



ELSEVIER

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Informal coercion in acute inpatient setting—Knowledge and attitudes held by mental health professionals



Matthias Jaeger^{a,*}, Daniel Ketteler^a, Franziska Rabenschlag^b, Anastasia Theodoridou^a

^a Department for Psychiatry, Psychotherapy and Psychosomatics, University Hospital of Psychiatry Zurich, Lenggstrasse 31, 8032 Zurich, Switzerland

^b Nursing, Quality and Services, Development and Research, Psychiatric University Clinics, Wilhelm Klein-Strasse 27, CH-4012 Basel, Switzerland

ARTICLE INFO

Article history:

Received 27 February 2014

Received in revised form

16 July 2014

Accepted 10 August 2014

Available online 20 August 2014

Keywords:

Psychiatric ward

Therapeutic relationship

Mandatory treatment

Involuntary admission

ABSTRACT

This pilot study aimed at investigating how mental health professionals on acute psychiatric wards recognize different levels of formal and informal coercions and treatment pressures as well as their attitude towards these interventions. An explorative cross-sectional survey among mental health professionals ($N=39$) was conducted using a questionnaire that consisted of 15 vignettes describing typical clinical situations on five different stages of the continuum of coercion. Low levels of coercion are recognized adequately while higher levels are grossly underestimated. The degree of coercion inherent to interventions comprising persuasion and leverage was underestimated by professionals with a positive attitude and overestimated by those with a negative attitude towards the respective interventions. No associations of the ability to recognize different levels of coercion with ward or staff related variables were found. Higher knowledge on ambiguous variations of coercive interventions seems to foster more balanced reflections about their ethical implications. Advanced understanding of influencing factors of professionals' attitudes towards coercion could lead to improved training of professionals in utilizing interventions to enhance treatment adherence in an informed and ethical way.

© 2014 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Informal coercion and treatment pressures (for definitions, see Table 1) are frequently used in community mental health care and have gained increasing clinical and scientific attention recently (Jaeger and Rossler, 2010; Molodynski et al., 2010; Burns et al., 2011). In inpatient setting informal coercion is also existent but in the light of formal coercion practices it is prone to be clinically and scientifically ignored (Gaskin et al., 2007; Scanlan, 2010). If applied uncritically informal coercion such as persuasion, leverage, offers and threats hold the risk of increasing patients' perceived coercion thereby interfering with the therapeutic relationship (Sheehan and Burns, 2011; Theodoridou et al., 2012). From an ethical perspective it is obligatory to consider carefully if a treatment pressure can be justified in the light of the caring therapeutic relationship and the professional duties (Dunn et al., 2012). If consequently reflected, those interventions can be embedded in the person-centered care of choice (Geller, 2012). Staffs' attitudes on and knowledge about formal and informal coercion are fundamental to these considerations but to date there is only limited evidence available. Attitudes towards formal coercive measures

depend amongst others on external factors such as individually experienced treatment practices and internal factors such as emotional exhaustion and therapeutic optimism (Happell and Koehn, 2011). With respect to patient-related factors, staff is most likely to accept highly restrictive formal interventions when patients are physically violent (Wynn et al., 2011). Attitudes of patients towards informally coercion interventions strongly depend on contextual factors (Jaeger and Rossler, 2009). To date there is no data on attitudes of professionals towards informal coercion available.

The aim of the present pilot study was to evaluate how precisely staff working in acute inpatient setting would recognize different levels of coercion and treatment pressures by means of typical clinical vignettes and their attitude towards these interventions. In addition, the associated factors of knowledge and attitudes were explored.

2. Methods

2.1. Study sample

An explorative cross-sectional survey was conducted. A questionnaire was distributed to all staff on four acute psychiatric wards of the Psychiatric University Hospital Zurich ($N=80$) in summer 2012. The wards provide 72 beds and five seclusion rooms altogether for the acute and emergency treatment of individuals

* Corresponding author. Tel.: +41 44 744 47 83; fax: +41 44 744 47 88.

E-mail address: matthias.jaeger@puk.zh.ch (M. Jaeger).

Table 1
Spectrum of informal coercion and treatment pressures according to Szmukler and Appelbaum (2008).

Term	Explanation
Voluntary treatment	Autonomic decision to accept treatment
Informal coercion	Treatment pressures which are not regulated by the law
Persuasion	An appeal to reason. The benefits and risks of treatment are discussed with the patient in the context of his value system
Leverage	Utilitarian approach demanding certain behaviour as adherence to medication or outpatient treatment in return for desired resources (inducements, emotional attention)
Coerced voluntarism	Threats of negative sanctions
Compulsory treatment	Coercive practices which are regulated by the law; formal coercion

between 18 and 65 years with any psychiatric disorder. The wards did not differ regarding staff to patient ratio, sociodemographic and clinical variables of patients, and utilized capacity. The local ethics committee has confirmed the study as part of a larger study protocol in accordance with the Declaration of Helsinki.

2.2. Assessment

A questionnaire consisting of 15 vignettes describing typical clinical situations was created (see Appendix A for short version in English translation, original questionnaire in German language available as Supplementary material online). The vignettes were compiled by two psychiatrists, a nurse, and a linguist. First, approximately 30 clinical situations were devised. Then, a default score was assigned to each vignette according to a five-point scale ranging from 0 to 4 (values and equivalent interventions based on Szmukler and Appelbaum (2008) given in brackets): no coercion (0), little coercion (1=persuasion/conviction), moderate coercion (2=leverage/inducement offers), severe coercion (3=threats of negative sanctions), and formal coercion (4=legal and/or physical force). This classification was performed independently by the three clinical professionals. Afterwards, for each stage of coercion three situations with congruent classification were chosen. Thus, the final questionnaire included 15 situations on five different stages of the continuum of coercion (Lidz et al., 1998; Szmukler and Appelbaum, 2008). The questionnaire was completed as a self-report. Participants were instructed to assess the degree of coercion for each situation according to the five-point scale (0=no coercion to 4=formal coercion). In addition, participants had to rate on each situation whether they approved the procedure, i.e. if they had the opinion that the described intervention was ethically acceptable (1=positive attitude) or not (0=negative attitude).

To evaluate possible influencing factors on knowledge on and attitudes towards coercion the following scales were added to the questionnaire: Good Milieu Index (GMI) comprising five items to assess satisfaction with work (Moos, 1997), the Social Distance Scale (SDS) with seven items (Link and Cullen, 1986), psychological distress was measured by the 10 items version of the Symptom Check List (SCL-10) (Nguyen et al., 1983), the seven-item Recovery Attitudes Questionnaire (RAQ-7) (Borkin, 2000), the Staff Attitude Coercion Scale (SACS) with 15 items (Husum et al., 2008), and the Essen ward climate evaluation scale (CES) (Schalast, 2008). The GMI had a value range from 0 to 3, all other scales had a range from 0 to 4 with higher values indicating more favorable assessment of work satisfaction and the ward atmosphere (GMI, CES), more recovery oriented attitudes (RAQ), more positive attitudes towards coercion (SACS), more social distance (SDS), and more psychological distress (SCL-10).

2.3. Analyses

As a first step, descriptive analyses were performed for each vignette. The percentage of participants who met the default score of the degree of coercion as well as the mean score and standard deviation (S.D.) of the total sample were calculated per item. Moreover, the percentage of participants who approved the respective procedure as acceptable were calculated and the mean score of those participants was compared to the group who did not approve the procedure using *T*-Tests.

As a second step, the "Knowledge on Coercion Scale" (KCS) was constructed. The difference between the actual rating by participants and the default score was calculated for each item resulting in a positive value in case of overestimation and a negative value in case of underestimation of the degree of coercion. Initially, the mean of these 15 difference-scores was calculated resulting in a two-tailed measure with positive or negative values indicating general over- or underestimation of coercion. This preliminary measure had a high internal consistency (Cronbach's alpha=0.86) and was considered as an indicator of knowledge on (and recognition of) the spectrum of coercive interventions with the possibility to distinguish over- and underestimation. It was used to test for group differences

according to professional background of the participants using analysis of variance (ANOVA).

The final Knowledge on Coercion Scale, KCS was conceptualized as a one-tailed continuous measure and constructed by inverting negative values of the single difference-scores into positive values. The sum of the 15 positive scores resulted in the KCS with lower values indicating better and higher values indicating poorer knowledge on coercion. The KCS had an acceptable internal consistency (Cronbach's alpha=0.62). Bivariate correlations were conducted in order to test for associations between KCS and the scales (RAQ-7, SACS, CES, GMI, SCL-10, SDS), demographic variables and work experience. Pearson's correlation was used for continuous and normally distributed variables. Spearman's rank correlation was used for ordinal and non-normally distributed variables.

Finally, for each stage of coercion an attitudes index was calculated as the sum of positive attitudes towards the interventions described in the three vignettes per stage of coercion. This resulted in five attitude indices (one measure per stage of coercion) with four categories ranging from 0 to 3 each. As the attitude indices had unacceptable internal consistency (Cronbach's alpha < 0.5) they were treated as ordinal variables. Bivariate rank correlations (Spearman) were conducted between the attitude indices and the KCS as well as the other scales and staff related variables.

The data were analyzed with IBM SPSS Statistics Version 20 (Statistical Package for the Social Sciences, IBM Corporation, 2011). Scales underwent a reliability analysis to determine internal scale consistency by Cronbach's Alpha. All scales had acceptable internal consistency for the present sample (Cronbach's alpha 0.65–0.80) and appeared to be normally distributed (tested by Q-Q-diagrams, skewness and kurtosis).

3. Results

The response rate was 49% ($n=39$). Characteristics of the participants as well as parameters (Mean, S.D.) are presented in Table 2. Participants who did not have experience in one or more of the three other treatment settings depicted at the bottom of the table only worked on acute (mostly closed) wards such as the study wards.

The results of the descriptive assessment of the vignettes are displayed in Table 3. The degree of coercion of interventions including threats of negative sanctions or formal coercion was clearly underestimated (deviation from default scores > 0.5) while the assessment of situations with no coercion was mostly adequate. Interventions in the middle range of coercion (Persuasion, Leverage) were assessed within 0.5 score deviation of the default scores. However, most of these items were divergently scored by participants who approved the respective intervention compared to those who disapproved it. The latter participants scored the degree of coercion significantly higher in most cases.

The mean score of the two-tailed preliminary measure was -0.44 (S.D. 0.54) indicating that the degree of coercion was generally underestimated by almost half a point. Comparison of means between professional groups revealed the least underestimation by physicians (-0.1 , S.D. 0.8), followed by nurses (-0.4 , S.D. 0.5) and other professions (-0.6 , S.D. 0.3). However, these group differences were not significant ($P=0.388$) and the groups differed considerably in size.

The mean sum score of the KCS was 11.5 (S.D. 4.6, range 3–20) indicating inadequacy in estimation of the degree of coercion of at

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات