

Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study

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Abstract

Purpose To explore involuntary patients' retrospective views on why their hospitalisation was right or wrong.

Methods Involuntary patients were recruited from 22 hospitals in England and interviewed in-depth. The study drew on grounded theory and thematic analysis.

Results Most of the patients felt mentally unwell before admission and out of control during their treatment. Despite

these common experiences, three groups of patients with distinct views on their involuntary hospitalisation were identified: those who believed that it was right, those who thought it was wrong and those with ambivalent views. Those with retrospectively positive views believed that hospitalisation ensured that they received treatment, averted further harm and offered them the opportunity to recover in a safe place. They felt that coercion was necessary, as they could not recognise that they needed help when acutely unwell. Those who believed that involuntary admission was wrong thought that their problems could have been managed through less coercive interventions, and experienced hospitalisation as an unjust infringement of their autonomy, posing a permanent threat to their independence. Patients with ambivalent views believed that they needed acute treatment and that hospitalisation averted further harm. Nonetheless, they thought that their problems might have been managed through less coercive community interventions or a shorter voluntary hospitalisation.

Conclusions The study illustrates why some patients view their involuntary hospitalisation positively, whereas others believe it was wrong. This knowledge could inform the development of interventions to improve patients' views and treatment experiences.

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Introduction

Psychiatry treats a significant number of patients against their will and there is much debate on the ethical justification and the best practice of coercive interventions [1]. It is often assumed that patients cannot recognise their need

for treatment when acutely ill, but are grateful for having been involuntarily treated when they recover [2]. This assumption has been partly supported by empirical research indicating that between 39 and 75% of involuntary patients retrospectively believe that their treatment was justified [3–5]. However, this still leaves a substantial proportion of patients who do not feel that their treatment was right for them and whose resentment might affect their future care [6]. Little is known as to why some view their involuntary hospitalisation positively and others do not [3]. Evidence from quantitative studies is inconclusive and no associations between socio-demographic and clinical characteristics (i.e. age, gender, diagnosis, symptoms, etc.) and the patients' views have been established [3, 4]. Higher initial treatment satisfaction has, however, been linked to perceiving involuntary hospitalisation as right [4]. This suggests that patients' experiences and evaluations of their treatment rather than their clinical and socio-demographic characteristics may determine their views. Experiences and thought processes are best understood through qualitative research, but work in this area, which could shed light on why patients form positive or negative assessments, is scarce [7]. A better understanding of these processes may inform the practice of involuntary treatment and the design of interventions aimed at those who experience involuntary hospitalisation negatively.

Hence, the present qualitative study aimed to explore involuntary patients' retrospective views on why they perceived their hospitalisation as right or wrong.

Methods

Study design

The design drew on grounded theory and on thematic analysis. Grounded theory is a method aiming to inductively build a theoretical explanation of a social phenomenon based on the study data [8]. Thematic analysis is used to identify a limited number of themes that adequately reflect the study data, by comparing and refining emerging topics [9]. The research team, including researchers with backgrounds in psychiatry, psychology, sociology and nursing met regularly to discuss the study design, implementation and analysis. Service-user researchers were involved in all stages of the study (design, data collection and analysis) to ensure that their perspectives were reflected in the interpretation of the data.

Sample and data collection

We conducted in-depth semi-structured interviews with 59 patients involuntarily admitted in acute wards in 22

hospitals across England under Sects. 2, 3, and 4 of the Mental Health Act 1983. Participants were recruited between July 2003 and July 2005. Section 4 allows emergency detention for up to 72 h, Sect. 2 involuntary admission for assessment for up to 28 days and Sect. 3 involuntary admission and treatment for up to 6 months. The interviewees were selected from a sample participating in a larger quantitative investigation of involuntary admission [4]. After complete description of the study, they gave written informed consent to be interviewed; the detailed inclusion criteria and recruitment process have been described elsewhere [4, 10, 11].

The interviews were conducted by seven researchers (including two service-user researchers) between 3 months and 1 year after the index admission and always after discharge, so that participants could retrospectively assess their involuntary treatment. Interviewers were independent of the patients' care. The interviews usually took place at participants' homes and lasted between 30 and 90 min. 10 out of the 69 patients invited to take part in the study declined to do so. Hence, the response rate for participation in the study was 86%. Table 1 summarises the participants' characteristics.

The sampling was purposive: both patients who believed that their involuntary hospitalisation was right and those who perceived it as wrong were included. This selection was based on the patients' assessments on a single-item 3 months after their admission, which was collected in the quantitative part of the study ("Today do you find it right or wrong that you were involuntarily admitted?" rated on a Likert-type scale from 0 'entirely wrong' to 10 'entirely right' and dichotomised as less than/equal to or greater than the neutral midpoint of 5). Similarly, participants with different clinical and socio-demographic characteristics (i.e. age, gender, ethnicity, diagnosis, psychiatric history, section of the MHA, length of hospital stay) were selected to achieve an inclusive sample. New participants were recruited on the basis of their potential similarities or discrepancy from the patients already interviewed and sampling continued until saturation of the topics emerging from the interviews was reached. The Multi-Centre Research Ethics Committee (ref: MREC/03/0/96) approved the study, which has therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki.

A topic guide for the interviews was finalised between four researchers (including three service-user researchers), and covered the following topics: patients' experiences of admission and treatment and their views on why this intervention was right or wrong for them. These researchers trained all the interviewers in using the guide.

Table 1 Clinical and socio-demographic characteristics

	Positive group (<i>N</i> = 28)	Negative group (<i>N</i> = 19)	Ambivalent group (<i>N</i> = 12)	Total sample (<i>N</i> = 59)
Gender				
Female	14 (50)	7 (37)	4 (33)	25 (42)
Male	14 (50)	12 (63)	8 (67)	34 (58)
Age (M ± SD)	39.7 ± 10.4	38.1 ± 10.3	32.3 ± 8.6	37.7 ± 10.2
Ethnicity				
White	21 (75)	11 (58)	5 (42)	37 (63)
Black	2 (7)	6 (32)	6 (50)	14 (24)
Asian	3 (11)	2 (10)	1 (8)	6 (10)
Other	2 (7)			2 (3)
Diagnosis				
Schizophrenia (or other psychosis)	12 (46)	11 (58)	4 (40)	27 (49)
Affective disorder	10 (39)	7 (37)	3 (30)	20 (36)
Other	4 (15)	1 (5)	3 (30)	8 (15)
Past hospitalisation				
Yes	20 (71)	16 (84)	5 (42)	41 (70)
No	8 (29)	3 (16)	7 (58)	18 (30)
Section of the MHA 1983				
Sect. 2	14 (50)	8 (42)	8 (67)	30 (51)
Sect. 3	10 (36)	9 (47)	3 (25)	22 (37)
Sect. 4	4 (14)	2 (11)	1 (8)	7 (12)
Length of index stay in days (M ± SD)	66.2 ± 56.2	75.6 ± 69	61.8 ± 51.2	68.3 ± 58.9
Justification of sectioning (quantitative single item)				
Yes	19 (68)	1 (5)	2 (18)	22 (38)
No	9 (32)	18 (95)	9 (82)	36 (62)

Values are in *N* (%)

Data analysis

All the interviews were audio-recorded and transcribed verbatim. The participants were assigned to different groups based on how they perceived their hospitalisation, as expressed in the qualitative interviews. The definition of different groups was agreed on after discussions in the research team. The construction of these groups facilitated further analysis and the identification of differences between interviewees with different views. Inter-rater reliability for assigning participants to groups was assessed between two researchers (including a service-user researcher) in 20 interviews, including interviewees from all the groups. The researchers agreed on 100% of interviews.

The transcripts were then analysed thematically, following the stages of open, axial and selective coding described in grounded theory. Open coding was used to explore, name and categorise topics found in the text. Axial coding allowed us to relate and contrast emerging topics to each other and selective coding facilitated the identification of the core themes emerging from the data [8]. The emerging themes in each group were counted [9]. The same

two researchers developed a coding frame capturing the emerging themes, which was further discussed and refined in team meetings. To examine coding reliability, the researchers independently coded 12 interviews and compared their results in two phases. During phase 1, the coding of six interviews was discussed until agreement on the meaning and application of each code was reached. In phase 2, inter-rater reliability was calculated, based on the six remaining interviews, as the proportion of agreements to the total number of both agreements and disagreements [12]. The overall rate for this was 79%. The two researchers then coded all the transcripts, using MAXqda software (Version 2) for qualitative data analysis.

Results

Patients with positive, negative and ambivalent views

Three groups of patients with distinct views on their involuntary hospitalisation were identified: those who believed that it was right, those who thought it was wrong

and those with ambivalent views. More specifically, out of the 59 participants, 28 expressed overall positive views (the “positive” group); 24 of those had initially found their admission wrong and later changed their mind, whereas four reported having always been positive or neutral towards their hospitalisation. Nineteen patients believed that their admission was wrong (the “negative” group): 12 of them had always been negative towards their hospitalisation, whereas 7 patients went through a short questioning phase contemplating whether their involuntary admission was necessary, but later returned to their initial negative views. Twelve participants expressed ambivalent views (the “ambivalent” group): eight had initially felt that their hospitalisation was wrong and were retrospectively ambivalent about it and four believed that they needed hospital treatment, but mostly disagreed with the involuntary nature of the admission.

As illustrated in Table 1, participants with various socio-demographic and clinical characteristics were represented in each of the three groups.

Shared experiences between these groups and differences in their views are presented. The frequency of these in each group and in the total sample is shown in Table 2.

Common experiences between groups

Although the patients in different groups held distinct views on whether their involuntary admission was right, some experiences were shared by the majority of interviewees.

Mentally unwell/at risk before admission

90% of the interviewees felt mentally unwell and/or at risk before their admission. They reported feeling bewildered, behaving out of character, losing control over their behaviour (47 participants). “I took an overdose, and I climbed some scaffolding and they got the police and

sectioned me. I would have never gone up there, I’m terrified of heights! It’s weird, I thought I was going mad” (participant 35, “ambivalent” group). They described dramatic changes in their mood, feeling distressed or frantic and elated (45 participants). Self-harming behaviour, suicidal urges, self-neglect and risky behaviour were frequently experienced (25 participants). “I was a danger to myself... I was telling people to pick up their litter and you can’t do that here, I was being not safety-conscious, taking risks” (participant 28, “positive” group). Twenty-eight participants also described that they were argumentative or that they intended to or actually engaged in physically aggressive behaviour, due to their mental health deteriorating. Sleeping problems (14 participants) and increased alcohol and drug use (10 participants) were also common.

Such mental health problems were reported by all the participants in the “positive” and the “ambivalent” groups, and the majority (68%) of those in the “negative” group. Some of the interviewees in the “negative” group (32%), however, felt that they either did not have any problems or that their problems were not severe enough to require acute intervention.

Feeling out of control during hospitalisation

Various experiences, including not receiving sufficient information, not being involved in treatment decisions, perceiving professionals as having power over patients, and experiencing coercive measures contributed to the patients feeling out of control during their hospitalisation. More specifically, 92% of the participants felt that they found out from professionals that they had been committed, whereas alternative treatments or voluntary admission had not been offered. They believed that they did not receive adequate information on the reasons for their hospitalisation, their rights, and the admission and treatment process. “They never told me why I was sectioned, it’s like taking you and

Table 2 Common experiences and reasons underlying distinct views of the hospitalisation as right or wrong

	Positive group (<i>N</i> = 28)	Negative group (<i>N</i> = 19)	Ambivalent group (<i>N</i> = 12)	Total sample (<i>N</i> = 59)
Mentally unwell/at risk before admission	28 (100)	13 (68)	12 (100)	53 (90)
Feeling out of control during hospitalisation	25 (89)	19 (100)	10 (83)	54 (92)
Coercive measure(s) in hospital ^a	17 (61)	14 (74)	9 (75)	40 (68)
Need for coercive intervention	28 (100)	4 (21)	12 (100)	44 (75)
Averting risk and feeling safe in hospital	25 (89)	2 (11)	10 (83)	37 (63)
Need for non-coercive treatment	4 (14)	17 (89)	10 (83)	31 (53)
Unjust infringement of autonomy	6 (21)	14 (74)	5 (42)	25 (42)

Values are in *N* (%)

^a Forced medication, restraint, seclusion or threats for any of these measures

locking you up, never telling you why you are being locked up! I felt like a prisoner!” (participant 38, “negative” group). In hospital, they felt that the staff had power over them and that they were forced to adhere to a ward routine that they did not like. “They want you to go to bed at ten o’clock, even though there’s no reason why you shouldn’t be up after ten. It’s just easier for them... they try to give the impression that they are in charge and that’s that!” (participant 44, “negative” group). Confronted with this reality, they felt helpless and that they were losing control over their lives. “It’s horrible, they’re in control of you, you’re not in control anymore...” (participant 30, “positive” group). The majority of the participants (68%) also reported being exposed to coercive measures, such as restraint, seclusion or forced medication. “They injected me and I thought I was going to die. I was physically restrained for that injection!” (participant 47, “positive” group).

Despite these common experiences, each group held distinct views on whether their involuntary hospitalisation was right. The themes underlying each group’s attitudes are presented below.

Why do patients retrospectively believe that their involuntary hospitalisation was right?

Need for coercive intervention: not recognising problems when unwell

Patients in the “positive” group (100%) believed that they needed to be involuntarily admitted, as when acutely unwell, they find it hard to recognise that they need help. They believed that hospital treatment (mainly medication) was necessary, as their mental health problems were too severe to be managed through less intensive community treatments. “I never had episodes to that degree before... even though my keyworker came round to try and get me to take my medication, I wouldn’t have it ... it had to be enforced because I had to get better” (participant 57, “positive” group).

Although they all mentioned that they needed medication, 25% also perceived that their hospital treatment was necessary to improve their social situation (e.g. housing and finances) or because it gave them the opportunity to talk to professionals about their problems (14%). “They came to see my house and they went with me to the benefits office to see that my money gets through before they discharged me” (participant 17, “positive” group).

Averting risk and feeling safe in hospital

Participants with overall positive views (89%) retrospectively believed that they had been a risk to themselves or

others before admission and saw the involuntary hospitalisation as a necessary measure to prevent further harm. “I tried to stab someone, I was self-harming... it was necessary for me to be put in hospital because I was getting very out of control” (participant 6, “positive” group). They also viewed the hospital as a safe place where they could take a break from their lives and recover. “[The hospital] gave me the rest that I needed. I hadn’t slept properly for 2 weeks... I didn’t feel safe going to sleep at home...[in hospital] I quickly settled down and felt better” (participant 34, “positive” group).

The frequency of these themes in each group is presented in Table 2.

More quotes illustrating patients’ views on why involuntary hospitalisation was right are presented in Appendix 1.

Why do patients believe that their involuntary hospitalisation was wrong?

Need for non-coercive treatment

89% of the patients with negative views believed that they needed some help from services, but saw the involuntary hospitalisation as an unnecessarily intensive and coercive intervention. They reported that their hospitalisation had a negative impact on their mental health, as they felt worse due to being treated against their will. They wished to be given more time to calm down and deal with their problems on their own and to be offered less coercive support from services. “I’ve had this mental illness for years. So I know I’ve had it all my life, but I prefer to do it within the bounds of my family, not in a hospital...I realise that I needed help, but I would have preferred to have gone to my General Practitioner(GP), and say alter my medicine. Not be kept in hospital against my will” (participant 31, “negative” group). They thought that their problems could have been managed through receiving medication from community mental health teams, outpatients, home treatment teams, general hospital wards, or crisis housing. “I need medication; not being in a mental institution... I needed the home treatment team, because they come everyday and I have to take the tablets in front of them, which is good, so I make sure I take my tablets” (participant 24, “negative” group). Some specifically reported that psychological therapy or specialised treatments, e.g. for personality disorders, would have been more appropriate. “There weren’t any other patients that self-harmed and I don’t know if the hospital understands. I need somewhere that’s going to help me, and understand, and work with me through it, not force medication on me” (participant 23, “negative” group).

Unjust infringement of autonomy

74% of the patients with overall negative views considered their involuntary hospitalisation an unnecessary disruption of their lives. “I certainly didn’t need to be sectioned. I was very anxious to get home, to find out where my dog was and to get my business running and get myself back on my feet... I have lost so much money through being sectioned... I lost all the trade over Christmas” (participant 40, “negative” group). This was perceived as an injustice and led to perceptions of themselves as victims of the mental health system. “I’m one of the victims of it ‘cos ... just as you’re getting yourself better at home, they want to put you back in hospital...” (participant 9, “negative” group). It was also perceived not as an isolated incident, but as a constant threat to their efforts to manage their lives independently. “They can’t come and disrupt people’s lives! I wanna build my life, get my life back, try and go to university... when I tried to go back into university they sectioned me. It’s just a waste of my time!” (participant 4, “negative” group). Patients feared that this impact of the mental health system on their lives is permanent and felt that professionals have wrongly decided to section them on this occasion (or might decide to do so in the future) because of their previous involuntary hospitalisation(s). “Once you’ve been in hospital if they say you’ve got to go into hospital, you have got to go; like being under the surgeon’s knife: once under the surgeon’s knife, always under the surgeon’s knife” (participant 16, “negative” group).

More quotes illustrating patients’ views on why involuntary hospitalisation was wrong are presented in [Appendix 2](#).

Why are patients ambivalent as to whether their involuntary hospitalisation was right or wrong?

Patients with ambivalent views shared the same concerns with both the “positive” and the “negative” groups (Table 2). They believed that they had mental health problems requiring acute intervention, which they found hard to recognise before admission (100%). They also saw the hospitalisation as a way to avert further risk and the hospital as a safe place, which offered them the opportunity to recover (83%). At the same time, they (83%) retrospectively believed that their problems could have been managed through less coercive interventions. Unlike the “negative” group, ambivalent patients were open not only to community interventions, but also to a short voluntary hospital admission. “I probably needed to go to hospital but I don’t think I needed to be sectioned. And I didn’t need to stay there for four weeks. It was right in certain circumstances but wrong in others... I needed time

to get myself together but ... I don’t think I needed to be there for as long as I was. I could see that I was going through a difficult time and all hell was breaking loose... But hospital should be for a couple of days and then you need to get the person back up and running and that’s done through counselling, exercise, talking...” (participant 37, “ambivalent” group). 42% were also concerned about their lives being disrupted due to staying in hospital for a long time, perceived this as an injustice and were preoccupied about the wider impact of involuntary hospitalisation on their independence. As they felt that the costs and the benefits of involuntary hospitalisation were of equal importance, they were unsure as to whether the intervention was right. “If I were to be let out and still have my delusions, maybe I wouldn’t have gone back to my normal mental health state. So maybe it was the right thing to section me... but in a way I could have had those same tablets from my GP, so maybe I did need hospitalisation, maybe I didn’t. It did help me being in hospital, but it also wasted a lot of my time” (participant 26, “ambivalent” group).

In this section, we attempted to summarise the main concerns underlying participants’ positive, negative or ambivalent evaluations of their involuntary admission. It is important to note, however, that although the majority of the participants within each group shared these concerns, the distinction between the groups was not absolute. Some interviewees also shared views with the participants from different groups (at least at some parts of the interview), as demonstrated in Table 2. For example, 21% of the patients with overall negative views reported that they might have needed coercive intervention at the time of admission and 14% of the participants in the “positive” group believed that they might have needed non-coercive treatment.

Discussion

The great majority of involuntary patients retrospectively believed that they were mentally unwell before their admission. They also experienced involuntary hospitalisation as a time when they felt powerless and lost control over their lives, as they thought that they were not involved in the admission and treatment process and felt forced to comply with professionals’ decisions. However, some patients retrospectively thought that this intervention was right for them, whereas others expressed negative or ambivalent views. Those who agreed with the intervention believed that it ensured they received medical treatment, averted further harm and offered them the opportunity to recover in a safe place. They felt that coercion was necessary, as they could not recognise that they needed help when they were acutely unwell and would have refused any

treatment. Those who believed that involuntary hospitalisation was wrong thought that their problems could have been managed through less intensive and/or coercive community interventions, and experienced the admission as an unjust infringement of their autonomy, which poses a permanent threat to their independence. Patients with ambivalent views believed that they needed acute treatment and saw the hospitalisation as averting further harm. At the same time, they thought that their problems might have been managed through less coercive community interventions or a shorter voluntary hospitalisation.

Strengths and limitations

Although previous smaller studies have examined patients' experiences of involuntary treatment [7], this is the first qualitative study exploring what patients think about their involuntary admission and why they reached these conclusions. The sample size was large (the combined total sample of all previous qualitative studies in this area was 54 patients). Participants were recruited from 22 hospitals across England. Service-user researchers were involved in all stages of the study. The high inter-rater reliability between a service-user and a non-service-user researcher suggests that the results were not highly influenced by individual interpretations.

On the other hand, patients' retrospective accounts, although potentially more complete, less emotionally charged and less affected by acute illness, might be open to memory biases and influenced by current relationships with services. Similarly, it might be hard for patients who are now in a different mental state (not acutely unwell) to reconstruct what they experienced, thought or wanted at the time of admission. To some extent, participants' accounts might also reflect their retrospective attempt to rationalise their views. Another limitation is that the participants' mental state at the time of the interview was not explicitly assessed and it is possible that their expressed views might have been influenced by current symptoms. Lastly, although the response rate for participation in the study was high, we do not know to what extent the findings can be generalised to the patients who are unwilling or unable to take part in the research.

Findings in the context of previous literature

The study findings add to a large body of evidence indicating that the patients appreciate receiving support for their mental health problems and having access to a safe place during a crisis [7, 13–15]. Nonetheless, they feel aggrieved when they believe that they are not involved in the treatment decisions and that their autonomy is violated [15–23].

Previous studies with involuntary patients, however, did not clarify whether these issues were seen by most patients as negative and positive aspects of their overall experience of hospitalisation or whether they reflected views supported by distinct groups who assess their admission as either positive or negative [7]. The present study illustrates why, although most patients share some common concerns and experiences, they arrive at distinct views on whether their involuntary admission was right. More specifically, it sheds light on specific concerns for each group, which could inform the development of interventions to address the issues that were important for the patients with overall negative or ambivalent views.

Patients who retrospectively agree with the intervention believe that coercive treatment was necessary, although unpleasant. Their views on why this is so reflect psychiatrists' considerations when they decide whether to use coercion, i.e. weighing capacity, risk and clinical benefits, versus potentially negative experiences due to the use of coercion [24]. This finding might be considered reassuring for clinicians and is in line with earlier assumptions that patients are appreciative of having been treated against their will when they recover [2]. For these patients, the intervention might not have a negative impact on their future engagement with services. Nevertheless, psychoeducation on relapse prevention might offer them a better understanding of their acute symptoms and prevent future involuntary admissions [22, 25].

Patients with negative or ambivalent views, on the other hand, are particularly concerned about the use of coercion, although most of them retrospectively believe that they have mental health problems and would be open to non-coercive interventions. It appears, therefore, that lack of insight into mental illness, a factor often assumed to contribute to patients' negative evaluations of their treatment [26], might not have determined these patients' views, at least not when insight is defined in a strict, dichotomous way. Although levels of insight might fluctuate at different points in time and the relationship between insight and treatment evaluation needs to be further explored, our findings suggest that the fear of the negative impact of involuntary hospitalisation on the patients' autonomy is more important in shaping their evaluations. Having been subjected to this coercive intervention at least once, they are worried that this may make future involuntary admissions more likely and compromise their independence and their sense of themselves as autonomous individuals. This concern may lead to the retrospective view that involuntary treatment was wrong and even detrimental. This interpretation is consistent with evidence indicating that some patients view hospitalisation as a threat to their social position and an implication that they are unable to look after themselves and live their lives independently [20, 27, 28].

As a response to this perceived threat, patients might reject psychiatric services altogether to avoid feeling stigmatised and devalued [27–30].

Addressing the concerns of patients with negative and ambivalent views poses a great challenge for clinicians and services. This is not only an ethical and humane issue, but might also lead to improved treatment outcomes. Evidence indicates that viewing treatment as right and/or satisfactory and perceiving lower levels of coercion is linked to clinical improvement [29–32], reduced involuntary readmissions [4], increased engagement with services and better therapeutic relationships after discharge [5, 33]. Specific interventions to address these patients' concerns do not exist yet. However, findings from this study highlight areas that need to be considered when developing such interventions.

It is plausible that in some cases alternative acute interventions, such as home treatment, assertive outreach, crisis housing, etc. could be considered. This might also depend on service resources, availability of alternative acute settings and social support for patients [20]. On the other hand, it is unclear whether less coercive interventions would be considered adequate solutions for some of these patients in this crisis. Clinicians might have disagreed with the patients' assessment and believed that their problems were too severe to be managed through less intensive treatment. Effective ways to address and negotiate such disagreements remain to be found [34–36]. Nonetheless, evidence indicates that when patients believe that their opinions are taken into account and that decisions are made with their best interests in mind, they feel less coerced, even when treated against their will [15, 16, 37–40]. Advance statements might also contribute to patients feeling empowered, valued and more actively involved in their care [23, 41]. Alternatively, even if the patients and the clinicians disagree on whether the index admission was justified, placing more emphasis on prevention of future crises and negotiating how future involuntary admissions can be avoided, i.e. through engagement with community services and improved self-care might be seen as validating by the patients. Similarly, offering patients choice over some aspects of their involuntary hospital stay (i.e. type of medication, involvement in activities in the ward, control over sleeping/eating routines, etc.) might increase their sense of control over their lives.

Conclusions

This study illustrates that involuntary hospitalisation might be seen as necessary by some patients at a time of crisis, as it allows them to recover in a safe place. At the same time, another group of patients experienced their hospitalisation as unnecessarily coercive and believed that it had a

profound negative impact on their lives and their sense of themselves as autonomous and independent individuals. It is important for services to ensure that the necessity to compulsorily treat patients for a short time does not compromise the long-term goals of promoting empowerment and autonomy.

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Conflict of interest The authors declare that they have no conflict of interest.

Appendix 1 Why do patients believe that their involuntary hospitalisation was right?

Need for coercive intervention: not recognising problems when unwell

“Positive” group

I was becoming extremely anxious and psychotic, so I did need to be taken into hospital... Once it goes past a certain point, I don't understand the processing, I don't understand why I need to go into hospital... so I think I did need to be taken under section because I don't think I'd have agreed voluntarily... (participant 42)

I think if I'd been voluntary I would have left and it wouldn't have made me better ... I think it was right being sectioned, it has helped in the long run definitely (participant 32)

The main helpful part of the sectioning was to get me back onto treatment. Take me out of the community for a while and get me back on my medication, back on my treatment (participant 6)

At the time I was annoyed, but I do think they did the right thing, looking back now and having flashbacks and the daft things I was doing, but it didn't seem daft at the time...because I wasn't well...when you're like

that you don't think, you think that you're all right (participant 52)

I needed to be sectioned because when I become high and elated it's very hard for me to recognise it myself. Probably at these times if I'd been able to take myself voluntarily then that probably would have been a better choice. But the problem is I'm not very good at going voluntarily... people talk about trigger factors, but I can only say I've never been really able to recognise that happening (participant 13)

"Ambivalent" group

When I'm ill I don't normally realise that I'm ill; maybe I didn't believe I needed treatment... that's what comes in time ...when I realise I was getting things wrong, that's when I started realising I did need treatment (participant 10)

I suppose looking back on it, it was good that I got put in there because I got put on medication and that I think must be helping me (participant 41)

Averting risk and feeling safe in hospital

"Positive" group

I was threatening to kill my brother's partner. I'd stabbed her in the chest... I needed to have been [sectioned]. I would have... I would have either killed someone or I would have killed myself (participant 6)

I certainly would have been a serious problem at work. As a school teacher ... there would be loads of complaints from parents, and I would have got myself the sack... so I'm glad it [involuntary admission] happened (participant 49)

I was a danger to my family and myself so I had to get admitted to hospital ... cos I'd threatened me brother-in-law, so I had to get admitted to hospital for my own safety and for my brother-in-law's safety (participant 59)

I was glad I was in hospital... I couldn't be anywhere else at that time... I didn't think I was well enough to come out... I was scared of going out, frightened" (participant 27)

I wanted to stay [in hospital]. I didn't want to go home... I was a bit frightened to go out, I got really paranoid and I wouldn't go out" (participant 5)

"Ambivalent" group

It went on for about a month, and then I said to God 'I'm going to kill someone soon'...I'm glad I was [sectioned] in a way, 'cos I was, like, collapsing down the street so I'm glad I was picked up in a way (participant 41)

I suppose yeah [I needed hospital treatment] just 'cos if I carried on thinking the way I was thinking maybe it would have got worse and maybe I would have started like accusing the wrong people... I suppose [it helped] just in the fact that it gave me time to reflect and think about what was going on (participant 22)

Appendix 2 Why do patients believe that their involuntary hospitalisation was wrong?

Need for non-coercive treatment

"Negative" group

Well, honestly I didn't think I needed hospital treatment, I felt like if my Community Psychiatric Nurse came to me say twice a day to see how I was doing it would be fine (participant 38)

I wouldn't have needed a section...I could have been put in another part of the hospital where I wasn't round people really severely mentally ill, on heroin and whatever else they were on... and I'd have got better ten times quicker (participant 53)

I just needed counselling, someone to talk to about my problems ... I take this new medication, my consultant found me the right one just on a one-to-one basis, and it doesn't have no side effects. If I wouldn't have gone into hospital and I would have stayed out on a one-to-one basis, like seeing him on the outpatients clinic, then there would have been no problem, but someone along the line made it more complicated (participant 14)

I didn't want to stay in hospital, I wanted to come home and rest at home... 'cos if I hadn't been sectioned I would have been allowed to come out, I could've crashed out here and set up something more comfortable... and I could have found out what was going on with my girlfriend...and my life... (participant 11)

On reflection I wasn't very well at the time and I did need some care, but that could have been done in an entirely different way and I was made much worse by

what happened to me. I needed some outpatient care; some drug therapy, that's all (participant 33)

“Ambivalent” group

I shouldn't be here, I should be at home, sleeping and listening to my music... I would like to sleep in the room for maybe 2 weeks by myself and then I would be alright (participant 25)

I would have stayed in hospital... I went there voluntarily and ended up getting sectioned... I did agree to go to hospital... I probably did need the medication... I'm not too sure why I got sectioned... I don't think anyone really gave me a proper answer... I think it was the right thing for me to go to hospital... I just think it's a bit unfair being sectioned... (participant 10)

Unjust infringement of autonomy

“Negative” group

I want to take legal action against the people who did this to me [sectioning] and I would like some compensation because I've stopped playing professional cricket due to this and one day I'm playing cricket, next day I go into hospital and then my life stopped (participant 14)

After being sectioned I've realised that police can walk in at any time in your own home! It's MY home! ... and drag me out in handcuffs. On top of that, it's made all the neighbours call me “Mad”. Children in the street are stoning my windows! I've been labelled by being dragged out by the police (participant 58)

They never let go of you, and you are perfectly fit but you have to [attend outpatients] because once you were sectioned... It's a waste of the doctors' time, it's a waste of my time and I have to ask a neighbour to take me because it's an out-of-the-way place to get to (participant 33)

The consultant was saying “You've got a medical record and once you've got a medical record then I can do anything I like”...and I don't think it should be based on that at all. It should be assessed on each admission! (participant 48)

“Ambivalent” group

The effect of me being sectioned was catastrophic to myself and my children. Social services had my

daughter... they wouldn't let me know where she was, because I've got a mental health problem. My son had absolutely gone ballistic. He was now in hospital. My other daughter was told I wasn't coming back for six months after also being told that I was running up and down the motorway. She was put through an extreme amount of unnecessary stress. I wasn't even running up the motorway for a start. That didn't happen... (participant 45)

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