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Ratings of Coercive Interventions by Inpatients and Staff in Germany

To the Editor: In a study reported in the June issue, Whittington and colleagues (1) asked inpatients and staff at acute care facilities in England to rate 11 types of coercive interventions. Between 2003 and 2005 we conducted a study in Germany of 102 service users exposed to a coercive intervention in the previous month (60 patients experienced seclusion and 42 experienced mechanical restraint). Also included were 32 staff members who had carried out some of these interventions (50 incidents of seclusion and 30 of mechanical restraint). We assessed participants' general views of such interventions and their views of interventions in which they were involved.

The findings support and enhance those of Whittington and colleagues. For example, we found that, in general, participants most strongly disapproved of net beds and mechanical restraints. When service users were shown photographs of coercive interventions and asked to rate them regardless of which intervention they had experienced, they rated seclusion as the most appropriate. When staff were asked to rate only those interventions in which they

had been involved, they rated the intervention that they had applied as most appropriate.

When service users were shown a photograph of mechanical restraint, those who experienced mechanical restraint in the past month rated it as significantly more appropriate than did service users who experienced seclusion in the past month. This finding seems to argue strongly against deriving evidence about which interventions are least restrictive from questionnaire studies that assess general attitudes. Comparing participants' subjective experience by use of controlled designs is the best approach (2,3).

The statement by Whittington and colleagues that "evidence was found of strong disapproval among both staff and service users with regard to the introduction of mechanical restraint" is appropriate for England, where it has never been used, but these findings cannot be generalized to other countries. We assume that service users and staff most strongly approve of interventions with which they are familiar and most strongly disapprove of those which they have seen only in photographs. For countries where net beds are used—for example, Austria, Slovakia, and the Czech Republic—we have no data to compare attitudes of staff and service users toward net beds and toward seclusion or restraint. Attitudes toward net beds might be much more positive in these countries, because patients in net beds have more freedom to move than those in mechanical restraint and more opportunity to communicate than those in seclusion.

However, some ethical aspects of coercive measures cannot be addressed by randomized controlled trials: Is it ethical to keep humans in cages? Is it ethical to keep them fixed with belts in five points? Coercive interventions are an issue not only of medicine and evidence but also of specific cultures, and research must take these cultural aspects into account. Even if individuals' disapproval of manual restraint,

locked-door seclusion, and coerced intramuscular medication increased with their experience of these interventions, we believe that the conclusion of Whittington and colleagues—that these methods should be avoided as much as possible—should be applied to different cultures with caution.

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In Reply: We thank Dr. Bergk and his colleagues for their comments on our article. We agree that this is a complex area that requires subtle and sophisticated research methods to establish findings that can be used with confidence to shape practice. As we stated in the article, the findings can serve as a benchmark against which other samples can be compared, and we are gratified that similar relative ratings have been found in Germany, confirming the low level of acceptability of mechanical restraint.

We cannot agree that experience of a coercive measure increases approval by patients. Our results showed that for the more severe containment methods (seclusion and manual restraint), experience was associated with less approval; however, for less severe methods (constant special observation), experience was associated with greater approval. Only for staff

was experience associated with more positive ratings. We do, however, think that the work of Dr. Bergk and his colleagues highlights what might be a very important factor influencing patients' attitudes toward their experience of inpatient psychiatric care as a whole—that is, their first experiences of coercive measures.

We believe that questionnaires surveying general attitudes toward coercive measures have a role as long as other factors—for example, exposure to specific coercive measures—are factored into the conclusions. Although each person's experience during each incident is unique, it is important to ascertain general views by using structured tools so that comparisons between groups can be made. The design of a study, controlled or otherwise, seems to us irrelevant to the issue of accurate measurement of attitudes. Furthermore, although these findings from England and Germany cannot resolve ethical debates, they can inform the discussion and enable, among other things, the collective voice of service users to be heard.

Thus, although we do not expect our evidence to settle an ethical judgment, it does pose a challenge to countries in which mechanical restraint is used. For how is it that psychiatric practice in the United Kingdom does without mechanical restraint at all, without any apparent negative consequences and without high use of seclusion?

**Richard Whittington, Ph.D.,
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Oral Health and Hygiene Among Persons With Severe Mental Illness

To the Editor: In the June issue Ponizovsky and colleagues (1) reported changes in dental health and oral care needs of psychiatric inpatients after dental services were implemented in Israeli psychiatric hospitals. But the authors did not address the question of whether psychiatric patients have poorer oral health than a comparable group from the general popula-

tion. There is evidence from several countries that the dental health of patients with severe mental disorders is poor (2,3). Because dental health has been found to be related to socioeconomic status (4) and most persons with severe mental illness live in poor conditions, we sought to determine whether mental illness has an independent influence.

We compared the dental health of 120 patients with a *DSM-IV* diagnosis of schizophrenia or schizoaffective disorder (62 males and 58 females; mean±SD age of 45.3±15.6) and 118 social welfare recipients from the same geographic area who did not have a mental illness (61 males and 57 females; mean±SD age of 41.0±11.3). Patients were recruited in 2008 from consecutive admissions to a psychiatric hospital, an outpatient clinic of this hospital, and residential homes (40 patients from each setting). Control group participants were recruited from visitors to social welfare services in the same area. Because of concerns raised by the ethics committee, dental examinations were not conducted. Instead, a self-report questionnaire that elicited sociodemographic data and information about oral diseases and oral hygiene was administered in person. All participants provided informed consent.

No significant between-group differences were found with respect to gum bleeding, periodontitis, and the mean frequency of toothache. The total number of missing teeth reported by the participants was significantly greater in the patient group. The proportion of persons who brushed their teeth at least twice a day was significantly lower in the patient group (54% compared with 76%), but no differences were found in the proportion who brushed their teeth for at least two minutes at a time (61% in the patient group and 59% in the comparison group).

Except for having more missing teeth, the oral health of persons who had a severe mental illness was similar to that of persons of the same socioeconomic status who did not have a mental illness. However, oral hy-

giene was poorer in the patient group than in the group of social welfare recipients. These findings support those of Ponizovsky and colleagues and also demonstrate the need for further efforts to prevent oral diseases among patients with severe mental illness. A major limitation of this study was the use of a self-report questionnaire instead of a dental examination. In addition, patients were recruited from diverse treatment settings; future studies should compare patient groups from each setting with each other as well as with a control group.

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In Reply: We thank Dr. Flammer and his colleagues for endorsing our findings and reporting the results of their study. We share with them the wish to investigate direct and indirect effects of mental disorders on oral (dental) health.

Dental health and disease are the result of lifestyle and behavior, which are known to be closely related to socioeconomic status. Mental disorders affect both lifestyle and behavior. Therefore, it would be very difficult, and perhaps impossible, to

separate the effects of mental disorders from the effects of other variables, such as socioeconomic status, health habits, self-care, oral care, and diet. To control for confounding effects, carefully matched comparison groups are required.

Persons with mental disorders experience a change in their behavior as a whole, and thus it was difficult in our study of inpatients to distinguish changes caused by hospitalization from those caused by the disorders themselves. In addition, psychotropic drug treatment particularly affects patients' oral health. We do not know the relative contributions to oral health of these factors; however, we are aware of the sad fact that the oral health of persons with mental disorders is worse than the oral health of the general population. Therefore, we strongly agree with Dr. Flammer and his colleagues about the urgent need for further efforts to prevent and treat oral diseases—for persons in the general population, psychiatric patients in the community, and institutionalized patients. However, as our study showed, there are grounds for careful optimism: removal of barriers to dental care and delivery of dental services in hospital settings may substantially improve the oral health of inpatients. Training programs for mental health professionals that focus on dental health along with joint service planning by administrators and providers of mental health and dental health services may promote both oral health and access to dental care for persons with mental disorders.

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Paternalism or Lack of Time?

To the Editor: In their editorial in the August issue, Drs. Drake and Deegan (1) point out the usefulness—nay, the ethical and clinical necessity—of shared decision making

between patient and doctor. They ascribe the relative neglect of this imperative (there is apparently a greater level of neglect in European countries) to an ingrained and persistent “paternalism” among psychiatrists. On the basis of my 40 years of experience in community mental health services in several U.S. locations, let me suggest a possible additional, and perhaps even more influential, reason: lack of time.

Very often it takes only moments, at most a minute or two, for a doctor to run through alternatives in his or her own mind, compare them, and come to a decision about the best course to follow, especially if the doctor has already listened to the patient and elicited relevant information. However, to explain this reasoning to the patient, listen to the patient's objections and questions, and convince the patient that the doctor's choice is in the patient's best interests takes time—much more time than the doctor is “permitted” to spend with a patient by the third-party insurer.

In every system in which I have practiced, the maximum time allotted for a “medication visit” was 30 minutes, and in many places 20 or even 15 minutes was the limit. The time allotted included not only direct patient contact but also record keeping and, in one system, actually counting out and properly labeling the monthly medica-

tions handed to the patient. I might add that reductions in the time allotted per visit have pervaded not only psychiatric practice but virtually all medical encounters. Thirty-five years ago on the eve of a cholecystectomy, the anesthesiologist visited me to describe the anticipated procedures. Three decades later, I was all strapped in for surgery, IV tubes running, when a person totally unknown to me appeared at my head, partly out of sight, with the news, “I'm your anesthesiologist; do you want general or spinal anesthesia? I'd recommend the spinal.” So much for informed consent (fortunately all turned out well).

Increasingly, a visit to the doctor resembles being rolled through an automatic car wash instead of a personal consultation. This is the result not of “interfering government bureaucrats” but of allegedly “freely chosen” private (and, of course, for-profit) health plans. Given such constraints, it is no wonder that doctors do the best they can in their own heads and hope that their patients will trust them—“paternalistic” as that may seem.

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Dr. Kal, who is retired from private practice, lives in Fresno, California.

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