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Perceived fairness as main determinant of patients' satisfaction with care during psychiatric hospitalisation: An observational study

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ABSTRACT

Introduction: Patient satisfaction with care is widely recognized as one of the most important indicator of quality in mental health care. It can impact several treatment outcomes, such as treatment adherence and engagement with services. At the same time, as an outcome in itself, satisfaction with care is also affected by several factors, first and foremost by being coerced. The main aim of this study was to test if perceiving treatment pressures as fair and effective could positively impact patient satisfaction, even more than formal coercive measures.
Methods: Globally, 133 voluntary and involuntary inpatients were interviewed. Socio-demographic and clinical characteristics, including history of previous experiences of formal coercion and legal status of the hospitalisation, were collected through a structured questionnaire and medical charts. The participants were also asked to complete the Index of Fairness and Index of Effectiveness tools as well as a structured questionnaire on satisfaction with care. Simple and multiple linear regressions were performed.
Results: Although several factors were found to affect satisfaction with care when taken independently, perceived fairness was the stronger predictor of both satisfaction with treatment ($\beta = .234$; $p = .022$) and satisfaction with decision-making involvement ($\beta = .360$; $p < .001$) when controlling for confounders.
Conclusions: Our results point to the paramount importance of developing and implementing interventions that promote procedural fairness in psychiatric treatment and thereby improve patient satisfaction while reducing the risk of disengagement with care.

1. Introduction

Patient satisfaction with care is widely recognized as one of the most important indicator of quality in mental health care (Druss, Rosenheck, & Stolar, 1999; Hackman et al., 2007; Priebe & Miglietta, 2019; Ruggeri et al., 2007; Shipley, Hilborn, Hansell, Tyrer, & Tyrer, 2000).

Indeed, patient satisfaction with care can impact a variety of treatment outcomes, such as adherence to treatment and engagement with services (Priebe & Miglietta, 2019). Satisfied patients were found to be more compliant and more likely to complete their treatment while dissatisfied patients showed a higher risk of discontinuing treatment (Lebow, 1983; Miglietta, Belessiotis-Richards, Ruggeri, & Priebe, 2018; Woodward, Berry, & Bucci, 2017). In addition, higher satisfaction with care was found to be related to higher treatment benefits (Berghofer et al., 2001; Holcomb, Parker, Leong, Thiele, & Higdon, 1998; Priebe & Miglietta, 2019), global improvements (Hansson, 1989) and a reduced risk of involuntary readmission (Priebe et al., 2009).

At the same time, satisfaction with care is an outcome in its own right and has been extensively studied in order to identify its main determinants. Several factors have been found to be associated with treatment satisfaction, such as patients' quality of life (Berghofer et al., 2001), age (Rosenheck, Wilson, & Meterko, 1997), diagnosis (Kelstrup, Lund, Lauritsen, & Bech, 1993; Svensson & Hansson, 1994), level of functioning (Berghofer et al., 2001; Holcomb et al., 1998), treatment

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expectations (Berghofer et al., 2001), level of social support (Lippens & Mackenzie, 2011) and ward atmosphere (Rossberg & Friis, 2004). Recently, a systematic review has classified determinants of satisfaction with psychiatric inpatient services in two main categories: service-user and service related factors (Woodward et al., 2017). The review also concluded that coercion played a key role (Woodward et al., 2017).

Indeed, several studies have endorsed the strong relationship between the feeling of being coerced and satisfaction with care (Katsakou et al., 2010; Strauss et al., 2013; Svensson & Hansson, 1994). Perceived coercion is not exclusively related to formal coercive measures (Bonsack & Borgeat, 2005; Golay, Morandi, Silva, Devas, & Bonsack, 2019), but it also depends on the amount of the provided information, the participation to medical decisions (Prebble, Thom, & Hudson, 2015) and the exposure to informal forms of coercion and treatment pressures (Burns et al., 2011; Szmukler & Appelbaum, 2008). Patients' perceived coercion during hospital admission is strongly related to the patients' sense of "procedural justice" and of being treated fairly (Bennett et al., 1993; Hiday, Swartz, Swanson, & Wagner, 1997; Lidz et al., 1995; McKenna, Simpson, Coverdale, & Laidlaw, 2001; Monahan et al., 1995). Indeed, higher perceived coercion was associated with lower levels of perceived fairness and effectiveness (Van Dorn, Swartz, Elbogen, & Swanson, 2005). On the contrary, if the patient perceived that coercion was applied in their best interest and in a fair and respectful way, its negative impact might be reduced (Lorem, Hem, & Molewijk, 2015).

We hypothesized that when treatment pressures were perceived as fair and effective, patients were more satisfied with treatment, even though they were under formal coercion or had experienced formal coercion in the past. The main aim of this study was to test this hypothesis on a sample of voluntary and involuntary psychiatric inpatients. A better understanding of determinants of patient satisfaction is essential in order to improve the quality of services and thus increase patients' engagement with care.

2. Material and methods

2.1. Participants

Participants were recruited during their hospitalisation in five psychiatric hospitals of two French-speaking Swiss cantons (Vaud and Neuchâtel) between March 2020 and May 2021. Eligible patients were approached by a research assistant (trained master's degree psychology students or 6th year medical students) in the presence of their attending doctor or nurse. After receiving detailed information about the study, those who agreed to participate were interviewed individually. All participants signed a written informed consent before the interview.

Inclusion criteria were: to be aged between 18 and 65, to be hospitalised since more than 7 days but less than 15, and to be able to give a formal consent. Time restriction was implemented in order to mitigate potential memory bias for long hospitalizations and avoid interviewing patients in the very early and potentially acute phase of their hospital stay. People suffering from organic mental disorder or mental retardation, and non-French speaking were excluded.

The study was carried out in accordance with the recommendations of the Human Research Ethics Committee of the Canton Vaud and the Declaration of Helsinki. Approval was granted by the Human Research Ethics Committee of the Canton Vaud (*protocol #2016–00768*).

2.2. Instruments

Socio-demographic characteristics, such as age, sex (identified through self-identification), marital status, nationality and living conditions, diagnosis, history of previous experiences of hospitalisation and formal coercion, and legal status of the hospitalisation were collected through structured questionnaires and medical charts.

Patients perceived fairness and effectiveness of treatment pressures were measured following Swartz et al., (2004). The *Index of fairness* was calculated summing the participants answers to the following items: "Overall, the pressures or things people have done to try to get me into treatment or to stay in treatment (1) Were done by people who tried to be fair to me (2) Were done for my own good (3) Were not done out of real concern for me (reverse coded) (4) Didn't make me feel respected as a person (reverse coded)". The *Index of effectiveness* resulted from the sum of the answers to the following items: "Overall, the pressures or things people have done to try to get me to treatment or to stay in treatment (1) Made me more likely to keep appointments and take my medications (2) Help me get well and stay well (3) Help me gain more control over my life (4) Should be done again in the future" (Swartz, Wagner, Swanson, & Elbogen, 2004). Each item was rated on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

Participants' satisfaction with care was measured through two items of a structured satisfaction questionnaire developed by the Swiss National Association for Quality Development in hospitals and clinics (Swiss National Association for Quality development in hospitals and clinics (ANQ), 2018). The first item asked participants to evaluate on a 5-point Likert scale ranging from "poor" to "excellent" how they evaluate the quality of care. The second item asked patients if they have been sufficiently implied in decisions about their treatment plan. Answers ranged from 1 "not at all" to 5 "Yes, absolutely".

2.3. Statistical analysis

In order to identify the determinants of patients' satisfaction with care, simple and multiple linear regressions were performed. Satisfaction with treatment and satisfaction with decision-making involvement were entered as dependent variables. Index of fairness and Index of effectiveness were introduced as independent variables. Socio-demographic characteristics, diagnosis, history of previous experiences of hospitalisation and formal coercion, and legal status of the hospitalisation were also entered as independent variables in order to control for confounding effects. For categorical variables, the most represented categories were chosen as the reference category. Only the variables reaching a $p < .05$ level of significance in the simple models were simultaneously introduced in the multiple models.

Finally, to verify the robustness of our results, full multivariate models with no variables selection were also estimated for both satisfaction with treatment and satisfaction with decision-making involvement.

Significance was set at the .05 level. All statistical analyses were performed with the IBM SPSS 27.

3. Results

A total of 133 participants were included in the study. As shown in Table 1, slightly more than half were female (53.4%), the mean age was 39.9 (SD = 14.0) years old and 52.6% were single (52.6%). Most of the participants were of Swiss nationality (68.4%) and living independently (89.5%). Primary diagnoses were: Mood [affective] disorders (38.3%); Schizophrenia, schizotypal and delusional disorders (23.4%); Mental and behavioural disorders due to psychoactive substance use (15.6%); Disorders of adult personality and behaviour (12.5%); Neurotic, stress-related and somatoform disorders (9.4%) and Disorders of psychological development (0.8%). 26.5% of the participants were hospitalised for the first time. 27.1% were detained under compulsion and almost half of the participants had at least one previous experience of formal coercion (44.7%). Total scores of perceived fairness and effectiveness ranged between 4 and 20, with an average of respectively 16.1 (S.D. = 4.2) and 13.7 (S.D. = 4.2). Almost half of the sample (48%) evaluated the quality of the received care as "excellent" or "very good", while 30% of them were "absolutely" satisfied of their implication in the decision process.

Simple linear regression analyses of determinants of satisfaction with treatment are displayed in Table 2. Results indicated that satisfaction was higher if participants were married instead of single ($\beta = .185$; $p =$

Table 1
Study sample characteristics (n = 133).

Characteristics	
Age, (mean ± SD)	39.9 ± 14.0
Sex, % (N)	
Male	46.6% (62)
Marital status, % (N)	
Single	52.6% (70)
Married/Registered partnership	21.1% (28)
Divorced/Separated	25.6% (34)
Widowed	0.8% (1)
Nationality, % (N)	
Swiss	68.4% (91)
Living conditions, % (N)	
Independent housing	89.5% (119)
Main diagnosis (ICD-10), % (N)	
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	15.6% (20)
Schizophrenia, schizotypal and delusional disorders (F20-F29)	23.4% (30)
Mood [affective] disorders (F30-F39)	38.3% (49)
Neurotic, stress-related and somatoform disorders (F40-F48)	9.4% (12)
Disorders of adult personality and behaviour(F60-F69)	12.5% (16)
Disorders of psychological development (F80-F89)	0.8% (1)
First psychiatric hospitalisation, % (N)	26.5% (35)
Involuntary hospitalisation, % (N)	27.1% (36)
Previous experiences of formal coercion, % (N)	44.7% (59)
Index of Fairness and Effectiveness, (mean ± SD)	
Perceived Fairness Index	16.1 ± 4.2
Perceived Effectiveness Index	13.7 ± 4.2

Table 2
Variables related to satisfaction with treatment: simple linear regression analyses.

Predicting factors	B	S.E. B	β	p-value
Age	0.004	0.006	.051	.559
Sex (Ref. Female)	0.076	0.171	.039	.659
Marital status (Ref. Single)				
Married/Registered partnership	0.443	0.218	.185	.044
Divorced/Separated	0.174	0.204	.078	.395
Widowed	0.586	0.982	.052	.552
Nationality (Ref. Swiss)	0.370	0.181	.176	.043
Living conditions (Ref. Independent housing)	0.017	0.278	.005	.952
Main diagnosis (Ref. F30-F39)				
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	0.642	0.249	.243	.011
Schizophrenia, schizotypal and delusional disorders (F20-F29)	0.092	0.217	.041	.673
Neurotic, stress-related and somatoform disorders (F40-F48)	0.592	0.302	.180	.052
Disorders of adult personality and behaviour(F60-F69)	−0.158	0.270	−.055	.559
Disorders of psychological development (F80-F89)	−0.408	0.947	−.038	.667
First psychiatric hospitalisation (Ref. No)	0.142	0.194	.064	.467
Involuntary hospitalisation (Ref. No)	0.037	0.192	.017	.848
Previous experiences of formal coercion (Ref. No)	−0.356	0.170	−.181	.038
Index of Fairness and Effectiveness				
Perceived Fairness Index	0.088	0.019	.382	<.001
Perceived Effectiveness Index	0.067	0.020	.284	.001

Note. S.E = Standard Error.

.044), of Swiss nationality (β =.176; p = .043) and affected by Mental and behavioural disorders due to psychoactive substance use instead of Mood [affective] disorders (β =.243; p = .011). Moreover, people with higher scores on perceived fairness (β =.382; p < .001) and perceived effectiveness (β =.284; p = .001) also presented increased level of satisfaction with treatment. On the contrary, having experienced coercion in the past was associated with lower satisfaction (β = −.181; p = .038).

Table 3
Variables related to satisfaction with decision-making involvement: simple linear regression analyses.

Predicting factors	B	S.E. B	β	p-value
Age	−0.003	0.008	−.032	.712
Sex (Ref. Female)	0.245	0.231	.092	.291
Marital status (Ref. Single)				
Married/Registered partnership	−0.086	0.299	−.026	.775
Divorced/Separated	−0.161	0.279	−.053	.564
Widowed	1.486	1.345	.097	.271
Nationality (Ref. Swiss)	0.293	0.248	.103	.239
Living conditions (Ref. Independent housing)	0.277	0.376	.064	.462
Main diagnosis (Ref. F30-F39)				
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	0.501	0.344	.138	.148
Schizophrenia, schizotypal and delusional disorders (F20-F29)	−0.216	0.300	−.069	.474
Neurotic, stress-related and somatoform disorders (F40-F48)	0.551	0.417	.122	.189
Disorders of adult personality and behaviour(F60-F69)	−0.636	0.373	−.159	.091
Disorders of psychological development (F80-F89)	−1.449	1.309	−.097	.271
First psychiatric hospitalisation (Ref. No)	0.234	0.260	.079	.368
Involuntary hospitalisation (Ref. No)	−0.715	0.253	−.240	.005
Previous experiences of formal coercion (Ref. No)	−0.325	0.230	−.123	.159
Index of Fairness and Effectiveness				
Perceived Fairness Index	0.147	0.024	.472	<.001
Perceived Effectiveness Index	0.103	0.026	.326	<.001

Note. S.E = Standard Error.

Table 4
Variables related to satisfaction with treatment (n = 127) and satisfaction with decision-making involvement (n = 132): multiple linear regression analysis.

Predicting factors of satisfaction with treatment[a]	B	S.E. B	β	p-value
Marital status (Ref. Single)				
Married/Registered partnership	0.222	0.217	.096	.308
Divorced/Separated	0.137	0.201	.063	.496
Widowed	0.292	0.930	.027	.754
Nationality (Ref. Swiss)	0.239	0.180	.114	.187
Main diagnosis (Ref. F30-F39)				
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	0.424	0.247	.161	.089
Schizophrenia, schizotypal and delusional disorders (F20-F29)	0.197	0.221	.086	.374
Neurotic, stress-related and somatoform disorders (F40-F48)	0.454	0.297	.138	.129
Disorders of adult personality and behaviour(F60-F69)	−0.071	0.255	−.024	.783
Disorders of psychological development (F80-F89)	−0.325	0.893	−.030	.716
Previous experiences of formal coercion (Ref. No)	−0.124	0.193	−.064	.523
Index of Fairness and Effectiveness				
Perceived Fairness Index	0.053	0.023	.234	.022
Perceived Effectiveness Index	0.038	0.022	.166	.084
Constant	1.932	0.404		<.001

Predicting factors of satisfaction with decision-making involvement[b]	B	S.E. B	β	p-value
Involuntary hospitalisation (Ref. No)	−0.295	0.244	−.100	.228
Index of Fairness and Effectiveness				
Perceived Fairness Index	0.112	0.029	.360	<.001
Perceived Effectiveness Index	0.040	0.028	.128	.154
Constant	1.191	0.490		.016

Note: [a]R^2 =.26; [b]R^2 =.23; S.E = Standard Error.

When tested independently, perceived fairness (β =.472; p < .001) and effectiveness (β =.326; p < .001) also showed a positive impact on satisfaction with decision-making involvement, which was, on the contrary, significantly reduced if participants where involuntarily hospitalised (β = −.240; p = .005; Table 3).

When these predictors were entered simultaneously into the multivariate models, only the Index of perceived fairness held a positive significant effect on both, satisfaction with treatment (β =.234; p = .022) and satisfaction with decision-making involvement (β =.360; p < .001; Table 4).

To verify the robustness of our results, we also estimated a multivariate model including all predictors. For satisfaction with decision-making involvement we obtained the same pattern of results. For satisfaction with treatment in contrast, involuntary hospitalisation reached statistical significance (β =.197; p = .044), although its standardized effect was markedly smaller than the effect of fairness (β =.290; p = .007).

4. Discussion

The main aim of our study was to test the impact of perceived fairness and effectiveness on satisfaction with care. We hypothesized that perceiving treatment pressures as fair and effective could positively impact patient satisfaction, even more than formal coercive measures. The results suggested that perceived fairness, perceived effectiveness, experiences of formal coercion as well as some socio-demographic and clinical variables were all related to satisfaction with care when taken independently. Although, perceived fairness was the stronger predictor of both satisfaction with treatment and with decision-making involvement when controlling for confounders. Our hypothesis was hence partially confirmed, indicating that perceiving a treatment as fair is of the utmost importance, even more so than perceiving it as effective. This is important to be taken into account because reduced satisfaction could lead to disengagement with care and consequently to more coercion (Van der Post et al., 2014).

Previous studies have already suggested that, despite their high correlation, these two aspects do not necessarily exhibit the same behaviour. Indeed, while informal coercion has been found to negatively affect perceived fairness, no impact was found on perceived effectiveness (Jaeger & Rossler, 2010; Swartz et al., 2004). We can assume that if a patient perceives his treatment as fair, he will most likely also perceive it as effective and will therefore be highly satisfied with it. Conversely, a treatment considered as effective may in some cases still be perceived as unfair and therefore be unsatisfactory. A previous study indicating that the perception of the hospitalisation as useful and effective did not influence the feeling of its coerciveness seems to support this hypothesis (Golay et al., 2019).

Our results also suggested that perceived fairness was a stronger determinant of satisfaction with care than formal coercion itself. Indeed, even coerced patients displayed higher satisfaction when they perceived that the coercive measure was applied fairly. This is in line with a large number of previous studies indicating that the way coercion is implemented, explained and negotiated is crucial (Katsakou et al., 2010) and strongly influences the therapeutic relationship (Theodoridou, Schlatter, Ajdacic, Rossler, & Jager, 2012).

A qualitative study explored the patients' perceptions of the morality and fairness of attempts made by others (family members, friends and mental health professionals) to pressure them to be admitted to hospital (Bennett et al., 1993). The authors concluded that in order to perceive treatment pressures as fair, patients need to feel that they are included as much as they wish to be in the admission. Moreover, they must perceive that those involved in the process are motivated by an appropriate degree of concern for their well-being, behave honestly and openly and treat them with equality and respect (Bennett et al., 1993). To improve the patients' feeling of being included in the decisional process even when under coercion, the use of shared decision-making interventions (Burn, Conneely, Leverton, & Giacco, 2019; Elwyn et al., 2012) and tools, such as Joint Crisis Plan (JCP) (Henderson et al., 2004), should be promoted. The implementation of Open Dialogue (OD) strategies could also help to promote more open, respectful and transparent communication with patient (Freeman, Tribe, Stott, & Pilling, 2019; Olson, Seikkula, & Ziedonis, 2014).

This study had some limitations. First, our sample size was moderate, and further research should attempt to replicate our results in larger samples. Second, even if our models included several important variables, they did not include every potential confounding factors. Thirdly, a selection bias cannot be excluded. Patients with a rather negative treatment experience might have been less eager to participate in our study. However, the opposite is also possible, as patients who were dissatisfied with their treatment might have felt even more the need to share this feeling through participating in such a trial. Finally, our assessment was partly based on Likert scales. Several critiques have been raised about the use of these scales, considering the number of items needed for a scale, the number and meaning of the answer categories, and the best statistical methods to analyse the data. Nevertheless, this approach is extremely common and several criticisms directed against their usage were deemed unwarranted (Willits, Theodori, & Luloff, 2016).

5. Conclusion

This study indicated that patients were more satisfied with treatment if they perceived that it was provided fairly, regardless of its effectiveness. Together with the findings of a significant relationship between satisfaction with care and treatment long-term outcomes, this result point to the paramount importance of developing interventions that promote the procedural fairness of psychiatric care by enhancing the patients feeling of being included in the decisional process and their perception of the mental health professionals as open, transparent and respectful.

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Declaration of Competing Interest

The authors declare no conflict of interest in relation to the subject of the study.

Data availability

Data will be made available on request.

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