

PAPER

Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients

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ABSTRACT

Involuntary hospital treatment is practised throughout the world. Providing appropriate treatment in this context is particularly challenging for mental health professionals, who frequently face ethical issues as they have to administer treatments in the absence of patient consent. We have explored the views of 59 psychiatric patients who had been involuntarily admitted to hospital treatment across England. Moral deliberation theory, developed in the field of clinical bioethics, was used to assess ethical issues. Interviews were audio recorded and transcribed verbatim, and analysed through thematic content analysis. We have detected a number of circumstances in the hospital that were perceived as potentially conflictual by patients. We have established which patient values should be considered by staff when deliberating on ethically controversial issues in these circumstances. Patients regarded as important having freedom of choice and the feeling of being safe during their stay in the hospital. Patients also valued non-paternalistic and respectful behaviour from staff. Consideration of patient values in moral deliberation is important to manage ethical conflicts. Even in the ethically challenging context of involuntary treatment, there are possibilities to increase patient freedoms, enhance their sense of safety and convey respect.

INTRODUCTION

Involuntary hospital treatment is practised throughout the world. Providing appropriate and effective treatment to patients who have been hospitalised against their will is particularly challenging for mental health professionals.

During involuntary admissions, mental health professionals have to make a number of ethically challenging decisions. Therefore, analysing the concept of deliberation and understanding which values are the ones that influence the deliberation processes may be relevant for informing clinical practice.

Deliberation is a key concept in contemporary culture spread across several disciplines such as philosophy¹ political philosophy² and bioethics.³ Exploring deliberation through a medical ethics perspective⁴ and identifying best practices may be an important tool to help improve clinician–patient relationships.⁵ However, there is a lack of knowledge about deliberation in psychiatry, especially in the context of involuntary treatment.

Deliberating on moral issues is a process that consists of identifying reasons for values. Values are influenced by a number of emotional, traditional

and historical factors. Identifying reasons for our values is difficult as they are not completely justifiable through rationality and they are frequently in conflict with other people's values.⁶ From the perspective of ethics values, an ethical issue is always a clash between different values.⁷ Consequently, moral deliberation is a way to carefully consider values and make prudent decisions.⁸

Deliberation has three different steps: (1) deliberating on facts, that is, considering the circumstances and consequences of the decision; (2) deliberating on values, that is, identifying the moral character of the decision and the conflicting values involved; and, finally (3) deliberating on duties, that is, exploring all possible courses of action to identify the best option.³

In moral deliberation the concept of 'best' is considered analogous to the Aristotelian concept of *mesotēs* (intermediate).⁹ This means identifying a course of action that is equidistant from two extremes, each one representing a different value. The best course of action will consider both the opposite values involved in the decision-making process. This procedure aims to approach an ethical issue not in the manner of a 'dilemma' with only two extreme and opposite courses of action, but more in the sense of a 'problem' where is possible to identify an intermediate option.⁹

Involuntary hospitalisation in mental health is controversial by its very nature, being by definition a coercive treatment. Patients are in hospital against their will, and professional staff decision making is frequently in conflict with patient views. For that reason we consider moral deliberation as a useful approach to manage conflictual issues arising from involuntary treatment.

In order to apply deliberative methodology in mental health care, we have explored the perceptions of involuntary inpatients about situations taking place in the hospital. In fact, so far medical ethics has assessed only the values that should inform professionals' decision making. No studies have explored patients' views on values. Analysing the reports of patients who had experienced involuntary admission in different hospitals across England, we explored which values arose from their perceptions of care.

METHODS

Study design

The study was a secondary analysis of data from the 'Involve' Study (Outcomes of involuntary hospital admission in England).¹⁰ The study used

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purposive sampling. Data were analysed through thematic content analysis.¹¹ The original research team included researchers with backgrounds in psychiatry, psychology, bioethics, sociology, nursing and patient experience. The team conducting this specific analysis included an academic bioethicist, a research psychologist and two clinical and academic psychiatrists.

Sample and data collection

We conducted in-depth semistructured interviews with 59 patients who were involuntarily admitted to acute wards in 22 hospitals across England under sections 2–4 of the Mental Health Act 1983 (MHA). Participants were recruited between July 2003 and July 2005. Section 4 allows emergency detention for up to 72 h, section 2 involuntary admissions for assessment for up to 28 days and section 3 involuntary admission and treatment for up to 6 months. The interviewees were selected from a sample participating in a larger quantitative investigation of involuntary admission. After being provided with a complete description of the study, they gave written informed consent to be interviewed; the detailed inclusion criteria and recruitment process have been described elsewhere.¹²

The interviews were conducted by seven researchers (including two service-user researchers) between 3 months and 1 year after the index admission and always after discharge so that participants could retrospectively assess their involuntary treatment in its entirety. Interviews were independent from the patient's care, usually took place at the participant's home and lasted between 30–90 min. Of the 69 patients who were invited to take part in the study, only 10 declined to do so.

The sampling was purposive: participants with different clinical and sociodemographic characteristics (ie, age, gender, ethnicity, diagnosis, psychiatric history, section of MHA, length of hospital stay) were selected to achieve an inclusive sample (table 1).

New participants were recruited based on their potential similarities or discrepancies from patients already interviewed, and

sampling continued until saturation of the topics emerging from the interviews was reached. The Multi-Centre Research Ethics Committee (ref: MREC/03/0/96) approved this study, which has therefore been performed in accordance with the ethical standards laid down in the Declaration of Helsinki.

A topic guide for the interviews was finalised by a group of four researchers (including three service-user researchers) and covered patients' experiences of admission and treatment. All interviewees received training in interviewing according to the topic guide.

Data analysis

All interviews were audio recorded and transcribed verbatim. The transcripts were analysed through thematic analysis¹³; following this technique, open, axial and selective coding¹⁴ was performed and emerging themes were counted.¹⁵

Two researchers (including a service-user researcher) developed a coding frame capturing the emerging themes, which was further discussed and refined in team meetings. To examine coding reliability, the researchers independently coded 12 interviews and compared their results in two phases.

During phase one, the coding of six interviews was discussed until agreement on the meaning and application of each code was reached. In phase two, inter-rater reliability was calculated based on the six remaining interviews, as the proportion of agreements in relation to the total number of agreements and disagreements.

The overall inter-rater agreement was 79%. The two researchers then coded all transcripts, using MAXqda software (V2) for qualitative analysis. We used coded transcripts for identifying experiences in line with situations taking place in the ward and related values.

RESULTS

The main clinical and sociodemographic characteristics of the interviewed patients are reported in table 1.

We explored patients' experiences of hospital treatment and we identified circumstances where conflicts between staff and patients had taken place and their values could collide. We also detected three related values that should be considered when applying moral deliberation in the context of involuntary hospitalisations.

Lack of control about decision making in the hospital: freedom

Patients retrospectively reported a restriction of their freedom in the hospital. In all, 92% of the patients interviewed reported that they were not involved in decision making on treatment and felt that their rights had been violated.

They are in control of you, your are not in control anymore (participant 51, female, aged 27).

All your rights are taken away, it's horrible, you are not in control anymore (participant 27, male, aged 29)

More often the loss of control was experienced as a result of a paternalistic attitude of professionals; 41% of patients perceived being overpowered by staff.

They mostly talked to you like children most of the time ... You can't any other time to have food and a cup of tea...When I went there I didn't have any money and I had a bank card, but I couldn't go to the bank and they couldn't take me (participant 28, male, aged 25).

Table 1 Clinical and sociodemographic characteristics

Characteristic	Total sample (N=59)
Gender	
Female	25 (42)
Male	34 (58)
Age, mean±SD	37.7±10.2
Ethnicity	
White	37 (63)
Black	14 (24)
Asian	6 (10)
Other	2 (3)
Diagnosis	
Schizophrenia	27 (49)
Affective	20 (36)
Other	8 (15)
Past hospitalisation	
Yes	41 (70)
No	18 (30)
Length of index stay in days, mean±SD	68.3±58.9
Justification of sectioning (quantitative single item)	
Yes	22 (38)
No	36 (62)

Values are in N (%).

Well, it's the way the staff...they sort of overpower you...they tell you what to do all the time (participant 2, male, aged 24).

Nurses in there just don't seem to care ... they just wanna like boss patient about (participant 47, male, aged 36).

Because of the paternalistic attitude of staff, patients did not feel empowered to participate in treatment. Just 25% of interviewed patients affirmed that they attempted to self-determine during their hospitalisation.

They just seem to like being bossy (participant 18, male, aged 33).

As soon as you get in there they give you medication... and basically if you refuse too many times they put you in what they call the lock, the proper lock-up (participant 31, male, aged 42).

Further, 54% of patients experienced restriction of freedom because of limited options for activities.

(Staying in the hospital) ... was horrible. That was horrible. Because...I really felt trapped then, and I had nothing to read... when I can't do anything...I find quite frightening really (participant 43, female, aged 38).

While the loss of freedom was the prevailing perception, some patients also reported positive experiences; 63% declared that they had been involved to some extent in decisions in the hospital and that they felt their freedom was respected.

Somebody bought my laptop to me and I could play CDs and it would give these sort of spacey lava lamp effects on the screen which is nice and meditational, so that was calming (participant 17, male, aged 23).

A total of 56% reported a lack of information on involuntary hospitalisation and treatment. However, a significant group of patients were satisfied about their involvement in decision making on treatment. In fact, 17% of interviewed patients reported that they were allowed by staff to participate in care planning (table 2).

When they sat down with me and...we done the Care Plan together. That is the only time out of all my admissions... It does make a difference, because then I have some say in it, in the Care Plan (participant 4, male, aged 39).

Benefits of involuntary treatment in terms of risk reduction: safety

A total of 86% of patients recognised that they were unwell before their admission and 83% also experienced benefit from involuntary treatment. Particularly important was the perception of being safe in the hospital, reported by 27% of patients.

Patient: I had the gases on for quite a while, the smell was, quite strong, and police could smell it when they come in from downstairs, so they disconnected all the gas.

Table 2 Perception about loss control and freedom

Perception	Total sample (N=59)
Lack of participation in decision making	54 (92)
Being treated as inferior	24 (41)
Attempt to self-determine	15 (25)
Some participation/freedom	37 (63)
Lack of information	33 (56)
Respectful to be involved	10 (17)

Values are in N (%).

Interviewer: ... you really think that it was right at that point to section you?

Patient: Yeah ... because of my safety, my safety and other people's safety, [was more important] to keep me safe than let me have my freedom (participant 30, female, aged 48).

I needed a place of safety (participant 7, female, aged 20).

I needed peace (participant 15, female, aged 30).

I need a safe space that was away from any kind of predatory male (participant 22, male, aged 41).

I was just too scared... it was the right thing (to be treated in hospital) (participant 3, male, aged 21).

Related to the safety values, there was specific concern about the risk at the moment of admission; 68% of patients declared that they could have represented a risk to themselves or to others (table 3).

I think I was presenting a danger to myself (participant 19, female, aged 38).

I was scared, scared to going out, frightened (participant 42, female, aged 27).

The aspects of my sectioning that were necessary were that I would have actually killed myself or I would have killed someone and myself (participant 46, male, aged 25).

So for my own safety and everything else, and for the baby, I had to go into hospital... for my own safety and the safety for the child (participant 13, female, aged 38).

Considering, listening and care in personal regard: respect

Respect was consistently linked with the quality of the relationship between patients and staff. Feeling respected or not was a major criterion for patients' appraisal of the care received in the hospital—44% of patients reported that staff were disrespectful in this regard.

I found out that sometimes they ignored you, they weren't really listening to what you were saying, they didn't sort of like treat you with respect. I didn't think it was respect, some of them the way spoke to you (participant 5, female, aged 42).

They are behaving too strict, they are treating the patients with respect (participant 16, female, aged 25).

Disrespectful... They take you with push or whatever (participant 8, male, aged 36).

Another aspect related by patients to respect is staff abusive behaviour: 22% of the sample reported that they had felt abused by staff.

Some of them are very handed ... (participant 35, female, aged 38).

Table 3 Perceptions about risks, benefit and safety

Perception	Total sample (N=59)
Benefit from treatment	49 (83)
Hospital as a safe place	16 (27)
Risk to self or others	33 (56)
Recognition of being mentally unwell before admission	51 (86)

Values are in N (%).

I suppose you sort of feel like you've been violated (participant 38, male, aged 46).

You know, really, really pushing and insisting that she will undress me. I can undress myself (participant 49, female, aged 40).

Restriction of freedom in the ward was influenced by labelling attitudes and stigma from staff according to 36% of interviewed patients:

You're on your guard all times...when it got quiet, that was when I had a huge panic attack, and I just woke up in just urine. I had wet myself, because I'd passed out, and I was knocking the door asking if I could have some water. Look, please can I have some water, and ... a slightly sort of bully (responded) "oh leave her, she's only faking it anyway" (participant 40, male, aged 41).

A total of 91% of patients also considered that being treated with respect by staff is a helpful element of care (table 4):

I respected him and he respected me as well...they are just more on the level with you ... not like they are treating you like a kind of nurse patient relationship (participant 21, male, aged 35).

Finally, some patients reported that they wanted their cultural norms or sexual orientation to be respected:

What did I like most? ... They had halal, halal Muslim food... that was nice ... (participant 33, male, aged 26).

DISCUSSION

Main findings

Patients consider a paternalistic staff attitude to decision making in the ward as a threat to their freedom. They claim a lack of participation and information, and they think that being involved in treatment can be a way to protect their autonomy.

Safety in the hospital is related to perceived benefits of the treatment and risk management.

Patients consider respect a fundamental ingredient of appropriate care. A respectful approach consists of: considering patient views, listening to them and having a good relationship with them. Some patients complained about not being respected, and, in some cases, about the abusive approach of staff and a 'labelling' attitude.

Deliberating about facts

The legal framework for involuntary hospitalisations formally defines specific parameters for involuntary admission.¹⁶ From a legal perspective, there are three reasons justifying the use of coercion in mental health: presence of mental illness, risk and need for treatment.¹⁷

Frequently, hospitals tend to be busy places for most of the time, with high patient and staff turnover.¹⁸ Organisational pressure has a negative impact on the quality of care, and patients may define their experience of hospital stay as boring and unsafe.¹⁹ Continuity of care is considered by mental health professionals as an essential condition to have a good quality of care.²⁰

In order to manage conflicts using moral deliberation in involuntary hospitalisation we should consider the following facts: (1) the clinical circumstances of patients, that is, diagnosis, prognosis and treatment; (2) the legal framework of treatment of an involuntary nature; and (3) the special circumstances of the psychiatric ward that potentially reduce the quality of care.

All these elements related to the circumstances will play a role in the definition of professionals' duties.

Deliberating about values

We have identified three particularly important values, among those involved in conflicts related to involuntary hospitalisation, namely, freedom, safety and respect.

In all, 83% of patients admitted that they benefitted from treatment. However, in some cases they complained about a loss of control and a lack of involvement in decision making. Research evidence shows that patients feel they are not involved in treatment decisions²¹ and experience a reduction of their autonomy and freedom of choice.²²

Patients have positive perceptions about safety in the hospital. Involuntary hospitalisation is seen as a clinical setting where the benefits of treatment in terms of risk reduction are achieved. Patients consider hospitalisation as a way to reduce the risk generated by symptoms and illness. There are consistent findings on the explicit wish of patients to stay in a safe place during a crisis.²³

Patients' feeling of being respected can be greatly affected by attitudes of staff and is reduced when patients perceive they are treated in an abusive way, or labelled for their illness.

Conflicts in involuntary hospitalisation frequently take place because patients' values can be in contrast with staff values.

According to the Hippocratic Oath, doctors must aim to benefit patients' and protect their vulnerabilities. Medical ethics takes up these duties in two principles: the principle of beneficence and the principle of non-maleficence.²⁴ The first one involves preventing harm, providing benefits and balancing benefits against risk and cost, the second one prescribes to not cause harms intentionally or negligently to other.²⁵ Both are related to the protection of life and health values. In fact, staff attempt to protect life and health values through patients' treatment and preserve patients themselves and others from danger related to psychiatric illness.

Ethical issues in involuntary hospitalisation are frequently related to the conflict between life and health values on one side and freedom, safety and respect on the other. Deliberating on values means identifying which conflicting values (eg, life and freedom) are felt as important by the clinician and the patient when making a specific decision.

Deliberating about duties

The selection of values representing the conflict is important in order to define the best course of action. The aim of moral deliberation in involuntary hospitalisation is to identify an intermediate course of action respecting at the same time all values in conflict. If we consider life and freedom as the reason for the conflict, the best course of action will respect the need of staff to apply the principle of beneficence and the need of patients for autonomy.

CONCLUSIONS

Moral deliberation can be a useful tool to manage conflict between professional staff and patients in involuntary hospitalisation.

Patient values frequently in conflict are freedom, safety and respect; staff values are life and health. The best course of

Table 4 Perceptions about staff attitudes

Perception	Total sample N=59)
Staff disrespectful	26 (44)
Staff abusive	13 (22)
Staff labelling and stigma	21 (36)

Values are in N (%).

action in order to manage conflict in involuntary hospitalisation should respect the values of professionals and patients.

Patient values should be considered in the process of deliberation on ethically controversial issues and this also applies to the challenging context of the involuntary hospital treatment.

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Competing interests None.

Patient consent Obtained.

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