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Review Article

# Perceptions and Attitudes towards Involuntary Hospital Admissions of Psychiatric Patient

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## Abstract

**Introduction:** Involuntary admissions to acute psychiatric units are one of the most ethically challenging practices in Psychiatry. However, published literature falls back in examining this area that touches patient's rights and freedom.

**Objectives:** To examine patients', physicians' and relatives' attitudes towards involuntary hospitalization.

**Method:** Authors searched PubMed and Medline for articles published in the last 15 years (between January 1999 and January 2014); choosing English-language articles of studies based on samples drawn from inpatients admitted on an involuntary basis.

**Results:** Out of a total of (198) published papers in refereed journals, there were (n=36) articles, including four reviews and thirty three original research papers which met the inclusion criteria for our review. All (n=36) papers examined patients', relatives', and professionals' attitudes towards involuntary admission and perception of coercion. Of the total publications, there were (n=12) research articles which solely examined patients' perception of coercion. The "European multi-site research project on coercion in psychiatry" (EUNOMIA) research project has provided extensive evidence for the current status on patients' attitudes towards involuntary hospitalization and coercion. Significant proportions of patients regarded that involuntary admission as justified. However, attitudes towards coercion appeared to be more complex, and patients' attitudes varied between studies. In a number of studies, the diagnosis was the main predictor of the admission status.

**Conclusion:** There is evidence that the majority of patients who initially perceived that they did not need hospitalization revised their belief after hospital discharge and reported that they had needed hospital treatment.

**Keywords:** Involuntary; Hospitalization; Attitudes; Coercion; Professionals; Next of Kin

## Introduction

Advocating for patients is an important strategic goal of mental health. This should include both effective patient day to day care, and defending patients' rights. Involuntary admission is one of the ethically challenging practices in psychiatry. However, it is crucial to examine in more depth, patients', psychiatrists', and relatives' perspectives.

The frequency of compulsory admissions to psychiatric hospitals varies considerably between countries depending on the mental health act legislation that define the criteria and practices of compulsory admissions in these countries [1]. Although the criteria for detention of the mentally ill are broadly similar in most jurisdictions, to include patients' at risk to themselves or to others, nearly 20-fold variations in detention rates were found in different parts of Europe. These variations

in detention rates appear to be influenced by professionals' ethics and attitudes, sociodemographic variables, the public's perceptions about risks arising from mental illness and by the respective legal framework [2,3]. In a recent large Swiss study examining inpatients (n = 9698), there was an overall of 24.8% involuntary admissions, 6.4% seclusion or restraint and 4.2% coerced medication, and risk factors for involuntary admission were numerous. Results suggested that the type and severity of mental illness are the most important risk factors for being subjected to any form of coercion [4-7]. In a retrospective chart review of a Greek study involving (n=282) admissions, authors reported that involuntary admissions were associated with statistically significant higher levels of restraint and seclusion, with 11.0% of cases subjected to some form of coercive physical measures, and lengthy mean duration of seclusion and mechanical restraint of 64.9 hours [8].

**Risk Factors Associated with Involuntary Hospitalization**

European research has provided evidence for the current status on patients' attitudes towards involuntary hospitalization and coercion. The most large and prominent study was the "European Multi-Site Research Project, "EUNOMIA" which included a sample consisted of (n =2326) legally coerced patients and 764 voluntarily admitted who also felt coerced. This project shed light in some details on the following issues; the association of patients' views of involuntary hospital admission, the differences in legislation between different European countries, patient characteristics associated with positive outcomes of coerced hospital admission, and the differences between coercive measures (e.g. mechanical restraint, seclusion and forced medication) used during these hospitalizations. It also provides suggestions for good quality in involuntary admission [9,10]. Involuntary coerced admissions appear to be associated with poorer clinical outcomes than with voluntary admissions. In the "EUNOMIA" Project, Kallert et al, examined a total sample consisted of (n=2326) legally coerced patients and (n=764) patients with voluntary admissions who also felt coerced, from 11 European countries. Authors demonstrated that poor outcome after one month and after three months, was associated with higher baseline symptoms, being unemployed, living alone, repeated hospitalisation, being legally a voluntary patient, and less satisfied with treatment, [10]. Further, involuntary patients demonstrated lower levels of social functioning, had higher suicide rates than voluntary patients, and were more dissatisfied with the treatment and more frequently felt that hospitalization was not justified [10,11]. Other risk factors associated with involuntary admission may include; young age (20 years or less), female gender, a diagnosis of psychotic disorder and being hospitalized for the first time [7, 12]. In a review, Katsakou and Priebe, concluded that patients with more marked clinical improvement tend to have more positive retrospective judgements [13]. The qualification of the certifying physician, a history of previous hospitalization, presence of psychotic symptom, lower levels of social functioning, linguistic communication problems, all can influence the rate of compulsory versus voluntary admissions [4,7,12,14 -18]. It appears that the complex nature and negative events during the admission process were more common among patients with involuntary admission, but were also observed among those who were voluntarily admitted, where patients were exposed to verbal or physical force [13,15,16-23]. It was emphasized that minimizing patient's perception of coercion during hospital admission may impact positively on the course and adherence to treatment [24]. Patients assessed as dangerous and received involuntary treatment were associated with significantly longer duration of untreated psychosis, were associated with a worse prognosis, increased risk of suicide and were linked to serious violence [25]. Bipolar patients often needed involuntary hospitalization, and some patients become aggressive, abuse illicit substances, and have poor insight. This was demonstrated in the European-Mania-in-Bipolar-Longitudinal-Evaluation-of-Medication (EMBLEM) study in which (n = 55) out of (n=95) patients needed involuntary hospital admission [26]. Reviewing a Swiss Psychiatric register including (n = 9698) inpatients, It was found that the nature and severity of mental illness were the most important predicting risk factors for being subjected to any form of coercion [27]. Katsakou et al, examined involuntary inpatients (n=778) admissions. Perception of coercion was associated with less satisfaction with treatment [28]. Swartz et al, reported that only 36% of consumers with chronic psychiatric disorders, reported fear of coerced treatment as a barrier to seeking help [29]. Although compulsory admission was strongly associated with perceived coercion, especially among those with poor insight, other authors did not find significant association between perceived coercion and engagement with follow-up or with treatment adherence [30 - 33].

**Objectives**

If patients' attitudes towards involuntary hospitalization and coercion are to be understood among patients, then a detailed inquiry about the features and specifications of patients', physicians', and relatives' perceptions to involuntary admission are needed. From reviewing literature on patients' attitudes to involuntary admission across the globe, there are limited numbers of published research, and there is no reliable or valid instrument to examine patients' attitudes towards involuntary admission.

The objective of this project is to review the recently published research of patients', relatives' and professional' attitudes towards involuntary admission.

The objective of the present systematic literature search and review was to examine the recent research and to address the following specific questions:

1. What are the prevailing attitudes among patients, professionals and the public regarding involuntary admission to psychiatry units?

2. Do patients' perceptions towards involuntary admission change over time with hospital treatment?

3. Based on empirical evidence from literature, could a list of specification summarizing patients' attitudes to involuntary admission be constructed?

## Material and Methods

We conducted a Pub Med search during January 2015, covering the period from January 1999 to December 2014 using the following keywords in different combinations: perceptions, attitudes, patients, relatives, next of kin, physicians, professionals, compulsory, formal, involuntary, coercion, admissions, hospital, and psychiatry.

Following the electronic search, hand searches of the literature were undertaken. The search strategy yielded 186 research articles, reviews and commentaries concerning studies examining involuntary hospital admissions and admissions associated with coercion, under mental health acts in different countries. This output constitutes a gross total; including a number of studies that appeared more than once (n= 89), when the different keyword combinations were used in the search.

Of the remaining (109) references, 36 met the following inclusion criteria for our review, about patients', relatives', and professionals' perceptions of coercion and involuntary hospitalization: 1) articles written in English, 2) studies based on samples drawn from patient populations admitted on an involuntary basis, 3) articles exploring perceptions and attitudes of patients admitted involuntarily to psychiatry units, 4) articles examining the attitudes of mental health professionals including physicians' and other allied mental health workers', and 5) articles exploring relatives' attitudes towards involuntary hospitalization or coercion during hospital admission. The authors excluded articles (n = 27) focusing solely on epidemiological, and demographic aspects, and studies that solely examined clinical outcomes related to involuntary admission such as clinical improvements, and adherence to follow up treatments (n= 14). Also, we excluded research studies or articles examining legal aspects and legislations related to compulsive admissions, and those comparing mental health legislation in different countries (n = 32). Figure 1, summarizes the flow of search strategy for this review.

### Results of Literature Search

Of the final 36 that met the inclusion criteria, there were only 3 published European reviews [13, 16, 32], two of which examined patients' attitudes, associated risk factors, and clinical outcomes among the involuntary hospitalized coerced patients [13,16]. The third Medline review examined the attitude of the general population, mental health professionals, and relatives towards coercive measures in psychiatry, especially those related to involuntary admission and treatments [32].

Of the remaining 33 research papers, there were twenty papers examined patients' attitudes towards involuntary hospitalization and coercion, two research papers examine patients' attitude change, over time, six research papers examined professionals' attitudes (Physicians, Psychiatrists, Psychologists, and Lawyers), and five research papers examined the perceptions of relatives, next of kin, public members, and other stakeholders towards involuntary hospitalization.

The final 36 studies and reviews that met all inclusion criteria are listed in the Table1, along with key characteristics of the studies (e. g, author, journal, country of research, sampling, and research method). None of the papers examined in these older reviews [13, 16, 32], is included in our review. In the first review, there were (n =18) studies that were published between 1977- 2004, and examined patients' attitudes and outcome predictors among involuntary admissions. Authors found, retrospectively that between 33% and 81% of patients regarded the admission as justified, and the treatment as beneficial. Also, patients with more marked clinical improvement had more positive retrospective judgments [13]. In the second review, the same authors analyzed (n=5) qualitative studies employing thematic analysis, to explore patients' attitudes to involuntary admission. Authors reported that patients' perceptions seemed to vary and had both the positive and negative perceptions towards involuntary hospitalization.

The main areas that appeared to be of concern to patients included; patients' perceived autonomy, participation in making decisions for themselves, and about losing their sense of identity [16]. Out of the (n=36) publications that met the selection criteria, there were (n=31) studies which were carried out in European countries, four from USA, and one from China.

### Patient's Attitudes towards Involuntary hospitalization

In a cross-sectional survey conducted among inpatients (n = 872) of a Swiss psychiatric hospital to assess their subjective view of admission with emphasis on legal status, and perceived coercion, 74% of patients felt that they were under pressure to be hospitalized, whether or not they were involuntarily admitted. However, seventy percent felt their admission was necessary [34]. Also, using a semi-structured interview, (O'Donoghue et al, 2010), examined patients' (n=81) perception of the involuntary admission and reported that the majority of patients felt that the treatment they received was beneficial. However, some patient perceived a negative impact upon the relationship with their family and on the relationship with their doctors, as a result of the involuntary admission, and about a third felt their chances for employment could be affected [19].

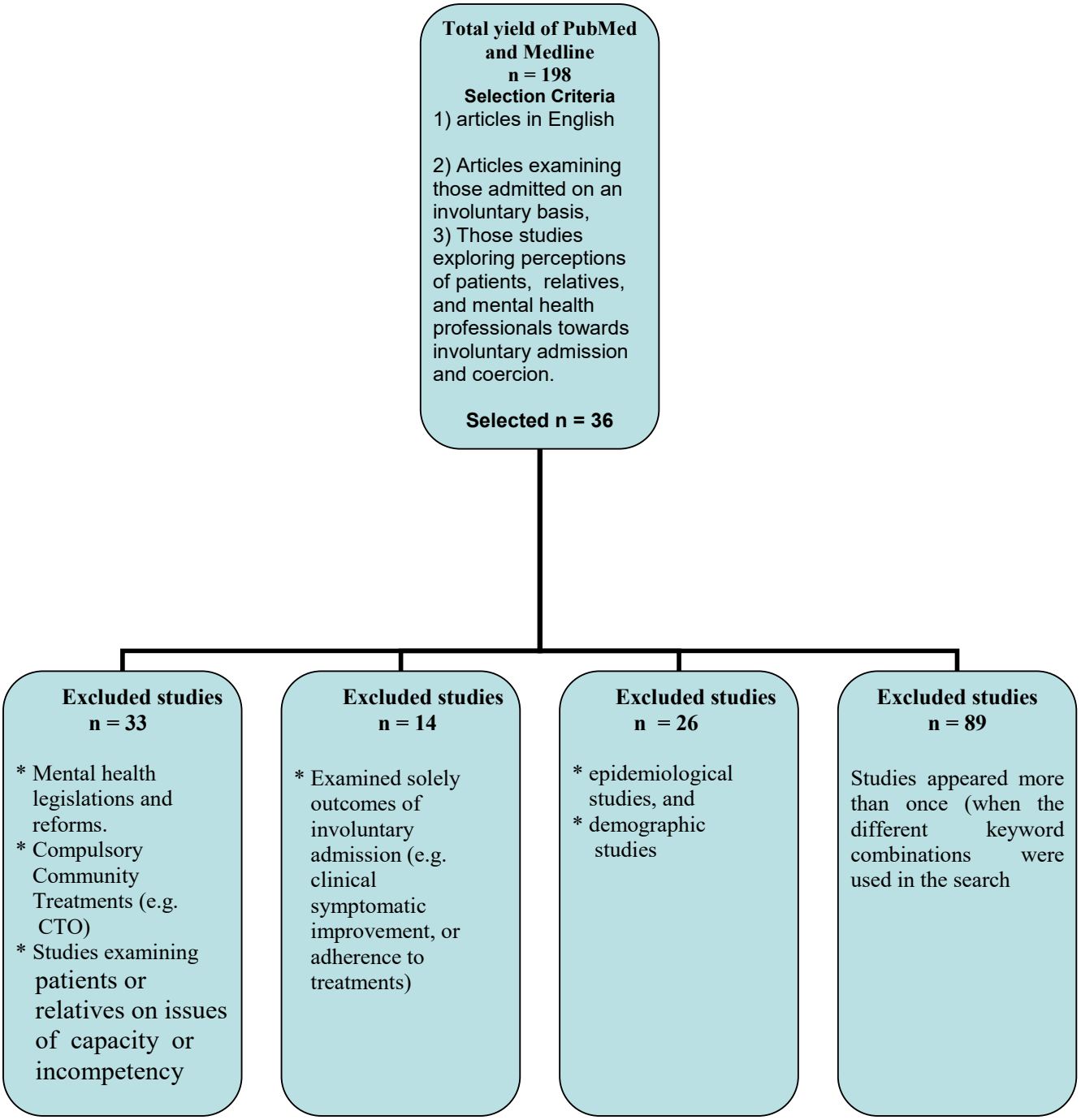


**Figure 1.** The Flow of Search Strategy

| | Author (year) | Country | admission type | Sample size | Outcome measures | Objective |
|---|---|---|---|---|---|---|
| 1 | Johansson and Lundman, 2002 | Sweden | Involuntary patients | 5 | Qualitative methods and semi-structured interview | Patients' experience of involuntary psychiatric |
| 2 | O'Donoghue et al, 2010 | Ireland | Involuntarily Hospitalization | 81 | semistructured interview | Patients' perceptions of involuntary hospitalization, and impact on relationships in family and with doctors |
| 3 | Katsakou et al, 2011 | UK | Involuntarily Hospitalization in 22 hospitals | 270 | Qualitative study, focus groups interviews, and thematic analysis | Patients' perceptions of Involuntarily Hospitalization |
| 4 | Rusch et al, 2014 | Switzerland | recent involuntary hospitalization | 186 | self-report, structured and semi structured questionnaire | The cognitive appraisal of stigma of involuntary hospitalization |
| 5 | Priebe et al, 2009 | UK | involuntary inpatients' | 1570 | semi structured interview | Retrospective patients' views of involuntary hospitalization, and long term outcomes |
| 6 | O'Donoghue et al, 2011 | Ireland | Patients' Involuntarily Hospitalization | 68 | Structured interviews | Perceptions of involuntary admission and risk of subsequent readmission |
| 7 | Richardson et al, 2010 | UK | patients admitted Involuntarily | 232 | structured questionnaires and 19interviews | Patients' attitudes and satisfaction of involuntary admissions |
| 8 | Svindseth et al, 2007 | Norway. | Involuntary and voluntary patients | 102 | structured interview | Patients' experience of humiliation |
| 9 | O'Donoghue et al, 2013 | Ireland | voluntarily and involuntarily | 161 | MacArthur Admission Experience Client Satisfaction | Service users perceptions of Coercion |
| 10 | Tan, 2010 | UK | formal compulsory treatment | 29 | semi structured interview | Perception of coercion of compulsory treatment in anorexia patients |
| 11 | Ivar Iversen et al, 2002 | Norway. | Involuntary and voluntary patients | 223 | Structured interview visual analogue scale and the MacArthur Perceived Coercion Scale (MPCS), | Perceived coercion |
| 12 | Fiorillo et al, 2012 | Italy | Involuntarily or felt coerced | 3093 | Structured and semistructured interviews | Perceived coercion |
| 13 | Kjellin L, et al 2004 | Sweden | Voluntary and involuntary | 138 involuntary +144 voluntary | structured interview | Perceived coercion |
| 14 | Bonsack and Borgeat, 2005 | Switzerland. | Voluntary and involuntary | 87 | A cross-sectional survey | Perceived coercion |
| 15 | Poulsen, 1999 | Denmark | voluntarily and Involuntarily Hospitalization | 143 paticipated | semistructured interview | Examining perceived coercion |
| 16 | Poulsen et al, 2001 | Denmark | involuntary commitments | 143 | Semi structured interviews, and medical files | To examine validity of patients' statements on coercive measures |

| | | | | | | |
|---|---|---|---|---|---|---|
| 17 | Sheehan and Burns, 2011 | UK | Voluntary and involuntarily Hospitalization | 164 | structured interviews | Relationship between perceived coercion and involuntary hospitalization |
| 18 | Katsakou et al, 2010 | UK | involuntary inpatients' | 778 | Semi structured interview | Coercion and treatment satisfaction |
| 19 | Kallert et al, 2011 | Germany | Involuntary and voluntary admissions | 2326 & 764 | Brief Psychiatric Rating Scale. | Perceptions and outcomes of the coerced patients |
| 20 | Sorgaard, 2004 | Norway | Voluntary and involuntary | 190 admissions | Structured questionnaire | Changes in perception to coercion |
| 21 | Gardner et al, 1999 | USA | Voluntarily and involuntarily | 433 | Semi-structured interview | Attitude change of patients to hospitalization, over time, and perceptions of coercion |
| 22 | Priebe et al, 2010 | UK | involuntarily | 2326 (from11 countries) | Semi structured interview | Attitude change of patients tohospitalization, over time |
| 23 | Katsakou and Priebe, 2006 | UK | involuntary inpatients | 18 studies | observer-rated clinical change and self-rated outcomes | REVIEW: Retrospective perceptions |
| 24 | Katsakou, and Priebe, 2007 | UK | involuntary admission | 5 Qualitative studies | Medline-search | REVIEW: |
| 25 | Jepsen et al, 2010 | Denmark | General Practitioners | 13 | Focus group | Physicians' perceptions |
| 26 | Shao et al, 2012 | China. | psychiatrists | 314 | Survey, using questionnaire | Psychiatrists' perceptions |
| 27 | Luchins et al, 2004 | USA | Psychiatrists | 432 | Survey utilizing a vignette | Psychiatrists' perceptions |
| 28 | Lepping et al, 2004 | Germany & UK | Mental health professionals (psychiatrists, nurses, workers | 623 in Germany, 231 in UK | Qualitative study, using 3 vignette scenarios of detainable patients & questionnaire | Attitudes of mental health professionals and lay people |
| 29 | Lauber and Rössler, 2007 | Germany | involuntary admission | survey" 1990-2006 | Medline-search | REVIEW Attitude of the general population, and mental health professionals |
| 30 | Wynn et al, 2007 | Norway | admit and treat involuntarily | 340 psychologists | questionnaire containing three patients' Vignettes | Psychologists attitudes Towards coersion |
| 31 | Luchins et al, 2006 | USA | involuntary treatment | 89 lawyers | vignettes | Lawyers attitudes |
| 32 | Wallsten et al, 2008 | Sweden | committed and voluntarily patients over time | 84 committed and 84 voluntary in 1991) & (118 committed and 117 voluntary in (1997-1999) | semi structured interview | Patients and next-of-kin's' attitudes |
| 33 | Swartz et al, 2003 | USA | Four groups of stakeholders | Patients-104 General public = 59 Family members =49 Clinicians = 85 | short vignettes | Stakeholders ( patients, families, clinicians and public) |
| 34 | Diseth et al, 2011 | Norway | stakeholders | 62 respondents | 30 item structured questionnaire | stakeholders (former patients, relatives, members of supervisory commissions, psychiatrists, other physicians, and lawyers |
| 35 | Jankovic et al, 2011 | UK | Compulsory admission of a close relative | 29 families | semi structured interview, qualitative study | Family perceptions |
| 36 | Borgeat and Zullino , 2004 | Switzerland. | involuntary treatment of mania | 500 patients and their families | clinical vignette, and visual analogue scales | Attitudes of self-help organizations |

**Table 1.** Summary of the main characteristics of the 36 published articles, included in this review, on attitudes towards involuntary hospital admission of psychiatric patients

by the admission status (involuntary or voluntary) in levels of perceived coercion, perceived pressures, procedural justice, perceived necessity, or satisfaction with services [41].

When patients' statements on coercive measures were compared with medical file information, patients stated to have been subjected to more coercion than was evident from the files, in particular in statements about forced medication [42].

**Change of patient's Attitudes over time, towards involuntary hospitalization**

There is strong empirical evidence to suggest that the negative attitude towards involuntary hospitalization changes over time. In the (EUNOMIA) prospective research project in 11 countries, consecutive involuntary patients (n= 2326) were interviewed within one week, at one month of admission and after three months. Between 39 and 71% considered that their admission was justifiable after one month, and this attitude changed to 86% after three months. Authors found that females, those living alone and those with a diagnosis of schizophrenia had more negative views [39 - 45]. Gardner et al, examined (n = 267) patients who were interviewed about their involuntary hospitalization within two days of their admission and were re-interviewed 4-8 weeks following discharge. Authors reported that 52% of patients have changed their attitude towards involuntary hospitalization, to a more accepting one, and only minority who considered admission as necessary, tended to change their attitude to the contrary [46]. Also and others interviewed individuals admitted involuntarily, at one year following discharge to investigate their perception of involuntary admission over time. Authors demonstrated that large proportion (60%), believed that their involuntary admission was necessary [19, 44]. Also found that 40 % of patients considered that their involuntary admission was justifiable one year later. Authors also found that higher initial treatment satisfaction, poorer global functioning, being on benefits, and living alone were associated with more positive retrospective views of the admission [45].

With regards to coercion conducted a study in 67 acute wards in 22 hospitals in England, involving (n =778) patients. Patients who perceived less coercion at admission and during hospital treatment were more satisfied overall, when assessed for satisfaction over time up to one-year follow-ups. Authors found that although patients who perceived less coercion at admission and during hospital treatment were more satisfied overall, whereas coercive measures documented in the medical records were not linked to their overall satisfaction with treatment [28].

In conclusion, there is evidence that the majority of patients who initially perceived that they did not need hospitalization revised their belief after hospital discharge and reported that they had needed hospital treatment. However, perceptions of coercion was more complex, and more persistent over time depending on the processes perceived from the admission pro-

In a recent large descriptive qualitative study, at the Social & Community Psychiatry Unit, of the institute of psychiatry, to explore involuntary patients' retrospective views on why involuntary hospitalisation was right or wrong, involuntary patients from 22 hospitals in England were interviewed in-depth, utilizing the grounded theory and thematic analysis [19]. Authors identified three groups of patients with distinct views on their involuntary hospitalization: those who believed that involuntary hospitalization was acceptable, those who thought it was not acceptable and those who had an ambivalent attitude. Those with retrospectively positive views believed that hospitalization ensured that the received treatment, averted further harm and offered them the opportunity to recover in a safe place. Many felt that coercion was necessary, as they could not recognize that they needed help when they were acutely unwell. Substantial minority perceived the involuntary admission negatively and felt that their admission was unfair, could have been handled in less aggressive manner, and experienced hospitalization as violation of their freedom and autonomy. A third group of patients was described by authors as ambivalent because they believed that they needed the involuntary hospitalization that averted further harm to them. However, they thought that their admission could have been handled in the community or with shorter voluntary hospitalization [19]. In multiple linear regressions, (Rusch et al, 2014) found that more self-stigma was predicted independently by higher levels of shame, self-contempt and stigma stress, and that a greater sense of empowerment was related to lower levels of stigma stress and self-contempt [35].

In one study, it was noted that the adverse circumstances associated with the forceful involuntary admission may lead to significant perception of humiliation. Commonly, patients reported that during admission they were exposed to verbal or physical force [20]. (Tan JO, et al, 2010) examined compulsory treatment among anorexia patients, who seemed to agree with the necessity of compulsory treatment in order to save life. But what mattered most to them was not whether they had experienced restriction of freedom, but the nature of their relationships with parents and mental health professionals [36].

Patients' negative perception about involuntary hospitalization and coercion is quite complex, and not necessarily related to the degree of restriction of freedom. Most authors reported that, while on one hand significant proportions experienced that their freedom was violated, on the other hand they felt that they were given the opportunity to be taken care of and to recover in a safe place.

**Perceived coercion during Hospitalization**

In the large " European multi-site research project on coercion in psychiatry (EUNOMIA), it was reported that high perceived coercion at admission was reported by both the involuntary and voluntary patients. This study included (n=3093) patients who were involuntarily admitted to hospitals, in 11 Europe-

an countries. However, coercion was more likely (89% of patients) to be reported by the involuntary patients [10]. In this study, perceived coercion, global functioning, and symptom severity were assessed after admission and at a 3-month follow-up. Coercion was found, to be associated with poor global functioning. Authors reported that the improvement in mental state and the global functioning was associated with a reduction in the perception of coercion, and that perception of coercion tends to decrease significantly over time [12]. Others reported that the main predictor of felt coercion was seclusion, and that coercion tends to be rather persistent and not amenable to interventions that included engaging patients in the formulation of the treatment plan [37].

Procedural Justice during the admission process is of crucial importance to the development of positive or negative perception of coercion. This involves the perception of justice, and of being respectfully involved in a fair decision-making process regarding admission [34]. It was demonstrated in several studies that both voluntary and involuntary patients may experience coercion during admission. However, involuntarily admitted patients are more likely to perceive coercion, especially those who have experienced more force due to their uncooperative attitudes to the admission process. For this reason, coercion is not necessarily associated with the patient's legal status. Patients who perceived coercion commonly report that they were not heard [12,29,33]. For example, in a recent study examining coercion in both the involuntarily and the voluntarily admitted patients, perceptions of coercion was found to be significantly more prevalent (89%) among the involuntarily admitted patients, than among the voluntarily admitted patients (48%) [22]. A high perceived coercion score was significantly associated with a poor rating of the therapeutic relationship with treating professionals. Even, among voluntarily hospitalized patients, more coercion was reported when patients rated their relationship with the admitting clinician negatively [22]. Also, (Ivar Iversen et al, 2002), Investigated perceived coercion, among patients (N= 223) admitted both voluntarily and involuntarily to acute wards in Norway. Authors used a visual analog scale (CL), the MacArthur Perceived Coercion Scale (MPCS), and a five-item questionnaire, to measure perceived coercion. Patients admitted to acute wards were included and interviewed within five days of admission. Commonly, the involuntary group experienced significantly higher levels of perceived coercion in the admission process than the voluntary group [38,39]. Coercion was associated with female gender, poorer global functioning, and more positive psychotic symptoms. It was claimed that these results suggest that the nature and the severity of mental illness were the most important risk factors for being subjected to any form of coercion [12,21,38]. Poulsen et al, found that detention after a voluntary admission results in a statistically significant higher perception of coercion [40]. In contrast, O'Donoghue et al, found no differences cedure to follow-up, and the overall patients' attitudes toward hospitalization does not seem to change to a more positive one overtime [34,39].

Patients' perceptions towards involuntary admission from different studies which fulfilled our search criteria are summarized to form a list of 21 main items.

The list of attitudes toward involuntary admission was developed at four levels of the taxonomy of attitudinal objectives: awareness, willingness to respond, preference and conceptualization for a value, and commitment (Appendix A). This was adapted from Hopkins and Krathwohl [47].

**Appendix A**

**Families and next of kin attitudes towards involuntary admissions of their relatives**

Compulsory admission of a close relative can be a major source of stress for relatives and caregivers. Interviewed in-depth (n=30) caregivers to investigate their attitudes to the involuntary admission of their relatives who were admitted to 12 hospitals in England [48]. Investigators identified four major themes of perceptions including; relief and conflicting emotions in response to the relative's admission; frustration with a delay in getting help; being given the burden of care by services; and some relatives had concerns about confidentiality. Authors also reported that although relief was the predominant emotion as a response to the relative's admission, it was accompanied by feelings of guilt, and that caregivers frequently experienced difficulties in obtaining help from services prior to admission. Some relatives thought that services responded to them mainly where there was a crisis, rather than prevented a crisis from taking place, and some family caregivers wanted more information and wanted to have a say in the decisions made about their relatives treatments [40]. In another study to examine and compare the differences in attitudes, before and after the mental health law reform in Sweden among involuntarily and voluntarily admitted patients and their next-of-kin towards involuntary psychiatric admission, a great majority of the patients and the next-of-kin stated that decisions regarding compulsory admission should be taken by doctors. In this study, demonstrated that most patients and next-of-kin considered decisions about involuntary psychiatric care and the decision for coercion, to be a medical decision in the first place which should be made by doctors in order to protect the patient [49].

It could be concluded that, in order for caregivers to be effective partners in care, a balance needs to be struck between valuing their involvement in providing care for a patient and not overburdening them.

**APPENDIX A: Table of Specification, Taxonomy of the Attitudinal Objectives**

| Attitudinal objectives | Awareness | Willingness to accept or respond | Preference & conceptualization of a value | Commitment | Total |
|---|---|---|---|---|---|
| The awareness that I received appropriate treatment during my hospitalization | P1 | | | | 1 |
| The conceptualization that being detained as an involuntary patient has averted further harm to me | | P2 | | | 1 |
| Accepting that he / she was offered the opportunity to recover in a safe place. | | P3 | | | 1 |
| Accepting the need for help when was acutely ill | | P4 | | | 1 |
| The perception that I was coerced excessively | | | P5 | | 1 |
| Holding a strong concept that the problem could have been managed through less coercive interventions | | | P6 | | 1 |
| I think that my hospitalization was not necessary at all | | | P7 | | 1 |
| The false perception that hospitalization was unjust | P8 | | | | 1 |
| The false perception that *hospitalization constitute an infringement of my rights* | P9 | | | | 1 |
| *I felt that I was not heard* | P10 | | | | 1 |
| The perception that *his / her point of view was not seen* | P11 | | | | 1 |
| Holding a strong concept that *hospitalization posed a permanent threat to my independence* | | | P12 | | 1 |
| The preference that the problem might have been managed through a voluntary hospitalization | | | P13 | | 1 |
| The preference that problems might have been managed through a shorter hospitalization | | | P14 | | 1 |
| This admission had a negative impact upon the relationship with my family | | | P15 | | 1 |
| Holding a strong concept that the relationship with doctors / psychiatrist was negatively impacted by this involuntary admission | | | P16 | | 1 |
| I felt that the prospects for my employment could be affected | | | P17 | | 1 |
| Committed to hold to his / her legal *rights, as an involuntary patient* | | | | P18 | 1 |
| Accepting a timely freedom when my doctors allow | | P19 | | | 1 |
| The false perception that hospital was a humiliating experience | P20 | | | | 1 |
| Accepting that I was treated with respect during hospitalization | | P21 | | | 1 |
| **Total** | **6** | **5** | **9** | **1** | **21** |

Adapted from Krathwohl et al, 1964

(Diseth et al, 2011), identified three meaningful main attitudes which are entertained by stakeholders. These attitudes included, emphasis on a balance between protecting the patient 's rights, patients' autonomy, as well as the necessity of using involuntary commission for some patients with severe mental disorders. Respondents tended to have differences in attitudes reflecting their respondents' role in mental health care [50].

(Swartz, 2003) examined four stakeholder group including subjects with schizophrenia disorders, family members, clinicians, and members of the general public. The four groups showed remarkably similar views about the preferred outcomes in the treatment of schizophrenia. All groups gave the highest preference to avoiding involuntary hospitalization, followed by avoiding interpersonal violence. It was concluded that stakeholders were willing to accept the coerciveness of outpatient commitment [51].

**Attitudes of mental health professionals towards involuntary hospitalizations**

There is empirical evidence to suggest that the attitudes towards involuntary treatment also depends on variables such as the medical professional's profession, age, nationality and experiences with mental illness. For example, it was demonstrated that limiting the right to require compulsory admissions to fully certified psychiatrists can reduce the rate of compulsory versus voluntary admissions [14]. Surveyed psychiatrists (n = 432), to examine their attitudes to involuntary admissions and its relationship to responsibility for mental illnesses. This study examined whether psychiatrists' responsibility affects their decisions about involuntary hospitalization. A vignette characters were utilized to elicit psychiatrists' responses and attitudes. Authors found that making decision to involuntarily hospitalize persons with mental illness increased significantly with the level of risk of harm to the patient or to others, and that the decision varied significantly between psychiatric diagnoses [52]. The same author investigated lawyers' attitudes toward involuntary hospitalizations and involuntary medication. Authors found that a decisions to hospitalize persons with mental illness involuntarily increased significantly with the level of risk of harm and this was attributed to responsibility to prevent recurrence of mental illness. However, the decisions to recommend involuntary medication were not related to attributions of responsibility [53].

Also, when Chinese Psychiatrists (n = 314) were surveyed using a questionnaire to assess their attitudes about the procedure of involuntary admission to mental hospitals, some showed stricter attitudes especially females psychiatrists, those aged under 35, with a low education level and those with a low position in the institution [54]. When psychologists were surveyed about their views and attitudes about involuntary admissions, coercion and treatments, the majority recommended coercion for violent patients, and if the patient had difficulties in dealing with activities of daily life. However they appeared to be in favor of involuntary admission to involuntary treatment with medication [55].

To examine mental health professionals' and lay-people' attitudes towards involuntary treatment, and to compare results between England and Germany, (Lepping et al, 2004), developed three scenarios of potentially detainable patients and presented them to professional staff. Overall, authors demonstrated that there were no significant differences in perceptions towards involuntary hospitalization and involuntary treatment between lay-people and mental health professionals [56]. Also in a review examining involuntary admission and the attitude of the general population, and mental health professionals by, it was found that the majority of the general public or mental health professionals were in support of involuntary admissions, and involuntary hospitalization [32].

used a clinical vignette to explore the There were 503 respondents who disagreed that patients should decide about their hospitalization and favored some involuntary treatment over treatment refusal. There was an agreement between patients, relatives and caregivers related to acceptance of involuntary hospitalization and coercive treatment. Respondents agreed to trust in the role played by the treatments by professionals, and family members supported decisions for coercive treatment [57].

## Summary and Discussion

Based on empirical evidence from recent research examining patients' attitudes to involuntary admission, the majority of patients reflected positively retrospectively on their involuntary admission. In some studies, retrospectively the proportions of patients who viewed their involuntary admissions as justifiable reached 70 %. These positive attitudes should constitute an invaluable opportunity that could be used to examine different perceptions in more depth, and to examine the psychosocial risk factors associated with mental illness. It was demonstrated that efforts to decrease seclusion and restraint may be accompanied by an increased risk of harm to psychiatric patients. Professional decisions to admit patients involuntarily when necessary, seemed to be supported by the next of kin and the lay person, and there was an agreement between professional's and the public attitudes towards involuntary hospitalization. It appears from current available research, that the nature and severity of mental illness were the most important predicting risk factors for being subjected to any form of coercion (6,7, 14 -17]. As far as the attitudes to coercion is concerned, it was concluded that the nature and the severity of mental illness were the most commonly determinant factors for being subjected to any form of coercion, and involuntary coerced admissions appear to be associated with poorer clinical outcomes than with voluntary admissions [12,21,33].

Developing social programs to address negative attitudes and engaging patients in psycho-education are crucial to improving positive perceptions towards admissions in particular, and adherence to treatment in general. Although patients' perceptions of involuntary treatment are well described in the literature, future research should explore differences between patient groups, such as diagnostic groups, and high-risk factors groups, which are not extensively examined in present literature. Future research should also examine in more depth and in detail, patients' perceptions to different coercive measures, such as seclusions and physical or chemical restraints, which are still widely used in acute psychiatry units. Developing reliable and valid measures of patients' perceptions of coercion may assist in deeper understanding of patients' attitudes and may shed light to developing an effective mental health act legislations. Studies on patients' and relatives' perspectives are scarce and showed that involuntariness and coercion were associated with feelings of being excluded from participation in the treatment. Because of its reflections and repercussions on legal, human rights and ethical issues, there are many patients' and public questions need to be addressed about Coercion. Finally, the development of a reliable instrument with evidence of validity, to measure patients' perceptions towards involuntary admission or coercion may prove useful in examining patients' attitudes at more depth.

One major strength for conducting this review, was to identify, formulate and construct a list of specifications about the most salient features of patients' attitudes towards involuntary hospitalization. Based on empirical evidence from the review of literature, the list of specifications of patients' attitudes towards involuntary hospitalization ( Appendix A), was constructed which could be the used as the basis for developing an instrument or a questionnaire with evidence for content validity, to measure patients' attitudes towards involuntary hospitalization. However this is being examined further in a psychometric study for developing such instrument.

Overall there is paucity in the research of this important area of forensic psychiatry which touches patients' freedom.

Results from future research among the public, mental health professional, and independent patients' advocacy agencies, is crucial to better understanding and developing managing strategies for patient with severe mental illness, without violating their rights. It is equally crucial that clinicians understand patients' and relatives' perceptions to help minimize the negative perceptions of injustice or of coercion among both the voluntarily or the involuntarily admitted patients, by attending more closely to procedural justice issues.

## Conclusion

There are widespread high levels of negative attitudes towards involuntary hospitalization among patients admitted involuntarily to psychiatry, including significant perception of humiliation, and violation of freedom. However, there is strong evidence to suggest that retrospectively substantial majority of patients considered that their involuntary admission was justifiable over time.

## Conflict of Interest

There was no financial assistance received and there is no another conflict of interest.

### Author's Contributions

The corresponding author contributed to the review of the literature, and its compilation, drafting the article, interpretation of data, and will be responsible for the final approval of the version to be published.

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