Research report

COERCION EXPERIENCE OF PATIENTS WITH MENTAL ILLNESS IN A TERTIARY CARE HOSPITAL IN KERALA

Anagha Unnikrishnan[1], TK Saleem[1*], CA Smitha[2]

[1]Government College of Nursing, Kozhikode, Kerala
[2]Department of Psychiatry, Government Medical College, Kozhikode, Kerala
[**]Corresponding address: Government College of Nursing, Kozhikode, Kerala, PIN – 673008.
Email: tksaleem@gmail.com

Abstract

Background: Coercion is a negative experience that interferes with the basic freedom and rights of patients with mental illness. The present study focuses on understanding the experience of coercion in patients with mental illness during their admission to a tertiary care hospital. **Objectives:** The study aims to assess the coercion experience of patients with mental illness who are undergoing treatment from a teaching hospital in a northern district of Kerala. The study also looked into the relationship between coercion experience and socio-demographic variables. **Methods:** A semi-structured interview schedule to assess socio-demographic variables and MacArthur Admission Experience Survey to assess the coercion experience of patients with mental illness were used in this study. The study sample included 84 patients with mental illness who had admission experience in the last two years. **Results:** Findings of the study revealed that 36.9% of patients with mental illness experienced high coercion and another 29.8% reported a moderate level of coercion. Affective reactions to hospitalization showed confusion (48.80%) and sadness (40.48%). A significant negative correlation was established between coercion experience and age, drug compliance and age of onset of illness. There was no significant relationship between coercion experience and sex, marital status, religion, socio-economic status, educational status, occupational status, diagnosis category, place of residence and regularity of treatment. **Conclusion:** A significant proportion of patients report coercive experiences during their admission for psychiatric treatment. Coercion is a negative experience that adversely affects the outcome. The study is attempting to highlight whether there is a need to lessen coercion.

Key words: Mental illness, admission, coercive experiences.

INTRODUCTION

Mental health care focuses on promoting recovery and respect for the rights and life-satisfaction of people with mental illness. Coercion is frequent in psychiatric practice, particularly involuntary admission and restriction of movement during the acute phase of mental illness.[1] Definition of the term 'coercion' includes 'compulsion, 'persuasion' and 'threat'.[2] Coercive measures which are permitted by the respective laws of the countries often get in conflict with individual

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freedom.[3] Coercive interventions may be necessary for the optimal treatment of patients with severe mental health problems. But coercive experiences may be traumatising and may have a negative impact on the long-term outcome in patients with mental illness.[4]

Coercion is the deprival of the rights, desires, needs and choices of a patient with mental illness.[5] It is contended that conventional mental health law discriminates against persons with a mental disorder since it does not respect such persons' autonomy.[6]

Coercion and the loss of patients' dignity are major controversial issues in mental health research and practice.[7] As a part of clinical care, coercion is routinely employed in mental healthcare.[8] There are considerable differences in the methods of coercive measures between individual institutions. Institutional characteristics considerably impact the patient experience on coercive measures.[8] When coercion is unavoidable, choosing the most effective yet safe and humane method as possible is very important.[9] There are limited studies on understanding the coercion experience of mentally ill people in India.[10] Indian state of Kerala is known for its better public health care system and high health indices. Mental health care and treatment is provided in diverse settings in public and private institutions. Systematic and routinely collected data on the subject of coercion is important to study the outcome of the policy decisions and law to reduce negative experiences of patients with psychiatric illness.[8] Outcome of this study will help mental health professionals to respect patient experiences and improve patient care.

METHODS

This study aimed to identify the coercion experiences of patients with mental illness and find out the relationship between their coercion experience and selected variables. The study population was persons with mental illness with admission experience. The sample size was calculated on the basis of a study that reported an average of 80% psychiatric patients experienced coercion on admission.[11] So, the sample size for this study was estimated to be 84 participants. Participants fulfilling the eligibility criteria were selected consecutively. Patients who were above the age of 18 years and those who were having at least one admission experience within the previous 2 years were included in the study. Patients who suffer from conditions such as schizophrenia, schizoaffective disorders, bipolar disorder or substance use disorders as per ICD-10 or DSM-5 criteria were included. Participants with a grade 4 insight status or in remission state of the illness were recruited. Patients with formal thought disorder, cognitive impairment, mental retardation, and personality disorders were excluded.

Coercion in this study was operationally defined as patients' perception of any action or threat of actions which compels the patient to behave in a manner inconsistent with his or her own wishes as measured by MacArthur Admission Experience Survey (MAES). MAES is a 16-item questionnaire, one item was descriptive – affective reactions to hospitalization. MAES has sub-scales such as Perceived coercion, Negative pressure and Voice scale, rated as true, false and don't know. The fourth sub-scale, Affective reactions to hospitalization was a descriptive qualitative measure.[12,13] The scale has adequate reliability and validity for use in Indian context.[10] Internal consistency reliability of the translated tool was estimated to be 0.6. The scale has been in the public domain for academic purposes. The tool was translated to Malayalam and language validity was established by translation-retranslation procedures. A semi-structured questionnaire was prepared to collect socio-demographic and clinical variables such as age, sex, religion, educational status, years of education, occupation, socioeconomic status, place of residence, type of family, marital status, area of admission, age of onset of illness,

Table 1. Sample characteristics

Variable	Category	f (%) (N=84)
Age in years	Less than 30	29 (34.9)
	31 – 40	22 (25.6)
	41 – 50	18 (20.9)
	51– 60	15 (18.6)
Gender	Male	35 (41.7)
	Female	49 (58.3)
Marital status	Unmarried	26 (30.9)
	Married	38 (45.2)
	Separated/widow	20 (23.9)
Educational status	Primary education	6 (7.1)
	Secondary education	10 (12.0)
	Higher Secondary	40 (47.6)
	Graduation/above	28 (33.3)
Occupation	Unemployed	14 (16.6)
	Manual labourer	31 (37.0)
	Homemaker	21 (25.0)
	Regular employment	18 (21.4)
Place of residence	Rural	72 (85.7)
	Urban	12 (14.3)
Family type	Nuclear	52 (62.0)
	Joint	16 (19.0)
	Three generational	16 (19.0)

f – frequency

Table 2. Level of coercion experience

Characteristics of coercion (MAES Scoring)	f (%) (N = 84)	95% CI
< 5 (Low)	28 (33.3)	(23.42- 44.46)
6–10 (Moderate)	25 (29.8)	(20.27-40.73)
11–15 (High)	31 (36.9)	(26.63-48.13)

f – frequency, MAES – MacArthur Admission Experience Survey

duration of admission, duration from last hospitalization, diagnosis, length of hospitalization, years of illness, experience of electroconvulsive therapy (ECT), family support, and regularity of treatment. Drug compliance was measured on Medication Adherence Rating Scale (MARS) which was translated to Malayalam and language validity was established.[14]

Ethical approval and permission from concerned authorities were obtained. Informed consent was taken from individual participants.

The study was conducted in the Psychiatry department of Government Medical College Hospital, Kozhikode during the month of April 2021. The participants who met the inclusion criteria were selected for the study. The participants were seated comfortably. Investigator explained the purpose of the study to each participant. After this, informed consent was obtained from each of them. In situations when the participants were not able to give the consent, it was obtained from caregivers. Privacy and confidentiality of the data was assured. Preliminary screening was done by the investigator using mental status examination criteria with special emphasis on insight and general intelligence. Clinical records were reviewed to confirm the responses under the clinical data. On average, 15 minutes were taken for each participant and data from 5-7 participants were collected daily. Data were subjected to descriptive and inferential statistical analysis using the SPSS for Windows, Version 18.

RESULTS

Socio-demographic and clinical variables are presented in Table 1. Based on the diagnosis, 16 (19%) participants were diagnosed as schizophrenia, 51 (60.8%) as mood disorders and 17 (20.2%) with substance use disorders. All the 84 participants had got admitted at least once in a government hospital, and 43 participants (51.2%) of them had at least one admission in private psychiatric institutions. .Among the participants, 55 (65.48%) had admission experience within the last six months, 21 (25.0%) had admission experience in the 6 months to 1-year period and 8 (9.52%) had admission experience in the 1- to 2-year period. In 34 (40.5%) participants, duration of illness was for more than 10 years. When family support was enquired, 73 (86.9%) participants responded that their family was supportive. Only 2 participants received ECT treatment in the past. When regularity of treatment was enquired, 94% (n=79) of the participants reported that they were regular at treatment

and follow up. On MARS scale, 50 % of the participants had good drug compliance and another 50 % of participants had poor drug compliance.

Coercion Experience Of Patients With Mental Illness

On MAES, results showed that 36.9% of participants experienced high coercion and 29.8% experienced moderate level of coercion. (Table 2). On the affective reaction to admission experience, 48.80% were confused, 40.48% were sad and none were pleased (Table 3). When relationship between MAES score and patient variables were analysed, age (-0.253), drug compliance (-0.461), age of onset of illness (-0.338) showed significant negative correlations (Table 4). No significant difference on MAES mean scores of participants with different diagnostic categories were found (Table 5). Group difference tests for mean scores of males (7.72, standard deviation (SD) = 4.88; n = 36) and female participants showed no significance. Similarly, no significant relationship was observed between MAES score and gender, marital status, religion, socio-economic status, educational status and, occupational status in this sample.

DISCUSSION

The present study was intended to assess the coercion experience of patients receiving treatment for mental illness from a tertiary care medical college hospital in Northern Kerala. We found that a considerable proportion of participants experienced coercion during their treatment. General Hospital Psychiatric Units (GHPUs) have been recommended as a solution to stigma and rights violation in mental health care.[15] Kerala's government health-care system functions relatively well in comparison to that of other Indian states as well.[16] This study was conducted in a GHPU and the participants had admission experience in the same setting within the previous six months. Patients' experience may be different in dedicated psychiatric hospitals, as patient rights violations are common in psychiatric hospitals in India, despite enactment of many laws.[17]

Table 3: Coercion experience - Reaction to hospitalization

Affective reactions to hospitalization	f (N = 84)	%
Angry	22	26.19
Sad	34	40.48
Pleased	0	0.0
Relieved	26	30.95
Confused	41	48.80
Frightened	11	13.10

f – frequency

When mental health is an effort to restore individuals' overall well-being and standard of living, an ideal mental health setting should work in accordance with their needs and interests, safeguard their rights, and improve their sense of well-being.[18] Unfortunately, many mental health settings are not working in favour of their own governed rules and regulations and are negatively impacting the recovery and relapse.

We found that 66.7% of the participants experienced moderate to high coercion, where 36.9% reported high coercion and 29.8% reported moderate level of coercion. This signifies the purpose of the study to bring into light the level of coercion experienced by patients in a mental health facility. These findings are consistent with the result from another study on coercion experience of patients with mental illness in an Indian mental health setting, where 73% reported high coercion.[10] Mental health treatment facilities in India have become less restrictive and more humane over the years.[19]. Despite progress in many areas, people with mental health conditions often experience severe human rights violations, discrimination, and stigma.[20] When coercive interventions cannot be avoided, it is important to take care of the painful subjective experience of coercive interventions.[4]

Table 4: Relationship between coercion experience and patient variables

Characteristics	Pearson r	p-value
Age	- 0.253	0.02*
Drug compliance (MARS)	- 0.461	< 0.01**
Age of onset of illness	- 0.338	< 0.01**

*- significant at 0.05 level,**- significant at 0.01 level, MARS - Medication Adherence Rating Scale

Confusion and sadness were the two emotional reactions expressed by participants towards admission for psychiatric treatment in this study. None of the respondents were pleased about the admission experience. Studies have discussed the admission experience of patients with mental illness from different countries including India.[10,21] Relationship between patient and care providers is an important component in psychiatric care.[22] Patient experiences adversely affect these relationships and patient outcome.

In psychiatric treatment settings, variables that predicted the highest risk for coercive methods being used against patients included age, gender, and psychiatric diagnosis.[23] We found a significant negative correlation between coercion experience and age of the participants. Younger age and psychosis are predictive factors of violence and subsequent coercive treatment in psychiatric care.[24]

It is estimated that up to 80 percent of patients are nonadherent to treatment recommendations at some point during their illnesses.[25] In addition to several other factors, coercive experiences too contribute to nonadherence in psychiatric patients.[26] The experience of admission to the hospital is an important factor that influences willingness to take medications.[27;] The perception of coercion and negative pressure to enter the hospital are associated with nonadherence to psychiatric medications.[27] This study found a significant negative relationship between drug compliance and coercive experiences. It is important that patients experience only the least level of such negative situations during their treatment.

Table 5: Group difference in coercion experience – diagnosis

Diagnosis	Mean (SD)	F (*df*), p-value
Psychosis/ Schizophrenia (n=16)	8.56 (3.30)	1.11 (*df=2*), 0.336
Mood disorders (n=51)	7.04 (4.57)	
Substance use disorders (n=17)	8.35 (4.09)	

SD – standard deviation, *df* – degrees of freedom

Similarly, we have also found a significant negative correlation between age of onset of illness and coercive experiences which shows that younger patients perceived more coercion.

Conclusion

This study shows that coercive experiences are common in psychiatric treatment settings. Coercive interventions may help to regain insight and alleviate symptoms in serious mental disorders. But it is traumatising to most patients and adversely affect the recovery process. This study was delimited to cross-sectional understanding of coercion experiences among patients with mental illness. It is recommended that studying subjective experience of coercive interventions provides an opportunity to understand the effectiveness of measures to reduce negative experiences and protect the rights of patients with mental illness. Attempt to reduce coercive experiences in the clinical settings is part of continuing quality improvement in mental health care.

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