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# An Ethical Assessment on Patients Involuntarily Admitted to the Psychiatric Ward of a University Hospital

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## ABSTRACT

**Objective:** Involuntary hospitalizations are commonly applied in the treatment of psychiatric disorders. These practices have been controversial since they may pose morally questionable situations. This study aimed to reveal the clinical characteristics of patients who were involuntarily admitted to the psychiatry clinic as well as the reasons behind the involuntary admission decision and to examine the findings from an ethical point of view.

**Materials and Methods:** Socio-demographic and clinical records of patients who had been involuntarily admitted to a university hospital between January-2013 and January-2019 were collected retrospectively. These data were compared with the variables of the voluntarily admitted patients who were matched with the involuntarily admitted study group in terms of admission year, sex, and age.

**Results:** There was no significant difference between the two groups in terms of socio-demographic characteristics. The frequency of involuntary hospitalization was found to be higher in patients with psychotic disorders. These patients had a longer duration of hospitalization and were given long-acting antipsychotics more frequently. There was no significant difference between the groups in terms of risk of doing harm to oneself/others and treatment needs.

**Conclusion:** Involuntary hospitalizations would contradict further with the principle of respect for patient's autonomy in comparison with those done due to the risk of doing harm to oneself/others. Prolonged hospitalization and long-acting drug choices in the absence of the risk of giving harm to oneself/others may contradict basic ethical principles, such as the right to choose one's treatment. Caution should be taken against potential ethical issues while considering involuntary hospitalization.

**Keywords:** Involuntary admission, respect for autonomy, stigmatization

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## INTRODUCTION

Ethical debates on treatment methods applied to psychiatric patients and the length of their hospitalization have been increasing worldwide (1). Involuntary hospitalization/compulsory treatment is defined as the hospitalizations/outpatient treatments applied by court order regardless of the consent of the person and his legal advisor until the risk of doing harm to oneself or others due to a mental disorder disappears or significantly decreases, to ensure the treatment of the person and the peace/safety of the society. The widely accepted approach in today's psychiatry is that patients are treated mostly in the community, but outside institutions, as well as that they are enabled to participate in their treatment processes. In this context, it is recommended that involuntary hospitalization/compulsory treatment should be kept as short as possible and by time transformed into voluntary treatment, patients should be prevented from being dependent on hospitalization, their reintegration to the society should be ensured, and they should be provided with support by their family/friends and other social institutions (2, 3). For this purpose, some studies aiming to eliminate involuntary hospitalizations are carried out in some countries such as the Netherlands (4). Nevertheless, involuntary hospitalization and compulsory treatment can often come up in some cases during the diagnosis and treatment of psychiatric disorders. Involuntary hospitalizations and compulsory treatment can be applied due to the possibility of harming oneself or others, impairment in judgment abilities, and lack of insight into one's symptoms/disorders (5, 6).

Involuntary hospitalizations and compulsory treatment can cause problems both legally and ethically as they violate basic civil rights, restrict the freedom of individuals, and can impose significant responsibilities on physicians (7). This high sense of responsibility may cause physicians to cross their limits and ignore the autonomy of individuals while exercising their authority. For this reason, in many countries, involuntary hospitalization and compulsory treatments are carried out according to the legal regulations developed to protect the autonomy of individuals and to minimize their vulnerability of individuals (8). Nevertheless, in daily practice, ethical violations and/or moral dilemmas are frequently experienced in involuntary hospitalizations. In particular, the best interests of the patient, the benefit of society and autonomy of the patient may conflict with each other, and thus the

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psychiatrist may face moral dilemmas arising from this conflict in involuntary hospitalization practices.

The view that psychiatric patients usually pose a risk of harming themselves or other people and increased social distancing toward these patients remains a current social problem (9). In this respect, involuntarily hospitalized (IHP) patients might be exposed to such ethically problematic approaches and/or practices more frequently than those who are voluntarily hospitalized (VHP). Furthermore, it is likely that they are stigmatized by both society and health-care professionals more often.

Unfortunately, studies on the ethical dimension of involuntary hospitalizations as important sources of moral dilemmas are very few both worldwide and in Turkey. All relevant studies that have been published in Turkey were carried out in training and research hospitals with a forensic medicine service (10, 11). However, there are potential other centers such as university hospitals where involuntary hospitalizations are performed as well. Therefore, trying to understand the current situation in the country only through the findings of these studies may cause bias. In this framework, it is highly important to investigate clinical preferences regarding the necessity of involuntary hospitalization and features such as treatment choices and the duration of hospitalization over a university hospital sample.

In this study, we aimed to investigate retrospectively the clinical features and the hospitalization indications of patients who were IHP to at the Department of Psychiatry of a university hospital, in comparison with the data obtained from patients who were VHP at the same institution, and to analyze them with regard to possible ethical problems.

The main hypotheses of the study are as follows: (a) The diagnosis of psychotic disorders was higher in the IHP group than VHP group; (b) according to the medical records, the IHP group had a higher risk of harming themselves or others than the VHP group; (c) IHP group received more long-acting antipsychotic medication than VHP group; and (d) IHP group stayed in the hospital longer than VHP group.

## MATERIALS and METHODS

In the study, the medical records of the patients who were involuntarily admitted to the Department of Psychiatry of a university hospital in the past 5 years (between January 2013 and January-2019) were examined. During this period, a total of 48 cases were detected. The socio-demographic and clinical variables of these cases such as age, sex, marital status, education level, employment status, psychiatric diagnosis, length of hospitalization, the indication for hospitalization, and the treatments they received during hospitalization were taken into consideration. Patients who were admitted voluntarily to the same clinic and were age and sex-matched with the IHP 48 patients were included in the study as a control group. To minimize any selection bias, consecutive age and gender-matched controls were collected one by one from the oldest records toward recent ones.

The medical records of the patients were collected according to the duration of hospitalization (0–15 days, 15–30 days, 1–3 months, and 3 months–1 year), indications for hospitalization (ex-

citation, treatment refusal, risk of suicide, risk of harming oneself or others, drug refusal, exacerbation of psychotic symptoms, and poor self-care), and treatments received (oral antipsychotic per se and long-acting antipsychotic alone or combined with oral). To compare the clinical characteristics of the two groups, they were grouped under the following classifications; (a) diagnoses, psychotic disorders (schizophrenia, schizoaffective disorder, psychosis not otherwise specified, substance-related psychosis, postpartum psychosis, atypical psychosis, and delusional disorder), mood disorders (bipolar affective disorder, and unipolar affective disorder), and other (obsessive-compulsive disorder, personality disorder, and substance abuse), (b) duration of hospitalization (short-term hospitalization as “1–30 days” and long-term hospitalization as >30 days), (c) treatments (oral and long-acting), and (d) the indications for the hospitalization (risk of harming oneself or others, and need for an arrangement of treatment). The study was approved by the Health Sciences Ethics Sub-Committee of the University (04-292-19).

## Statistical Analysis

Arithmetic means, standard deviations, frequency, and percentage rates were calculated. A Chi-square test was used for the comparison of the categorical variables between groups while the student t-test was used for continuous variables. A value of  $P < 0.05$  was considered statistically significant. The data were analyzed using IBM SPSS 20.0 (Armonk, NY: IBM Corp).

## RESULTS

The average ages of IHP group were  $42.19 \pm 11.46$  and  $38.63 \pm 10.77$  for the VHP group which poses no statistical difference between the two groups ( $t=1.569$ ,  $p=0.120$ ). The number of males ( $n=32$ ) among IHP group was twice as high as females ( $n=16$ ). When the VHP group and IHP group were compared, no significant difference was found in terms of gender ( $\chi^2=1.568$ ,  $p=0.148$ ), marital status ( $\chi^2=0.028$ ,  $p=0.867$ ), education level ( $\chi^2=4.923$ ,  $p=0.085$ ), and employment status ( $\chi^2=1.161$ ,  $p=0.560$ ) (Table 1).

Clinical variables of voluntarily and IHP patients were compared. 34 patients were diagnosed with psychotic disorder, 13 patients had mood disorder and one patient was classified in other diagnoses in the IHP group while 12 patients were diagnosed as psychotic disorder, 30 patients as mood disorder, and six patients were classified in the other diagnoses in VHP group (Table 2). For testing the first hypothesis, we regrouped those with the mood disorder and those having other diagnoses into a single group and searched for any significant group difference between them and the patients with psychosis. It was found that the frequency of psychotic disorders in the IHP group ( $n: 34$  [72.9%]) was significantly higher than the VHP group ( $n: 12$ , [27.1%]) ( $\chi^2=22.051$ ,  $p<0.001$ ).

In terms of the duration of hospitalization, it was found that ( $n: 28$ , [58.3%]) of the IHP group and ( $n: 13$ , [27.1%]) of the VHP group were long-term hospitalized ( $\chi^2=9.579$ ,  $p=0.004$ ).

In terms of the treatments that the study and the control groups received, it was found that 50% of the IHP group and 18.8% of the VHP group were treated with long-acting antipsychotics. As a result, it was shown that the use of long-acting antipsychotic drugs

**Table 1.** Socio-demographic characteristics of the patients who were IHP and VHP

	IHP (n=48) (%)	VHP (n=48) (%)	Statistical analysis
Age	42.19±(ss:11.46)	38.63±(ss:10.77)	t=1.569, p=0.120
Sex			$\chi^2=1.568$ , p=0.148
Male	32 (66.7)	26 (54.2)	
Female	16 (33.3)	22 (45.8)	
Marital status			$\chi^2=0.028$ , p=0.867
Single	19 (39.6)	25 (52.1)	
Married	18 (37.5)	22 (45.8)	
Other	11 (22.9)	1 (2.1)	
Education			$\chi^2=4.923$ , p=0.085
Primary school	3 (6.3)	13 (27.1)	
High school	10 (20.8)	15 (31.3)	
Undergraduate and over	19 (39.6)	18 (37.5)	
Other	16 (33.3)	2 (4.2)	
Employment status			$\chi^2=1.161$ , p=0.560
Unemployed	21 (43.8)	29 (60.4)	
Employed	13 (27.1)	14 (29.2)	
Retired	6 (12.5)	4 (8.3)	
Not identified	8 (16.7)	1 (2.1)	

IHP: Involuntarily hospitalized; VHP: Voluntarily hospitalized

was statistically significantly higher in the IHP group compared to the VHP group ( $\chi^2=10.390$ ,  $p=0.002$ ).

Finally, the indications for hospitalization of the patients were grouped in terms of whether they pose a risk of harming themselves or others. Accordingly, it was found that people posing a risk of harming themselves or others constitute 62.5% of the VHP group whereas they compose 54.2% of the IHP group. It was found that 37.5% of the VHP group and 45.8% of the IHP group were hospitalized for an arrangement of treatment and this difference was not statistically significant ( $\chi^2=0.686$ ,  $p=0.535$ ). Clinical variables of the groups regarding the diagnosis, duration of hospitalization, indications for hospitalization, and treatment modalities are given in Table 2.

## DISCUSSION

In this study, we aimed to examine the socio-demographic and clinical characteristics of patients who were hospitalized involuntarily in the past 5 years at a university hospital and to discuss the ethical problems that might emerge around this topic.

In the study, no significant group difference was found between IHP and VHP groups in terms of gender (66.7% of men). This percentage is similar to the rates (72% and 68% for males, respectively) reported in other studies examining involuntary hospitalization in Turkey (10, 11). This situation may be related to the common perception of male patients who are more dangerous for themselves than females. On the other hand, there are differences between various countries in this regard. For example, in a study examining involuntary hospitalizations in Croatia, it was

shown that 64.6% of the patients were female (12). In another study on the socio-demographic and clinical characteristics of patients who were hospitalized involuntarily in Europe, no significant difference was found in involuntary hospitalization rates of both sexes (13). In the aforementioned study, it was emphasized that physical restraints were applied to males more frequently than females during involuntary hospitalization and that health-care professionals might be prejudiced that male patients could be more dangerous.

The average age of the individuals who were admitted to the hospital involuntarily and voluntarily found in our study is similar to those reported in some studies conducted both in Turkey and abroad (10–12). Apart from this, no difference was found between the two groups in terms of socio-demographic characteristics such as education level, employment status, and marital status (Table 1). In their study, Gültekin et al. (10) found no difference between these groups in terms of education level and marital status, but they observed that the rate of employment was higher in the group of VHP patients. Considering that previous studies were conducted mostly in inpatient training and research hospitals and with larger samples and that disability due to chronic psychiatric diseases was taken into account, a significant difference in occupational functionality against involuntary hospitalizations can be expected. However, the lower sample size in this study and the fact that the sample group was selected from a single university hospital may be explanatory regarding the lack of significant difference between the groups in terms of employment status.

One of the motivations for conducting this study was to discuss whether some ethically questionable clinical approaches are

**Table 2.** Comparison of the clinical characteristics of patients who were IHP and VHP

	IHP (%)	VHP (%)	Statistical analysis
Psychiatric diagnosis			
Psychotic disorders	34 (70.8)	12 (25.0)	$\chi^2=17.015$ , $p=0.000$
Mood disorders	13 (27.1)	30 (62.5)	
Other	1 (2.1)	6 (12.5)	
Duration of hospitalization			$\chi^2=9.579$ , $p=0.004$
Short-term (1–30 days)	20 (41.7)	35 (72.9)	
Long-term (>30 days)	28 (58.3)	13 (27.1)	
Indication of hospitalization			$\chi^2=0.686$ , $p=0.535$
Harming oneself/others	26 (54.2)	30 (62.5)	
Arrangement of treatment	22 (45.8)	18 (37.5)	
Treatment			$\chi^2=10.390$ , $p=0.002$
Oral	24 (50.0)	39 (81.3)	
Long-acting antipsychotic drugs	24 (50.0)	9 (18.8)	

IHP: Involuntarily hospitalized; VHP: Voluntarily hospitalized

displayed more often in dealing with IHP patients compared to voluntary hospitalizations. For example, the possibility that patients with psychotic disorders are more likely to be hospitalized involuntarily than those with other disorder group and that they are considered “dangerous” is regarded in this context. The reverse is also possible; the reason why most of the individuals who are admitted to hospital involuntarily are diagnosed with a psychotic disorder may be that this diagnosis is considered as a clear and sufficient justification for “dangerousness” and therefore, physicians may show a tendency to prefer such a diagnosis for unidentified cases (14). In addition, the fact that IHP patients were hospitalized for longer periods, in such a manner that their autonomy might be ignored, and that long-acting antipsychotic drugs were preferred more was also considered within this framework. According to the results of the study, patients with psychotic disorders were more frequently hospitalized involuntarily than those with mood disorders, the rate of long-acting antipsychotic use was higher in IHP patients, and they stayed in the hospital for longer periods of time. Therefore, our results may at least indicate that ethically questionable clinical approaches might be performed in this respect. Regarding the risk of harming themselves or others, there was no significant difference between the groups. Accordingly, the hypothesis related to this situation was rejected.

It has been shown in the previous studies that psychotic patients are exposed to involuntary hospitalization more frequently than those with other diagnoses and that the duration of hospitalization of this group is longer than that of those who were hospitalized voluntarily (15, 16). Besides, in studies conducted in our country, it was also shown that patients who were hospitalized involuntarily were mostly diagnosed with schizophrenia (10, 11). Stigmatization is another important problem in psychotic disorders (17). Stigmatization that patients with schizophrenia are exposed to has two dimensions; positive and negative. Involuntarily hospitalization is mostly associated with the negative dimension. Attributed unpredictability, incapability of making rational deci-

sions, and the risk of doing harm to others are examples of this attitude. Unfortunately, not only the public suffers from stigmatization but also psychiatrists may have stigmatizing attitudes toward their patients, which can be considered an important source of involuntary hospitalization (18). It was also been shown that patients are exposed to hospitalized more involuntarily hospitalization more often due to stigmatization (19). Moreover, the research highlighted that both voluntary and involuntary previous admissions increase the risk of subsequent involuntary hospitalization in psychotic disorders (20). In this context, there seems to be a relationship between stigmatization and involuntary hospitalizations in these disorders. In our study, consistent with the findings of previous research, it was shown that patients with a psychotic disorder diagnosis became subject to involuntary hospitalization more often than those without.

In our study, we observed that involuntary hospitalizations lasted longer. Similarly, Ielmini et al. (21) found that the mean duration of hospitalization for the IHP group was twice as longer than that of the VHP patients. In another study, Gültekin et al. (10) observed a strong tendency toward significance in terms of the difference between the duration of involuntary and voluntary hospitalizations.

In our study, we also observed that the rate of using long-acting antipsychotic treatment was higher in the IHP group compared to the VHP group. This finding is consistent with the results of a follow-up study conducted in ten European countries about IHP individuals (22). In that study, it was observed that 730 of the 2030 people received compulsory treatment (forced drug administration, and physical restraints such as fixation and isolation) during their hospitalization. After 3 months, semi-structured interviews were conducted with these patients 3 months later, and it was observed that especially the compulsory drug treatment was associated with negative attitudes toward treatment. As revealed in our study, the fact that long-acting drugs were preferred more frequently than oral drugs can be interpreted in a similar way. Although the administration of long-acting drugs enables patients to receive the



treatments they basically need, it can restrict their right to decide on the available treatment options. In this context, IHP patients might be included in decision-making processes regarding their treatment processes less often, and from a holistic point of view, it can be suggested that they gradually lose control over their own well-being (23–25).

At this point, the “need for treatment” argument should be based on criteria that would justify involuntary hospitalization and if such criteria are not available, they should be determined and standardized. Otherwise, the current decisions for involuntary admissions would seem arbitrary. The absence of standardized criteria may cause the treatment team to adopt a paternalistic role in solving the current clinical problems. According to this approach, the physician feels almost unlimitedly strong and responsible and establishes a poor participatory relationship with the patient (25, 26). Inviting patients to participate in treatment decisions, providing them with detailed explanations, being open to their “off-topic” stories to empathize with them, trying to understand their reasons for refusing treatment by active listening, and exploring solutions together with them require a great deal of effort and time. It is known that physicians and other health-care professionals frequently resort to paternalism to overcome stress, difficulties, and conflicts arising from heavy workload (27). The fact that a person is subjected to treatment by restricting his freedom, even though he/she is not considered “dangerous,” maybe a reflection of such an attitude.

The present study has several limitations. First, its retrospective design does not allow researchers to establish exact causal relationships. Significant differences between clinical parameters may be due to the higher incidence of psychotic disorders in the IHP patients who may also have poor insight, more severe disability, and less treatment compliance. In this respect, the fact that psychotic patients are hospitalized for longer periods, as well as that the long-acting antipsychotics are applied to them more often to ensure their treatment compliance is of importance in terms of the beneficence principle. Nevertheless, it should be kept in mind that in case the patient refuses the treatment, risk of ethical violation arises especially if involuntary hospitalization is performed on the grounds that the patient’s treatment should be regulated rather than considering his/her state of dangerousness. Besides, it should be questioned whether the psychiatrist tends to diagnose “psychotic disorder” in those for whom involuntary hospitalization is preferred and especially when they are difficult to diagnose.

Another important limitation of the study is the relatively lower sample size and involvement of a single study center. Therefore, the generalizability of its findings with regard to other involuntary hospitalizations throughout Turkey should be interpreted attentively. On the other hand, the socio-demographic and clinical characteristics of the patients admitted to university hospitals may differ from those admitted to other psychiatric clinics. Furthermore, diagnostic variety poses another limitation. There was only one patient with a different diagnosis in the IHP group. However, this divergence demonstrates that patients with such diagnoses can also be subjected to involuntary hospitalization. Finally, since the study is based on retrospective analysis, it can be said that there is an additional limitation regarding the loss of data.

## CONCLUSION

Involuntary hospitalization in psychiatry often induces controversy because of the ethically questionable practices it may cause. The findings of our study highlighted the issue of whether the autonomy of individuals is sufficiently respected. The main reason for coercing people to reside in a hospital and receive treatment, regardless of their preferences, may not be the presence of risk of harming themselves and/or others, but the opinion of the health-care team that these people need proper treatment. Besides, it was also determined that these people were exposed to long-acting medications more often than the control group. At this point, ensuring the patient’s best interest and the principle of respect for patient autonomy clash. This conclusion has once again highlighted the importance of guidelines involving recommendations for the health-care team about involuntary hospitalization decisions. Although preliminary studies have been carried out; unfortunately, there is not any mental health law regulating how involuntary hospitalization processes and compulsory treatments should be carried out in Turkey. Similarly, there are not any guidelines on the clinical and ethical dimensions of the issue. Especially the current conditions determined by the increasing workload may cause mental health to take over excessive responsibility, and not be able to protect the patient’s rights and freedoms. Further studies focusing on the principle of the beneficence of the patient and the society and how to respect for patient autonomy at the highest level may guide researchers (28). In addition, further studies aiming to reveal the current situation in Turkey on a larger scale and to produce applicable solutions to actual problems are also needed.

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