieckus *et al.* 2007*)*

The Scale to Assess Therapeutic Relationships in Community Mental Health Care (STAR) is a brief scale specifically developed to assess the therapeutic relationship in community mental health care. The STAR-P, the patient version of the scale, consists of 12 items from which three subscales can be derived: positive collaboration, positive clinician input and non-supportive clinician input. It has been found to have good psychometric properties and test-retest reliability and is suitable for use in research (McGuire-Snieckus *et al.* 2007).

Patients' rate each item on a five-point Likert scale, ranging from never to always. Total scores can be obtained for an overall rating of the therapeutic relationship, as well as individual subscale scores. Total scores range from zero to 48 with high scores indicating a better therapeutic relationship. Positive collaboration scores range from zero to 24, positive clinician input scales from zero to 12 and non-supportive clinician input scores from zero to 12, with high scores reflecting a better relationship.

***CAGE Questionnaire* (CAGE; Allen *et al.* 1988)**

The CAGE Questionnaire consists of four questions about an individual's substance use which can be applied to the use of both drugs and alcohol. These ask whether the individual: feels they need to cut down on their use; is annoyed by others complaining about their use; feels guilty about their use; needs to use first thing in the morning. In this study, scores were dichotomized and patients were categorized as having either no substance abuse symptoms or as having two or more substance abuse symptoms (Monahan *et al.* 2005).

***Helping Alliance Scale* (HAS; Priebe & Gruyters 1993)**

See Section 2.2.3 for description.

***Global Assessment of Functioning (GAF;* American Psychiatric Association 1994)**

See Section 2.2.3 for description.

4.2.4 Data analysis

Data were entered into a database and analyzed using the Statistical Package for Social Sciences (SPSS V. 14.0; SPSS, Chicago).

Descriptive statistical analyses were performed on baseline sociodemographic and clinical characteristics.

Univariate analyses were conducted to examine the association between perceived coercion score (zero to five) and sociodemographic, clinical and admission experience variables. Spearman's rank order correlation was used to test the relationship between continuous variables and perceived coercion scores. Associations between categorical variables and perceived coercion score were examined using Mann-Whitney U Tests (comparison of two groups) and Kruskal-Wallis Tests (comparison of three or more groups) as appropriate. Post-hoc analyses of significant associations between categorical variables (with three or more groups) and perceived coercion score were carried out using Mann-Whitney U Tests. Statistical significance of post-hoc analyses was determined using a Bonferroni correction. Differences were considered significantly different at $p<0.017$ (for three groups).

Multiple variable logistic regression analysis was also conducted. This was used to investigate the relationship between variables that were significantly associated with perceived coercion score and perceived coercion level (low score: zero to one; or high score: two to five) in univariate analysis. Collinearity diagnostic tests were run to examine multicollinearity between variables and standardized residuals and Cook's distance values were inspected to assess the influence of individual cases on the model.

4.3 Results

4.3.1 Responders and non-responders

Fifty patients attending appointments at an outpatient clinic, meeting the study inclusion criteria (see Section 4.2.2), were approached to take part in the study. Of these, 42 patients agreed to take part in the study and 8 refused. The majority of patients who refused gave no reason for declining.

4.3.2 Baseline characteristics of sample

Baseline sociodemographic and clinical characteristic data were collected through the interview. A review of computerized records was used to verify this information and collect further data. The sociodemographic and clinical/service use characteristics of the participating sample are shown in Tables 36 and 37 respectively.

Summary of baseline sociodemographic characteristics

The mean age of the sample was 40.1 (*SD*=12.9). The majority of the sample were male (*N*=22, 52.4%), white (*N*=41, 97.6%), single (*N*=23, 54.8%), living independently (*N*=30, 71.4%) and unemployed (*N*=24, 57.1%). The mean number of years in formal education was 14.1 (*SD*=3.4). Most of the sample did not have children (*N*=24, 57.1%), but 13 of those who did were in regular contact with them (*N*=13, 72.2%).

Table 36: Sociodemographic characteristics of sample

Characteristic	**Sample (*N*=42)**	
	***N* or mean**	**(%) or (*SD*)**
Age [mean (*SD*)]	40.1	(12.9)
Sex		
male	22	(52.4)
female	20	(47.6)
Ethnicity		
white	41	(97.6)
other	1	(2.4)
Marital status		
single	23	(54.8)
divorced/separated/widowed	8	(19.0)
married/cohabiting	11	(26.2)
Living arrangement		
independent	30	(71.4)
supported housing	12	(28.6)
Education		
up to age 16	23	(54.8)
16 and over	19	(45.2)
Employment		
employed	13	(31.0)
unemployed	24	(57.1)
student	5	(11.9)
Children		
yes	18	(42.9)
no	24	(57.1)
Regular contact with children		
yes	13	(31.0)
no	5	(69.0)

Table 37: Clinical and service use characteristics of sample

Characteristic	**Sample (*N*=42)**	
	***N* or mean**	**(%) or (*SD*)**
Diagnosis		
schizophrenia	11	(26.2)
affective	21	(50.0)
other	10	(23.8)
Co-morbid substance abuse		
yes	15	(35.7)
no	27	(64.3)
Age at onset [mean (*SD*)]	22.9	(10.8)
Age at first contact with services [mean (*SD*)]	29.1	(11.6)
Previous admission to hospital		
yes	27	(64.3)
no	17	(35.7)
Previous MHA admission		
yes	14	(33.3)
no	28	(66.6)
Ever in community under MHA		
yes	5	(11.9)
no	37	(88.1)
Global assessment of functioning [mean (*SD*)]	59.1	(11.7)

4.3.3 Experiences of leverage in the community

Patients' experiences of leverage in the community were investigated through a series of interview items. Only relevant subsets of patients were questioned in greater detail about their experiences. Table 38 provides a summary of these experiences.

Hospitalization as leverage

Over one-third of patients (*N*=27, 64.3%) had been previously admitted to a psychiatric hospital. Over half of these patients (*N*=14; 51.8%) had been admitted under a MHA section. Of these, five had spent time in the community subject to provisions of the MHA either on Section 17 leave or a Supervised Discharge Order.

Money as leverage

Half of the patients (*N*=21, 50.0%) reported having ever received state benefits, although only two had received these through a formalized financial guardian. In neither of these two cases was receiving their benefit subject to them being in mental health care. 18 patients (42.9%) indicated that someone else helped them to manage their money and in four of these cases money went directly to their money manager. Patients reported having access to their money dependent on whether they were in mental health treatment in three of these 18 cases.

Table 38: Experiences of leverage in the community

Leverage	**Sample (*N*=42)**	
	N	**(%)**
Hospitalization		
ever in hospital		
yes	27	(64.3)
no	15	(35.7)
ever in hospital under MHA		
yes	14	(33.3)
no	28	(66.6)
ever in community under MHA		
yes	5	(11.9)
no	37	(88.1)
Money		
ever had someone assist you with managing your money		
yes	18	(42.9)
no	24	(57.1)
ever had money dependent on mental health treatment		
yes	3	(7.1)
no	39	(92.9)
Criminal justice system		
ever been arrested		
yes	9	(21.4)
no	33	(78.6)
ever had charges reduced/dropped or avoided jail if in MH treatment		
yes	2	(4.8)
no	40	(95.2)
Housing		
ever required to stay in treatment to live somewhere		
yes	13	(31.0)
no	29	(69.0)
Child custody		
have children		
yes	18	(42.9)
no	24	(57.1)
ever been told that access to children be restricted if not in MH treatment		
yes	4	(9.5)
no	38	(90.5)
Any leverage		
ever experienced any leverage		
yes	20	(47.6)
no	22	(52.4)

Criminal justice system as leverage

One-third of patients (*N*=14, 33.3%) had been picked up by the police when they had not been charged with a crime and over one-fifth of patients (*N*=9, 21.4%) had been arrested. In two of the nine cases where patients had been arrested, the charges had been reduced or dropped or the patient had avoided jail by agreeing to adhere to mental health treatment.

Housing as leverage

Nearly one-third of patients (*N*=13, 31.0%) indicated that they had lived in accommodation where they had been required to stay in treatment. Four of these 13 patients had also been told that obtaining accommodation would require them to be in mental health treatment.

Child custody as leverage

Eighteen (42.8%) patients had children. Thirteen patients had regular access to their children and lived with them in 11 cases. Four of the parents had been told that their access to their children would be limited if they did not adhere to mental health treatment.

Experience of any leverage

Nearly half of the patients (*N*=20, 47.6%) had experienced at least one type of leverage. The number of leverages experienced ranged from one to three. One-third (*N*=14) had experienced one type of leverage, while five had experienced two and one patient had experienced three.

Attitudes toward the use of leverage

Patients were asked to rate statements about whether the use of leverage in the community helps people to stay well. Ratings were made on a five-point Likert scale, ranging from strongly agree (score of one) to strongly disagree (score of five). A summary of these statements and ratings are shown in Table 39. The use of money as leverage was viewed more negatively than the use of criminal justice, housing and child custody.

Table 39: Agreement with the use of different types of leverage

Statement	**mean**	***SD***	***MDN***	**min**	**max**
One way to help people get well is to hold back some of their money unless they go to treatment	3.3	1.3	3.5	1	5
Being told to get treatment by a police officer, probation officer or judge helps people stay well	2.6	1.0	2.0	1	5
Being told to get treatment to get or keep housing helps people to stay well	2.8	1.1	2.0	1	5
Being told that access to their children will be restricted unless they get treatment helps people to stay well	2.6	1.0	2.0	1	5

4.3.4 Associations of baseline data and experience of leverage

Associations between sociodemographic and clinical/service use characteristics and any experience of leverage (yes or no) were examined. *T*-tests were used to test the relationship between continuous variables and experience of any leverage. Associations between categorical variables and experienced leverage were examined using chi-square test.

There were significant associations between experience of leverage and living arrangement, previous admission to hospital and previous compulsory admission under the MHA. Those who had experienced leverage were significantly more likely to be living in supported housing ($\chi^2(1)=1.44$, $p=0.003$), to have been admitted to hospital ($\chi^2(1)=4.11$, $p=0.04$) and to have been detained under a MHA section ($\chi^2(1)=4.77$, $p=0.03$).

Table 40: Associations between experience of any leverage and sociodemographic/clinical/service use characteristics

Characteristic	**Experience of leverage (*N*=20)**		**No leverage experienced (*N*=22)**		**Significance of Difference**
	***N* or mean**	**(%) or (*SD*)**	***N* or mean**	**(%) or (*SD*)**	
Age [mean (*SD*)]	37.4	(11.0)	42.5	(14.3)	$t(40)=0.96, p=0.34$
Sex					$\chi^2(1)=2.4, p=0.12$
male	7	(35.0)	13	(59.1)	
female	13	(65.0)	9	(40.9)	
Marital status					$\chi^2(1)=0.76, p=0.38$
single/divorced/separated/widowed	16	(80.0)	15	(68.2)	
married/cohabiting	4	(20.0)	7	(31.8)	
Children					$\chi^2(1)=0.07, p=0.79$
yes	9	(45.0)	9	(40.9)	
no	11	(55.0)	13	(59.1)	
Living arrangement					$\chi^2(1)=1.44, p=0.003$
independent	10	(50.0)	20	(90.9)	
supported	10	(50.0)	2	(9.1)	
Children					$\chi^2(1)=0.72, p=0.79$
have children	9	(45.0)	9	(40.9)	
does not have children	11	(55.0)	13	(59.1)	
Education					$\chi^2(1)=0.00, p=0.98$
up to age 16	11	(55.0)	12	(54.5)	
16 and over	9	(45.0)	10	(45.4)	
Diagnosis					$\chi^2(2)=0.44, p=0.80$
schizophrenia	5	(25.0)	6	(27.3)	
affective	11	(55.0)	10	(45.4)	
other	4	(20.0)	6	(27.3)	
Years in treatment [mean (*SD*)]	11.3	(8.8)	10.9	(11.9)	$t(40)=0.34, p=0.90$

Characteristic	**Experience of leverage (*N*=20)**		**No leverage experienced (*N*=22)**		**Significance of Difference**
	***N* or mean**	**(%) or (*SD*)**	***N* or mean**	**(%) or (*SD*)**	
Previous admission					$\chi^2(1)=4.11, p=0.04$
yes	16	(80.0)	11	(50.0)	
no	4	(20.0)	11	(50.0)	
Previous MHA admission					$\chi^2(1)=4.77, p=0.03$
yes	10	(50.0)	4	(18.2)	
no	10	(50.0)	18	(81.8)	
GAF [mean (*SD*)]	58.3	(11.9)	59.9	(11.7)	$t(40)=0.44, p=0.41$

4.3.5 Experiences during community mental health care

Patients' experiences of pressures in community were investigated in a series of interview items and standardized scales.

Consequences of not adhering to treatment or attending appointments

Patients were asked about various consequences that may occur if they did not adhere to treatment or attend their appointments. Specifically they were asked, "In the last six months, if you did not take your medication or come to your appointment at the clinic, did you think someone would...". A summary of these statements are shown in Table 41.

Patients were most likely to feel that someone would be angry or disappointed them if they did not adhere to treatment (*N*=31, 73.8%). No patients believed that their money would be restricted if they did not adhere.

Table 41: Perceptions of consequences of not adhering to treatment in the community

Statement	**Yes**		**No**	
If you did not take your medication or come to your appointment at the clinic did you think someone would…	*N*	**(%)**	*N*	**(%)**
make you go to the hospital	11	(26.2)	31	(73.8)
section you	9	(21.4)	33	(78.6)
notify the police	3	(7.1)	39	(92.9)
not give you spending money	0	(0.0)	42	(100.0)
make you leave where you live	7	(16.7)	35	(83.3)
restrict access to your children⁺	1	(5.6)	17	(94.4)
fire you from your job^	3	(23.1)	10	(76.9)
make life difficult for you	17	(40.5)	25	(59.5)
be angry or disappointed in you	31	(73.8)	11	(26.2)

⁺only those with children, *N*=18; ^only those employed, *N*=13

Attitudes toward pressures

Patients were asked about the use of pressures in community treatment. Each statement started, "Overall, the pressures or things people have done to get me into treatment or stay in treatment …", and patients were asked to respond to each statement with either "true" or "false". A summary of the statements are shown in Table 42.

The use of pressures was viewed positively by the majority of patients. Most patients believed that the things people did to get them into and stay in treatment were done for their own good (*N*=41, 97.6%), should be done again in the future if needed (*N*=40, 95.2%) and were done by people who tried to be fair to them (*N*=40, 95.2%). Nearly one-thirds of patients (*N*=13, 31.0%), however, reported that the use of those pressures did not make them feel respected as a person.

Table 42: Attitudes to the use of pressure in the community

Statement	**Yes**		**No**	
Overall, the pressures or things people have done to get me into treatment or stay in treatment…	*N*	**(%)**	*N*	**(%)**
made me more likely to take my medication	34	(80.9)	8	(19.1)
have been done by people who tried to be fair to me	40	(95.2)	2	(4.8)
were for my own good	41	(97.6)	1	(2.4)
were not done out of real concern for me*	36	(85.7)	6	(14.3)
helped me get and stay well	38	(90.5)	4	(9.5)
helped me gain more control over my own life	35	(83.3)	7	(16.7)
did not make me feel respected as a person*	29	(69.0)	13	(31.0)
should be done again in the future if needed	40	(95.2)	2	(4.8)

* reversed scored

Negative pressure

As shown in Figure 13, negative pressure scores ranged from one to the maximum of six. The mean negative pressure score was 5.4 (*SD*=1.3) with a median of 6.0. The distribution was negatively skewed with over 70% of patients (*N*=30, 71.4%) reporting no negative pressure. Individual subscale items are shown in Table 43. The scale had high internal consistency with a Cronbach α coefficient of 0.70.

Figure 13: Negative pressure scores

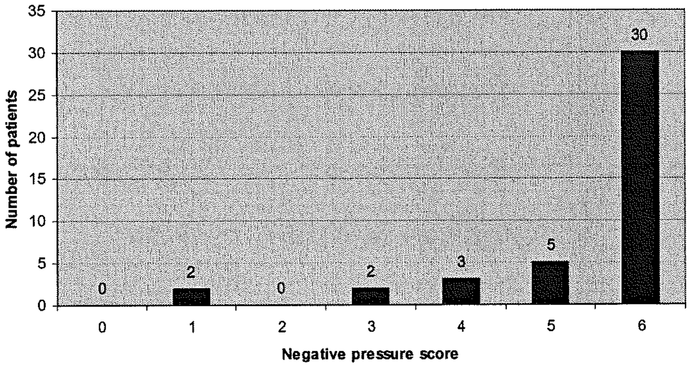


Table 43: Responses to individual items of the negative pressure scale

Item	*N*		%	
	true	**false**	**true**	**false**
People tried to force me to come to the clinic	6	36	14.3	85.7
Someone threatened me to get me to come to the clinic	3	39	7.1	92.9
Someone physically tried to make me come to the clinic	0	42	0.0	100.0
I was threatened with sectioning	3	39	7.1	92.9
They said they would make me come to the clinic	6	36	14.3	85.7
No one tried to force me to come to the clinic*	9	33	21.4	78.6

* reverse scored

Procedural justice

Procedural justice scores (Figure 14) ranged from the minimum of zero to the maximum of four. The mean procedural justice score was 0.5 (*SD*=0.83) with a median of 0.0. The distribution was positively skewed with over two-thirds of patients (*N*=29, 69.0%) experiencing the greatest "voice" score. The responses to individual items in the scale are shown in Table 44. The scale had good internal reliability with a Cronbach α coefficient of 0.62.

Figure 14: Procedural justice scores

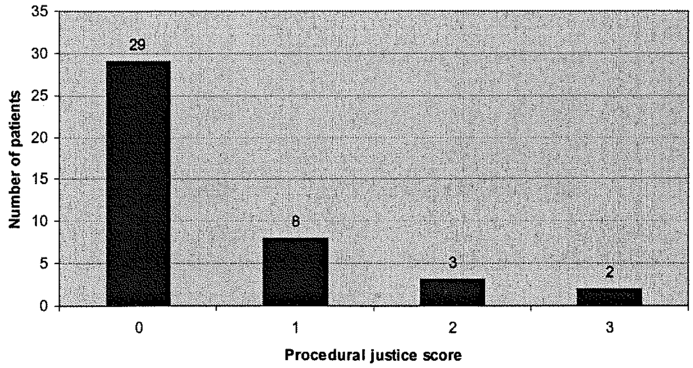


Table 44: Responses to individual items of the procedural justice scale

Item	*N*		%	
	true	**false**	**true**	**false**
I had enough of a chance to say whether I wanted to come to the clinic	34	8	81.0	19.0
I got to say what I wanted about coming to the clinc	37	5	88.1	11.9
My opinion about coming to the clinic didn't matter*	35	7	83.3	16.7

* reverse scored

Perceived coercion

As shown in Figure 15, perceived coercion scores ranged from one to the possible maximum of five. The majority of patients experienced low levels of coercion. The mean score was 1.3 (*SD*=1.6) with a median of 1.0. The responses to individual items in the scale are shown in Table 45. The scale was highly internally reliable with a Cronbach α coefficient of 0.77.

Figure 15: Perceived coercion score

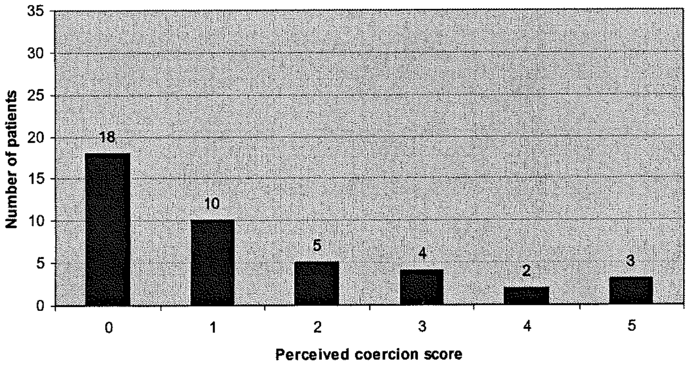


Table 45: Responses to perceived coercion scale items

Item	*N*		%	
	true	false	true	false
I felt free to do what I wanted about coming to the clinic	32	10	76.2	23.8
I chose to come to the clinic	38	4	90.5	9.5
It was my idea to come to the clinic	27	15	64.3	35.7
I have a lot of control over whether I came to the clinic	31	11	73.8	26.2
I had more influence than anyone else over whether I came to the clinic	27	15	64.3	35.7

4.3.6 Therapeutic relationship in community mental health care

Patient ratings of the therapeutic relationship were made using the Scale to Assess Therapeutic Relationships in Community Mental Health Care (STAR; McGuire-Snieckus *et al.* 2007) and the Helping Alliance Scale (HAS; Priebe & Gruyters 1991). Responses to the STAR are shown in Table 46 and to the HAS in Table 47.

Total scores on the STAR ranged from 13 to 48. The mean STAR score was 39.85 (*SD*=8.4, *MDN*=42.0). The mean scores on the positive collaboration, positive clinician input and non-supportive clinician input subscales were 20.0 (*SD*=4.9, *MDN*=22.0, range: 4-24), 9.3 (*SD*=2.8, *MDN*=10.0, range: 2-12) and 10.5 (*SD*=2.0, *MDN*=12.0, range: 6-12) respectively.

Total scores on the HAS ranged from 60 to 450. The mean HAS score was 278.6 (*SD*=99.5; *MDN*=280.0; range: 0-450).

There was a strong positive correlation between total STAR and total HAS score (*rho*=.62, *p*<.01).

Table 46: Scores on the Scale to Assess Therapeutic Relationships in Community Mental Health Care (STAR)

Question	**Sub**	**mean**	***SD***	***MDN***	**min**	**max**
My clinician speaks with me about my personal goals and thoughts about treatment	PCI	3.2	0.9	3.0	1	4
My clinician and I are open with one another	PC	3.3	1.0	4.0	0	4
My clinician and I share a trusting relationship	PC	3.3	1.0	4.0	0	4
I believe my clinician withholds the truth from me*	NCI	0.4	0.9	0.0	0	3
My clinician and I share an honest relationship	PC	3.5	0.6	4.0	1	4
My clinician and I work towards mutually agreed upon goals	PC	3.5	0.8	4.0	1	4
My clinician is stern with me when I speak about things that are important to me and my situation*	NCI	0.7	1.2	0.0	0	4
My clinician and I have established an understanding of the kind of changes that would be good for me	PC	3.2	1.1	4.0	0	4
My clinician is impatient with me*	NCI	0.4	0.8	0.0	0	3
My clinician seems to like me regardless of what I do or say	PCI	3.0	1.2	3.0	0	4
We agree on what is important for me to work on	PC	3.2	1.1	4.0	0	4
I believe my clinician has an understanding of what my experiences have meant to me	PCI	2.1	1.2	4.0	0	4
TOTAL		39.8	8.4	42.0	13	48

Subscales:
PC–positive collaboration, PCI–positive clinician input, NCI–non-supportive clinician input (*rev scored)

Table 47: Scores on Helping Alliance Scale (HAS)

Question	**mean**	***SD***	***MDN***	**min**	**max**
Do you feel understood by your clinician?	75.1	24.2	80.0	5	100
Do you feel criticized by your clinician?*	16.9	18.9	10.0	0	75
Is your clinician committed to you and involved in your care?	79.9	22.9	85.0	10	100
Is this treatment right for you?	77.4	22.2	85.0	10	100
TOTAL	352.0	91.8	370.0	60	450

* reversed scored

4.3.7 Associations of baseline data and perceived coercion

Univariate analyses were used to test the association between perceived coercion and baseline characteristics. Perceived coercion was investigated as a continuous variable.

As perceived coercion scores were not normally distributed, non-parametric statistical tests were used. Spearman's rank order correlation was used to test the relationship between continuous variables and perceived coercion scores. Associations between categorical variables and perceived coercion score were examined using Mann-Whitney U Tests (comparison between two groups) and Kruskal-Wallis Tests (comparison between three or more groups) as appropriate.

Sociodemographic characteristics and perceived coercion

As shown in Table 48, gender was the only sociodemographic variable significantly associated with perceived coercion score. Males experienced significantly higher levels of perceived coercion (*MDN*=1.0, range 0-5) than females (*MDN*=1.0, range 0-5; *Z*=-2.10, *p*=0.04).

Clinical/service use characteristics and perceived coercion

As shown in Table 49, there were no significant associations between any clinical/service use characteristics and perceived coercion score.

Table 48: Associations between perceived coercion score and sociodemographic characteristics

Characteristic		Perceived Coercion Score					
	N	mean	SD	MDN	min	max	Significance of Difference
Age	42						$rho=-.23$, $p=.15$
Sex							$Z=-2.10$, $p=0.04$
male	22	1.6	1.5	1.0	0	5	
female	20	1.0	1.6	0.0	0	5	
Marital status							$Z=-1.28$, $p=0.20$
single/div/sep/widowed	31	1.5	1.7	1.0	0	5	
married/cohabiting	11	0.7	1.0	0.0	0	3	
Children							$Z=-1.22$, $p=0.22$
yes	18	0.9	1.4	0.5	0	5	
no	24	1.6	1.7	1.0	0	5	
Living arrangement							$Z=-1.74$, $p=0.08$
independent	30	1.1	1.5	0.5	0	5	
supported housing	12	1.9	1.7	2.0	0	5	
Education							$Z=-0.77$, $p=0.44$
up to 16 years old	31	1.5	1.7	1.0	0	5	
16 years old and above	11	0.7	1.0	0.0	0	3	
Employment							$H(2)=5.46$, $p=0.07$
employed	13	0.5	0.7	0.0	0	2	
unemployed	24	1.5	1.5	1.0	0	5	
student	5	2.6	2.5	3.0	0	5	

Table 49: Associations between perceived coercion score and clinical and service use characteristics

Characteristic		**Perceived Coercion Score**					
	N	**mean**	***SD***	***MDN***	**min**	**max**	**Significance of Difference**
Diagnosis							*H*(2)=1.20, *p*=0.55
schizophrenia	11	1.7	1.7	2.0	0	5	
affective disorder	21	1.2	1.5	1.0	0	5	
other	10	1.1	1.6	0.0	0	4	
Number of years in treatment	42						*rho*=-.03, *p*=.77
Previous admission to hospital							*Z*=-0.37, *p*=0.71
yes	27	1.3	1.5	1.0	0	5	
no	15	1.3	1.8	1.0	0	5	
Previous MHA admission							*Z*=-0.70, *p*=0.48
yes	14	1.5	1.6	1.0	0	5	
no	28	1.2	1.6	1.0	0	5	
GAF score	42						*rho*=-.20, *p*=.16

4.3.8 Associations of experiences and perceived coercion

As shown in Table 50, both the therapeutic relationship score and having ever experienced leverage were significantly associated with perceived coercion score. Patients who had ever experienced leverage had significantly high perceived coercion scores (*MDN*=1.0, range 0-5) than those who had not (*MDN*=0.0, range 0-5; *Z*=-1.96, p=.05). There were also significant moderate negative correlations between perceived coercion score and total STAR score (*rho*=-.32, *p*<.05) and positive collaboration (*rho*=-.33, *p*<.05). There was a significant moderate positive correlation between perceived coercion score and non-supportive clinician input (*rho*=.40, *p*<.05).

Negative pressure and procedural justice scores were also significantly associated with perceived coercion scores. There was a strong negative correlation between negative pressure and perceived coercion score (*rho*=-.62, *p*<.01) and a strong positive correlation between perceived coercion and procedural justice score (*rho*=.50, *p*<.01). Negative pressure can account for 38.4% of the variance in perceived coercion score and procedural justice can account for 25.0%.

Table 50: Associations between perceived coercion score and community mental health care experiences

Characteristic		**Perceived Coercion Score**					
	N	**mean**	***SD***	***MDN***	**min**	**max**	**Significance of Difference**
Ever experienced leverage							Z=-1.96, p=0.05
yes	20	1.7	1.6	1.0	0	5	
no	22	1.0	1.5	0.0	0	5	
STAR	42						rho=-.32, p<0.05
STAR – PC	42						rho=-.33, p<0.05
STAR - PCI	42						rho=-.15, p=.37
STAR - NCI	42						rho=-.40, p<0.05
HAS	42						rho=-.20, p=.23
Negative pressure	42						rho=-.62, p<0.01
Procedural justice	42						rho= .50, p<0.01

4.3.9 Logistic regression model of community perceived coercion

Logistic regression was used to investigate the relationship between variables which were significantly associated with perceived coercion. For this analysis, perceived coercion scores were dichotomized around the mean of 1.3 (as used in Bindman *et al.* 2005). This divided the sample into low (score zero to one) and high (score of two or higher) perceived coercion groups.

Five variables were entered into the logistic regression model (forced entry): gender (male/female), any experience of leverage (yes/no), therapeutic alliance score (STAR), negative pressure score (AES-Comm) and procedural justice score (AES-Comm). As shown in Table 51, this demonstrated that when all variables were controlled for perceived coercion was only significantly associated with negative pressure score. The model described below accounts for 47%-65% of the variance in perceived coercion.

Table 51: Forced entry logistic regression model of factors associated with high perceived coercion in community treatment

				95% CI for exp *b*		
Factor	***B***	**SE**	***p***	**lower**	**exp *b***	**upper**
male	2.58	1.48	0.08	0.27	13.14	238.98
having ever experienced leverage	0.04	1.18	0.97	1.46	1.04	10.55
total STAR score	-0.12	0.09	0.16	0.36	0.88	1.05
experience of low negative pressure *	-1.72	0.87	0.05	1.06	0.18	0.99
experience of low procedural justice	0.78	0.76	0.31	0.28	2.18	9.78
constant	11.69	5.84	0.05		11196.4	
R^2=.50 (Hosmer & Lemeshow), .47 (Cox & Snell), .65 (Nagelkerke); Model $X^2(5)$=26.20, *N*=41, **p*<0.05						

4.4 Discussion

The aims of this study were to assess the prevalence and pattern of leverage use in community mental health care and to determine whether patients perceive the use of leverage as coercive. To our knowledge, it is the first study in the United Kingdom to investigate how often different forms of leverage are applied to patients receiving mental health care in the community. It is a simplified replication of the study conducted by Monahan *et al.* in five states in the USA (Monahan *et al.* 2005). The data collected through this study will form the basis for a larger study of leverage and perceived coercion in community mental health care in England.

4.4.1 Principal findings

Leverage use

Almost half of the patients in this sample had experienced at least one form of leverage during their time in community mental health care. The most prevalent type of leverage was housing (31% of patients), followed by the use of the MHA in the community (12%), custody of children (10%), money (7%), and the criminal justice system (5%). As shown in Table 52, these results are very similar to that found by Monahan *et al.* (2005).

Table 52: Comparison of prevalence and pattern of leverage experienced in this study and Monahan et al. *(2005)*

Leverage	**Reported in this study**	**Reported in Monahan *et al.*^**
Housing	31%	23-40%
MHA in community/outpt commitment*	12%	12-20%
Child custody	10%	5%$^{+}$
Money	7%	7-19%
among those with money handler	17%	15-31%
Criminal sanction	5%	15-30%
among those ever arrested	22%	38-49%
Experience of any type of leverage	48%	44-59%

* in this study, MHA in the community was defined as Section 17 leave or a SDO
^ range reported because data collected from five sites
$^{+}$Busch & Redlich (in press)

Despite a great difference in sample size, with the Monahan *et al.* (2005) study including over 1000 participants and ours including only 42, there was great similarity in the results. The percentage of patients having ever experienced leverage in this study was within the narrow range found across the five sites in the American study. In both studies, housing was the most commonly applied leverage and the prevalence of use of mental health legislation in the community and money as leverage was similar. Although Monahan *et al.* (2005) did not assess the number of patients who had been threatened with loss of custody of their children if they did not participate in care, we included this in our study (Nicholson 2005). As Monahan *et al.* plan to expand the types of leverage investigated in their empirical research, it will be of interest to see whether the prevalence of child custody as leverage is similar between the USA and UK (Monahan, personal communication).

The main difference in the results of the studies was in the use of criminal sanction as leverage. This is likely due to the greater number of mental health courts and jail diversion schemes in the United States. These have developed to cope with the high number of people in the criminal justice system with severe mental illness. In diversion schemes, individuals can avoid going to jail if they agree to get treatment for their mental disorder. From 1992 to 2002 the number of diversion schemes increased from 52 to 299 (TAPA 2004). Similarly, there are now more than 100 mental health courts in the United States which deal only with mentally ill offenders. While similar programs are being introduced in England, they are not as many as there are in the United States (Mikhail *et al.* 2001). In addition, jail diversion schemes in the UK tend to shift mentally ill offenders out of the criminal justice system at an earlier stage than the American system. In the USA, these offenders would appear in court and then be diverted into the mental system by the judge. In the UK, the diversion into the mental health system may be initiated before they reach the courts. This could result in under-reporting of criminal sanction as leverage in the UK.

It is also important to note the similar levels of the use of mental health legislation to mandate compliance with community care. While most American states have outpatient commitment laws allowing for compulsory community treatment, community treatment order (CTO) legislation has not yet been enacted in England. These results suggest that other sections of the current MHA, specifically Section 17 and Supervised Discharge Orders (SDOs) are already being used as *de facto* CTOs (Burns 2000). This is of particular interest because the inclusion of CTOs in the recently proposed MHA bill has been a highly debated issue. It may be possible to study individuals receiving these *de facto* CTOs to see whether they are effective in improving clinical outcomes and acceptable to patients receiving care (Canvin *et al.* 2002).

We also investigated associations between experience of leverage and sociodemographic and clinical characteristics. We found that living in supported housing, being unemployed, being previously admitted to hospital and having been admitted under the MHA were significantly associated with experience of leverage. Secondary analysis of the Monahan *et al.* (2005) data also found that housing is more likely to be used as leverage when it is specially designated for mentally ill individuals (Allen *et al.* 2003; Robbins *et al.* 2006).

The cross-sectional nature of the data makes it difficult to draw causal inferences about these relationships. For example, unemployment and experience of leverage may be associated through housing, as unemployed individuals may be more likely to live in supported housing; or through money as they may be more likely to be in receipt of state benefits than those who are employed; or individuals who are severely ill may be more likely to be unemployed and to be subject to leverage. This may be supported by the finding that leverage use is associated with previous informal and compulsory admission to hospital. This could indicate that leverage may be more likely used for people with more severe or enduring illness. Monahan *et al.* (2005) found that experience of leverage was associated with being young, having more severe illness, multiple admissions to hospital and extensive outpatient service use.

Attitudes toward use of leverage

Whether the use of leverage in the community is fair and effective has been much debated. Some argue that it acts as motivation for people to get and stay in treatment, while others suggest that patients avoid mental health care for fear of its use (Group for the Advancement of Psychiatry 1994; Campbell & Schraiber 1989; Swartz *et al.* 2003; Bonnie & Monahan 2005).

Empirical research examining attitudes toward the use of leverage has produced mixed results. A study by Swartz *et al.* (2004) found that 62% of patients with schizophrenia reported that mandated treatment was effective and 55% reported that it was fair. Elbogen *et al.* (2005) found that nearly two-thirds of patients disagreed with the statement that "one way to help people with serious mental health problems to stay well is to hold back their money unless they keep going to treatment", while Robbins *et al.* (2006) found that those who were subject to housing as leverage were more likely than others to report it as effective in helping people stay well.

In this study, we also found mixed attitudes toward the use of leverage to mandate community treatment. Attitudes toward use of housing, criminal justice system and child custody as leverage were generally positive. However, the withholding of money as leverage was rated more poorly than the others and the majority of patients reported that they disagreed with its use. Although the use of money managers has been associated with improved clinical outcomes (Conrad *et al.* 2006), it has been suggested that loss of control of finances may be particularly stigmatizing for mentally ill individuals and engender feelings of disempowerment (Elbogen *et al.* 2003). The use of money as leverage may also increase conflict in the patient-clinician relationship and damage the therapeutic alliance (Angell *et al.* 2007).

Perceived coercion

We also wanted to investigate whether patients found community mental health care coercive. While understanding perceptions of coercion has been highlighted as an important ethical issue in community psychiatry (Christensen 1997), few empirical studies have examined this issue and most have focused on the use of outpatient commitment and perceived coercion (Swartz *et al.* 2003; Elbogen *et al.* 2005; Robbins *et al.* 2006; Redlich *et al.* 2006; Davidson & Campbell 2007).

The majority of patients in this sample experienced no or low levels of perceived coercion. The mean perceived coercion score was similar to that found in studies of community mental health care in Northern Ireland and the USA (Davidson & Campbell 2007; Swartz *et al.* 1999).

Univariate analysis found that higher perceived coercion scores were significantly associated with: having ever experienced leverage; being male; having a poor therapeutic relationship with the keyworker; and experiencing negative pressure and low levels of procedural justice. The small sample size in this study did not allow for analysis at the level of individual leverages. Previous studies have suggested that some tools are more associated with perceived coercion. The use of housing and money has been found to be associated with perceptions of coercion (Elbogen *et al.* 2005; Robbins *et al.* 2006), while the use of criminal sanction as leverage is not perceived as coercive (Redlich *et al.* 2006).

Multiple variable analysis in this study found that, after controlling for all other variables, only negative pressure remained significantly associated with perceived coercion. This suggests that feeling threatened or forced to accept community treatment can lead a patient to experience high levels of perceived coercion (Monahan *et al.* 2003).

Attitudes toward treatment pressures

As previously mentioned, many people are concerned that the use of pressure and leverage in community mental health care may damage the therapeutic relationship, discourage patients from seeking treatment and decrease adherence with treatment (Swartz *et al.* 2003, Swan Han 2003). In this study, however, patients' attitudes toward the use of pressure were very positive. Over 90% of patients reported that pressures they had experienced had helped them stay in treatment and that they would want people to pressure them to stay in treatment in the future if needed. As this study did not isolate what those specific pressures were or where they originated, further investigation is warranted. It is also important to note, however, that almost one-third of patients reported that these pressures did not make them feel respected as a person. This ethical aspect of the use of pressures to encourage treatment should be examined.

4.4.2 Limitations of study

This was a very small study in terms of sample size as it was intended to be an exploratory pilot study. This means that it was not possible to examine the relationship between some variables (e.g. between sociodemographic characteristics and the experience of specific leverages). Moreover, there may not have been sufficient statistical power to isolate significant relationships between some variables. The larger study of leverage use and perceived coercion, for which this study laid the foundation, will include 600 participants. It is hoped that this study will be able to investigate these associations more definitively.

As the study only included patients attending a single outpatient clinic, it may not be representative of patients' views in other areas. However, the similarity between these results and those in the Monahan *et al.* (2005) study suggests that the experience of leverage during community mental health care may be similar across jurisdictions. It will be important to validate these results with studies in other areas of England and internationally, as regional differences in service provision have been noted (Ford *et al.* 1997)

The study was also limited to patients receiving treatment from community mental health teams (CMHTs). However, those in other mental health care services may be more likely to be subject to leverage. For example, patients under the care of Assertive Outreach Teams (AOT) who have increased involvement with social services, chronic and severe mental illness, and problems with non-adherence may be more likely to have leverage applied. Similarly, the use of leverage is well documented in the substance abuse literature (Miller & Flaherty 2000). While this study was limited to CMHT patients for practical reasons, the larger study for which this was a pilot will investigate leverage use and perceived coercion in CMHTs, AOTs and substance misuse teams. This will allow for comparison across these services.

As previously noted, the study was a cross-sectional design which makes it difficult to make inferences about causality. A longitudinal study of leverage use and perceived coercion in the community is needed to investigate this issue. Such a study should include data collection from medical notes, clinicians and social services as well as patient self-report to allow for triangulation of information from different sources.

4.4.3 Summary

This study attempted to investigate several empirical questions related to the use of leverage in the community and perceptions of coercion during community treatment. These are important questions as "requiring adherence to community-based mental health treatment is now the single most contested human rights issue in mental health law and policy" (Monahan *et al.* 2003). Our results suggest that the current debate over the introduction of Community Treatment Orders in England and Wales may be too focused on legally mandating adherence with treatment, which continue to frame compulsory community treatment as an extension of compulsory hospitalization (Monahan *et al.* 2003). This should be broadened to include other forms of leverage such as those investigated in this study. We found that nearly half of patients in this sample who were under the care of community mental health teams had experienced leverage to improve their adherence with treatment in the community. Further investigation of the prevalence and pattern of leverage use is necessary in England and internationally. The effect of leverage, on both clinical outcomes and patient attitudes toward mental health care, should also be examined.

5 Qualitative analysis of patient experiences of psychiatric hospitalization

5.1 Introduction

The use of coercion in psychiatric care has long been a controversial issue. Research in this area has traditionally focused on the use of legal compulsion to mandate hospitalization. More recently, with an increased focus on patient-centered health care, studies have investigated experiences of coercion from the patient's perspective. Although early research was hampered by the lack of an operationalized definition of coercion, the development of scales to measure levels of perceived coercion quantifiably has allowed for systematic study of this concept in recent years. While these quantitative studies are useful for determining levels of perceived coercion, qualitative methods may be more appropriate for answering questions about patient perceptions of coercion. Specifically, the use of qualitative methods allows for a more in-depth and nuanced understanding of the experience of coercion, issues surrounding its use and for the exploration of patient accounts in their own words. As Bennett *et al.* (1993) noted, "a complete account of the role of coercion in mental health hospital admissions will only be achieved by a combination of qualitative and quantitative methods".

5.1.1 Combining quantitative and qualitative methods

Quantitative and qualitative methodologies have often been viewed as incompatible and discipline-specific (Pope & Mays 1995; Giacomini & Cook 2000). Whereas quantitative studies "aim to test well-specified hypotheses concerning some predetermined variables", studies using qualitative methods "tend not to ask whether or how much but rather to explore what, how and why" (Giacomini & Cook 2000). Clinical and biomedical research has traditionally relied upon quantitative methods, while qualitative studies have been favoured primarily in the fields of sociology and anthropology (Pope & Mays 1995).

The need to combine quantitative and qualitative methods to fully understand the complexities of health care services has been increasingly recognized (Abell 1990, Hammersley 1992, Pope & Mays 1993, Pope & Mays 1995, Malterud 2001). Qualitative methods also offer "insight into social, emotional and experiential phenomena in health care" (Jones 1995). This may be of particular value in the field of health services research where an understanding of beliefs, experiences, attitudes and preferences is important (Gilchrist & Engel 1995). As qualitative methods can enable researchers to "pursue systematically the kinds of research questions that are not easily answerable by experimental methods" (Green & Britten 1998), combining quantitative and qualitative methods allows researchers to tackle different aspects of the same phenomenon (Jones 1995).

Quantitative and qualitative methodologies can be used together in different ways. Firstly, qualitative research can precede quantitative research to define areas of interest and aid in the development of scales and measures. Secondly, qualitative research can follow a quantitative study to aid in the interpretation of results. Finally, qualitative and quantitative methodologies can be used to study the same phenomenon in different ways allowing for triangulation among various sources of data. By combining the methodologies in this way, an increased understanding of complex issues and concepts can be gained.

5.1.2 Qualitative research and mental health care

Research in mental health care has used a variety of qualitative methods including interviews (Sinclair & Green 2005), focus groups (Coggan 1997), observations (Rosenhan 1973) and analysis of written documents (Glasby & Lester 2005). These have investigated issues such as stigma (Liggins *et al.* 2005), illness and treatment phenomenology (Watts & Priebe 2002; Koivisoto *et al.* 2003; McCabe & Priebe 2004; Sinclair & Green 2005), satisfaction with health care services (Chien 2005), experiences of care (Sameulsson *et al.* 2000; Canvin *et al.* 2002; Priebe *et al.* 2005), professional burnout (Reid *et al.* 1999) and attitudes toward treatment (Carrick *et al.* 2004). They have examined the views of patients (Rogers & Pilgrim 1994; Koivisto *et al.* 2004; Shattel *et al.* 2006; Johansson & Eklund 2003), clinicians (Pinfold *et al.* 2001) and carers (Highet *et al.* 2004), as well as public attitudes (Angermeyer *et al.* 2001).

5.1.3 Qualitative research and coercion

As noted in Chapter One, quantitative research of coercion has traditionally been concerned with the use of legal and objectively coercive measures in mental health care. This has been mirrored in the qualitative literature where studies have focused on patient experiences of involuntary hospitalization (Crisanti 2000) and the use of threat of involuntary admission in the hospitalization process (Gilboy & Schmidt 1971). In more recent years, with the introduction of compulsory care in the community, qualitative methods have been used to examine how mental health service users and clinicians respond to Supervised Discharge Orders (SDOs) and guardianship in the United Kingdom (Pinfold *et al.* 2001; Canvin *et al.* 2002).

Qualitative research and perceived coercion

Almost by definition, studies of patients' perceptions of coercion lend themselves to qualitative methods. However, research in this area has been primarily focused on the development of measures to quantify levels of perceived coercion in patient populations. The most widely used is the MacArthur Perceived Coercion Scale (MPCS; Gardner *et al.* 1993).

Qualitative methods were used in the initial stages of development of the MPCS. Focus groups with patients, carers and clinicians were used to highlight important issues (Hoge *et al.* 1993). The first study using the MPCS also included a qualitative component (Bennett *et al.* 1993). Bennett *et al.* (1993) reviewed the transcripts of interviews conducted with 70 of the 157 patients who were recruited in the study. They identified "three morality-related themes…in patients' accounts of what they experienced as coercive in the mental hospital admissions process". These were: inclusion, patients' belief that they had been participants in the process that led to their hospitalization; motivation, patients' belief that the reason behind others' actions during the process were driven by an appropriate level of concern for their well-being; and good faith, patients' belief that others had acted openly and truthfully during the process.

Since this early research of perceived coercion, few studies have combined quantitative and qualitative methods. Hoge *et al.* (1997) analyzed narrative accounts of admission from seven "coerced voluntary" patients (scores of three or more on the MPCS) and 18 "uncoerced involuntary" patients (scores of two or less on the MPCS). These interviews were conducted at the time of admission. The coerced voluntary patients reported "interactions involving coercion" and also situations in which they were "passive" with others "taking action and making decisions". The narratives of uncoerced involuntary patients indicated two main types of patient, those whose "deficits in…thought organization and logic" had resulted in their involuntary admission and "those who were designated as involuntary" in order to transport them to hospital. A study of perceived coercion currently being conducted across Europe (EUNOMIA; see Kallert *et al.* 2005) is also including a qualitative component (Priebe, personal communication)

In our quantitative study of perceived coercion in psychiatric inpatients (see Chapter Two), 164 patients participated in a structured interview about their experiences during the hospitalization process. The MPCS was used to determine levels of patient perceptions of coercion during hospitalization. Similar to other studies in the field, we found that legal status was a crude measure of perceived coercion. 48% of informally admitted patients experienced high levels of perceived coercion, while 11% of those detained under a MHA section experienced low levels of perceived coercion. Our results suggested that sociodemographic and clinical factors had little or no effect on perceptions of coercion and that MPCS scores were most associated with patients' experiences during the hospitalization process.

5.1.4 Summary

The need to combine quantitative and qualitative methods to fully understand the complexities of health care services is increasingly recognized (Pope & Mays 1993, Pope & Mays 1995, Malterud 1993). Quirk and Lelliot (2001) have noted that there is generally a lack of qualitative research in mental health care. As perceived coercion is a concept with social, emotional and experiential aspects, we believe it is particularly amenable to qualitative research. In this study, we used in-depth interviews and qualitative analysis to explore patients' experiences during the hospitalization process and investigate how this may be influenced by their legal status at admission and perception of coercion. Following completion of the quantitative study, we devised a topic guide to explore how patients who have been admitted to psychiatric hospital narrate their experiences of hospitalization retrospectively and to examine how we can learn from these narratives to shape mental health policy and research.

5.1.5 Aims

This study had three main aims:

- to explore how patients who have been admitted to a psychiatric hospital tell their story of admission
- to investigate what influences patients' experiences during the hospitalization process and how these experiences affect their relationship with mental health services
- to compare the themes that develop through analysis of these interviews with current mental health policy and health services research in the area of coercion

5.2 Methods

5.2.1 Study design

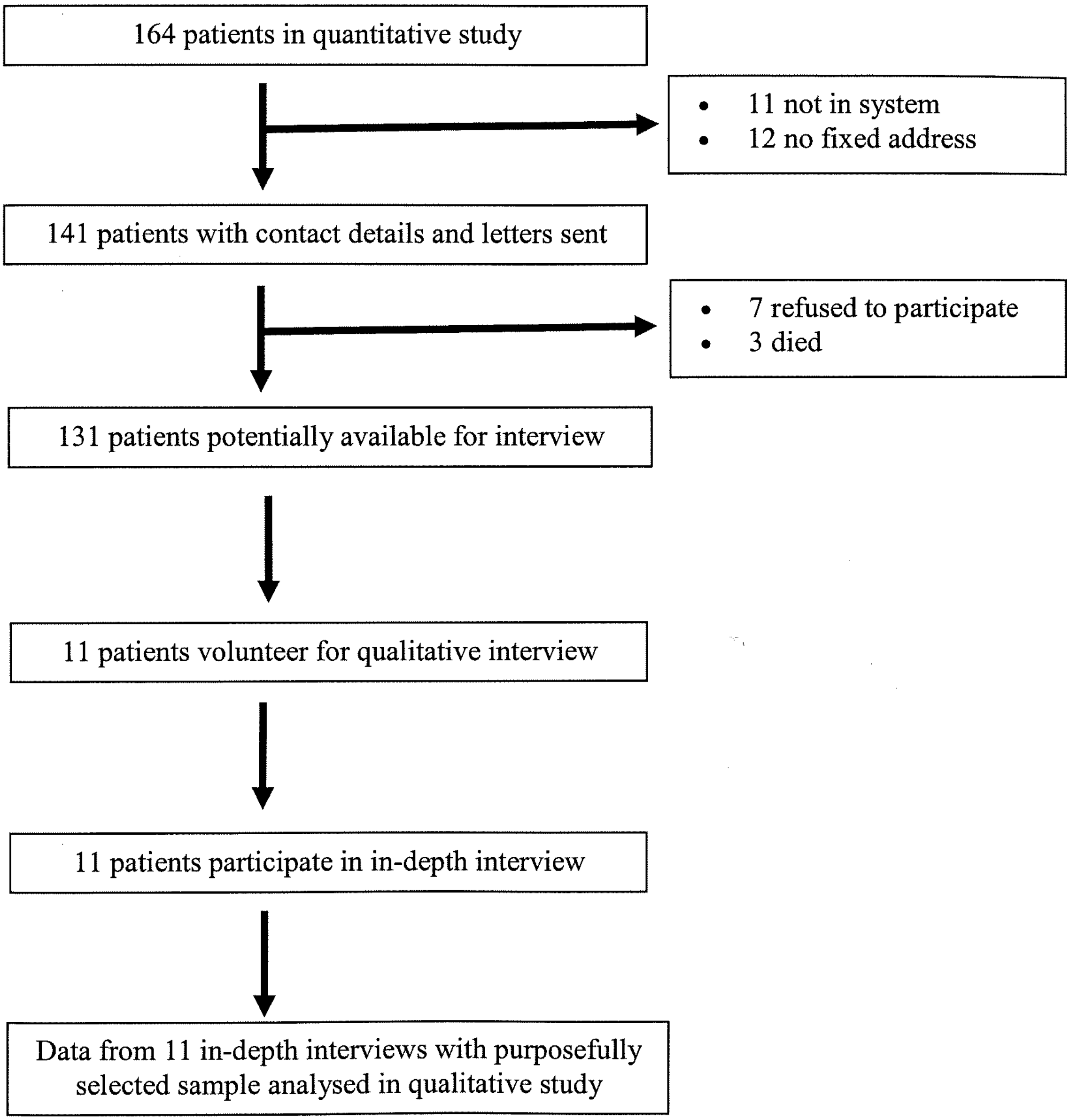
The study was a qualitative analysis of data collected through in-depth interviews. It was nested within a larger quantitative study of perceived coercion during the psychiatric hospital admissions process. The interviews were conducted with a sample of patients who had previously participated in a structured interview about their experiences of the hospitalization process in 2005 (see Chapter 2). The study received ethical approval from the Mid and South Buckinghamshire Local Research Ethics Committee and the Oxfordshire Mental Healthcare NHS Trust Research and Development Committee.

5.2.2 Participants

Participants in this study were part of a cohort recruited to take part in a study of perceived coercion in psychiatric hospital admissions, as described in Chapter 2. In the informed consent process of the quantitative study, patients could indicate agreement to future contact for a qualitative interview. They would be informed, in writing, about the qualitative study at a later date and would have the opportunity to decide to take part or not.

Figure 16 shows that contact details were available in the autumn of 2006 for 141 of the original 164 patients. This information was accessed using the computerized Patient-

Figure 16: Selection process for patients included in qualitative study


164 patients in quantitative study
11 not in system
12 no fixed address
141 patients with contact details and letters sent
7 refused to participate
3 died
131 patients potentially available for interview
11 patients volunteer for qualitative interview
11 patients participate in in-depth interview
Data from 11 in-depth interviews with purposefully selected sample analysed in qualitative study

Centred Information System (PCIS) maintained by the Oxfordshire and Buckinghamshire Mental Healthcare Trust. A letter of invitation and patient information sheet were sent to each of these individuals, informing them that the qualitative study was beginning and inviting them to indicate if they did not wish to receive further correspondence. Responses were received from 21 people. Seven were not interested in participating, relatives indicated that three participants had died since they had participated in the quantitative study and 11 people responded to say that they were interested in participating in the qualitative study.

Sampling

The aim of the qualitative interviews was to explore further patients' experiences of the hospitalization process and examine how this was influenced by their legal status at admission and their perception of coercion. As the qualitative study was nested within a larger quantitative study, data on the patients' previous hospitalization experiences were available. This made it possible to use purposeful sampling to select out cases to maximize variation in the sample (Sandelowski 1995; Coyne 1997; Patton 2002). As shown in Table 53a, four groups of interest were identified by stratifying the sample from the quantitative study by legal status at admission (informal or under MHA section) and perceived coercion score (low or high). Eleven of the individuals who responded to the invitation letter were interviewed. Table 53b shows how they fit into the subgroups of interest.

Table 53a: *Stratification of sample for interview selection*

	PERCEIVED COERCION LEVEL	
LEGAL STATUS	**low**	**high**
informal	67	61
compulsory	4	32

Table 53b: *Stratification of patients who participated in interview*

	PERCEIVED COERCION LEVEL	
LEGAL STATUS	**low**	**high**
informal	5	4
compulsory	0	2

5.2.3 Interviews

In-depth interviews were conducted with 11 participants. These were carried out in a private office at the Department of Psychiatry, University of Oxford. The interviewer had previously met each participant when they were involved in the quantitative study conducted between 12-24 months prior to the in-depth interview.

The session started with a further explanation of the study, including a description of the interview format and the need for recording. Informed consent was subsequently gained from each participant. As the potential influence of professional role on patient accounts has been noted (Richards & Emslie 2000), special attention was placed on ensuring that participants knew their responses were anonymous and that the interviewer had no role in their care. Interviews lasted between 48 and 66 minutes in length and a topic guide (see Table 54) was used to ensure that similar subject matter was covered with all participants. The topic guide was not prescriptive, however, and each interview was reflexive and allowed for areas of interest to be explored. The first part of the interview was unstructured with patients being asked to "tell me about that admission to hospital". The second section was semi-structured with the patient being asked about particular issues that may not have been mentioned in the initial narrative, including the events leading up to hospitalization, any choices in the admissions process and the impact of the admission on their relationships and their engagement with services.

Table 54: Interview topic guide

Topics and prompts	
1	Tell me about that admission to hospital?
a	What was happening beforehand?
b	What were the events that led up to your admission?
c	How did you feel during that time?
2	How did you end up being admitted from hospital?
a	Who else was involved in the admissions process?
b	What was their role?
c	What would they have said about your admission to hospital?
3	What choices did you have in the admissions process?
a	How were these choices presented?
b	How did you feel about these choices?
c	How did you consider these choices?
4	What did you expect from admission?
a	What could have been different about the admissions process?
b	What was particularly good about your admission?
c	What was particularly bad about your admission?
5	How did your admission change the way you feel about mental health services?
a	How has it changed your relationship with the people involved?
b	How has it changed your engagement with services?
c	How would you describe your relationship with services?
6	How did this admission compare to your other admissions to hospital?

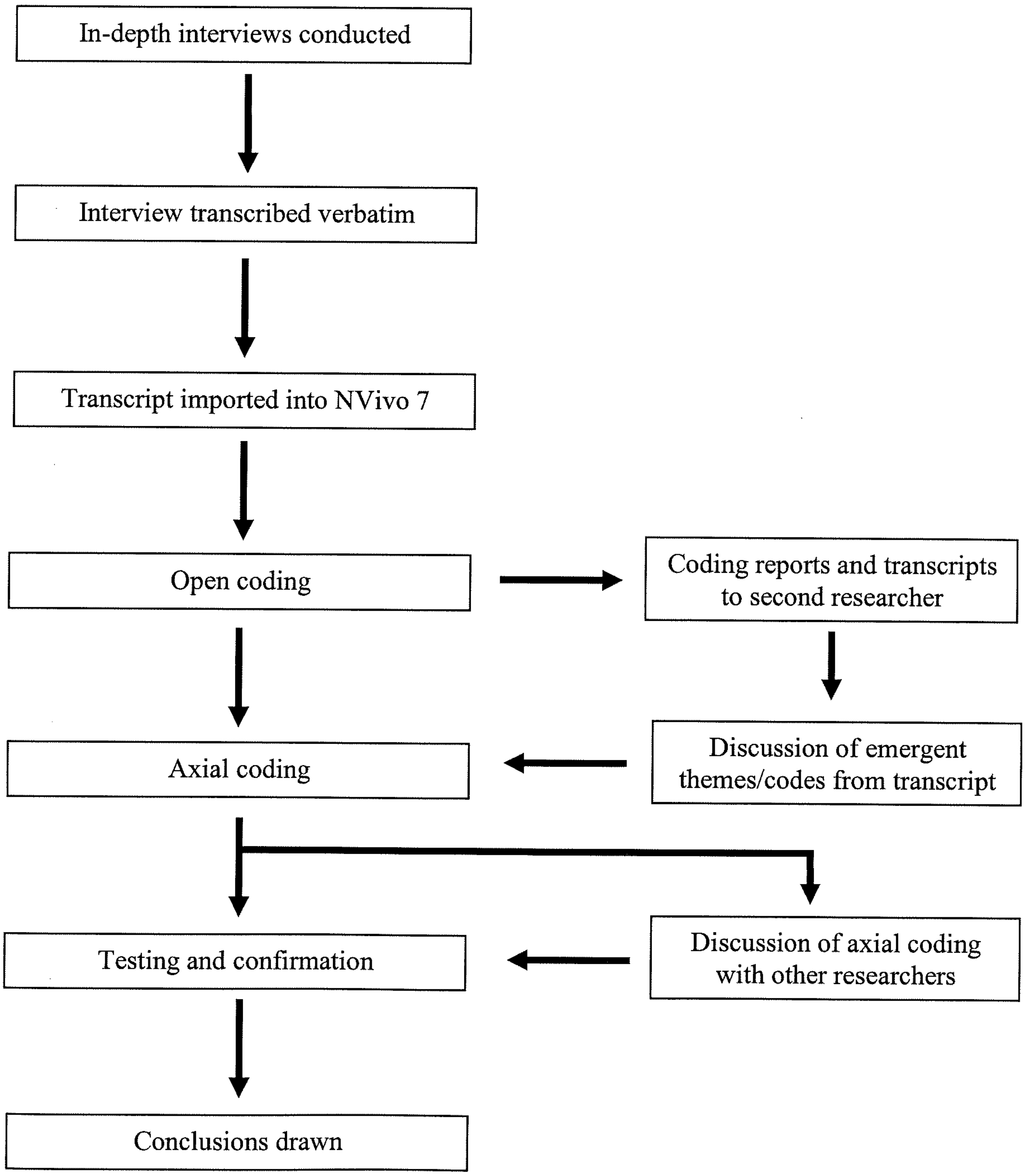
Interviews were recorded using a digital recorder (Olympus DS-330) and then transcribed verbatim by the interviewer. If requested, transcripts could be returned to participants and any subsequent corrections were noted; however no transcripts were requested. All transcripts were then imported into NVivo 7 software (QSR International; Melbourne, Australia) to aid data analysis.

5.2.4 Data analysis

Thematic analysis was used to examine the data collected from the interviews. The analytic process is summarized in Figure 17. The researcher had receiving training in both thematic coding (DIPEx 2006, 2007) and computer-assisted qualitative data analysis (CAQDAS 2007).

Initial coding of transcripts commenced after five interviews had been conducted (Ziebland & McPherson 2006). The coding framework reflected emergent themes identified by the researcher and from existing theory and research in the field of coercion in mental health care. During this open coding process, sections of text were collected under different headings and more codes were identified as the analysis progressed. The use of NVivo 7 computer software aided in the systematic comparison and analysis of the data (QSR International; Melbourne, Australia). To help ensure reliability in the analysis, the coding reports and a sample (*N*=3) of transcripts were reviewed independently by another qualitative researcher. Similarities and differences in the codes

Figure 17: Qualitative data analysis


In-depth interviews conducted
Interview transcribed verbatim
Transcript imported into NVivo 7
Open coding
Coding reports and transcripts to second researcher
Axial coding
Discussion of emergent themes/codes from transcript
Testing and confirmation
Discussion of axial coding with other researchers
Conclusions drawn

developed were discussed, but inter-rater reliability scores were not calculated as they are not appropriate for open coding analysis (Morse 1997).

Following this open coding process and discussion of emergent themes, axial coding was used to group these themes into broader categories and investigate the relationship between themes (Strauss & Corbin 1990, Miles & Huberman 1994, Silverman 2004, Ziebland & McPherson 2006). Axial coding decisions were discussed with other health services researchers. To improve analytic rigor, the process endorsed by Miles and Huberman (1994) was then used to test and confirm the results. This requires researchers to question the quality of their data considering the possible effects of selection bias and interviewer role. Emergent themes are then compared with possible rival explanations and evidence from deviant cases.

5.3 Results

5.3.1 Participants

As shown in Table 55, eleven patients participated in in-depth interviews. Of these patients: seven were male and four were female; six had been diagnosed with schizophrenia and five with an affective disorder; five had experienced low levels and six had experienced high levels of perceived coercion; nine had been informally admitted, while two had been admitted under a MHA section.

Table 55: Characteristics of sample

Identification number	**Gender**	**Diagnosis**	**Legal status of admission**	**Perceived coercion level**
1	male	affective	informal	low
2	male	affective	informal	low
3	male	schizophrenia	informal	low
4	male	affective	informal	high
5	male	schizophrenia	sectioned	high
6	male	schizophrenia	informal	high
7	female	affective	informal	high
8	female	schizophrenia	informal	low
9	female	affective	informal	high
10	male	schizophrenia	sectioned	high
11	female	schizophrenia	informal	low

5.3.2 Stories of admission to hospital

Our first aim was to explore how patients who had been admitted to hospital tell their story of admission.

Situations leading to admission

The majority of patients (10/11) described a period of stress or illness leading up to their admission to hospital. In some cases (5/11) this was due to family or relationship problems:

> *"Um, I'd had, had a very stressful time in 2004. Um, I'd lost two jobs, I'd had a lot of disputes and legal cases going on. Um, I got isolated from friends and family and I was living at home with someone who wasn't very sympathetic at all. Who, who, hardly seemed to notice that I was there anyway." (Interview 2)*

Others (5/11) described a worsening of their mental disorder symptoms:

> *"I was getting really sick, I was getting very depressed. I go about three months, I get depressed again, it's a continuous cycle, I've been doing this since I was 16. And, um, I remember listening to the news, reading, looking at the news on the TV and I thought I was responsible for it. So I thought people were talking about me, you know, trying to harm me, all sorts. See I was really paranoid. And uh, I was getting very violent as well. I get violent when I'm not well 'cuz I think people are talking about me and are gonna*

> *harm me. And I had awful dreams, awful dreams. I wake up sweating, thrashing about. It's just my mind playing tricks on me." (Interview 4)*

In only one case did the patient feel that they did not require admission to hospital:

> *"Um, the police come and got me. I couldn't work out what was happening. I hadn't done nothing wrong. I couldn't make out why the police come and got me. I hadn't been under the weather, or I weren't feeling like I had done before. I had fallen mentally ill before and I know what it feels like to go a bit off-key. I wasn't feeling ill then, when they came and got me. I felt they done it for no reason." (Interview 5)*

Getting admitted to the hospital

Although there was variation in the pathways that patients took to hospital, we found that patients' stories of admission could be classified into four groups: seeking admission (three cases), accepting admission (four cases), forced choice admission (two cases) or no choice admission (two cases).

Seeking admission

Some patients spoke about actively seeking hospitalization. One man described contacting his GP following a particularly stressful period of time in his life:

> *"I'd spent a month at home, um, after cracking up on medication but the medication didn't seem to be working so eventually I asked to come into*

> *hospital and, um, came up one evening and had the, um, the review and, assessment, rather, and, ah, they let me come in and I was here for about five weeks." (Interview 2)*

Another spoke of seeking hospitalization and then feeling worried during the assessment that he would not actually be admitted:

> *"I can't remember whether I phoned my GP or on my care plan it says that I can contact the hospital directly. I think there's, um, that's it, there's an alternative to admission team. And we spoke to them. That's right, that's right, that's right, that's right. And they came over and saw me and they said come in and see the doctor and they made a time for me to go in. That's it, it was in the afternoon and it was a Sunday and they came Sunday morning and saw me and made an appointment for me to come in at sort of late afternoon to see the doctor."*
>
> *[asked about how the admission process made him feel]*
>
> *"Um, it was almost as if, you felt as if you had to, jumping through hoops to, to, prove that you felt like that. That there was a presumption that admission was not a good idea and that that was the starting point and you had to fight your way from there. What, the, the presumption wasn't you know that you were ill and that you need help, because 'A to A' had already made that assessment or else they wouldn't have asked you to go in, that, that, that wasn't the scenario. The presumption was that you, you, you would be better off at home." (Interview 6)*

In another case, a patient spoke of repeatedly attempting to gain admission to hospital and feeling that her requests were not being taken seriously:

> *"Um, and I think I was going through a bit of a manic phase where I felt I just couldn't slow down, I couldn't stop and my mind wouldn't stop and I couldn't rest and um. I think I kept going to the doctors and the doctors couldn't help me, wouldn't help me, and I think eventually my friends all got together and phoned on my behalf and then I was admitted." (Interview 9)*

Accepting admission

Other patients told stories of being offered admission to hospital. In some cases, this process was very explicit with patients being offered hospitalization and then actively accepting this offer. In one case this took place over a period of weeks:

> *"Um, and I thought going in, um, the psychiatrist I'd been seeing asked if I'd like to go into hospital. First of all I refused. On the second time, on the next appointment seeing him, he asked me again and told me that, um, being away from home and because I was more stressed at home, it might help. I immediately agreed, I thought, I was concerned about my wife being home on her own, but she said she could cope." (Interview 3)*

Another patient, following an overdose, had been admitted to a general hospital and wanted to leave. When she asked to leave, she was assessed by several psychiatrists:

> *"Um, so I, I, I'd saw a couple of psychiatrists I think and one of them said, "Oh, if you can't stay here then you can go to [ward] but we don't want you to go home". So I said that's fine, [ward] is fine, I know [ward] [laughs], I'll go there. So that's how it went." (Interview 8)*

In some cases, however, patients accepted hospitalization in a more passive manner. Patients described situations in which they were offered admission and accepted, in effect, by not refusing. One man had been admitted to a general hospital and then was transferred to a psychiatric hospital. Although he notes his informal legal status, he never mentions being asked about or accepting admission:

> *"I went to the [general hospital] and I was in the [general hospital] for about a fortnight and they took me then one night, on a Friday evening, up to [psychiatric hospital]. I went voluntary. All right. And then I'd been in there two and a half days and my daughter come and fetch me from there and took me to [another psychiatric hospital]."*
>
> *[when asked about being voluntarily admitted]*
>
> *"But I didn't have a chance to say no though. I wasn't aware that I was there voluntarily until my daughter told me, until she actually come to pick me up to take me away and one of the main nurses said to her that, um, "Oh yeah, you, has no one told your father here because he's a voluntary patient so he can leave anytime he wants to."*
>
> *[when asked about whether he had a choice in the process]*

> *"I was told I was going to the [psychiatric hospital] and that was it. You know, they'd come along about five o'clock and said "Get all your stuff in your bag and you're going to [psychiatric hospital]." (Interview 1)*

Another woman spoke of being admitted even though she did not want to be:

> *"I'd been referred to the crisis team in, um, in their ineffectualness they hadn't told me they'd discharged me. But I rang them up saying I was feeling increasingly suicidal, so they asked me to come up and see the doctor and I got, I got admitted from, from that assessment and then I was in there for two months in [ward]."*
>
> *[when asked how she felt about admission]*
>
> *"Um, and uh, when I was told that they wanted to admit me, I have to admit I didn't particularly want to be, but I know, I know I say was admitted voluntary and so I didn't have any pressure on me to you know be sectioned or to be voluntary admission. But um I knew common sense wise that I just wasn't right and I needed some help and support." (Interview 7)*

Forced choice admission

In two cases, patients were told that, if they did not accept informal admission, they would be sectioned. One man, who had been admitted to hospital under the MHA eight times previously, described this situation and his negative opinion of it:

> *"I seen my CPN, I've got a CPN and have for a long time, and I did go down the doctor's didn't I? My CPN phoned, that's it. I didn't go down the doctors, my CPN done it for me. And then I went to [town] and was assessed there and see the doctor there, that's right. I see a GP there and then I, um, he sent me here."*
>
> *[when asked about how admission was suggested]*
>
> *"The doctor here, he said "You can't go home, we're admitting you" and I don't think I wanted to stay. And he said, "The choice is yours, you either come in voluntary or we'll section you"."*
>
> *[when asked what was bad during the admissions process]*
>
> *"Not giving you the choice, not giving you the choice to go home and do that, whatever you want to, whether you want to kill yourself or kick the bloody dog or whatever. I don't, they took that away from me, whether I was voluntary or whether I was sectioned. They take it away from you, to give you the choice. The choice was you come in voluntary or you get sectioned, so what sort of choice is that? So, there's nothing good about it." (Interview 4)*

Another patient was frightened to enter hospital, but agreed to admission after her social worker said that they might have to consider using the MHA:

> *"...by that time I didn't want to come into hospital. I'd convinced myself because I was so ill, I'd convinced myself that if I came in I wouldn't come out... But in the end they had to hint, they didn't really push, they hinted that,*

> *you know, if you, we might have to consider the using the MHA, is what they said, and I knew what they meant. I mean, rationally, they, I really did need to go in, but I couldn't really, I was scared, you know, but perhaps my more rational side would have said yes but my more rational side wasn't about. And so when they said we might have to consider it I thought "Well, I don't really want to be sectioned 'cuz you lose a bit of control, you know, I better agree to it"." (Interview 11)*

No choice admission

The two patients who had been sectioned during the index admission described situations in which they were given no choice about hospitalization. Both did not want to be admitted and were transported to hospital by the police. In one case, the police and clinicians came to the patient's home:

> *"They asked me a lot of questions about how I was feeling and they asked me questions about money and well, I couldn't see where they were at and eventually they arrest me. But I was sat in my flat in [town] in my underpants being interviewed by about 8 people...Dr. [Name] kept trying to ask me if I was under the weather and if I was ill. But I wasn't feeling ill. I wasn't feeling ill at all. I felt quite well. I was surprised the police and ambulance to the door so I wasn't quite stable in my speech and so it would have appeared that I was ill because I was put at or made nervous by the police... The police took me to [Ward] and let me on [Ward] actually, took my cuffs off..." (Interview 5)*

In the other case, the patient was picked up by the police in a park and assessed at the police station:

> *"I believe I didn't want to be going into hospital. I was pleading my sanity and trying to get myself to work the assessment process." (Interview 10)*

Uniqueness of each admission

All of the patients interviewed were able to remember and talk about the index admission as a unique event. Even those who had been hospitalized numerous times (8/11), either prior to or following the index interview, were able to separate the events of that particular admission from others. In two of these cases, they compared their experience during the index admission with other periods of hospitalization spontaneously. One man spoke of seeking hospitalization during the index admission and compared that with being threatened with sectioning and persuaded to come to hospital during his most recent admission:

> *"And I'd say that this last time, last month, it was completely different than that."*
>
> *[when asked how was it different]*
>
> *"Outside I was worse, outside I was really, really terribly ill. Losing weight and in complete fear and anxiety the whole time. Not speaking to anybody, really, you know, really [cough] more or less they forced me to come in.*

> *They threatened the Mental Health Act on me cuz they knew that I was just getting worse. So by the time they, by the time they persuaded me I'd been taking this medication for quite some time and the moment I got in the hospital I recovered."* *(Interview 2)*

Another reported that the admission process was different each time:

> *"A whole new process. It's not like the last one, it's totally different, you feel different, you go through the whole process again...The whole process of being ill is totally different. I've never had one the same and I've had lots."* *(Interview 4)*

Several of those who had been admitted repeatedly mentioned the inevitability of being hospitalized again:

> *"So it'll happen again, it always does, a couple months down the line I'll probably end up here again, something will go wrong in my life and that'll be another. You know. But I'm used to it now, I know I'm depressed and psychotic. I got used to it."* *(Interview 4)*

> *"I felt that it wasn't providing a service, it was actually um well, I'm sure you've heard of it, the revolving door syndrome. As soon as you get out, you end up back in because the support's not out there when you get out."* *(Interview 7)*

Others spoke of their hospitalization as something they hoped would never happen again:

> *"I thought that, I was that ill, when I was in hospital, that I thought if I should get out I'll never look back and I should never want to be like that again." (Interview 1)*

> *"Um, I know, I know in future if um if there was, God forbid, another admission I wouldn't accept being quizzed about history." (Interview 6)*

Stories of admission and perceived coercion

Following coding and thematic analysis, we explored whether there were any differences in the stories of those who had experienced low and high perceived coercion at the time of the index interview. We found that all the patients who had reported low levels of perceived coercion told stories of either seeking or accepting admission. Those who reported high levels of perceived coercion mainly (4/6) told stories of forced choice or no choice admission. In the remaining two cases of high perceived coercion, one patient told a story of help seeking (Interview 6) and the other of help accepting (Interview 7). Both of these patients mentioned that, although they chose to enter hospital and were not pressured during the process, they had had no other option but to be hospitalized. When asked what choices she had in the admissions process, one patient stated:

> *"None."*
>
> *[when asked what other options she considered]*
>
> *"There wasn't any other options." (Interview 3)*

Similarly, when asked what choices he had in the admissions process, the other individual stated:

> *"I suppose I could have made the choice to walk out and, but that wasn't an option for me because I didn't. It just wasn't an option…I would have taken." (Interview 6)*

5.3.3 Influences on patient experiences

Our second aim was to investigate what influences patients' experiences during the hospital admission process.

Legal status

All patients brought up the issue of legal status spontaneously, without prompting, when they described their admission to hospital. More specific questions were used to investigate their experiences of or views on legal status.

Most patients (9/11) associated compulsory hospitalization with restrictions of their activities on the ward and ability to leave the hospital. Several noted that being able to walk around the grounds and being under less observation was a benefit of informal admission:

> *"Well, I've never been sectioned but I just felt that it's better to be an informal patient. It kind of means that you can walk round the grounds after*

> *a few days. You're not imprisoned [laughs] and, um, so I didn't want to lose those little, 'cuz I'd been in the hospital ward before I knew the people under section were, uh, um, were watched a little more. I didn't want the restrictions, so in agreeing to come in voluntarily I just avoided that really." (Interview 2)*

> *"Um, there's the obvious logistical separations of leaving the ward that if you're, um, on which observations you're on, 15 minute or hourly or whatever you're still under the same circumstances of where you can go and and what you can do. Um, I'm not aware of what other circumstances a section would make." (Interview 6)*

Another man noted he felt stigmatized as a sectioned patient on a prior admission and so he chose to enter informally this time:

> *"I also didn't want to be sectioned because they've got you by the balls when you're sectioned. You can't do nothing...I felt more relaxed I must admit 'cuz I didn't have that stigma over my head that I was here for x amount of months or weeks and I could go out into the grounds and when it was nice and I got better. You can't do that when you're sectioned, you stay on the ward, your you. When you're a voluntary patient they watch you but they don't follow you. Yeah." (Interview 4)*

The same man talked about having the opportunity to leave hospital when he wanted as an informal patient:

> *" Cuz when you feel a bit better, like it might be in six months down the line, it might be a week, you can walk. When you're under section, you can't. But, um, you can't do that when you're under section." (Interview 4)*

Two patients commented that legal status does not really matter and that there is really no difference between being admitted informally or under the MHA. They reported that once you are admitted informally it can be difficult to get discharged from hospital when you want to leave:

> *"Not that it matters but, I mean it doesn't matter, there's no such thing as a voluntary patient in any event, so um, but yeah."*
>
> *[when asked what she meant by that statement]*
>
> *"There isn't because, um, when you've spent a whole month over there at Christmas and, uh, you're just trying to leave [laughs] and they don't let you go they just say, well, you know, um, if you insist we'll section you. And, uh, you know, so why don't you kind of think about that or something similar. Um, you say, well can I go outside for a walk, no, you're on 15 minutes obs, you know, and things like that. So when you do, when you insist on things, in my experience, and not just in that admission, my experience before, I've never been on a section, there's never been a choice. Um, and that, uh, I've had to kind of got get well enough to be sensible about things before they'll actually say yes you're voluntary, yes, okay." (Interview 8)*
>
> *"Oh yes, I was threatened with sectioning when I wanted to go home on a particular day and uh um this woman said well, I don't know you if you try to*

> *go I should put you on a section 5.2. [laughs] I thought 'I think I better stay' then." (Interview 7)*

To them, the choice to be admitted informally is really a choice to avoid excessive formality when going on leave and at discharge:

> *"... the choice is really to avoid all the paperwork." (Interview 8)*

In contrast to the negative descriptions of compulsory admission, two patients associated sectioning with being cared for and having their care extended to the community respectively. An informally admitted patient reported that she would have preferred compulsory admission, as it would have made her feel safer in hospital:

> *"I think that the staff would have had to have watched me more. Um, and I wouldn't have been able to have gone out and be so vulnerable outside. I don't know much about sectioning, but I just know that if you're sectioned they have the right to keep you there for your own safety or for other people's safety and I really, really think I should have been sectioned for my own safety." (Interview 9)*

Another patient spoke about being discharged under the MHA and then requesting to be readmitted from the community:

> *"I've been sectioned but I've been discharged, on a conditional discharge, because I've been released into a new house. And from the discharge process in hospital I've been to, to, set up a trial period to, to, have a safety net back*

> *in place, in case things didn't go smoothly as they should be going. And I've been into hospital. I was sectioned, I was on a section but I'd asked to be admitted so I could spend some time there." (Interview 10)*

The same man framed the use of compulsion as a restriction of human rights. Most of the others (9/11) spoke only of it in practical terms. He commented that while a section can *"be imposed"* and be *"a loss of liberty"*, other environments do not:

> *"safeguard health or treat you or keep me safe or prevent me from hurting myself or other people and those are quite, I can understand why that's in place." (Interview 10)*

Similarly another man, informally admitted at the index interview, said that being admitted resulted in a loss of his rights:

> *"All your rights go. You got no rights left. I, I feel that way anyway because they're doing everything for you." (Interview 4)*

Relationships with people involved in the admission

Patients' experiences of admission were also shaped by their relationship with the people involved in the hospitalization process.

Clinicians

The majority of patients (10/11) noted a preference for being admitted by someone with whom they had previous experience. Patients reported that having trust in the person who was admitting them made the process easier. They commented, in most cases, that these relationships had developed over time. A man who was admitted under the MHA described how he had developed a trusting relationship with his consultant and how that influenced how he viewed the treatment options he was offered:

> *"So if he treats me with a smile or has me constantly consenting in the judgments and decisions he's making, that helps establish trust. It's about focusing on the relationship, working that relationship between doctor and client, to establish what you can trust him for. And when the doctor's been good he's been someone who, I've seen his decisions, I've benefited sometimes from decisions he's made, that's help to form trust and I've felt that that I've been quite happy with the decisions the doctor's made concerning my treatment, be it medication, be it Section 17 if I was in hospital or being away from hospital, come discharge, or be it the amount of support I'm being offered at a given time." (Interview 10)*

An informally admitted patient described how knowing her consultant over a long period of time had helped her to trust his judgment and know that he was acting in her best interest:

> *"Um, well, I actually really like my consultant and I trust him. And, um, and I know if he thinks that I ought to be in there then then I really, I really ought to because he's very much for um you know when I'm getting ready to leave and stuff, he wants me to make my own decision about leaving and um he's very keen to sort of support me to leave you know. So I know that he wouldn't have me there unless he thought I was pretty out of it...Uh, well, I think because I've seen him, he's been my consultant, and I think, you do see other people in the, you know, his SHOs and, you know, other doctors that are on when he's not and he had this locum for a while. And um, but I think it's just knowing him, you know, over time. And um I think that, as I say, he's actually more, um, really knows me more, really knows I'm when I can actually cope with being at home, whereas I think if someone didn't know me they might not be so uh trusting or something." (Interview 8)*

The importance of knowing someone during the hospitalization process was also noted by a patient who recognized a member of the 'Alternatives to Admission' team from a previous admission during his assessment:

> *"Um, now, I didn't know who was going to come out and see me and as soon as he arrived and knocked on the door, I could almost have hugged him. Um, he was, it was, it was, a, a, a big boost to me because I knew that I could talk with him and I knew he would listen." (Interview 6)*

In contrast to this, one patient commented that it was hard to trust the duty doctor who he had not met before:

> *"Cuz you don't trust the doctors here cuz you don't know them. Although you know they're here to help you, you don't know what they're going to do.*
>
> *[when asked what would have happened if he had known someone]*
>
> *"It would have been a lot easier. It would have been a lot easier. Yeah, whether it was a CPN or whatever, somebody you can trust, even me brother or someone like that. Someone you can really trust you know who has your best interest in their hands" (Interview 4).*

Patients also reported finding the admissions process difficult when they did not feel listened to or understood:

> *"Because you know psychiatrists, um, uh, I don't know, oh, I don't know, but I just find it frustrating, um, there's not people there who are willing to listen. If they don't understand, if they can't read something out of their textbook and put a label on somebody then they're baffled by the person, totally baffled and don't know what to do. So you just throw them back out on the street to get on with it." (Interview 9)*
>
> *"Um, so I don't feel anyone really acknowledged the fears and what I'd done and the fact that I'd you know it was actually a big thing for me. Um, and it was almost brushed under the carpet and not really talked about. Um, and I needed to talk about." (Interview 6)*

A lack of continuity of care left one patient frustrated when he was admitted to hospital. He felt that his consultant did not see him enough to know whether he was unwell or not:

> *"It's twice that Dr. [Name]'s brought me in. He's away big gaps and then turns up and tells me I'm ill. It's not a medical opinion he takes me for. He's not seeing me to know that I'm ill. If he was seeing me and knew that I was ill I could understand it. But he's just showing up after a two year gap. he hasn't seen me, he doesn't know how I am. I could be half dead, I could be a brain surgeon but he just turns up." (Interview 5)*

Although he had a long term relationship with his consultant, this was viewed negatively by the patient:

> *"I don't like him at all. I don't like the man."*
>
> *[when asked whether he ever liked him]*
>
> *"No, never did. He used to threaten me." (Interview 5)*

Family and friends

Family and friends played diverse roles in the admissions process. These could be viewed as being positive, negative or neutral. One patient noted that his sister *"was the mediator with the psychiatrist"* and that his daughter had been involved in his transport between hospitals. He said their involvement was the best thing about the admissions process:

> *"No, I wasn't given a choice to go to [psychiatric hospital] but I went because me daughter said she was taking me. And I thought naturally that*

> *that's my family and she knows best and I didn't know that I could go to there and be happy." (Interview 1)*

Another noted that having a friend with her during the assessment process was beneficial:

> *"I think it was comforting really to have her there because I knew that that I felt safe with her." (Interview 9)*

In two cases, families were described as having their own agendas during the admissions process. As these opposed the patients' preferences regarding admission, they were presented as sources of conflict:

> *"Um, It's, it's, um, it's quite difficult because I, I, I think it's quite difficult to take from the partner a, um, truly honest opinion because they have their own agenda. My own wife that she doesn't like to see me in hospital and will tell anyone that she can deal with me at home, even though I'm crying out not to." (Interview 6)*

> *"I think my mother phoned the hospital. Said that I was being unreasonable or something. I'm not sure. I think it was my mum that told them…My mother's not involved, but if she can't get her own way she stirs." (Interview 5)*

When asked whether their family was involved in the admission process, two patients noted that they had asked them not to be:

> *"I try not to let me family know when I'm ill. I've had a lot of episodes and a lot of, you know, acute episodes and I've tried not to bother them." (Interview 2)*

> *"Not during admissions but afterwards they come up to see me and my brother does. My sisters a bit frightened and I don't want my daughters to see me like this. So I've asked them not to come." (Interview 4)*

5.3.4 Effect of admission on relationship with services

When asked how their relationship with mental health services had changed since the admission, many patients (7/11) noted that it had improved. One man, who reported that he viewed his consultant as an enemy during the admissions process, said that he was now glad that he had been admitted:

> *"I was, um, I can remember feeling as if they were my enemies. Cuz I was determined to go and kill myself and they stopped me. I mean for my own good, but I didn't see it as that. I just see it as they're interfering, they're stopping me from doing what I should be doing. I'm glad they stopped me because otherwise I wouldn't be here today." (Interview 4)*

Several others mentioned that it had improved their relationship with their care teams:

> *"Um, I, I have a much better relationship with my team now, after the admission. Um, I think because I was on their books and they didn't really know much about me because it's an out of sight, out of mind. I'd been moved to that team after the sort of problems I'd experienced and it was*

> *another one of the resolutions that the Trust agreed to, that they would move me to a new team. And I arrived at the new team and I don't think they would have sat down and read the notes or anything like that. I was just like on the books. But this admission forced them to focus their mind on who I was and what my problems were and um as a result, now when I got to see them it we know what we're talking about. We don't have to compartmentalize it or explain or anything like that. So the admission, after admission it was much stronger working relationship with the team." (Interview 6)*

> *"I think it, I, I, over the past few years I've tried to be more open with psychiatrists. I don't know maybe it's made me a bit more open and honest as well too." (Interview 3)*

However, in other cases (2/11), the admission to hospital confirmed patients' negative view of their clinician or services:

> *"Um, I got a belief that the mental health services are so up the duff and they don't seem like they care for long...I only see my CPN. I don't seek out anything. I know it's Dr. [Name] that's doing it."*

> *[when asked how he participates in mental health services]*

> *"No, I avoid them. I don't, I don't want to participate in them. I just want to get on with my life and be left alone." (Interview 4)*

> *"My admission to hospital has made me realize how bad mental health services are and how it's made me more and more negative. Especially when you're discharged with no support. So actually I am, it's made me more*

> *aware of what there isn't there for people like me. And how people like me are more and more often shunted out into the community and expected just to get on with it. And I'm, other people, have even more enduring mental health problems. Um, it's made me very negative about it. I mean I have actually put an official complaint in." (Interview 7)*

In the remaining two cases, patients said that their relationship with services had stayed the same following their admission.

5.3.5 Comparison of themes with current policy and research

Our final aim was to compare the themes that developed through the analysis with current mental health policy and research. Four issues were viewed as being particularly relevant. These were limited resources, Mental Health Act Tribunals, competency and conditional discharge.

Limited resources

Most of the patients (9/11) mentioned spontaneously that mental health resources for inpatient and community care were limited:

> *"I think mental health services are very underfunded. I think, I think there's no fault with the people who are working in the hospitals. I think the government could do more. Because I think there are more people out in the*

> *community and in hospital that could maybe be helped more. I really do think that strongly." (Interview 3)*
>
> *"I think the mental health services is a good thing. They need more funding because there's so many people who've got, who are mentally ill. And uh, everytime you go into hospital, it's different." (Interview 4)*
>
> *"They haven't got enough room or there's not enough staff, they've got a bed but not enough staff or whatever. Things that shouldn't in the best perfect world shouldn't come into play um they impinge on the doctor's thought process. So um whether staff are instructed to to to to act that way, that that is the best way to interview prospective patients. Um, in order that they, they, in order that they keep admissions to a minimum." (Interview 6)*
>
> *"Um, I, um, I have just asked to be referred to a different team because I feel that, um, I'm not getting the right care and attention...the [team] is lacking the um a number of staff and because of the cutbacks they're not prepared to replace them." (Interview 7)*

The most commonly mentioned issue was a shortage of inpatient beds:

> *"So I work in quite close contact with the AOT and they support me in the community. So they're quite keen to keep me out of hospital. I know there's often a shortage of beds or beds are for certain people to use so even it's really that there's not room for me in the hospital so it's one way I can't access treatment." (Interview 10)*
>
> *"Because beds are scarce. When I saw the psychiatrist and the nurse chatting about leaving hospital. This was sort of like on Tuesday. And I said*

> *that I thought I was going on Saturday and she said, oh no you're going tomorrow, Wednesday, because we need the bed. Someone desperate is out there and very ill and maybe their family is really stressed out because of them and the person suffering, you know. So one goes out and another one comes in. Just keeps rolling." (Interview 3)*

> *"And um from what I know about shortage of beds and stuff I don't think they shove you in there unless they think you ought to be in there [laughs]" (Interview 8)*

Tribunals

Two patients, one who was compulsorily admitted during the index admission and another who had previously been admitted under the MHA, commented on Mental Health Act Tribunals. One stated that he had never appealed when he had been sectioned because:

> *"I thought it wouldn't get me anywhere at all. I was thinking that it would be like talking to the people who put you there. Like they were just humouring you. Like you'd just be going to go home in six weeks time and then you couldn't. But I did get out of the hospital last time. I felt that they would, they'd never forgive me for getting out of the hospital last time." (Interview 5)*

The other, who had appealed, said:

> *"You go to arbitration, you're in trouble with the staff and you don't know what to say in front of all these people who've got your future in their hands. You don't know what to say to them. That's what you talk about is when you go to Tribunal you should have a lawyer there with you. Somebody to speak for you. That's what you need. I don't think you need it when you're being admitted, I mean that's up to your doctor, that's nothing, that's for your own good, but these tribunals they, I've been to three and I've got refused every time...But that's where you need somebody, you need a psychiatrist-cum-lawyer. To answer questions for you, go on a one-to-one basis. Talk to you before a Tribunal, days before, get to know him, get relaxed, tell him how you feel, and he can talk to them, he goes in there and speaks for you. I've been in these rooms with 12 people. And I don't know what to say. You just break down and cry because you're so frightened. You know, you shouldn't have to go to Tribunal, it should be a lawyer." (Interview 4)*

Capacity

Three patients mentioned that they may not have had the capacity to make the decision to enter hospital, even though they were admitted informally.

> *"Only that I felt that I don't think the question arose with the nurse or the staff to ask me about going to [psychiatric hospital] because I don't think that I could have given an answer anyway. As a positive answer, if they had said "do you want to go to [psychiatric hospital]" I don't know that I could have said yes or no to that. Because I wasn't, at that point, um, capable of doing*

anything. Cuz I didn't even know me own mind then. I was just, just looking around and nothing was registering. If it was like you were watching television and you got your mind on something else. See what I mean." (Interview 1)

"I mean, rationally, they, I really did need to go in, but I couldn't really, I was scared, you know, but perhaps my more rational side would have said yes but my more rational side wasn't about...It's all to do with my brain [can't understand] and it's a common symptom. And you can't help it, you know, it's happened before, but this time I thought my brain really had gone and when I was in hospital, I'd have no control over my life." (Interview 2)

"So I felt as though I was being a burden to everybody especially as I didn't want to be there. Um, and, I think the decision was made that I was going to the psychiatric hospital. I didn't have much choice in it. I don't recall them, if they did ask, I wasn't really in a state of mind, coherent mind from the [overdose] drugs, to have made that decision anyway." (Interview 8)

Conditional discharge

One patient spoke of having been discharged from hospital on conditional discharge:

"I'd been discharged to the community on a conditional discharge. I've had times when I've been on extended leave or working up towards complete discharge I've had times of extended leave where I had to see a doctor or meet with a doctor even though I was spending most of time outside of hospital. So it was new to actually have an extended discharge but have it as a trial and have a safety package, a safety netting for set in the community."

[when asked about how he felt about having that 'safety netting']

"I thought it was sensible really. Because I know that respite is important. If I needed help or felt reasonably out of hand or I've not been managing myself, I don't know, I can seek help. I've been known to seek help." (Interview 10)

5.4 Discussion

The aims of this study were to explore how patients who have been admitted to psychiatric hospital tell their story of hospitalization and to investigate what influences patients' experiences during this process. We also wanted to determine whether the issues raised by patients about hospitalization were similar to those currently being debated in mental health policy and research.

5.4.1 Principal findings

Stories of admission

All of the patients interviewed in this study told detailed stories of the index admission to hospital. They recalled how they felt, as well as their own and others' actions, during the admissions process. Those who had been admitted more than once were able to compare the index admission to other hospitalization experiences, indicating that patients view each admission experience as a unique event. This suggests that each contact with services provides an opportunity for fostering relationships and positive views of the mental health care system (Johansson & Lundman 2002).

The results of this study support philosophical conceptualizations of coercion as constrained volition. In this conceptualization, coercion is not limited to situations where the patient has no choice but also includes those where a patient must choose from a limited range of options (Wertheimer 1987, 1993). Options which result in the individual being worse off than a specified baseline result are considered "threats" and are perceived as coercive; while options which result in the individual being better off than the baseline are considered "offers" and not coercive (Szmukler 1999).

All of the patients who perceived low levels of coercion in this study told stories of seeking or accepting hospitalization. In these cases, hospitalization was viewed as an offer, as accepting hospitalization put them in a situation better than the one they were in before admission. In contrast, most patients who experienced high perceived coercion told stories of being forced or threatened to enter hospital. Their stories indicated that, at the time of their admission, they viewed psychiatric hospitalization as a negative option. Two patients who felt high perceived coercion at the index admission told stories of seeking and accepting hospitalization respectively. When questioned further about the decision to be admitted, they both reported that they had no option but to enter hospital. One man acknowledged that he could have walked out on the assessment process, but stated that this was not an option for him. This confirms the importance of examining coercion subjectively and from the patient's perspective.

The results of this qualitative study also support the findings of a previous quantitative study indicating that patients' perceptions of coercion are stable over time (Gardner *et al.* 1999). Gardner *et al.* (1999) found that, at follow-up between two and six weeks after discharge, patients' scores on the MacArthur Perceived Coercion Scale (MPCS) did not change significantly from those at admission. This was true even when patients revised their belief about the need for admission. Our results were similar and indicated that, even when patients retrospectively acknowledged the need for or benefit of admission, they often still told stories of being forced or threatened into hospital. Although six of the patients perceived high levels of coercion at the index admission, only two reported that the admission had negative effects on their relationship with services. The other nine patients interviewed indicated that the admission improved their relationship with services or had confirmed their positive relationship.

Influences on admission

Patients' experiences of admission were often influenced by the legal status of their admission and their relationship with others involved in the hospitalization process.

Legal status

All patients mentioned the legal status of their admission spontaneously, without prompting, during the interview. When questioned further about the role of legal status on the admissions process, most spoke about the use of compulsion in practical terms. The majority of patients viewed hospitalization under the MHA negatively because it placed limitations on their activities on the ward (e.g. higher levels of observation or restrictions on going for walks around the grounds) and increased the procedural complexity of getting leave or discharge.

Most discussions of compulsion in public policy and the academic literature, however, are framed in terms of human rights and ethics, focusing on issues of liberty, autonomy and personal integrity (Szasz 1975; Radden 2002; Tannsjo 2004). Discussions about the use of compulsion in terms of moral absolutes are limiting because they focus on whether or not the use of the MHA is ethically permissible. The issue of how to reduce the negative aspects of compulsion tends to be ignored in such debates. In clinical practice, where the use of informal admission procedures is preferred but compulsion is justifiable under specific conditions, reducing the negative aspects of compulsion remains of great importance.

The results of this study suggest that it may be possible to reduce some of the negative aspects of compulsion by giving patients as much freedom as possible within the hospital environment (e.g. supervised walks around the grounds) and by reducing the procedural barriers to getting leave or discharge. While we recognize that legal and procedural safeguards are an integral part of compulsory hospitalization, these do not need to be burdensome to patients.

This view is further supported by the finding that some patients viewed compulsory hospitalization positively. In this study, two patients associated compulsion with improved care. An informally admitted woman said that she would have felt more safe knowing that the staff had a legal obligation to watch her and keep her on the ward. A man, who had been compulsorily admitted, said that his conditional discharge from hospital under the MHA had reduced the procedural burden of readmission when he had difficulty coping in the community. These two examples suggest that it is possible to reduce the negative experiences and stigma associated with compulsion.

Relationships with others

Patients' relationships with others, particularly clinicians, had great influence on their experiences during the admissions process. This supports previous research that has identified the therapeutic relationship as a central component of good psychiatric care

(Olofsson & Norberg 2001; Olofsson & Jacobsson 2001; Johansson & Lundman 2002; Johansson & Eklund 2003; McCabe & Priebe 2004).

Our results demonstrated that patients preferred to be admitted by a clinician who they had known over a long period of time. The benefit of longer relationships in building strong therapeutic alliances has also been recognized by clinicians (Seale *et al.* 2006). However, the duration of the patient-clinician relationship was not always indicative of its quality or patients' experiences during the admissions process.

In this study, positive admission experiences were characterized by patients: having trust in the clinician's judgment, believing that the clinician was acting in their best interest, and feeling that they had been listened to and understood. These findings support previous research indicating that patients assess the "morality" of the process by which they are admitted to hospital (Bennett *et al.* 1993). Bennett *et al.* (1993) found that patients who felt that they were included in the decision making process and that the others involved were motivated by genuine concern perceived lower levels of coercion during admission.

Relationships with families and friends also influenced patients' experiences during the admissions process. In some cases, the involvement of family and friends was viewed positively. This usually occurred when they provided support or helped mediate the relationship between the patient and clinician. In contrast, their involvement was also described as a source of conflict when the view of the family was at odds with that of the patient. While psychiatric decision making should take into account the opinions of family and friends, it is important to remember that these do not always reflect the preferences of the patient.

Comparison of themes with current policy and research

Patients often raised issues of mental health services which are currently being scrutinized in both policy and research. These included: limited resources, Mental Health Act Tribunals, decision making capacity and compulsory community treatment.

Firstly, nearly all of the patients mentioned the limited resources available for mental health services. The most commonly mentioned issue was a shortage of inpatient beds. Patients also noted that staffing shortages, in hospital and the community, concerned them and limited their access to appropriate treatment. Patients' views should be sought during policy discussions of resource allocation in mental health care.

Secondly, two patients who had been compulsorily admitted to hospital reported that they feared attending Mental Health Act tribunals. The fact that relatively few patients appeal their admission under the MHA has been described and debated in the literature (Bradley *et al.* 1995; Burns & Raphael 1995). This study suggests that patients want advocacy, advice and information throughout the appeals process. As patients' perceptions of coercion are correlated with the amount of procedural justice they experience (Lidz *et al.* 1995), Tribunals may provide an opportunity to increase patients' "voice" in the admission process and facilitate therapeutic jurisprudence. There is also growing support for this concept, which suggests that law can be used as a potential therapeutic agent in mental health care to promote the psychological well-being of patients (Winick 1997).

Thirdly, the issue of capacity was raised by three patients who were admitted informally. They mentioned in their interview that they may not have been coherent enough or capable of saying yes or no to admission (Hoge *et al.* 1997). At present, patients who do not refuse treatment, even if they lack capacity, can be admitted informally to hospital without recourse to mental health legislation. The Mental Health Capacity Act, likely to be enshrined this year, will provide further legal protections for patients who lack capacity in the hospital admissions process.

Finally, one patient mentioned that he had been under compulsion in the community, following conditional discharge (Supervised Discharge Order; SDO) from hospital. The issue of compulsory community care has been hotly contested in England and Wales in recent years. He viewed this experience positively, saying that it provided him with additional support in the community. While he was the only patient to speak about compulsion in the community in this sample, his comments were similar to other patients who indicate that safety and support is a benefit of SDOs (Canvin *et al.* 2002). This suggests that compulsion can be viewed as beneficial when the restriction on patients' rights is matched with the reciprocal responsibility of mental health services to provide access to timely and quality care.

5.4.2 Limitations of this study

This was a qualitative study of patients' experiences during the hospital admissions process. While we attempted to include informally and compulsorily admitted patients who had experienced both high and low levels of perceived coercion (see Figure 53b), we were not able to interview any patients who had been admitted under a MHA section but reported low perceived coercion ("uncoerced involuntaries"). This group, although small in the original sample, is of particular interest because their perceptions of coercion are at odds with their legal status. A previous qualitative study including this group noted that this discrepancy was often due to cognitive impairments at the time of admission or systemic barriers to admission (Hoge *et al.* 1997). The exploration of their stories of admission may have led to the identification of themes not noted in this study.

In addition, we interviewed only a small number of participants from the original quantitative study. While all patients in the original study had agreed to be contacted about the qualitative component of the research, only 11 volunteered to be interviewed. The patients who were willing to participate in the interview may not be representative of the group. This is a general limitation of qualitative research where rigorous data collection requires that participants be willing to discuss their experiences. The aim of this study, however, was to gain a more thorough understanding of experiences, not their prevalence. While we noted the number of patients who discussed different experiences, this was to provide a sense of the commonness of each experience and identify deviant cases. The aim was not for statistical generalization to the broader population of hospitalized patients (Seale *et al.* 2006)

The results of this qualitative study must also be considered in terms of the situation in which data were collected. We conducted interviews in a private office in an academic department at the hospital where several of the patients had been admitted. We felt that an individual interview was most appropriate for discussing personal experiences and perspectives (Giacomini & Cook 2000). While being interviewed at a hospital may have influenced patients' responses, we feel that this had little effect on our results. When the interviews were arranged all patients were asked whether they would be able to come to the University Department for the interview and all agreed. At the end of each interview, we also asked the participant whether they would have been more comfortable being interviewed at another location (e.g their house) and all said no. Some even responded that they were more comfortable not discussing hospitalization at home.

5.4.3 Summary

This was a qualitative study exploring patients' experiences during the psychiatric hospitalization process. This study built on our quantitative study of patients' perceptions of coercion during the hospital admissions process. Data collected in that study enabled us to selectively sample patients who had experienced high and low levels of perceived coercion levels and informal and compulsory admission. The development of the qualitative topic guide was also informed by the results of the quantitative study. While qualitative analysis has long been recognized as an important aspect of perceived coercion research (Gardner *et al.* 1993; Bennett *et al.* 1993; Hoge *et al.* 1998; Hoyer 1999; Kaltiala-Heino 1999), a limited number of studies in this area have incorporated qualitative methods (Bennett *et al.* 1993; Hoge *et al.* 1998).

Our results suggest that patients are able to tell detailed stories of their hospital admission. Their experiences are most influenced by their relationships with others involved in the admissions process and their legal status. The degree to which patients feel coerced into hospital tends to be stable over time, even when their view about whether that hospitalization was necessary changes. In this sample, hospital admissions were often deemed to have had positive effect on patients' relationships with services and those involved in their care. Further investigations using qualitative methods should be conducted to inform the development of interventions for reducing perceptions of coercion in the admission process.

6 Conclusions

6.1 Summary of empirical results

The controversy over the use of coercion in mental health care has traditionally been framed in terms of whether it is legally and ethically permissible. Intertwined in this debate is the question of whether the use of coercion can be justified. Empirical arguments, both for and against the use of coercion, have been raised. Research investigating whether coerced treatment can be effective, however, has been limited by the lack of a definition of what constitutes coercion or coercive practices.

In recent years, research in this area has adopted a subjective definition of coercion which suggests that "coercion is any action the individual says it is" (Hiday & Goodman 1992). This conceptualization of "perceived coercion" has resulted in an increased interest in this area of research.

This thesis investigated both patients' and clinicians' perceptions of coercion in mental health care. It aimed to determine the levels of perceived coercion experienced by both inpatients and outpatients (Chapters 2 and 4), examine clinicians' perceptions of coercion (Chapter 3), and explore patients' experiences during the psychiatric hospitalization process using qualitative thematic analysis (Chapter 5). A summary of the four empirical chapters of this thesis is provided below:

Chapter 2 describes an investigation of patients' perceptions of coercion during the psychiatric hospital admissions process. Using quantitative analysis, the level of perceived coercion experienced by patients admitted to acute adult psychiatric wards in Oxford was investigated. Associations between perceived coercion and sociodemographic/clinical characteristics and admission experiences were also explored. The results indicated that there was little association between perceived coercion and sociodemographic and clinical characteristics. Perceptions of coercion tended to reflect patients' experiences and beliefs during the admissions process, specifically whether they felt forced or threatened and whether they had a sense of procedural justice.

Chapter 3 describes an examination of clinicians' perceptions of coercion during the psychiatric hospital admissions process. For each patient included in the study described in Chapter 2, we contacted the clinician responsible for their admission. Quantitative analysis of the data from these patient-clinician dyads demonstrated that a small, but substantial, proportion of clinicians felt coerced to admit the patient to hospital. Perceptions of coercion were associated with: clinicians feeling pressure beyond medical need to admit the patient; the patient having a high level of education; and the clinician experiencing high levels of negative pressure and low levels of procedural justice during the admissions process.

Chapter 4 describes an investigation of patients' perceptions of coercion during community mental health care. The study examined the use of leverage to improve treatment adherence and the association between these leverages and perceived coercion. The results of the study indicated that nearly half of patients had experienced at least one type of leverage. While levels of perceived coercion were low, some patients still felt highly coerced during community care. Quantitative analysis indicated that perceptions of coercion were most associated with the experience of negative pressure in the community.

Chapter 5 describes a qualitative investigation of patients' experiences of psychiatric hospitalization. Eleven patients, who participated in the study described in Chapter 2, took part in a semi-structured interview about their experiences of hospital admission. The topic guide, as well as the selection of individuals for interviews, was informed by the earlier quantitative study. Using qualitative thematic analysis, we explored how these patients told their story of the admissions process and examined what influenced their experiences. The results suggested that patients are able to tell detailed stories of admission to hospital and that their experiences during the admissions process are most influenced by their relationship with others involved and their legal status.

6.2 Implications for research

In their summary of early perceived coercion research, Monahan *et al.* (1999) suggested that research in this area should: assess the prevalence of high levels of perceived coercion; investigate the determinants of perceptions of coercion; examine the effect of perceptions of coercion on outcome; and develop interventions for reducing high levels of perceived coercion.

To date, most studies of perceived coercion have focused on investigating the prevalence and determinants of perceived coercion. The results of these studies suggest that the experience of coercion is similar in the USA and Europe, with the majority of compulsorily admitted patients and a substantial proportion of informally admitted patients perceiving that they are highly coerced. In almost all studies, there has been limited association between perceived coercion and sociodemographic and clinical characteristics. Patients' perceptions of coercion appear to be most influenced by whether they felt forced or threatened and whether they felt they had a voice during the admissions process.

The studies presented in this thesis confirm and extend previous studies of perceived coercion, by describing this phenomenon in clinicians and investigating it in a population of patients receiving care from community mental health teams. Further theoretical examination of the conceptualization of coercion in clinicians is required. Research is also needed to investigate perceived coercion in those receiving care in the community as this is the primary locus of treatment for most patients.

Relatively little research has been dedicated to examining the effects of perceived coercion on outcome (Nicholson *et al.* 1996; Rain *et al.* 2003a, 2003b; Bindman *et al.* 2005). These studies have concluded that the level of perceived coercion has little association with outcome. However, they have focused on objectively measured clinical outcomes, including symptomatology, rehospitalization, and treatment adherence. The experiential nature of perceived coercion suggests that it may be more appropriate to investigate subjective outcomes, such as therapeutic alliance and satisfaction with services. The views of patients and other stakeholders in mental health care should be incorporated when identifying which outcomes should be assessed (Trivedi & Wykes 2002).

Similarly there has been little research investigating methods of reducing perceptions of coercion and only one published study has reported the development and testing of an intervention (Sorgaard 2004). This intervention was designed to increase patients' sense of procedural justice by engaging the patient in the formulation of the treatment plan, performing regular evaluations about treatment progress, and renegotiating these plans when necessary. While the intervention had no effect on perceived coercion during admission, it did significantly improve patients' satisfaction with their treatment. This may be because the intervention focused on the treatment following admission, instead of on the process by which the patient was admitted. We propose that the development and experimental testing of interventions, targeting the hospital admission process, should be a priority of future research.

Interventions which may be effective in reducing perceptions of coercion by increasing procedural justice and decreasing negative pressure include: the use of advance directives and crisis cards during the admissions process (Hamann *et al.* 2003; Swanson *et al.* 2006), and clinician training to improve specific aspects of communication during the admission process. The theoretical basis of these interventions should be grounded in empirical research and they should be tested using rigorous experimental methods.

6.3 Implications for clinical practice

Mental health policy and clinical practice guidelines clearly state a preference for informal care over the use of compulsion whenever possible. However, in recent years, there have been increased rates of use of the MHA to compel admission to hospital and later this year legislation to allow for compulsory community treatment with Community Treatment Orders (CTOs) is likely to be enacted. The studies included in this thesis suggest that the focus in clinical practice should also be to reduce perceptions of coercion in mental health care, not necessarily just to reduce the use of mental health legislation.

The results of our studies have shown that patients, in hospital and in community care, and clinicians may perceive that they are coerced. In all of these populations, there were similar associations between high levels of perceived coercion and experiences of negative pressure and procedural justice. This highlights the importance of the therapeutic relationship during psychiatric decision making. When either party does not feel that they have been listened to or understood, or when they feel forced or threatened, their perceptions of coercion are higher.

Understanding the complexities of the relationship between perceived coercion and therapeutic alliance will require sophisticated and nuanced research. In clinical practice, however, it is possible to implement changes which may reduce perceptions of coercion and improve communication between patients and clinicians. Firstly, the decision making process should be explicit and transparent. Each party involved should have the opportunity to discuss their points of view. Secondly, even when the decision making process restricts individual preferences, it may still be viewed positively if the patient views the restriction as being in their best interest. Finally, there is good reason to believe that even coercive interactions can provide an opportunity to strengthen the alliance between the individuals involved.

7 Appendices

7.1 Admission Experience Survey

Perceived Coercion Scale

1. I felt free to do what I wanted about coming into the hospital.
4. I chose to come into the hospital.
7. It was my idea to come into the hospital.
13. I had a lot of control over whether I went into the hospital.
14. I had more influence than anyone else on whether I came into the hospital.

Negative Pressures Scale

2. People tried to force me to come into the hospital.
6. Someone threatened me to get me to come into the hospital.
8. Someone physically tried to make me come into the hospital.
9. I was threatened with sectioning.
10. They said they would make me come into the hospital.
11. No one tried to force me to come into the hospital. [*reverse scored*]

Procedural Justice/Voice Scale

3. I had enough of a chance to say whether I wanted to come into the hospital.
5. I got to say what I wanted about coming into the hospital.
12. My opinion about coming into the hospital didn't matter. [*reverse scored*]

7.2 Clinician Admission Experience Survey (C-AES)

Perceived Coercion Scale

1. I felt free to do what I wanted about the patient coming into hospital.
4. I chose for the patient to come into hospital.
7. It was my idea for the patient to come into hospital.
13. I had a lot of control over whether the patient came into hospital.
14. I had more influence than anyone else over whether they patient came into the hospital.

Negative Pressures Scale

2. I felt forced to admit the patient into hospital.
6. Someone threatened me to get me to bring the patient into hospital.
8. Someone physically tried to make me bring the patient into hospital.
9. I was would have sectioned the patient to get them into hospital.
10. They said they would make me bring the patient into hospital.
11. No one tried to force me to bring the patient into hospital. [*reverse scored*]

Procedural Justice/Voice Scale

3. I had enough of a chance to say whether I wanted the patient to come into hospital.
5. I got to say what I wanted about the patient coming into hospital.
12. My opinion about the patient coming into the hospital didn't matter. [*reverse scored*]

7.3 Admission Experience Survey – Community Version

Perceived Coercion Scale

1. I felt free to do what I wanted about coming to the clinic.
4. I chose to come to the clinic.
7. It was my idea to come to the clinic.
13. I had a lot of control over whether I went to the clinic.
14. I had more influence than anyone else on whether I came to the clinic.

Negative Pressures Scale

2. People tried to force me to come to the clinic.
6. Someone threatened me to get me to come to the clinic.
8. Someone physically tried to make me come to the clinic.
9. I was threatened with sectioning.
10. They said they would make me come to the clinic.
11. No one tried to force me to come to the clinic. [*reverse scored*]

Procedural Justice/Voice Scale

3. I had enough of a chance to say whether I wanted to come to the clinic.
5. I got to say what I wanted about coming to the clinic.
12. My opinion about coming to the clinic didn't matter. [*reverse scored*]

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