

Review article

Detention of the mentally ill in Europe – a review

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Objective: The frequency of compulsory admission varies widely across Europe. Although there has been some research on a nation-wide level, no work has been done to compare mental health legislation in different countries in relation to detention rates and to patients' perception of hospital detention.

Method: Databases and government statistics were searched for regional, national and European data. Legal frameworks were compared and reviewed in relation to patients' and professionals' views.

Results: Nearly 20-fold variations in detention rates were found in different parts of Europe. Criteria for detention of the mentally ill are broadly similar when it comes to patients at risk to themselves or others. However different rules apply for involuntary treatment in the interest of the patient's health.

Conclusion: Variations in detention rates across Europe appear to be influenced by professionals' ethics and attitudes, sociodemographic variables, the public's preoccupation about risk arising from mental illness and the respective legal framework.

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Introduction

Involuntary admission and detention are widely used to treat patients with mental illness in Europe. Mental health legislation on federal and regional levels provides criteria for detention and treatment. The user rights movement and a focus on community based services have led to changes in regulations and practice over the last 30 years. For example, psychiatric departments in or attached to general hospitals have replaced the old asylums in many places. However, psychiatric patients remain the only client group who can be treated against their will. Little is known about patients' perception of involuntary admission in different countries. Legislation varies widely across Europe and a huge variation in detention rates has been found (1). Detention in itself may have adverse effects on the mental health of patients. Users' initiatives have drafted advance directives (2) to determine the way they are treated in hospital in case they are unable to give informed consent. European integration may warrant the formulation of common standards in service provision and regulation. To quantify

detention in psychiatric hospitals detention rates can be calculated on a population basis per year. However, to understand detention the respective legal framework and the way users perceive being detained in a hospital in addition to the actual conditions of detention need to be taken into account. The aim of this paper is therefore to present an overview of the current situation in a wider context. The paper reviews (A) detention rates, (B) mental health legislation and (C) users' and professionals' perception of detention in hospital, and finally identifies future fields of research.

Material and methods

Embase and Medline databases were electronically searched for papers on 'coercion', 'detention', 'commitment', 'compulsory admission/treatment', 'mental health legislation', 'perception of treatment/detention/coercion' and 'involuntary treatment/admission'. The criteria used in selection were data on frequency of involuntary treatment, perception of detention and coercion by users and professionals, information on the legal

framework for involuntary admission in Europe. The search examined papers published from 1985 onwards.

In this review, to obtain comparable data, detention rates are distinguished from compulsory admission rates. This is because voluntarily admitted patients can be detained later on and involuntarily admitted patients may be discharged or may stay on a voluntary basis. Wherever necessary detention rates were calculated using available population statistics. Data on forensic patients was excluded. The Statistical Bulletin by the British Department of Health (3) and the Annual Report by the Mental Health Act Managers of Newham Community Health Service in London (4) provided data from England. Furthermore, we used results of previously unpublished data from the 'Alpe-Adria Association for promotion of Mental Health' on compulsory treatment in five European regions: Pordenone, Trieste, Portogruaro (all Italy), Klagenfurt (Austria) and Kaufbeuren (Germany). This research was conducted in 1995 and provides data on all (nonforensic) involuntary patients treated over a 6-month period in these regions including information on their psychosocial background, methods of treatment and follow-up arrangements (5).

Information on mental health legislation was obtained from the original legal text in Germany and England, information on other countries from scientific publications. Published original articles and reviews on users' perception of detention in hospital and professionals' attitudes were selected from Embase and Medline Databases.

Results

Detention rates

Table 1 shows data from some parts of Europe. Detention rates in psychiatric hospitals/departments are calculated per 100 000 inhabitants per year and do not include forensic patients. A nearly 20-fold variation in the frequency of detention can be found between Italy and Finland. Only two studies (5, 6) obtained data from different countries at the same time and by the same method. Even here there was a nearly 10-fold difference between two neighbouring and demographically similar regions in both Austria and Italy. The rise in numbers in England and Austria in the nineties is consistent on a regional and countrywide level. A similar two-fold increase in involuntary admissions was found in the Netherlands after new legislation was introduced in 1994 (7). Riecher-Rössler and Rössler explained urban-rural differences found by Spengler and Böhme (8) by 'special sociostructural conditions' (1). The detention rate in London is twice as high as in other parts of England (3).

Mental health legislation

As Riecher-Rössler and Rössler (1) pointed out, similar criteria for compulsory admission apply in principle: 1) (severe) mental disorder, 2) danger to him/herself or others, 3) (urgent) need for treatment. However, not all three criteria are included in all legal frameworks. Comparisons of mental health legislation in different countries have rarely

Country	Region	Authors	Period	Rate
Austria		Haberfellner & Rittmannsberger (14)	1992	94
			1993	118
			1994	125
Austria	Salzburg	Geretsegger et al. (13)	1989	43.9
			1994	148.5
Austria	Tirol	Stuppäck et al. (28)	1976–1986	58.3
Austria	Klagenfurt	Norcio & Toresini (6)	1992	44
		Toresini et al. (5)	1995	102
England		Department of Health (3)	1988–1989	45.7
			1998–1999	81.7
England	Newham (East London)	Annual Report... (4)	1998–1999	152
England	London	Department of Health (3)	1998–1999	154
Finland		Nenonen et al. (17)	1998	182.2
Finland	Tampere + Turku + Oulu	Kaltiala-Heino et al. (16)	1996	232.5 ¹
Germany	Different regions	Spengler & Böhme (8)	1984	18.6–127.3
Germany	Berlin-Neukölln	Smolka et al. (22)	1992/1993	55.4
Germany	Kaufbeuren	Toresini et al. (5)	1995	12.9
Italy	Trieste + Gorizia + Pordenone	Norcio & Toresini (6)	1992	10.92
Italy	Trieste + Portogruaro + Pordenone	Toresini et al. (5)	1995	12.4

Table 1. Compulsory treatment in Europe – detention rates per 100 000 inhabitants per year

¹ Calculated on working age population (18–64 years).

been produced and, when examined, consider only two countries at one time.

Röttgers and Lepping (9, 10) have examined mental health legislation and medical practice in England and Germany. In Germany, a patient can only receive treatment against his/her will if she/he is found to be unable to consent. A sheer 'need for treatment' would not suffice as long as there is no imminent and severe danger to him/herself or others. In England, compulsory admission for treatment is possible 'in the interests of his/her health ... (if) it cannot be provided unless he/she is detained' (Mental Health Act 1983). The most remarkable difference they found was, that in England psychiatric professionals (doctors and social workers) and relatives decide on compulsory admission, whilst in Germany a court always has to be involved.

Van Lysebetten and Igodt (11) have recently compared English and Belgian legislation. French and English psychiatric legislation have been examined by Laffont and Priest (12). Mental illness in the definition of the English Mental Health Act does not include all psychiatric disorders of the ICD 10. It is restricted to conditions with psychotic symptoms or cognitive impairment. Patients with learning disabilities and personality disorders can only be detained for 'abnormally aggressive or seriously irresponsible conduct' (Mental Health Act 1983) and if medical treatment is likely to alleviate or prevent a deterioration of their condition. In France and Belgium mental illness is not further defined. A similarity in French and English legislation is the prominent role of the nearest relative, who can apply for admission and has the right to discharge a patient, as long as there is no risk to public safety or, in England, to the patient's safety.

Both Austria (13, 14) and the Netherlands (7, 15) have introduced new psychiatric legislation in the early nineties. The new mental health laws emphasized users' rights and users' legal representation to safeguard their individual freedom. In Austria serious danger to the health or life of the patient or someone else as a consequence of mental illness is the prerequisite for compulsory admission. Two independent medical recommendations from psychiatrists are required. A committed patient has his/her advocate to make use of his/her rights, usually a social worker, who is not employed by the hospital but by an independent association. He/she will be seen by a magistrate within 4 days after admission to decide on the lawfulness of the detention. After another 14 days a third independent psychiatric recommendation has to be obtained. Paradoxically after the new legislation was introduced detention rates in both countries rose

sharply (5–7, 13). Many psychiatrists in Austria and the Netherlands feel in a defensive position and are concerned that they cannot act in the best interests of their patients (14, 15).

In Finland, a country with a relatively high rate of involuntary admission (16, 17) all three criteria for involuntary admission apply. A patient suffering from mental illness in need of treatment to prevent his/her deterioration can be referred to hospital if no other services are sufficient to treat him/her. A written medical recommendation independent from the psychiatric hospital is sufficient. The chief psychiatrist of the hospital decides whether the patient remains detained or not. Patients are entitled to appeal to the administrative court. Finland keeps a central discharge register of all coercive measures: seclusion, restraint, physical holding, compulsory medication, restrictions on leaving the ward and others.

Perception of detention in hospital

We identified seven papers examining users' perspective and attitudes to detention in hospital (18–24), five of these (19, 21–24) comparing voluntary and committed patients. Two studies sought to determine whether detention in hospital is related to post-traumatic stress (25, 26). Professionals' perspectives and attitudes are examined or discussed in four papers (2, 18, 27, 28) two of these discussing capability of consent to treatment (18, 27).

Rooney et al. (19) compared attitudes towards psychiatric admission in voluntary and involuntary patients in Ireland. Nearly half of the involuntary patients did not know, that they were admitted informally, while more than 50% of involuntary patients and over 20% of the voluntary patients found being in hospital similar to being in prison. Forty percent of the voluntary patients viewed their admission as a positive experience. Of the involuntary patients 17% viewed the admission as a positive experience, this rose to 32% at the end of their admission.

Westrin (21) found in 100 committed and 99 voluntary patients in Sweden that 80% of the committed and 7% of the involuntary patients thought they were committed, and 65% of the committed patients reported measures against their will vs. 29% of the voluntarily admitted patients. Smolka et al. (22) interviewed all patients admitted to a psychiatric department in Berlin over a 6-month period in 92/93, who were subjected to involuntary treatment ($n = 87$) and compared their views with a voluntary control group ($n = 29$). About 33% of the involuntary patients and 14% of

the control group said they had been subject to coercion. McKenna et al. (23) compared the perception of hospital admission in 69 detained and 69 voluntarily admitted patients in New Zealand. 'Involuntary patients had a stronger sense of coercion than informal patients', but coercion is felt by informal patients as well. Poulsen (24) investigated differences in perceived detention among involuntarily admitted patients, voluntarily admitted but later detained patients and a control group of voluntary patients without any detention. All patients were admitted on closed wards and experienced coercion to variable degrees. Perceived coercion was significantly higher in involuntarily admitted patients than in voluntary patients with those being detained later on experiencing more coercion than those staying voluntarily.

Priebe et al. (25) and Meyer et al. (26) did not establish a clear link between involuntary admission and subsequent PTSD symptoms in patients suffering from schizophrenia. There is an overlap of symptom scores for schizophrenia and PTSD, and enduring PTSD symptoms might be related to the frightening nature of psychotic symptoms as such rather than to detention in hospital.

Kullgren et al. (27) examined attitudes towards compulsory treatment among 197 Swedish psychiatrists by presenting case scenarios in a questionnaire. Whilst 98% regarded it as ethical to hospitalize a patient against his/her will who is a danger to him/herself or others, only 63% would use depot neuroleptics in a chronic psychotic patient who refuses medication and 46% found it unethical to hospitalize a patient against his/her will who is not a danger to him/herself or others. Female psychiatrists less often suggested the use of physical restraints and the compulsory use of ECT.

Amering et al. (2) asked 174 mental health professionals to draft 'advance directives' for psychiatric inpatient treatment as suggested by an Austrian users' initiative. Specific treatment methods were favoured by some and rejected by others: 30% of professionals would reject the use of antipsychotics, 10% would request them, and 20% opted for treatment with benzodiazepines. Forty-five percent would prefer to be treated with ECT when necessary, 22% rejected this treatment.

Vicente et al. (28) compared mental health professionals' attitudes to psychiatry in Chile, England and Italy. A strong medical model of mental illness in Chile corresponded with a lower satisfaction with their work, less tolerance to deviant behaviour in the community, and a higher need for psychiatric beds. In contrast Italian personnel openly and explicitly supported community based services. English professionals held an

intermediate position. Høyer (18) concluded in a recently published review 'on the justification for civil commitment' that 'values and beliefs in the mental health care system seem to be more important determinants for civil commitment rates than the specific criteria stated in the legislation.

Discussion

Detention rates

A critical review of the available data on compulsory treatment in psychiatric hospitals in Europe reveals huge differences in detention rates that need further explanation. Detention rates are rising in England, Austria and the Netherlands. The reasons may differ. In England, Szmukler and Holloway (30) recently attributed the increase in compulsory admissions to a 'preoccupation with "public safety"' 'and a tendency to seek "means of exerting control over patients"'. Turner and colleagues (31) suggest separating medical treatment and community supervision: 'psychiatrists treat people, but it is not their job to be responsible for individual citizens' behaviour in the community, which is an issue for the courts and statutory authorities'. However, changes in mental health legislation are likely to focus on compulsory treatment in the community and detention of patients perceived to be dangerous (32). In Austria and the Netherlands detention rates rose sharply despite changes in legislation that emphasized users' rights, adequate information of patients and their legal representation. Mental Health practice in Germany varies significantly and relatively poor quality of data is available. Low detention rates in certain areas of Italy may mirror a strong focus on community work, a demedicalized model of mental illness and the abolishment of asylums by law in 1978. High detention rates in urban areas seem to mirror the vulnerable living conditions of a highly mobile, deprived and multicultural population.

Legislation

Criteria for involuntary admission are largely similar in Europe when it comes to patients at risk to themselves or others. When this risk is not present, involuntary treatment in the best interest of patients' health is controversial. It is possible under English legislation, but it would depend on the patients' inability to give informed consent in Germany, and would not be possible in Austria. In England and Finland, where patients can be

detained for their own health regardless of their capability to consent to treatment detention rates are relatively high. However in Austria, governed by quite narrow legal criteria, similarly high detention rates are found. Neighbouring Germany seems to have lower rates: detention under the Guardianship Law is only possible for patients unable to give informed consent. A clearer and operationalized definition of what 'in the best interest of the patient's health' means might both reduce resistance and suspicion among user groups and facilitate useful comparative research.

Users' and professionals' perspective

Detention practice appears to be determined more by mental health professionals' beliefs and values than by legal requirements. Patients' perception of hospital admission does not always correlate with their legal status. Hidden coercion in psychiatric hospitals has rarely been addressed but could be defined as being subject to compulsory admission and/or coercion without a formal treatment/detention order as provided in relevant law. A substantial proportion of voluntary patients report to have been subjected to coercion and feel detained in locked wards. Patients or professionals may prefer informal admission to avoid being stigmatized or for other reasons. For example in regional legislation of Bavaria, south Germany, a detention order subsequently leads to an investigation of a patient's fitness to drive and his driving licence might be recalled. It is common practice therefore to advise patients to accept informal admission to avoid this procedure. Variations in detention rates might also be subject to the circumstances of admission and adverse treatment conditions in hospitals. Lauber et al. (33) found in a representative community survey that the general population and patients with treatment experience recognized the need for compulsory admission in case of mental illness. However, treatment conditions in hospitals vary and might therefore affect an individual patients' decision whether to accept in-patient treatment.

A clear limitation of this review was that detention rates are not routinely documented and published using comparable definitions in all EU member states or in all European countries. Comparisons across Europe are further complicated by problems of translation. Using English terms such as 'detention' for compulsory admissions in different countries does not necessarily imply that like is compared with like. Terminology is embedded in national cultures including the legal framework; and the precise understand-

ing of the different connotations requires good knowledge about the given health care and justice systems.

The selection of countries presented is not representative for Europe but rather indicative of where data was available. Figures on a local, regional and national level could facilitate naturalistic comparative studies utilizing the existing variance for identifying influential factors and effects. Areas for further research should include the extent of hidden coercion in psychiatric hospitals. Users' views could be more adequately explored if researchers would move on from concepts of compliance and insight to user-led research to determine the treatment required and accepted by users under circumstances that fulfil the legal criteria for detention. The impact of advance directives in this process is largely unknown but appears to be a promising approach. In relation to new legislation, reasons for the rise in detention rates in some parts of Europe need to be explored before mental health legislation can be harmonized in the European Union.

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