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Non-Voluntary Admission of Patients with Mental Disorders: Ethical and Social Issues

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Abstract

Non-voluntary admission of mentally ill patients is charged with multiple ethical issues and dilemmas, the most complicated being its dangerousness and predictability, the appropriate classification of patients into the corresponding risk category and the therapeutic decisions imposed in a paternalistic way. The paternalistic attitude of the physician is acceptable given that there is an obvious degree of social danger. The potentially violent, especially hetero-aggressive, behaviour has a great social impact resulting in patient stigmatization and isolation. The purpose of this paper is to highlight the social issues of patients with mental disorders, non-voluntary admitted. The study is retrospective and the data were collected from records of patients who have been non-voluntarily admitted from 2002 to 2011 in a psychiatric hospital in Iasi, Romania. The results show that among the risk factors in non-voluntary admission, hetero-aggressivity is one criterion under Article 45, paragraph a) Law 487/2002, frequently met in the study batch. Additionally, many non-voluntary admitted patients with mental illness have no medical insurance, being unemployed, unmarried / divorced and having a low social support. Community must be tolerant towards the mentally ill, regardless of the social integration of these patients. After discharge, a better social support may improve the prognosis, influencing the occurrence and evolution of mental illnesses. A strong support network is protective whereas a weak or lacking support network would make patients more vulnerable to stressful life events.

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Keywords: non-voluntary admission; mental disorder; social issues; psychiatric ethics; hetero-aggressivity.

Introduction

Medicine, from its beginnings as a social practice, faced various legal and ethical issues. In Psychiatry, as in other disciplines, ethical issues may be encountered both in research and in clinical practice. Patients with mental disorders were perceived by the community as a threat, being stigmatized and socially isolated (Marian, 2012). The grounds of the doctor-patient relationship and the patient's rights have two different moral requirements: the need to respect the autonomy and the need to protect those with a reduced autonomy. A person can be considered as autonomous if he/she can choose one of more options, reflecting and debating on that choice (Gavrilovici, 2012; Cohen, 2000). The patients' involvement in their own care requires a thorough education on self-care techniques on multiple levels: mentally, physically and socially (Christmas 2012 Schildmann, 2012). The old but adapted moral rules have ben grouped into medical and ethical statements as the Declaration of Helsinki.

From an ethical perspective, autonomy is the principle that embodies the respect for the individual, with fundamental rights and privileges in our community. On the other hand the psychiatric treatment may require long-term non-voluntary admission, which is being left to the free choice of the physician. Critics of the current psychiatric system believe that psychiatrists have the powers allow the unnecessary and unwanted interference in the lives of certain individuals with bizarre and socially unaligned behaviour. They consider that the causes of psychiatric illness are rather rooted in the community than in any psychological pathology. Is a mentally ill is somebody who is forced to take refuge from the social micro or macro pressures. Labelling any non-voluntary admitted patient as lacking rights would be wrong. The issue raised was determined by the isolation of the mentally ill for a variable period within a healthcare establishment, an isolation for which the patient gave no consent.

In Psychiatry there are two types of admission: one were the consent was given (voluntary) and non-voluntary admission. Non-voluntary admission is performed according to Law 487/2002, Law for mental health and the protection of persons with mental disorders (Law 129/2012). Prospective non-voluntary admissions must take into account the protection of institutionalized psychiatric care, both for preventive and rehabilitation purposes (Carasevici, 2006). The ethical issues related to non-voluntary admission should specifically consider the patient's autonomy (Hill, 2008).

Thomas Szasz gathered around him a circle of lawyers, forensics, sociologists and psychiatrists and together they tried to influence the psychiatric care system. By changing the concept of mental illness, they supported the idea of abolishing psychiatric hospitals, since they were no longer necessary. Despite a previous tendency to reduce the number of admissions in psychiatric hospitals, it is difficult to do it without providing first the services of community psychiatric nurses (Carasevici, 2006).

In the past, the mentally ill were seen as a permanent threat to their peers in the community. The general ethical principles substantiating the physician - mentally ill patient relationship aim to combat social and health discrimination of the mentally ill, while psychiatrists are regarded as the advocate of patients' social values and the compulsory admission will be considered as exceptional conduct. The restrictions on freedoms of the mentally ill will be considered only for the protection of the individual and community.

Choosing the best treatment and setting the prognosis are determined by an appropriate diagnosis. The social prognosis is less satisfactory for non-voluntarily admitted patients due to an absent or reduced illness awareness that generates a low compliance to the treatment. The stigma of mentally ill patients, which is still experienced, may contribute to this (Iliescu, 2009). The social support from both the family and the therapist is therefore very important as it relieves frustrations, the tendency to social isolation, relapses, recurrent non-voluntary admissions, the reduced compliance to treatment and the low addressability to psychiatric care etc.

Issues of social prognosis refer to: the level of academic education (training), social inclusion (independent employee, income level, dependent, social protection, insurance coverage). Other issues are: social limitations, stigma (specified prohibition or indirect access to certain jobs, unemployment, the prohibition of other activities – eg. the right to drive), marital status (married, single, children), quality of life and mortality. Hence, the stigma of an individual comes to dominate his/her peers' perception and behaviour. Psychiatric disorders with onset in childhood have an unfavourable social prognosis because they seem to have a negative impact on the level of education, finding a job, marriage and fertility. Social and academic limitations may be related to etiology, medication, discrimination by the community. The influence of mental disorders on the social prognosis is higher than for other chronic diseases (eg. asthma) (Iliescu, 2009).

The burden of the chronic disease and the quality of care for patients with chronic disorders is influenced by their own low socio-economic status (Bulgaru-Iliescu, 2012). The condition of the disease therefore exceeds the biological limits, being a socially deviant and undesirable state. Heredity, childhood environment, neurobiological factors, psychological and social processes seem to be important

factors determining mental disorders. Social problems such as unemployment for a longer period of time, poverty and homelessness, are frequently encountered. There will be noticeable differences regarding the patient's status and nature of the condition, considered normal or pathological, depending on the type of community and the level of development of the latter. There are still several negative factors affecting this medico-social process: divergent views on the diagnosis, prognosis, prevention and treatment of certain diseases, a really fashionable phenomenon in treating diseases and other circumstances involving the community and the health care system in the medical act.

From a social perspective, health is that condition of the body providing the best individual skills for individuals to optimally fulfil their social roles (friend, neighbour, citizen, husband, father, citizen, etc.). Parsons defines health as the state of optimum capacity of an individual to perform his or her expected social roles for which he/she has been socialized. Social issues are generated and amplified by multiple social, economic, family, professional, educational and medical factors as well as by indirect factors related to the professional level (Brasoveanu, 2006). Dysfunctional aspects have correlations with vulnerable population, social isolation being considered in addition to stigma and discrimination (Neagu, 2006).

Accountability for the daily activities should not represent a burden to the patient but on the contrary, it should stimulate his/her remaining psychological abilities. By feeling accepted and not excluded by their peers, patients are somehow determined to bring their behaviour in agreement with others. Patients diagnosed with mental disorder must face the pressures of the community. Stigma and discrimination are processes that affect both the patient and the social environment. Tolerance to psychological pain should be a compulsory concept in a respectful and understanding community. The community has an obligation to protect vulnerable people and family plays a central role in current psychiatric care both in terms of the pathogen role (inducing decompensation) and of health (Glenn, 2006; Fahey, 1995).

The criteria for non-voluntary admission generally involve an imminent danger to patients or to those around them, or the inability for self care, according to Law 487/2002, the law of mental health and protection of persons with mental disorders. In Psychiatry, as in all branches of Medicine, non-adherence to treatment is a serious problem with major implications in providing appropriate care, in patient prognosis and health costs. The low compliance to treatment results in multiple relapses and readmissions to psychiatric care services.

Methodology

The performed study is retrospective, quantitative, for a period from April 2003 until October 2011, the data being collected from observation forms of a batch of 167 non-voluntary patients from "Socola" University Hospital in Iași. Only non-voluntarily admitted patients have been considered in this study.

The research objective

The purpose of this article is to reveal the social issues in the mental disorders of patients non-voluntarily admitted for a period of approximately 10 years in a psychiatric hospital and also the extent to which non-voluntary admission was justified considering the psychosocial consequences of patient psychiatric labeling.

Discussions

The distribution by gender showed a higher rate of male patients (78.4%), with gender ratio 3.6 / 1. The batch distribution according to the area of origin showed higher frequency of patients from urban areas (70.7%), the U / R ratio being 2.4 / 1. In the studied cases we identified a high frequency of patients belonging to the 30-39 years age group (35.9%). The average age of patients from urban areas was 40.73 years, ranging from 19 to 79 years, while in rural areas the average age was 40.31 years with a range between 18-75 years, which shows the age homogeneity by the patient's area of origin ($t = 0.203$, $GL = 165$, $p = 0.839$). In the analyzed batch of patients we have observed a high frequency of unemployed patients (64.1%).

Table 1. Batch structure by occupation

Occupation	No. of patients	Male		Urban		Under 40	
		n	%	n	%	n	%
Unemployed	107	86	80,4	73	68,2	69	64,5
Retired	38	34	89,5	29	76,3	8	21,1
Employee	19	9	47,4	14	73,7	11	57,9
Student	3	2	66,7	2	66,7	3	100,0
Statistical significance		**p=0,001**		p=0,820		**p=0,00005**	

According to the epidemiological characteristics we have focused on the following aspects: (1) significantly lower rate of employed male patients (47.4%); (2) increased frequency of patients under 40 who were unemployed (64.5%). The studied cases showed a high frequency of patients with high educational level, 28.7% with a degree and 31.1% high school and post-secondary graduates.

Table 2. Batch structure by education

Education	No. of patients	Male		Urban		Under 40	
		n	%	n	%	n	%
Primary	6	5	83,3	3	50,0	2	33,3
Secondary	20	19	95,0	6	30,0	12	60,0
Vocational	41	36	87,8	24	58,5	20	48,8
College	44	32	72,7	38	86,4	29	65,9
Post-secondary	8	4	50,0	4	50,0	5	62,5
Higher	48	35	72,9	43	89,6	23	47,9
Statistical significance		p=0,056		**p=0,001**		p=0,421	

In the studied cases we have identified a frequency of approximately 50% of single persons, 16.7% of divorced persons and 2.4% widowed patients. The batch distribution based on epidemiological characteristics highlights the following aspects: (1) slightly lower frequency of widowed patients (50%); (2) significantly higher proportion of subjects coming from urban areas - widowers (100%) or divorced (89.3%); (3) there were significant differences by age group in terms of marital status, registering an increased frequency of single people aged under 40 years (79.5%).

Table 3. Batch structure by marital status

Marital status	No. of patients	Male		Urban		Under 40	
		n	%	n	%	n	%
Married	52	38	73,1	33	63,5	19	36,5
Divorced	28	20	71,4	25	89,3	6	21,4
Widower	4	2	50,0	4	100,0	0	0,0
Single	83	71	85,5	56	67,5	66	79,5
Statistical significance		p=0,107		**p=0,045**		**p=0,001**	

It should be noted that most admissions were emergency admissions (94.6%), yet only 65.9% of subjects had a health insurance plan.

Table 4. Batch structure by type of admission and social insurance

Marital status	No. of patients	Male		Urban		Under 40	
		n	%	n	%	n	%
Type of admission							
emergency	158	125	79,1	110	69,6	85	53,8
non-emergency	9	6	66,7	8	88,9	6	66,7
Statistical significance		p=0,641		p=0,371		p=0,682	
Health insurance							
insured	110	81	73,6	85	77,3	52	47,3
uninsured	57	50	87,7	33	57,9	39	68,4
Statistical significance		**p=0,036**		**p=0,015**		**p=0,015**	

Health insurance plans were identified with significantly higher frequency in male patients, patients from urban areas and patients aged over 40 years. Depending on the number of previous admissions the following issues are worth

mentioning: (1) most patients had 3-5 previous admissions (29.3%); 19.2% of patients had more than 10 previous admissions.

Table 5. Batch structure by the number of previous admissions

Number of previous admissions	No. of patients	Male		Urban		Under 40	
		n	%	n	%	n	%
First admission	47	33	70,2	36	76,6	30	63,8
Second admission	18	12	66,7	14	77,8	8	44,4
3-5 admissions	49	41	83,7	33	67,3	30	61,2
6-10 admissions	21	15	71,4	15	71,4	10	47,6
> 10 admissions	32	30	93,9	21	65,6	13	40,6
Statistical significance		**p=0,047**		p=0,709		p=0,181	

Most patients, according to the number of days of admission, were hospitalised between 31 and 40 days (26.9%), but it is worth noting the frequency of patients hospitalized for a period of time of over 30 days (12.6%).

Table 6. Batch structure by the number of hospitalisation days

Epidemiological features	**1-10**	**11-20**	**21-30**	**31-40**	**41-50**	**51-60**	**> 60 days**
Total, out of which:	**15**	**34**	**39**	**45**	**7**	**6**	**21**
Male	12	25	28	36	6	5	19
$\chi 2$=3,36; p=0,762	80,0	73,5	71,8	80,0	85,7	83,3	90,5
Urban	9	27	26	33	6	3	14
$\chi 2$=4,58; p=0,598	60,0	79,4	66,7	73,3	85,7	50,0	66,7
Under 40 years old	10	18	19	25	3	4	12
$\chi 2$=2,14; p=0,906	66,7	52,9	48,7	55,5	42,9	66,7	57,1

The diagnosis at discharge, compared to that originally established, was confirmed as follows: (1) delirium, dementia or other cognitive disorders at discharge were confirmed for 75% of patients, the remaining 10% of patients being initially diagnosed with schizophrenia and 5% with alcoholism, mood disorder or epilepsy; (2) alcoholism was confirmed in 92,6% of patients; (3) the diagnosis of schizophrenia was confirmed in 91.8% of patients; (4) the mood disorder at discharge was maintained in 60% of patients and established in 33.3% of patients who were initially diagnosed with schizophrenia; (5) the personality disorders are confirmed only in 40% of cases, the remaining patients being alcoholics; (6) the mental retardation diagnosis at discharge was not originally established, the two patients being initially diagnosed with delirium, dementia or other cognitive disorder or schizophrenia.

Table 7. Statistical indicators of days of hospitalization by the diagnosis at discharge

Diagnosis at discharge	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min	Max
					Lower Bound	Upper Bound		
Delirium, dementia or other cognitive disorders	20	43.50	28.315	6.331	30.25	56.75	9	104
Alcoholism	27	19.30	12.508	2.407	14.35	24.24	1	55
Schizophrenia and other psychotic disorders	98	41.57	33.441	3.378	34.87	48.28	7	197
Mood disorders	15	25.53	12.397	3.201	18.67	32.40	2	48
Personality disorders	5	11.20	5.933	2.653	3.83	18.57	2	17
Mental retardation	2	18.50	17.678	12.500	140.33	177.33	6	31
Total	167	35.57	29.797	2.306	31.02	40.13	1	197

The average number of hospitalization days was significantly higher in patients diagnosed with schizophrenia and other psychotic disorders (41.57 ± 33.44 days) and those with delirium, dementia or other cognitive disorders (43,50 ± 28 , 32 days) at discharge. The shortest hospitalization period was registered by patients diagnosed at discharge with personality disorders (11.20 ± 5.93 days) ($F = 4.199$, $GL = 165$, $p < 0.001$).

For patients at their first admission, the diagnosis was mainly schizophrenia or other psychotic disorders, confirmed at discharge in 26/28 cases ($\chi^2 = 2.35$, $GL = 4$, $p = 0.672$).

In the studied cases the following issues were noted: (1) 44.9% of the reasons for non-voluntary admission was hetero-aggressivity, while hetero-aggressivity showed a 26.3% frequency for the examination commission; (2) self-aggressivity was found in 12% of the reasons for non-voluntary admission and 13.2% of the reasons of the non-voluntary examination commission; (3) psychotic symptomatology was the reason of the committee meeting in 28.8% of subjects while in 14.4% of patients it was found among the reasons for admission.

In terms of statistics, the frequency distributions between the admission reasons and the non-voluntary examination motivation of the commission revealed statistically significant differences ($\chi^2 = 31.68$, $GL = 4$, $p < 0.001$). Subjects with hetero-aggressivity displayed associations with psychotic symptoms as follows: (1) delusional psychotic symptoms in 45.5% of patients depending on the reasons of

the non-voluntary examination commission and 22.7% depending on the reasons for admission ($\chi^2 = 15.35$, GL = 1, $p < 0.001$); (2) there was no awareness of the disease with a significantly higher frequency among motivation of the non-voluntary examination commission (40.9% vs. 2.7%) ($\chi^2 = 26.34$, GL = 1, $p < 0.001$). For subjects with both types of aggression: self- and hetero-aggressivity, the ratio referring to the association of psychotic symptomatology showed no significant differences between the admission reasons and the reasons of the evaluation committee ($\chi^2 = 0.23$, GL = 1, $p = 0.631$). In addition, the frequent lack of awareness of the disease has no significant differences from a statistical point of view ($\chi^2 = 0.75$, GL = 1, $p = 0.385$).

Conclusions

Patients who were non-voluntarily admitted need more than pharmacological support after discharge to have an acceptable quality of life. An accurate diagnosis that will determine the prognosis and the choice of best treatment are some of the patients' needs that have to be met by the physician. The diagnosis must also be accompanied by psychosocial prognosis and therefore the education of patients and their family in this regard play a very important role. Moreover, the normal activities at that age should be encouraged to avoid overprotection. With more help from the community, people with mental disorders will have a higher addressability to psychiatric assistance without being stigmatised.

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