

Patients' views of involuntary hospital admission after 1 and 3 months: prospective study in 11 European countries

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Background

Legislation and practice of involuntary hospital admission vary substantially among European countries, but differences in outcomes have not been studied.

Aims

To explore patients' views following involuntary hospitalisation in different European countries.

Method

In a prospective study in 11 countries, 2326 consecutive involuntary patients admitted to psychiatric hospital departments were interviewed within 1 week of admission; 1809 were followed up 1 month and 1613 3 months later. Patients' views as to whether the admission was right were the outcome criterion.

Results

In the different countries, between 39 and 71% felt the admission was right after 1 month, and between 46 and 86% after 3 months. Females, those living alone and those with a diagnosis of schizophrenia had more negative views. Adjusting for confounding factors, differences between countries were significant.

Conclusions

International differences in legislation and practice may be relevant to outcomes and inform improvements in policies, particularly in countries with poorer outcomes.

Declaration of interest

None.

Throughout the world significant numbers of people are admitted involuntarily to psychiatric hospital departments. How involuntary hospital admissions should best be legislated for and regulated is controversial.^{1–3} In the UK, the government has proposed two bills for a new mental health act in England and Wales since 2002. Following the wide resistance of professional groups, user organisations and parts of the media, both bills were withdrawn and the government settled for an amendment to the existing 1983 Act.^{4,5}

The debate on the most appropriate regulations and practice for involuntary hospital admission is guided by little, if any, research. There is no evidence about whether specific procedures are associated with different outcomes.^{6,7} Ethical and practical reasons may prevent experimental designs such as randomised controlled trials. In their absence, observational comparisons between sites with different legislation and practice are a viable method to explore the link between procedures and outcomes.

Countries across Europe share a similar background in terms of societal systems and history of psychiatry but vary substantially in their legislation for and practice of involuntary hospital admission.^{8,9} Involuntary admission rates vary by a factor of more than 10.^{1,10} Several studies have analysed the differences in legislation and policies but there is no evidence yet on whether there also are differences in outcomes.

Legislation for involuntary admissions is based on the assumption that individuals cannot recognise the need for hospital care because of the severe and usually acute symptoms of their illness. This would imply that they should later (once the acute phase is over) accept that the involuntary admission was the right intervention at the time.¹¹ Patients' retrospective view of the appropriateness of the admission has been used as an outcome criterion in studies in Australia, Canada, Sweden, the USA and the UK.^{12–18} Between 33 and 81% of involuntary

patients found the admission 'right' in retrospect. The rate varied according to the exact wording of the question and the time since admission.⁶

In this study we assessed patients' views on involuntary hospital admission after 1 and 3 months at sites in 11 European countries. We explored whether, and if so, to what extent, patients' retrospective views on admission varied between sites in different countries, whether these differences held true after controlling for differences in patient characteristics and what baseline patient characteristics were associated with more or less positive views across countries.

Method

Design and participants

The study was conducted as a multicentre prospective cohort study in 11 European countries: Bulgaria (Sofia), Czech Republic (Prague), Germany (Dresden), Greece (Thessaloniki), Italy (Naples), Lithuania (Vilnius), Poland (Wrocław), Slovakia (Michalovce), Spain (Granada and Malaga), Sweden (Örebro) and the UK (east London). Between one and five hospitals were studied in each country. Tel Aviv in Israel was originally included, but omitted from this analysis because of inadequate study implementation. All sites had in-patient units with voluntary as well as involuntary patients. Involuntary admissions were conducted according to national legislation and routine practice. The rationale and methods of the study, the characteristics of the participating hospitals and data about other mental health services in the catchment areas of the hospitals have been described in detail elsewhere.¹⁹ The inclusion criteria were: all in-patients in general psychiatric departments; admitted involuntarily; aged between 18 and 65 years; resident in the

catchment area; with sufficient command of the national language; able to give informed consent. Exclusion criteria were: admission because of intoxication; primary diagnosis of dementia; transfer from another hospital.

Procedures and measures

Patients were identified by researchers through ongoing contacts with clinical staff on the wards and the relevant administrators. Clinical staff in the participating wards introduced eligible patients to a researcher, who contacted the patient within the first week of admission, provided a full explanation of the study, and asked for consent. If written informed consent was obtained, the patient was assessed. This included an assessment of psychopathological symptoms, which were taken as baseline symptom levels. Further face-to-face interviews were conducted at follow-up at 1 and 3 months after admission. Patients were recruited between July 2003 and October 2005.

The primary outcome was the patients' retrospective view on the extent to which the admission was right or wrong at 1 and 3 months. Patients rated their response to the question 'Today, do you find it right or wrong that you were admitted to hospital?' on an 11-point Likert scale ranging from 0 (entirely wrong) to 10 (entirely right), which has been used in previous research.^{14,15}

Baseline sociodemographic and clinical characteristics and the diagnosis of the patients were obtained from medical records. These included data on age, gender, living situation (living alone *v.* living with others), employment situation (no current employment *v.* employment), previous hospitalisations (none *v.* one or more previous hospitalisations) and clinical diagnosis according to ICD-10.²⁰ Diagnoses were collapsed into three groups: schizophrenia or other psychosis (F20–29), affective disorder (F30–39), and 'others'. Researchers assessed baseline symptom levels on the 24-item version of the Brief Psychiatric Rating Scale (BPRS)²¹ which ranges from 24 to 168, with 168 indicating the maximum symptom severity. Researchers from all sites had joint training sessions in administering and rating this instrument and achieved an interrater reliability (intraclass correlation coefficient) of 0.78. The study was approved by the relevant national and/or local ethics committees.

Statistical analysis

The outcome variable was the patients' retrospective view on the extent to which the admission was right or wrong on an 11-point scale (0, entirely wrong; 10, entirely right), and was treated as quantitative in the analysis to fully utilise the variation in patient's responses and summarised by mean and standard deviation after examining its distribution. To present the primary outcome in each country in a clinically more meaningful manner, we also dichotomised the scale at five (the neutral middle point) and show the percentage of patients who rated above five indicating that they viewed their admission as more right than wrong. Descriptive summary statistics were also used to describe the distributions of the predictors of the outcome variable.

To account for possible correlations among repeated measurements, a generalised estimating equation (GEE) model was employed²² with patients' characteristics measured at baseline and time of measurement as fixed effects and patient as random effect. We performed GEE model analysis in three steps. First, we performed a univariate GEE model analysis for all predictors. Predictor variables that were significant at $P=0.05$ were subsequently entered in a multivariate GEE model analysis in the second step. Finally, we checked model assumptions by examining the residual plots.

The estimated effects of predictors on the primary outcome from the GEE models are reported together with their 95% confidence intervals. To identify the between-country differences, we derived a matrix of P -values for all possible pair-wise between-country comparisons from the estimated multivariate GEE model.

In England, age, gender, and clinical diagnosis were obtained for all eligible patients in the study including those who were not interviewed (approved by the Patient Information Advisory Group; ref: PIAG 2-10(d)/2005). Interviewed and non-interviewed patients were compared on the assessed characteristics to estimate a potential selection bias in the recruitment process.

Results

Sample characteristics

A total of 2326 patients were recruited in all countries and assessed at baseline. Table 1 shows the number of eligible patients and the selection process in each country.

Between 31 and 71% of eligible patients were interviewed within the first week of admission, and of these between 63 and 96% were followed up at 1 month, and between 55 and 93% at 3 months.

The characteristics of the participating patients are summarised in Table 2. Overall, 72% of patients were without employment, 66% lived alone, 71% had been hospitalised before and 62% were diagnosed with schizophrenia.

At the English site, baseline data were obtained for 181 out of those 183 patients who were eligible but not interviewed. Their mean age was 36.01 years (s.d.=11.41). Of these, 40% were female, 60% diagnosed with schizophrenia, 22% with affective disorders and 18% with 'other' diagnoses. The interviewed and non-interviewed patients were similar on the tested characteristics listed in Table 2.

The baseline characteristics of patients in the total sample followed up at 1 month (and at 3 months) were: 45.1% (45.5%) female; 73.1% (72.2%) unemployed; 35.3% (36.0%) living with others; 71.4% (72.3%) with a previous hospitalisation; 65.7% (64.7%) diagnosed with schizophrenia, 16.7% (17.2%) with affective disorders and 17.6% (18.1%) with 'other' diagnoses. The mean age of those followed up at 1 month was 38.87 years (s.d.=11.21), and of those followed up at 3 months 39.10 years (s.d.=1.13). The baseline BPRS mean score of those followed up at 1 month was 54.77 (s.d.=15.84) and of those followed up at 3 months 55.08 (s.d.=15.84). The assessed characteristics of the originally recruited sample and the samples followed up at 1 and 3 months were similar.

Patients' views on whether admission was right

Table 3 shows the percentage of patients who thought that the admission was right, as well as the means and standard deviations of their ratings for each country and each follow-up.

In the total sample, 55% thought at 1 month that their admission was right and 63% at 3 months. The percentages varied between 39 and 71% at 1 month, and between 46 and 86% at 3 months.

Across all countries, the distribution of the scores on the 11-point rating scale at 1 month (and 3 months) were: 0: 7% (13%); 1: 3% (2%); 2: 5% (4%); 3: 4% (5%); 4: 3% (3%); 5: 12% (11%); 6: 5% (5%); 7: 8% (9%), 8: 12% (13%); 9: 9% (12%); 10: 22% (24%).

Factors associated with patients' views

The univariate associations of all considered predictor variables including country of site with the outcome and the findings of

Table 1 Recruitment and follow-up rates at sites in all countries

	Bulgaria	Czech Republic	England	Germany	Greece	Italy	Lithuania	Poland	Slovakia	Spain	Sweden	Total sample
Eligible patients, <i>n</i>	475	581	451	466	349	280	120	334	439	850	306	4651
Absconded/discharged, <i>n</i>	27	80	30	186	58	7	1	30	41	219	49	728
Clinically too unwell, <i>n</i>	76	160	89	59	43	60	17	52	87	84	44	771
Asked to take part, <i>n</i>	372	341	332	221	248	213	102	252	311	547	213	3152
Refused to take part, <i>n</i>	63	139	64	76	26	84	17	100	15	126	116	826
Assessed at baseline												
<i>n</i>	309	202	268	145	222	129	85	152	296	421	97	2326
% of eligible patients	65	35	59	31	64	46	71	46	67	50	32	50
Assessed at 1-month follow-up												
<i>n</i>	297	165	179	120	178	116	66	141	221	264	62	1809
% of participants at baseline	96	82	67	83	80	90	78	93	75	63	64	78
Assessed at 3-month follow-up												
<i>n</i>	287	146	175	106	147	111	48	140	162	236	55	1613
% of participants at baseline	93	72	65	73	66	86	56	92	55	56	57	69

Table 2 Baseline characteristics of participating patients at sites in all countries and hospitalisation status at 1-month and 3-month follow-up

	Bulgaria (<i>n</i> = 309)	Czech republic (<i>n</i> = 202)	England (<i>n</i> = 268)	Germany (<i>n</i> = 145)	Greece (<i>n</i> = 222)	Italy (<i>n</i> = 129)	Lithuania (<i>n</i> = 85)	Poland (<i>n</i> = 152)	Slovakia (<i>n</i> = 296)	Spain (<i>n</i> = 421)	Sweden (<i>n</i> = 97)	Total sample (<i>n</i> = 2326)
Gender, <i>n</i> (%)												
Female	195 (63)	108 (53)	86 (32)	55 (38)	72 (32)	45 (35)	46 (54)	80 (53)	117 (40)	146 (35)	51 (53)	1001 (43)
Male	114 (37)	94 (47)	181 (68)	90 (62)	150 (68)	82 (65)	39 (46)	72 (47)	179 (60)	275 (65)	46 (47)	1322 (57)
Age												
<i>n</i>	309	202	265	145	222	127	85	152	296	421	97	2321
Years, mean (s.d.)	39.15 (10.24)	40.33 (13.26)	34.72 (9.73)	37.35 (11.68)	38.75 (10.29)	39.04 (10.32)	40.48 (11.67)	41.79 (11.71)	39.78 (10.47)	37.73 (11.08)	41.30 (11.92)	38.72 (11.12)
Employment, <i>n</i> (%)												
No	255 (87)	123 (61)	216 (82)	107 (74)	127 (57)	87 (69)	62 (73)	116 (77)	227 (77)	272 (66)	69 (71)	1661 (72)
Yes	37 (13)	78 (39)	47 (18)	38 (26)	95 (43)	39 (31)	23 (27)	35 (23)	69 (23)	143 (34)	28 (29)	632 (28)
Living situation, <i>n</i> (%)												
With others	124 (41)	84 (42)	65 (25)	47 (32)	55 (25)	36 (29)	33 (40)	67 (44)	132 (45)	106 (25)	29 (31)	778 (34)
Alone	170 (58)	117 (58)	191 (75)	98 (68)	166 (75)	88 (71)	50 (60)	84 (56)	163 (55)	313 (75)	66 (69)	1506 (66)
Past hospitalisation, <i>n</i> (%)												
At least one	236 (80)	148 (74)	193 (72)	104 (72)	137 (63)	93 (76)	71 (86)	99 (65)	175 (61)	269 (65)	82 (88)	1607 (71)
None	60 (20)	52 (26)	74 (28)	41 (28)	81 (37)	29 (24)	12 (14)	53 (35)	112 (39)	143 (35)	11 (12)	688 (29)
Diagnosis, <i>n</i> (%)												
Schizophrenia	249 (90)	120 (60)	154 (59)	67 (46)	161 (73)	85 (67)	78 (92)	108 (71)	143 (48)	225 (53)	38 (40)	1428 (62)
Affective disorders	24 (9)	25 (12)	61 (23)	31 (21)	28 (13)	25 (20)	2 (2)	23 (15)	19 (6)	95 (23)	29 (31)	362 (16)
Other	5 (2)	57 (28)	47 (18)	47 (32)	33 (15)	17 (13)	5 (6)	21 (14)	134 (45)	101 (24)	28 (29)	495 (22)
Symptoms, BPRS												
<i>n</i>	309	201	264	144	209	126	85	152	296	415	94	2295
Score, mean (s.d.)	69.09 (13.99)	50.23 (13.41)	51.26 (10.85)	54.25 (12.71)	48.55 (10.37)	73.16 (21.11)	58.23 (10.94)	47.98 (11.55)	49.94 (13.06)	45.30 (10.83)	48.36 (10.82)	53.39 (15.36)
Still in hospital at 1 month, <i>n</i> (%)	222 (75)	105 (62)	116 (50)	91 (72)	113 (57)	5 (5)	64 (81)	105 (73)	177 (61)	35 (9)	27 (37)	1060 (50)
Still in hospital at 3 months, <i>n</i> (%)	135 (47)	16 (11)	36 (17)	21 (19)	17 (10)	3 (3)	16 (27)	10 (7)	8 (3)	3 (1)	12 (16)	274 (14)
BPRS, Brief Psychiatric Rating Scale.												

Table 3 Patients' views on whether admission was right or wrong at sites in all countries

Patients' views of admission	Bulgaria	Czech Republic	England	Germany	Greece	Italy	Lithuania	Poland	Slovakia	Spain	Sweden	Total sample
1-month follow-up												
n	284	159	176	118	163	112	66	138	204	253	59	1732
Score, mean (s.d)	4.76 (3.31)	6.09 (3.54)	4.89 (3.91)	6.46 (3.44)	5.49 (4.07)	6.48 (1.81)	4.33 (3.71)	5.10 (3.84)	7 (3.85)	6.51 (3.24)	6.11 (3.81)	5.77 (3.63)
Wrong, %	55	43	53	36	52	29	61	51	33	38	42	45
Right, %	45	57	47	64	48	71	39	49	67	62	58	55
3-month follow-up												
n	265	112	175	105	134	102	45	137	144	224	54	1497
Score, mean (s.d.)	5.86 (3.30)	6.95 (3.04)	5.6 (3.98)	7.18 (3.08)	6.63 (3.73)	7.25 (1.54)	6 (2.84)	5.93 (3.69)	7.13 (3.74)	6.35 (3.29)	5.79 (3.72)	6.37 (3.43)
Wrong, %	42	32	46	30	39	14	49	39	31	34	54	37
Right, %	58	68	54	70	61	86	51	61	69	66	46	63

the multivariate analysis are shown in Table 4. Table 5 shows which differences between countries were significant in pair-wise *post hoc* comparisons, adjusting for the influence of all other significant predictor variables.

Patients' views on the appropriateness of their involuntary admission show significant differences between sites in different countries, even when adjusted for other predictor variables. The *post hoc* comparisons show that not all differences between sites in different countries were statistically significant, but the more substantial ones were, for example, patients' views in England are significantly less favourable than those in Bulgaria, Greece, Spain, the Czech Republic, Italy, Germany and Slovakia, whereas patients' views in Slovakia are significantly more positive than in all sites other than those in the Czech Republic, Italy and Germany.

All predictor variables considered further other than previous hospitalisation showed significant associations with outcomes in univariate analyses. In the multivariate analysis however, only gender, living situation and diagnosis were significantly associated with patients' views. Male patients and those living with others tended to find the admission more often right. Patients with schizophrenia had more negative views than those with other diagnoses.

Discussion

Main findings

One month after involuntary hospital admission, between 39 and 71% believed the admission was right. After 3 months, when the acute phase of the mental illness justifying the involuntary admission should be overcome for most patients, the rates are higher and range between 46 and 86%. The findings that a substantial proportion of patients do not agree retrospectively with the appropriateness of the admission may shed a critical light on the ethical justification of involuntary hospital admission. At the same time, an average of 63% found the admission right 3 months later which may be a reassuring finding for many clinicians, patients and their families. The figures are consistent with previous studies with smaller samples and usually less systematic methods.^{6,14,23,24} However, what is a totally new finding is the large variation across sites in different European countries. This variation is not explained by differences in sociodemographic characteristics, clinical diagnoses or baseline symptom levels considered in this study. The size of the differences are substantial, and many of them are statistically significant.

Strengths and limitations

This is the largest prospective study on outcomes of involuntary hospital admissions ever conducted and the first one to use the same methods across sites in a number of countries. It included centres in 11 European countries with different legislation and practice in involuntary admission. All patients were assessed face to face by trained researchers, and were recruited and interviewed within the first week of admission, which is challenging given that many patients had high symptom levels and all of them were in the hospital on an involuntary basis.

The study has a number of weaknesses: overall, only 50% of the eligible patients were interviewed, and the rate varied across countries. The rate may be seen as low in many other fields of health research, but has been described as good for these types of studies in acute settings with patients who are difficult to recruit.⁶ For comparison of recruited and non-recruited patients, data were only available for the English site, although both the followed up and non-followed up patients were compared at all sites. These

Table 4 Factors associated with patients' views on admission in univariate and multivariate generalised estimating equation analyses

Predictor variables	Univariate analysis			Multivariate analysis		
	B ^a	95% CI	P	B ^a	95% CI	P
Country						
England	0.00			0.00		
Lithuania	-0.10	-0.98 to 0.77	0.817	0.04	-0.84 to 0.93	0.923
Poland	0.29	-0.37 to 0.96	0.391	0.25	-0.41 to 0.93	0.454
Bulgaria	0.04	-0.51 to 0.60	0.882	0.64	0.02 to 1.27	0.041
Sweden	0.77	-0.09 to 1.63	0.080	0.77	-0.11 to 1.65	0.086
Greece	0.63	-0.00 to 1.27	0.051	0.61	-0.03 to 1.27	0.064
Spain	1.26	0.69 to 1.83	<0.001	0.43	0.03 to 0.84	<0.001
Czech Republic	1.22	0.57 to 1.88	<0.001	1.19	0.53 to 1.85	<0.001
Italy	1.64	0.92 to 2.36	<0.001	1.47	0.70 to 2.24	<0.001
Germany	1.49	0.79 to 2.19	<0.001	1.30	0.60 to 2.01	<0.001
Slovakia	1.92	1.31 to 2.52	<0.001	1.74	1.13 to 2.36	<0.001
Male v. female	0.77	0.47 to 1.06	<0.001	0.77	0.46 to 1.08	<0.001
Employed v. unemployed	0.44	0.11 to 0.77	0.008	0.17	-0.16 to 0.51	0.307
Living alone v. living with others	-0.56	-0.87 to -0.26	<0.001	-0.69	-1.02 to -0.37	<0.001
Diagnosis						
Schizophrenia	0.00			0.00		
Affective disorder	0.70	0.30 to 1.10	0.001	0.60	0.19 to 1.01	0.004
Other	0.84	0.45 to 1.22	<0.001	0.43	0.03 to 0.84	<0.001
BPRS score	-0.01	-0.01 to -0.00	0.035	0.00	-0.00 to 0.01	0.517
No past hospitalisation	0.17	-0.15 to 0.50	0.286			

BPRS, Brief Psychiatric Rating Scale.
a. Regression coefficient.

Table 5 P-values from pair-wise between-country comparisons derived from multivariate generalised estimating equation model

	England	Lithuania	Poland	Bulgaria	Sweden	Greece	Spain	Czech Republic	Italy	Germany
Lithuania	0.923									
Poland	0.454	0.648								
Bulgaria	0.041	0.165	0.257							
Sweden	0.086	0.190	0.272	0.781						
Greece	0.064	0.213	0.311	0.932	0.738					
Spain	<0.001	0.012	0.005	0.100	0.376	0.082				
Czech Republic	<0.001	0.013	0.009	0.102	0.363	0.097	0.909			
Italy	<0.001	0.004	0.004	0.021	0.170	0.036	0.419	0.497		
Germany	<0.001	0.008	0.006	0.059	0.264	0.064	0.659	0.759	0.694	
Slovakia	<0.001	<0.001	<0.001	<0.001	0.029	0.001	0.043	0.089	0.477	0.209

comparisons did not suggest a selection bias on the assessed characteristics, neither for the recruitment of eligible patients nor for the follow-ups. However, only a few characteristics were assessed.

We only studied between one to five hospitals in each country and do not know to what extent the data are representative for the country as a whole. In England we have data from a linked national study to estimate this.²⁴ The English sites in this international study were two hospitals in the London boroughs of Hackney and Newham. In 20 other hospitals, the same outcome data were assessed in 371 involuntary patients at 1 month and in 307 patients at 3 months. At 1 month, 45% ($n=166$) of patients felt that the admission was right (mean score 4.81, s.d.=3.99), and at 3 months 50% ($n=154$) expressed that view (mean score 5.34, s.d.=3.94). Outcomes at the two study-site hospitals in east London and the 20 other hospitals in England were similar, and using the data of those 20 hospitals would not have substantially changed the findings of the national comparisons. However, there are no similar data from other

countries to check whether the results at the study sites are representative for or different from the outcomes at other hospitals in the country.

Possible reasons for the differences

Can the identified differences in patients' views about involuntary admission be linked to the characteristics of the given legislation? There is no straightforward answer. The legislation in all countries is complex and has many features that are of potential importance. Any interpretation of the findings from the identified differences with the characteristics of the national legislation is a *post hoc* exercise and inevitably speculative.

One possible criterion to classify the national regulations is the extent to which they protect the rights and interests of the patients concerned.^{8,9} Seven criteria that vary between countries and may be seen as relevant for the protection of the interests of the patients are shown in the Appendix. Although the answers to the questions are not always clear cut, we established the number

of criteria for each country. The resulting ranking has similarities with the order of outcomes in the multivariate analysis of this study (with the most protective legislation and most positive patient views in Slovakia and Germany, and the least protective legislation and most negative views in England), but the criteria still leave many of the differences in patients' views unexplained.

A number of other national features might be important. These include the geographical position and political history (e.g. Western v. Eastern Europe), the relative expenditure of healthcare funding on mental healthcare,²⁵ the overall rates of involuntary admissions,² and the recruitment and follow-up rates in this study. However, none of these was clearly associated in our study with the differences identified in patients' views. There are three other possible factors accounting for the differences that were not assessed. First, patients at the various sites may have differed in relevant social or clinical characteristics that were not captured in the study. Second, national differences in the expectations of patients and overall rating tendencies may have favoured more or less positive answers to the outcome question. Finally, clinical practice (the behaviour of professionals towards involuntary patients and the methods employed to support and treat them) is likely to vary across Europe and impact on outcomes. Some aspects of clinical practice may be linked to national cultures and traditions and difficult to change, but others may reflect training and policies that are transferable to other countries.

Factors associated with outcomes across countries

Some patient characteristics were associated with views on admission across countries. Females expressed more negative views, as has been reported for other patient-reported outcomes in psychiatry, although this is not a consistent finding.^{26,27} Patients living alone more often rated the admission as wrong, which may reflect their difficulties adjusting to the confined space and the often tense atmosphere with fellow patients and staff on a ward. It may also be that patients living with others had often experienced conflicts and tension with these making the admission a relief and therefore the right decision in retrospect. During and after hospital treatment they are likely to have had discussions with their partners about their illness and received support from them. Both discussions and support may have led to more positive appraisals of the admission. Patients with schizophrenia had more negative views on admission, which may be linked to a more frequent lack of insight in these patients.²⁸ In the multivariate analysis, the degree of baseline symptoms was not associated with later views about the admission. Thus, this study provides no evidence for the assumption that a high level of initial symptoms is associated with more negative views about admission later.

Implications

The findings suggest that the great differences in the legislation and practice of involuntary hospital admission and subsequent treatment across Europe may indeed be associated with substantial differences in patients' views. Although the exact causal factors and mechanisms remain poorly understood, the differences between European countries appear to matter for outcome.²⁹ Future in-depth studies could identify those factors in legislation and practice that are specifically relevant to achieving more positive views from patients.³⁰ Countries with currently less favourable outcomes, such as England, might consider implementing them, and methods may be developed to strengthen these factors and improve outcomes across all countries.

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Appendix

Criteria to distinguish the legislation on involuntary hospital admission with respect to the protection of the interest of the patients

For each question the first option is seen as more protective of the interest of the patients.

Legislation criteria

- Is involuntary admission possible only when patients pose a risk to themselves and/or others, *or* also to avoid a more general threat to the patients' health?
- Can the admission be initiated only by authorities and medical doctors *or* also by other stakeholders?
- Does involuntary admission require the decision of a court *or* not?
- Is the period of time for which the hospital can decide to keep patients involuntarily on the wards without a formal decision for involuntary treatment shorter *or* longer than 24 hours?
- Is legal support guaranteed *or* not?
- With respect to appeal procedures to independent bodies, are there binding time periods for a response, and are people and/or institutions other than the patient authorised to appeal, *or* not?
- Is the decision for involuntary treatment measures separate from the decision for involuntary admission *or* not?

Criteria protecting the interest of the patients in each country

Seven: Germany (a–g).

Five: Slovakia (a, c, d, f, g), Sweden (a, b, d, e, f).

Four: Bulgaria (a, c, d, g), Czech Republic (a, c, d, g), Spain (c, d, e, g).

Three: Italy (b, f, g), Poland (b, c, e), Lithuania (a, b, c).

Two: Greece (c, f).

One: England (e).

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Psychiatrists in 19th-century fiction

Passages from the Diary of a Late Physician (1837), Samuel Warren

Fiona Subotsky

Samuel Warren (1807–1877) was a lawyer who eventually achieved the well-rewarded post of Master of Lunacy with responsibility to adjudicate on the financial affairs of lunatics. When younger, he had also for 6 years 'actively engaged in the practical study of physic', perhaps as apprentice to an apothecary. His many tales, published first in *Blackwood's Magazine*, inspired imitation from Poe, Le Fanu and Dickens, and concentrated on sensational medical case histories, especially including the supernatural, insanity and deathbeds, ideally all three, as below.

In *The Spectre-Smitten*, law student Mr M returns to gloomy Lincoln's Inn after a night of revelry, to find a figure of 'ghastly hue' sitting in his armchair, which then terrifyingly stretches out its arms and approaches. Mr M falls 'senseless on the floor', proceeding to frequent convulsions, twitchings and contortions. He recovers consciousness, but learning that his neighbour died on the night of the apparition becomes convinced he is haunted by him. The physician forms the opinion that Mr M is 'suffering from a very severe congestion of the vessels of the brain', and orders 'copious venesection – his head to be shaven, and covered perpetually with cloths soaked in evaporating lotions – blisters behind his ears and at the nape of the neck – and appropriate internal medicines'. This fails to prevent an attempted murderous assault with a razor after which the patient is put in a strait jacket, strapped to a bed, and removed to an asylum 'reduced to a state of drivelling idiocy – complete fatuity!' Even though Mr M improves somewhat, he is still convinced, despite the physician trying to reason with him, that he is constantly under the watch of a huge boa constrictor. Apparent recovery notwithstanding, he later destroys himself 'in a manner too terrible to mention'.

This is one of the more coherent stories. It is best if the reader can just relax and enjoy shock by shock, hoping that current interventions have made progress.

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