Working with People Who Feel Coerced

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What Counts as Coercion?

By the way, this isn’t a robbery, It’s just coercive borrowing

• John is a 24 y.o. man who has been brought into the crisis service by police after his mother called them saying that he was angry, yelling and threatening his parents.
• He came in in handcuffs, and police have said they will not release them until he is cleared by crisis staff.
• He has not been allowed to smoke, or call anyone, or go to the bathroom by himself. After 3 hours he said he was hungry and was eventually given a sandwich.
• After a long discussion with crisis staff, with the help of his parents, he eventually agrees to take some medication and go into the hospital.

Was this a voluntary admission?

• Legally was it voluntary?
• Did John feel it was voluntary?
• Does it matter if John feels it was voluntary or not?
• What do we know about the long-term consequences of such an admission?
• What do we know about how to improve long term outcomes after this admission?

Coercion and loss of control exists on a continuum

• I want help for my depression and I decide to come in
• My wife is concerned about my depression and urges me to come in
• My boss notices I am not focused or concentrating tells me to come in
• I have had a bad performance review at work and am told to come in or I will be fired
• I am out of work and part of disability requires that I come in
• I have been arrested after a fight and mental health court has required I come in or go to jail
• My parents are concerned I am suicidal and called the police, who have brought me in for assessment.

• Julie came in after being pressured by her parents. She agreed to see me so that I would tell them that there was nothing wrong with her.
• She had always been painfully shy, but over the past few years this became much worse. She dropped out of college 18 months ago because of anxiety of being around people.
• She also acknowledged that she was often confused about what was going on, described the radio and TV and even her CD player talking to her and commenting on her behavior. She also felt that if she was not very careful other people could read her thoughts.
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Assumption that voluntary patients are voluntary

- Voluntary and coerced are on ends of a lumpy and non-linear continuum
- When we see “voluntary” patients, they are some place on this voluntary to coerced continuum
- Degree of objective coercion is very different that patients perception of being coerced
- There is little data on formal coercion, and even less on coercion on the softer end of influence to control

Is forced treatment effective?

Kendra’s law in N.Y. Allowed for community treatment orders: comparison pre and post commitment after 6 months

- Involvement in case management 100% vs 53%
- Medication management 88% vs 66%
- Arrest, incarceration, psych hospitalization and homelessness dropped between 74 and 87%

Methodological Problems:
Treating clinicians involved in assessment, non-random assignment, and regression to a mean after crisis

Cochrane review of effectiveness of community based coercion

- As of 2013 only 3 studies n = 752 met RTC criteria (15 articles): Eliminated crossover trials and non-random controls
  - N.C study (Swartz);
  - N.Y. study (Steadman), and
  - OCTET (Burns) study from U.K.
- No statistical differences in readmission rate, arrest rates, homelessness, or other outcome data, except
- Decreased rate of victimization for people on compulsory community treatment

Kisely and Campbell 2014

Swartz et al re-analyzed North Carolina Study

- Initial community treatment orders 30-60 days
- At end of first year, no difference in rehospitalization rates between people on, and not on outpatient commitment
- Extended outpatient commitment + intensive outpatient services did lead to decreased hospital admissions
- Comparison of commitment less or more than 180 days
  - 57% fewer readmissions and 20 fewer hosp days than controls


Perception of coercion:

- Negative pressure
  - Distinct from benign pressure such as persuasion and inducement
  - Threats and force
- Process Exclusion
  - Whether patients views are considered by others
  - Motivation of others
  - Having voice and being validated

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Patient Perception of Coercion

- 331 subjects in larger study of outpatient commitment
- Serious mental illness, and previously hospitalized > 21 days
- Measure of:
  - Perceived coercion
  - Perceived negative pressure
  - Process exclusion
- Correlated .60 or higher with each other

Hiday et al. Patient Perceptions of Coercion in Mental Hospital Admission  Int J Law and Psychiatry 20(2) 1997

Perceived Coercion in Committed Patients

5 item scale on perceived coercion:
- “I felt free to do what I wanted about coming into the hospital”
- “It was my idea to come into the hospital”

Perceived Coercion
- Male, African American and Married
- Perceived Coercion associated with education

Hiday et al. Patient Perceptions of Coercion in Mental Hospital Admission  Int J Law and Psychiatry 20(2) 1997

Negative Pressure in Committed Patients

6 item perceived negative pressure scale
- “People tried to force me to come into the hospital”
- “I was threatened with commitment”

Perception of Negative Pressure with more Education, African American Women and White Men

Perception of Negative Pressure with African American Men

Hiday et al. Patient Perceptions of Coercion in Mental Hospital Admission  Int J Law and Psychiatry 20(2) 1997

Process Exclusion in Committed Patients

Consideration of patient views
[Does not include motivation of others which is part of fairness ]
- Lack of voice: “I had enough of a chance to say whether I wanted to come into the hospital”
- Validation: “No one wanted to know whether I wanted to come into the hospital”

Perceived Process Exclusion with Men and Marrieds

Hiday et al. Patient Perceptions of Coercion in Mental Hospital Admission  Int J Law and Psychiatry 20(2) 1997

MacArthur perceived coercion scale

Control: How much control did you have over being admitted
Choice: Did you choose to be admitted or did someone else make you come in
Influence: what had most influence on your being admitted, what you or what other people wanted?
Freedom: Once you were in the emergency room, how free did you feel to do what you wanted about being admitted
Idea: It was my idea to come into the hospital


Why do some voluntary patients feel coerced

91 of 270 voluntary pts on 9 acute wards in 2 hospitals in London perceived their admission as coerced
- Women more likely to feel coerced than men (47% Vs 29%)
- Age, ethnicity and dx not correlated with perceived coercion

In follow-up interview perceived coercion correlated with
- Perceiving the hospital treatment as not effective
- Alternative treatments as more appropriate
- Not participating sufficiently in the admission and treatment process
- Not feeling respected and cared for by professionals.

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Even coerced patients agree on need for treatment

91% of all patients, even those who felt most coerced, agreed that they had a mental health problem and needed treatment

Patients often felt coerced even if they felt treatment was beneficial

Perception of coercion was closely correlated with treatment satisfaction

“I needed some sort of treatment, but I don’t think that being locked up for 5 weeks is some sort of treatment”

Katsakou et al Psychiatric Research 187(2011) 275-282

Impact of Coercive Measures on Life Stories

• Some felt coercion needed, but others felt it was an over-reaction
• Need for more ordinary conversations with health professionals
• Impact of hospitalization as life changing event:
  – Impact on self-esteem and sense of self
  – Sense of vulnerability and fear of being coerced again
  – Impact of relationship and community life, felt under surveillance by family and friends

Sibitz et al Brit J of Psychiat (2011) 199, 239-244

Impact of Mental Health Court on Perceived Coercion and Procedural Justice

• N = 121 charged with nonviolent misdemeanors, does not present risk to public safety, has mental health problems, and agrees to use the MHC
• Control = 101 matched subjects from another county that did not have a MHC

Perceived Coercion and Procedural Justice in the Broward Mental Health Court

<table>
<thead>
<tr>
<th>Question</th>
<th>MHC</th>
<th>Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At court today, did you have enough opportunity to tell the judge what you think he needed to hear about your personal situation [voice]</td>
<td>6.07</td>
<td>3.69</td>
</tr>
<tr>
<td>2. At court today, did the judge seem genuinely interested in you as a person? [person]</td>
<td>6.06</td>
<td>3.98</td>
</tr>
<tr>
<td>4. At court today, did the judge treat you fairly? [fairness]</td>
<td>5.78</td>
<td>3.63</td>
</tr>
</tbody>
</table>

Correlated 63% with variance in outcome satisfaction R=.790, F(93,216) = 119.85, P<.001

Perceived Coercion and Procedural Justice in the Broward Mental Health Court

What do patients want?

Swedish Study of 173 pts admitted to hospital
Pts who reported participating more in their treatment planning during hospitalization reported greater treatment satisfaction, and more improvement after hospitalization


Patients had broad desire to be more involved in their mental health care decision making

Adams et al 2007: Shared decision making preferences in people with severe mental illness: Psych Services 58, 1219-1221

Client Experience in Midst of Psychiatric Crisis

• Consumer is told what the problem really is.
• Consumer is told what the solution to the problem should be.
• Consumer’s own views considered part of his or her illness.
• Assumption that judgment is impaired (why else would he or she be in crisis?)
16 of 21 RTC studies: improvement in health outcomes when quality of communication with physician was improved

- Physician asked many questions about the patients concerns, expectations, and functional difficulties
- Physician showed support and empathy
- Patient expressed feelings, opinions and information
- Patient perceived that a full discussion had occurred
- Patient was encouraged to ask questions
- Patient was successful at obtaining information
- Physician gave clear information accompanied by emotional support
- Physician and patient agreed about the problem and follow-up

Impact of Clinician Patient Communication
1995 Review of Literature of Medical Interviewing

- Traditional assumption was that the relationship was adequate and not a cause of concern
- Physicians interrupt pts on average 18 seconds into patient’s description of presenting problem
- 54% of patient problems and 45% of patient concerns missed by the physician
- Patients and physicians disagree about the presenting problem in 50% of cases

Influence of Patient-Clinician Relationship on Healthcare Outcomes (Kelley et al 2014)

- 2014 Review of 13 RCT studies that included validated outcome measures (started with 6459 articles)
  - Pain, weight loss, functioning, blood pressure, re-consultation rate, smoking quit rate, asthma QOL
- Excluded mental health, substance abuse and routine care
- Mixed inventions, some focused on
  - emotional care (empathy, respect, acceptance) and
  - cognitive care (information sharing, patient education)
- Effect sizes from d = -.23 to .66
- Overall effect size small d = .11 but statistically significant (p=02)
“Change the field”, especially if relationship is not going well

- Offer food
- Change where you are meeting
- Take a walk together
- Enlarge the field—get other people involved—supports for you, or for the client

Modes of request

Which is most effective:

1. What you are to do is…Do the following…Do this
2. I would like you to… I want you to… This is what I am asking you to do
3. So what you have agreed to try is… As I understand it, you will… So you will take responsibility for

(Levy and Carter 1976)

Do not require language for connection

- Be willing to just be with someone who has significant impairments and who may be psychotic.
- Be careful about asking too many questions if questions are difficult
- Talking is not the only way to develop a relationship

Perception of Coercion

- Requires perception of differences in power
- This can occur with or without formal coercion
- Can occur in our office as well as in the hospital
- Can occur whether we intend it or recognize it or not.

Issues of Power in the relationship

- Many human relationships involve power asymmetry
- “One up” people tend to minimize power hierarchies, while “one down” people are much more aware
- People with more power tend to be more direct, while people with less power tend to be passive and less overt

David Mechanic: Sources of Power of Lower Order Participants in Complex Social Structures: Admin Sci Quarterly 7(3) Dec 1962

Issues of Power

- The patient comes into our office where we are in charge
- We set agenda, timing and rules for appropriate behavior
- We get to label behavior as part of a diagnosis or “normal”
- We have access to a variety of resources, from medication to disability to special access to housing
- In the past we have been involved in committing patients, contacting DMV about driving, or initiating financial payees
- If there is a disagreement, outsiders will most likely agree with our point of view
What does the clinician want?
- Pt should calm down
- Be cooperative
- Avoid making threats
- Tell his story so that it makes sense
- Allow a risk assessment
- Take medication

What does the client want?
- Leave the ER and go home
- Get a place to stay tonight
- Get some food
- Have someone be nice/sympathize
- Have someone be on his side
- Get help with some specific problem, roommate, job, money, family

Increasing or decreasing power asymmetry is a clinical decision

Shared Decision Making and Motivational Interviewing are techniques that decrease the power hierarchy between patient and clinician

Motivational Interviewing and Treatment Engagement for People Seeking Treatment for Substance Abuse

423 substance abusers from 4 community based treatment programs, randomly assigned to standard 2 hr intake assessment or 2 hr MI informed assessment,
- Clinicians randomized to either use of standard assessment
  Pts drug hx, current use, current functioning, orientation
- Or trained in MI assessment
  Open ended question in MI style, empathy, provided choice, affirming change related statement, elicited self-motivational statements

Treatment was the weekly group sessions in both conditions


Motivational Interviewing and Treatment Engagement for People Seeking Treatment for Substance Abuse

MI assessment group more likely to be enrolled in treatment at 28 days
- 84% Vs 75 %, p = .04
- Increased retention in 3 of the 4 sites

Group data demonstrated no difference in substance use between MI and std assessment group (decrease substance use in 3 of 4 sites but not statistically sig)

No differences in retention at 84 days


Impact of therapist’s words on the adolescent brain, in the context of addiction treatment

Study of 17 binge drinking youth: 16.62 years old
- 2 treatment sessions, fMRI between sessions
- Re-evaluated for behavioral change after 1 month
- complex reflections: “you’re worried about your drinking”, “you’ve seen what happens to your friends after they have passed out”
- closed questions: “did you drink this weekend?” “Are you concerned about your safety?”


Complex reflections: increase in frontal (L inferior frontal gyrus) temporal (R superior temporal, L middle temporal) limbic (L amygdala), and occipital

Closed questions: increase in R superior temporal, L middle temporal and occipital

Regions of increased activity of complex reflections > simple questions
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What do we know

- Many patients feel some level of coercion, even if they are formally voluntary.
- This is likely to apply to patients we see in our office as well as patients we see in the hospital.
- Coerced patients tend to feel disempowered and “one down” to the clinician, even if the clinician does not feel “one up”.
- Based on extrapolation from limited data, issues of “due process”, listening to patients own explanation, and collaborating over treatment strategy seems to improve satisfaction and outcomes.

What else do we know

- Most patients, even those being treated involuntary, know they have some kind of mental health problem.
- “Insight” must be more than just the patient agreeing with us.
- One person cannot not collaborate. It takes two people to not collaborate (Miller and Relnick).

Perception of coercion has more to do with process and relationship than with the decision

1. Start with patient’s own goals
2. Be respectful
3. Involve the patient in decisions
4. Support and reinforce strengths: what the person does well
5. Involve family, friends and other supports
6. Take a long term view
7. Pay attention to culture