
Pergamon

International Journal of Law and Psychiatry
25 (2002) 109–117

INTERNATIONAL JOURNAL OF
LAW AND
PSYCHIATRY

Psychiatrists' perception of psychiatric commitment

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1. Introduction

Psychiatric commitment versus voluntary admission is, in emergency psychiatry, a crucial evaluation. In a study of Marson, Mc Govern, and Pomp (1988) of psychiatric decision-making in the emergency room, psychosis, incapacitating symptoms, prior hospitalization, and homicidal or suicidal features were important factors relevant to hospitalization. Inexperienced clinicians hospitalized more patients than experienced.

Hiday (1992) has described formal and informal methods in the USA for coercive hospitalization. Assorted pressures can be employed to get a patient to agree to voluntary admission. Monahan et al. (1995) have, in cases of psychiatric hospitalization, dealt with coercion as a dependent variable. For situations that they judged to be coercive, they proposed criteria for approval or rejection of the proposal to commit.

As to practices and attitudes of Swedish psychiatrists vis-à-vis compulsory treatment, Kullgren, Jacobsson, Lynöe, Kohn, and Levev (1996) used a questionnaire composed of clinical vignettes. Agreement was high re commitment of patients who belonged to well-defined diagnostic groups; but low re patients with disruptive behavior apparently associated with social problems. Differences between male and female responders were uncommon.

Voluntarily hospitalized patients who had filed a notice of intent to leave the hospital were studied in Boston by Appelbaum and Hamm (1982) and in New York by Schwartz,

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PII: S0160-2527(01)00114-5

Appelbaum, and Kaplan (1984) as to the attendant psychiatrist's decision for either their commitment or release. The decisions by these psychiatrists correlated well with legal criteria and clinical features.

The decision-making process in North Carolina re emergency commitment was investigated by Miller and Fiddleman (1988). Criteria used by law enforcement officers for emergency, involuntary hospitalization—namely mental disorder, dangerousness to self or others, and violent behavior—were not well articulated in most of their petitions.

Compulsory psychiatric care in Sweden re ethical justification, medical status, and social paternalism, was studied by Kjellin and coworkers (Kjellin, Andersson, Candefjord, Palmstierna, & Wallsten, 1997; Kjellin & Nilstun, 1993; Kjelling & Westrin, 1998; Kjellin et al., 1993). Investigation of the outcome and of the ethical justification for such psychiatric care showed that 30% of the patients did not fulfill the established criteria for involuntary treatment.

Sjöström (1997) explored the practical application of the Swedish Compulsory Psychiatric Care Act, especially identification of the need for compulsory care. Most important in a physician's psychiatric interview was assessment of the patient's insight as to the illness and his/her ability to make a considered, stable decision about hospital care and psychotropic medication.

Psychiatric patients' capacity to consent to voluntary hospitalization has been clinically assessed by Billick, Naylor, Majeske, Burgert, and Davis (1996) and Polythress, Cascardi, and Ritterband (1996). Such competency was, in the majority of both voluntarily admitted and committed patients, severely impaired.

The Swedish Compulsory Psychiatric Care Act (1991) permits retention at a psychiatric facility if the patient (a) suffers from a severe psychiatric disorder or categorically requires full-time psychiatric care and (b) either opposes such care or, because of the disorder, lacks the ability to arrive at or express a considered decision as to hospitalization.

A patient's therapeutic needs should determine whether or not coercive management is to be instituted. Also relevant, is the risk for injury to others. The provisions of the Compulsory Psychiatric Care Act are difficult to define and the decision-making process in conjunction with the execution of a certificate for compulsory psychiatric care is complicated.

Involuntary hospitalization due to mental illness involves judgments about ethical principles. The National Commision for the Protection of Human Subjects of Biomedical and Behavioral Research (1978) advocated principles such as beneficence, nonmaleficence, autonomy, and justice. *Beneficence* is the duty to benefit others; *nonmaleficence*, not to harm others. *Autonomy* refers to respect for the wishes of those involved, for their dignity and integrity. *Justice* concerns only distributive justice that, irrespective of sex, age, race, and politics, all have the same right to treatment.

Physicians' varying implementations of these ethical components reflect their biases and their capability to relate to patients, evaluate psychopathology, and appraise latent violence, as well as their awareness of ancillary resources outside the psychiatric facility.

This study examined involuntary admissions at an urban psychiatric emergency unit with a catchment area of 1.4 million inhabitants. About 20% of patients hospitalized from this unit were involuntary admissions.