ETHICAL AND LEGAL ASPECTS CONCERNING VOLUNTARY AND INVOLUNTARY ADMISSION OF PATIENTS WITH MENTAL DISORDERS

UNIVERSITY OF MEDICINE AND PHARMACY “GRIGORE T. POPA” IAŞI
FACULTY OF MEDICINE

DOCTORAL THESIS SYNOPSIS

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Project co-financed from the European Social Fund through the Department Operational Program for Human Resources Development 2007-2013
PRIORITY AXI 1 “Education and professional build to support economical growth and the knowledge based society”
MAJOR INTERVENTION 1.5 “Doctoral and postdoctoral programs supporting research”
Project Title: “PARTENERIAT INTERUNIVERSITAR PENTRU CREȘTEREA CALITĂȚII ŞI INTERDISCIPLINARITĂȚII CERCETĂRII DOCTORALE MEDICALE PRIN ACORDAREA DE BURSE DOCTORALE – DocMed.net” Contact Code: POSDRU/107/1.5/S/78702
Beneficiary: UNIVERSITY OF MEDICINE AND PHARMACY “IULIU HAŢIEGANU” CLUJ-NAPOCA
Partner 1: UNIVERSITY OF MEDICINE AND PHARMACY “GR. T. POPA” IAŞI

2014
# DOCTORAL THESIS SYNOPSIS

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<tr>
<td>AA</td>
<td>Alcoholic Anonymous</td>
</tr>
<tr>
<td>AAAIMH</td>
<td>American Association for the Abolition of Involuntary Mental Hospitalization</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>AD</td>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>CA</td>
<td>Compulsory Admission</td>
</tr>
<tr>
<td>CEDO</td>
<td>ro.Convenția Europeană a Drepturilor Omului</td>
</tr>
<tr>
<td>CI</td>
<td>ro.Consimțământ informat</td>
</tr>
<tr>
<td>CIOMS</td>
<td>ro.Consiliul Organizațiilor Internaționale de Științe Medicale</td>
</tr>
<tr>
<td>CIM</td>
<td>ro.Clasificarea Internațională a Maladiilor</td>
</tr>
<tr>
<td>DA</td>
<td>Dopamine</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>GAFS</td>
<td>Global Assessment of Functioning Scale</td>
</tr>
<tr>
<td>ECT</td>
<td>Electroconvulsive Therapy</td>
</tr>
<tr>
<td>EMBLEM</td>
<td>The European Mania in Bipolar Longitudinal Evaluation of Medication</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICCPR</td>
<td>ro.Convenția Internațională cu privire la Drepturile Civile și Politice</td>
</tr>
<tr>
<td>ICD-10</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>ICH</td>
<td>Harmonized Tripartite Guideline</td>
</tr>
<tr>
<td>IQ</td>
<td>Intelligence Quotient</td>
</tr>
<tr>
<td>MacCAT</td>
<td>MacArthur Competence Assessment Tool</td>
</tr>
<tr>
<td>MHA 2001 Mental Health Act 2001</td>
<td>Mental Health Act 2001</td>
</tr>
<tr>
<td>MMSE</td>
<td>Mini Mental State Examination</td>
</tr>
<tr>
<td>NDATSS</td>
<td>National Drug Abuse Treatment System Survey</td>
</tr>
<tr>
<td>NE</td>
<td>Norepinephrine</td>
</tr>
<tr>
<td>SEAS</td>
<td>Self-Stigma Assessment Scale</td>
</tr>
<tr>
<td>SIDA</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>UE</td>
<td>European Union</td>
</tr>
<tr>
<td>QoL</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WPA</td>
<td>World Psychiatric Association</td>
</tr>
</tbody>
</table>

The doctoral thesis is illustrated by 94 figures, 45 tables and 322 bibliographic references.

The research ensemble conducted during the doctoral studies could be finalized also due to my scholarship status in the project “Burse doctorale pentru doctoranzi competitivi în aria europeană a cercetării”, POSDRU/107/1.5/s/78702.
This doctoral thesis could not have been accomplished without the support and experience of Professor Vasile Astărestoae – University of Medicine and Pharmacy “Grigore T. Popa” Iași, to whom I address distinguished thanks for the trust, support, implication and especially for the given opportunity.
CHAPTER VI. MOTIVATION AND OBJECTIVES OF THE DOCTORAL STUDY

Taking into consideration the mental health law, there are two ways of admission in the psychiatric assistance services: voluntary and involuntary admission. The voluntary admission procedure takes place in the same way as any other medical service. The involuntary admission procedure takes place after all voluntary admission procedures were exhausted and the criteria for admission found in the law for mental health and protection of people with mental disorders was met. In society, the mental health law is necessary in order to protect people with mental disorders.

In psychiatry, as in any other discipline, ethical problems are confronted both in research and clinical practice. In the last years, ethical aspects of psychiatric practice were influenced by other disciplines like philosophy, psychology, theology and sociology. If during the communist period paternalism was promoted in the doctor-patient relationship, at present, patients are much more interested in psychiatric medical assistance, thus becoming an absolute necessity giving information to the patient. Even if at first glance we might say that the majority of ethical problems arise from involuntary commitments, there are still many divergent opinions that also imply aspects linked to obtaining a valid informed consent. Ethical controversies in psychiatry rise from the action of obtaining the informed consent, due to loose competence that ranges from case to case.

In the last 50 years, many changes were made in a lot of countries concerning psychiatric medical assistance, changes which bring up also many problems that can be found under ethical incidence. At present, patients with mental disorders have the same rights as any other patients from other specialties, this including the right to a private doctor-patient relationship. Different opinion currents have influenced the legislation regarding psychiatric medical assistance from many countries, especially the involuntary commitment of patients with psychiatric disorders. The admission criteria and the number of involuntary admissions vary throughout Europe dependent on different social and cultural contexts. Likewise, WHO reports show that countries in the Middle East have laws regarding mental health with a ratio of 57,1%, in comparison with countries in Europe that have mental health laws with a ratio of 91,8%. Over 50% of the mental health legislation was enforced in the year 1990, and from this, 25% was enforced after 2000. Consecutively, research pathways were opened in order to thoroughly investigate this subject and complete mental health legislation offers a clear perspective on the psychiatric medical assistance.

In Romania, decrees 313 from 1980 was replaced by the Law 487/2002, the law for mental health and protection of people with mental disorders, and in 2006 application norms of this law were approved. Law 129/2012 for modifying and completing Law 487/2002 surprises us with new legislation elaborations meant to align us to European norms. Regarding the fact that the law for mental health and protection of people with mental disorders in Romania emerged in the year 2002, this present study is meant to fathom the legislative regulations of voluntary and involuntary admission in the psychiatric medical assistance.

In this context, the doctoral study followed: investigating aspects linked to the lawfulness of the involuntary admission procedure of a patient with mental disorders and evaluating the knowledge connected to rights of psychiatric patients and professionals involved in the management of patients with mental disorders.
CHAPTER VIII. STUDY OF PATIENTS WITH MENTAL DISORDERS

VIII.1 INTRODUCTION

Voluntary and involuntary admission of patients with mental disorders is accomplished according to the law for mental health and protection of people with mental disorders (Crăciun et al., 2013). In the expertise literature, an avalanche of studies shows the variation of mental health legislation from one country to another. Even if in some countries there is mental health legislation, there is also no certainty that it is totally honored. In countries where mental health legislation is not up to date, promotion of human rights is exceeded by the frequency of their trespassing. Present mental health laws contain articles referring to patient protection, contention, involuntary admission, appeal and establishment protection. Although there is a lot of data, mental health legislation is a document that can be permanently improved. At the moment, respecting the psychiatric patient’s rights is an ethical obligation even more in countries that signed international conventions.

In Romania, decree 313 from 1980 was replaced by Law 487/2002, the law for mental health and protection of people with mental disorders, and in 2006 the norms for applying this law were approved. Law 129/2012 for modifying and completing Law 487/2002 surprises with new legislation elaborations meant to align us to European norms. Concerning the condition under which the law for mental health and protection of people with mental disorders in Romania was brought about in the year 2002, the present study’s objective is to thoroughly examine the legislation’s regulation of the voluntary and involuntary admission of patients in the psychiatric medical assistance. (Crăciun et al., 2012)

VIII.2 MATERIAL AND METHOD

The studied lot included a number of 202 patients involuntary committed during the period of August 2002 – July 2012 in the University Hospital „Socola” Iași. The study is retrospective, quantitative and data was taken out of admission sheets of involuntary admitted patients during a period of 10 years, according to the law for mental health and protection of people with mental disorders, Law 487/2002. The studied lot had data taken out of the involuntary admitted patients’ sheets. Selection criteria were elaborated for the selection study, criteria for inclusion and exclusion.

The study was approved by the Ethical Committee of U.M.F. “Grigore T. Popa” Iași, on the basis of the doctoral study’s protocol, done at the end of the first year of the doctoral period.

Data was centralized in databases SPSS 13.0 and processed with the statistical functions to which these are lent. In the statistical analysis were utilized descriptive methods but also analytical ones. The ANOVA ones underline the qualitative aspects of an ensemble, targeting the relation between different parts of a group or interdependence links between variables, at a signification bar of 95%, using these derived indicators:
- Medium value indicators: simple arithmetic mean, median, module.
- Dispersion indicators: standard derivation, variation.

When calculating the significant difference between two means, at the signification bar of 95%, the T-Student test was used, a quantitative test based on the mean and standard deviation for each lot in part. For parameter evolution the Paired Samples Test was used, which compares mean values in a single group, calculating differences between the series values of 2 variables and testing if the mean differs from 0. The $\chi^2$ test is unparametric and compares 2 or more frequency repartitions that came from the same population; it is applied when the expected events are excluded. The Pearson correlation coefficient renders the degree of linear association between two variables from the same group. In the graphic
expression, the $R^2$ coefficient was also used; this represents the square of the Pearson coefficient. The linear tendency ($y = ax + b$) underlines the prevalence’s evolution of an event after a monitoring period.

**VIII.3 RESULTS**

**Characteristics of the patient lots admitted with mental disorders**

By years of study, the distribution of the voluntary admissions had a constant tendency ($y = 10332 + 64.37x$), making a prognosis for the year 2013 of approximately 12000 voluntary admissions in a regime of continuous admission.

On the basis of studied cases, the maximum number of involuntary admissions per studied year was in 2007 (58 involuntary admissions), distinguishing a rising tendency for the next period ($y = 5.82 + 2.09x$) and making a prognosis for the year 2013 of about 30 involuntary admissions.

The distribution of the voluntary and involuntary admissions of patients with mental disorders in the studied lots is illustrated in figure 1.

![Figure 1: Distribution of voluntary and involuntary admissions of patients with mental disorders per studied years](image)

According to admission type, the frequency distributions by years of study were significantly larger in patients with mental disorders admitted in a regime of continuous commitment, by means of involuntary admission ($\text{Chi-Square} = 31.68; \text{df} = 10; \text{p} = 0.001$).

**Involuntary admitted lot**

On the studied lot, the maximum number of involuntary mentally ill patient admissions per year of study, in 2007 we highlighted an increasing tendency for the next period ($y = 5.82 + 2.09x$) (Fig.2).
Fig. 2. Number of involuntary admissions per year of study

The gender distribution of patients admitted involuntarily has highlighted a larger ratio of male patients (75.7%) and a gender ratio of 3/1. The sex ratio in the involuntary admitted lots has underlined in numerous studies a large ratio in the favor of the male gender in comparison with the female gender (Houston, Mariotto, 2011).

The lot distribution according to the origin environment has presented a high frequency in patients from the urban environment (70.3%), the proportion of levels U/R being 2.4/1.

In the cases studied, one can identify a high frequency of patients with mental disorders from the age group 30-39 years (33.2%).

Fig. 3. Case distribution by age group

The mean age for the female gender was of 41.67 years, with variations from 20 to 79 years, while for the male gender the mean age is found at a value of 40.31 years with
variations between 18 – 76 years, highlighting the homogeneity of age dependent on the gender of the patient (t = 0.447; df = 201; p = 0.505)(Fig.4).

**Table 1. The structure of the lot according to the occupation**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>No. of patients</th>
<th>From which male</th>
<th>From which urban</th>
<th>From which under 40 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Without a job</td>
<td>122</td>
<td>97</td>
<td>79.5</td>
<td>83</td>
</tr>
<tr>
<td>Retired</td>
<td>48</td>
<td>39</td>
<td>81.3</td>
<td>37</td>
</tr>
<tr>
<td>Wage earner</td>
<td>29</td>
<td>15</td>
<td>51.7</td>
<td>20</td>
</tr>
<tr>
<td>Pupil &gt; 18 years / student</td>
<td>3</td>
<td>2</td>
<td>66.7</td>
<td>2</td>
</tr>
<tr>
<td>Statistical significance</td>
<td></td>
<td>p=0.012</td>
<td></td>
<td>p=0.705</td>
</tr>
</tbody>
</table>

Depending on the epidemiological characteristics, one can highlight the following aspects: wage earners’ gender distribution is approximately equal (51.7% of men), in comparison with the retired group and the one without a job where the male gender was predominant (approximately 80%); likewise, without taking into account the job, the origin environment was urban (67-77%); the frequency was higher for patients with ages under 40 years without a job (63.9%).

According to the epidemiological characteristics, one can underline the following aspects: the frequency significantly higher of feminine gender patients with a high level of instruction (50% post high school studies, respectively 34.4% superior studies); the ratio was significantly higher for subjects who came from the urban environment with a high instructional status, high school studies (84.6%), superior studies (90.2%); no significant differences were highlighted between the age groups concerning the level of instruction.

On the studied cases one observed a frequency of 47.5% of unmarried people, to which one might add a ratio of 17.8% divorcees and 2.0% widows. The lot distribution according to the epidemiological characteristics is highlighting the following aspects: the equal frequency between genders of widowed patients (50%); the significantly higher ratio of widowed subjects who came from urban environment (100%) or divorcees (86.1%); significant differences between age groups were identified concerning the marital status, having a high rate of unmarried people under the age of 40 (80.2%).

One must note that admissions were made mainly in emergencies (95%), without registering significant differences, origin environments or age groups. Medical insurance was found in 64.9% of subjects with mental disorders, admitted involuntarily, with significantly higher frequencies in males, in patients with mental disorders who came from the urban environment and had ages higher than 40 years.

In first admitted patients, the number of commitment days varied between 1 and 149, with a mean of 26.73 ± 20.86 days. In subjects with more than 10 admissions, the mean number of commitment days was of 55.35 ± 29.48 days, significantly higher (p = 0.001) in comparison with the mean registered at anterior admissions.
The discharge diagnosis, in comparison with the initial one, was confirmed as follows:

- Of those subjects with an admission diagnosis of delirium, dementia or other cognitive disorders, when discharged, only 89.5% of patients had their diagnosis confirmed, the rest had their final diagnosis of schizophrenia or other psychotic disorders in 5.3% of patients and of mental retardation in 5.3%;
- Concerning those patients whose admission diagnosis was mental and behavioral disorders due to psychoactive substance abuse, their diagnosis was confirmed in 77.8%, meanwhile in 8.3% the final diagnosis was schizophrenia and other psychotic disorders;
- The diagnosis from the category schizophrenia and other psychotic disorders that was initially established, was confirmed in 93.6% of patients with mental disorders involuntarily admitted in the psychiatric hospital;
- The diagnosis form the category mood disorders was maintained in 86.7% from the involuntarily admitted patients with mental disorders;
- Personality disorders were confirmed in 57.1% of cases, the rest being patients whose discharge diagnosis was part of the diagnosis category schizophrenia or other psychotic disorders;
- The epilepsy diagnosis initially established, was not confirmed when discharged, those patients being diagnosed with one included in the category: delirium, dementia or other cognitive disorders;
- The diagnosis of mental deficiency was not present when involuntary admitting patients with mental disorders; the two patients initially diagnosed with delirium, dementia or other cognitive disorders or schizophrenia (Table 2).

<table>
<thead>
<tr>
<th>Admission diagnosis</th>
<th>Discharge diagnosis</th>
<th>Delirium, dementia or other cognitive disorders</th>
<th>Mental and behavioral disorders due to psychoactive substance abuse</th>
<th>Schizophrenia or other psychotic disorders</th>
<th>Mood disorder</th>
<th>Personality disorder</th>
<th>Mental deficiency</th>
<th>Epilepsy</th>
<th>Authorities demanded examination (ADE)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium, dementia or other cognitive disorders</td>
<td>17 (89.5%)</td>
<td>1 (2.8%)</td>
<td>2 (1.6%)</td>
<td>1 (6.7%)</td>
<td>-</td>
<td>-</td>
<td>1 (100%)</td>
<td>-</td>
<td>-</td>
<td>2 (10.9%)</td>
</tr>
<tr>
<td>Mental and behavioral disorders due to psychoactive substance abuse</td>
<td>-</td>
<td>28 (77.8%)</td>
<td>1 (0.8%)</td>
<td>1 (6.7%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30 (14.9%)</td>
</tr>
<tr>
<td>Schizophrenia or other psychotic disorders</td>
<td>1 (5.3%)</td>
<td>3 (8.3%)</td>
<td>113 (92.6%)</td>
<td>-</td>
<td>3 (42.9%)</td>
<td>-</td>
<td>-</td>
<td>2 (100%)</td>
<td>-</td>
<td>122 (60.4%)</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>-</td>
<td>1 (3.1%)</td>
<td>5 (13.2%)</td>
<td>13 (42.9%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>19</td>
</tr>
</tbody>
</table>
Table 3. Patient distribution according to discharge diagnosis criteria listed in ICD-10.

<table>
<thead>
<tr>
<th>Diagnosis code</th>
<th>n</th>
<th>%</th>
<th>Diagnosis code</th>
<th>n</th>
<th>%</th>
<th>Diagnosis code</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium, dementia or other cognitive disorders</td>
<td>F 01.3</td>
<td>1</td>
<td>0,5</td>
<td>F 20.0</td>
<td>46</td>
<td>22,8</td>
<td>F 31.0</td>
<td>1</td>
</tr>
<tr>
<td>Mental and behavioral disorders due to psychoactive substance abuse</td>
<td>F 23.2</td>
<td>2</td>
<td>1,0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 10.0</td>
<td>5</td>
<td>2,5</td>
<td>F 23.8</td>
<td>7</td>
<td>3,5</td>
<td>F 33.3</td>
<td>1</td>
<td>0,5</td>
</tr>
<tr>
<td>F 10.1</td>
<td>6</td>
<td>3,0</td>
<td>F 25.0</td>
<td>4</td>
<td>2,0</td>
<td>F 34.0</td>
<td>1</td>
<td>0,5</td>
</tr>
<tr>
<td>F 10.2</td>
<td>4</td>
<td>2,0</td>
<td>F 25.1</td>
<td>3</td>
<td>1,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality disorder</td>
<td>F 60.0</td>
<td>1</td>
<td>0,5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood disorder</td>
<td>F 32.8</td>
<td>1</td>
<td>0,5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental deficiency</td>
<td>F 71.1</td>
<td>2</td>
<td>1,0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia or other psychotic disorders</td>
<td>F 23.1</td>
<td>19</td>
<td>9,4</td>
<td>F 32.3</td>
<td>2</td>
<td>1,0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F 23.0</td>
<td>17</td>
<td>8,4</td>
<td>F 32.8</td>
<td>1</td>
<td>0,5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F 23.1</td>
<td>19</td>
<td>9,4</td>
<td>F 32.3</td>
<td>2</td>
<td>1,0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental deficiency</td>
<td>F 71.1</td>
<td>2</td>
<td>1,0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ETHICAL AND LEGAL ASPECTS CONCERNING VOLUNTARY AND INVOLUNTARY ADMISSION OF PATIENTS WITH MENTAL DISORDERS

According the law for mental health and protection of people with mental disorders, Law 487/2002, art. 47, align. 1, (Law 129/2012, art. 56, align. 1) the solicitation for involuntary admission of patients with psychiatric disorders can be made by the treating psychiatrist, the family doctor, the patient’s family. Likewise, the solicitation of involuntary admission of the patient with mental disorders according to the mental health law can also be made by the police, fire department, gendarmerie, prosecutor, civilian court or local public administration representatives.

In accordance with the law for mental health and protection of people with mental disorders, Law 487/2002, art. 47, align. 2, (Law 129/2012, art. 56, align.2), justifying the involuntary admission of patients with mental disorders in the psychiatric hospital is certified under the signature of those who solicit the admission. The justification of involuntary admission is accompanied by the data of the solicitor, the patient, the description of circumstances that led to admission and the known medical history.

In the studied lot, the solicitation of involuntary admission of patients with mental disorders in the psychiatric hospital came mostly from family members of the admitted patient (65.3%).

![Subject distribution according to the solicitor for involuntary admission](image1)

**Fig.4. Subject distribution according to the solicitor for involuntary admission**

In the studied cases admissions for the diagnosis category schizophrenia or other psychotic disorders (60.4%), mental and behavioral disorders due to psychoactive substance abuse (17.8%) and delirium, dementia or other cognitive disorders (9.4%) are dominant.

The mood disorders had a percentage of 7.4% admissions, and the personality disorders a percentage of 3.5%. The legal medical psychiatric expertise requested by the authorities was 1.0% from the total of involuntary admissions in the psychiatric hospital.

The transport of patients with mental disorders according to the law for mental health and protection of people with mental disorders, Law 487/2002, art. 48 (Law 129/2012, art. 57, align. 1) in the psychiatric hospital is usually made with the help of the ambulance department. If the patient’s behavior is a potential threat for himself and others, his transport to the psychiatric hospital in order to be admitted is made with the help of the police, gendarmerie or the fire department. Likewise, transport is realized respecting the dignity of the patient with mental disorders, all safety and physical integrity measures possible. According to the Law 129/2012, art. 57, align. 2, if the transport of a patient with mental disorders will be done by ambulance, it will always need someone to accompany it.
In the studied lot, transport of subjects with mental disorders for involuntary admission in the psychiatric hospital was made by ambulance under the supervision of the police (32.7%), then in a smaller number, by the police representatives with a ratio of 28.2%, and only by the ambulance in 10.9%. The family of patients with mental disorders insured transport to the psychiatric hospital in 26.2% of cases.

From all involuntary admissions that took place during those 10 years, from 2002-2012, for 172 subjects (85.1%) the committee for involuntary admission of patients with mental disorders had to gather.

The involuntary admission committee, according to the law for mental health and protection of people with mental disorders, Law 487/2002, art. 52, align. 1 (Law 129/2002, art. 61, align. 2), is made of 3 members, named by the hospital’s director. According to the law, these three members will be psychiatrists, others than those who admitted the patient and one doctor from another specialty and one representative of the civil society.

The mean number of committee gatherings in case of the diagnosis discharge category – delirium, dementia or other cognitive disorders, was of 2.27 with variations from 1 to 6 gatherings, and in case of schizophrenia or other psychotic disorders of 2.13; with variations between 1 and 13 gatherings. In case of the discharge diagnosis of mood disorders, personality disorders or mental deficit, the mean number of gatherings was significantly lower, of approximately 1-2 gatherings (p = 0.011).

One must take note of the fact that between the number of committee gatherings and admission days, there is a direct correlation (r = + 0.593), the large number of gatherings is significantly associated with a high number of admission days (p < 0.001).

At discharge, the most frequent number of recommended medications was of 3, in 38.5% of admitted patients in the psychiatric hospital by involuntary continuous mean of admission. Likewise, it is followed by a ratio of 22.5% of patients with mental disorders whom at discharge were given a number of 2 medications, and a lower ratio of patients that were given at discharge only one medication (13.5%). On the other hand, there was a percentage of patients that did not need treatment when discharged, these had a ratio of 1.5% from the studied lot.

At discharge, the number of recommended medications did not differ statistically according to the diagnosis (p = 0.099):
- The highest number of medications was recommended for patients with psychiatric disorders that were admitted by involuntary means, that could be included in the diagnosis category of: delirium, dementia or other cognitive disorders, varying from 2 to 6 types of medications, with a mean lot of over 3 medications;
- Likewise, in patients with mental disorders involuntary admitted in the psychiatric hospital, that were included in the diagnosis category of mood disorders, the mean number of recommended medications recommended at discharge was of over 3 medications;
- In patients with psychiatric disorders involuntary admitted in the psychiatric hospital with a diagnosis that was part of the category schizophrenia or other psychotic disorders, the mean number of medications recommended at discharge was of under 3;
- The lowest number of medications recommended at discharge was in case of patients with involuntary admission that were enclosed in the diagnosis category personality disorders or mental deficiency (mental retardation);
- In patients with psychiatric disorders involuntary admitted in the psychiatric hospital that were included in the diagnosis category – mental and behavioral disorders due to psychoactive substance abuse, the number of recommended medications at discharge varied between 1 and 4, with a mean of over 2.
In the whole lot, the signature was given by the patient either in the confirmed consent, either in the patient chart, under the involuntary admission committee, in 88.1% of cases; in 4.5% the representative’s signature is found either in the informed consent or in the patient’s chart, under the involuntary admission committee, and only in 7.4% of cases this decision was not made by the patient or by a representative. From the whole lot of signatures in the patient’s chart, a percentage of 95.2% of signatures belong to the patients and 4.8% of signatures belong to their representatives.

From all the subjects in whose cases the committee established as an involuntary admission motive self-harm ± harm to others: approximately 40% are alcohol abusers; and the involuntary admission committee established that 8% of patients had suicidal ideas/attempt and under 8% of subjects were refusing food at the moment of involuntary admission.

Psychotic symptomatology was dominated by delirious symptoms in 52.5% of patients when involuntary admitted and 32.2% of the examination committee motives for involuntary admission (p = 0.001).

The examining committee established in 30.2% of cases absence of disease perception in patients with psychotic symptoms, this being a reason why they recommend admission (p = 0.001).

The symptoms of delirium and hallucinations were found in percentages that did not have significant differences between the reasons for involuntary admission of patients and the ones of the involuntary admission committee.

In subjects that manifested self-harm, the following associations with psychotic symptoms were found: psychotic delirious symptoms in 16.7% of patients concerning the admission reasons and 36.8% concerning the involuntary examination committee.

In subjects with self-harm the following associations with psychotic symptoms were found: delirious psychotic symptoms in 16.7% of patients according to the admission reasons and 36.8% according to the reasons of the involuntary examination committee ($\chi^2=2.91$; GL=1, p=0.05); hallucinatory and delirious psychotic symptoms in 12.5% of patients and 18.4% according to the reasons of the involuntary examination committee ($\chi^2=0.07$; GL=1, p=0.793); the absence of disease perception was found with a frequency of 36.8% only in the case of involuntary examination committee motivation ($\chi^2=9.41$; GL=1, p=0.002).

In subjects with self-harm/harm to others were found the following associations with psychotic disorders: delirious psychotic disorders in 18.5% of patients between the reasons of the involuntary examination committee and 10.6% between the reasons for involuntary admission (p=0.452); hallucinatory and delirious psychotic disorders were found in 10.6% of patients as admission reasons and 37% as reasons for admission of the involuntary examining committee ($\chi^2=8.38$; GL=1, p=0.004); the absence of disease conscience was the reason of admission of the involuntary admission committee (59.3%) in patients involuntary admitted ($\chi^2=54.03$; GL=1, p<0.001).

In subjects with both types of aggression to self and to others, the psychotic symptoms were associated as follows: the ratio of associating as reasons for admission the delirious symptoms was significantly higher in patients with psychiatric disorders, in comparison with the involuntary admission reasons (27.1% vs 3.2%) ($\chi^2=6.31$; GL=1, p=0.012); hallucinatory and delirious psychotic symptoms were found in 14.3% among the admission reasons in patients with mental disorders and 16.1% among the writings of the involuntary examination committee ($\chi^2=0.01$; GL=1, p=0.950); absence of disease perception was the main reason for admission of the involuntary admission committee ($\chi^2=96.35$; GL=1, p=0.001).

The percentage of subjects that needed coercive measures, like mechanical restraint, involuntary admitted for symptoms like self-harm, was of approximately 58%, while subjects...
that did not need coercive measures were mainly admitted on the grounds of harm of others (43.3%). The frequency distributions did not have significant statistical differences (p = 0.147).

Approximately 60% of subjects that needed coercive measures were without a job and 20% were retired, but the frequency distributions did not differ significantly in comparison with those subjects that did not need coercive measures (p = 0.536). The majority of cases that needed coercive measures were registered in 2007, representing 13.5% of the total lot with mechanical restraint, and the fewer cases that did need coercive measures was registered in the year 2004 (1.9%). The lot of subjects with mechanical restraint registered an annual decrease in distribution (y = 8.05 – 0.21x). The percentage of male subjects was significantly higher in the lot of subjects that needed coercive measures (86.5% vs 72%) (p=0.036).

Fig. 5. Mechanical restraint according to the mentally ill patients’ symptoms that were involuntary admitted

The mean number of admission days in patients that needed coercive measures was slightly higher (37.54 vs 33.23 days), in comparison with patients that did not need mechanical restraint during admission, without any registration of significant statistical differences (p = 0.310).

VIII.4. DISCUSSIONS

The research was structured from the point of view of an analytical, observational, retrospective type of study, that included a mass of patients involuntary admitted in the psychiatric hospital “Socola” Iași, during a period of 10 years, in accordance with the law for mental health and protection of people with mental disorders, Law 487/2002.

On the studied lot, a greater percentage of male gender patients (75.7%) was found, with a sex ratio of 3/1. The field literature shows that the rates of involuntary admissions in Croatia, in the male gender, after 2000, highlight a significant increase in comparison with the female gender (Kozumpik et al., 2003).

In the studied cases, a frequency of 47.5% unmarried patients, to which we add a percentage of 17.8% divorced people and 2.0% widowed was found. According to studies, the hostile, violent behavior is associated with young age and disease beginning, but also with the status of unmarried/single person (Raja, Azzoni, 2005).

A large percentage of patients with mental disorders were admitted between 31 and 40 days (24.8%), although one must highlight the fact that over 11% of patients with mental
disorders had over 60 days of admission (11.4%). According to the studies from the specialty literature, in involuntary admitted patients, compared to the voluntary admitted ones, the admission period is higher (Roşca et al., 2006).

According to the law for mental health and protection of people with mental disorders, Law 487/2002, art.47, align. 1, (Law 129/2012, art.56, align. 1), in Romania, the request for involuntary admission of patients with mental disorders can be made by the treating psychiatrist, family doctor, patient’s family, police representatives, firemen, gendarmerie, prosecutor, civil court, likewise by representatives of the local public administration. Involuntary admission request in Ireland is made by the husband/wife or other relative, an authorized officer, police member (Latif, Malik, 2012). In Greece, when the subject has no relatives to request involuntary admission, the prosecutor himself can request admission (Douzenis et al., 2012). In the studied lot, the involuntary admission request of patients with mental disorders in the psychiatric hospital, according to the Law 487/2002, was largely made by the members of the admitted patient in 65.3% of cases, followed by police representatives (21.8%).

In the studied cases the following admission diagnoses are predominant: schizophrenia or other psychotic disorders (60.4%), followed by those from the category mental and behavioral disorders due to psychoactive substance abuse (17.8%) and delirium, dementia or other cognitive disorders (9.4%). The admission of a patient with mental disorders takes place according to the diagnosis criteria ICD 10. In England, numerous involuntary admissions were found more frequent in patients with the diagnosis of psychotic disorder, organic mental disorders, dementia and substance abuse (Keown, 2008, Mulder et al., 2008). In Croatia, patients that were found in the diagnosis category schizophrenia or other psychotic disorders, registered the majority of involuntary admissions (Kozumplik et al., 2003). In Switzerland can be involuntary admitted in a psychiatric institution only those that are part of the diagnosis category: alcoholics, substance addiction, those with learning disabilities and without self-care capabilities (Lay et al., 2012).

The transport of an individual with mental disorders according to the mental health law, the law for mental health and protection of people with mental disorders, Law 487/2002, art. 48 (law 129/2012, art. 57, align.1), to the psychiatric hospital, is usually made with the help of the ambulance service. If the patients’ behavior can be dangerous for him and others, his transport to the psychiatric hospital in order to be admitted is made with the help of the police, gendarmerie or the fire department. In the studied lot, the transport of subjects with mental disorders for involuntary admission in the psychiatric hospital was more frequently made by ambulance and under police supervision (32.7%); then, in a smaller number, only by police representatives in a ratio of 28.2% and only by ambulance in 10.9%. The family of the patient with mental disorders ensured transport for involuntary admission in 26.2% of cases. In Greece, an individual with mental disorders is escorted by the police at the emergency psychiatric hospital (Douzenis et al., 2012).

Among the patients with mental disorders at first admission, the diagnoses were mainly enclosed in the diagnostic category schizophrenia or other psychotic disorders, also mainly confirmed at discharge ($\chi^2=1.40; \text{GL}=4, \ p=0.843$). In patients at first admission in a psychiatric hospital, as an involuntary admission, factors associated with a longer period of admission days, are linked to the status of an unmarried individual, patient without a job and meeting the diagnosis criteria of dementia or schizophrenia (Segal, Burgess, 2006, Segal, Burgess, 2009).

In the studied cases, symptoms like harm of others was a large ratio of the involuntary admission reasons and it was 19.8% of the reasons of the involuntary admission committee, having frequency distributions statistically speaking ($\chi^2=118.05; \text{GL}=1, \ p=0.001$). Psychotic symptoms were dominated by delirious symptoms in 52.5% of patients when involuntary
admitted and 32.2% of the reasons of the examining committee for involuntary admission (p = 0.001). Involuntary restraining is strongly correlated with the severity of the mentally ill patients’ symptoms, especially those that presented with aggressive behavior (Kaltiala-Heino, 2010). In Europe, mental health laws have as involuntary admission criteria self harm and harm of others (Large et al., 2008). Criteria for involuntary admission in the U.S.A. refer to the patients’ incapacity to take care of himself/herself or to the danger potential for oneself or for others. Specific criteria vary from one state to the other (Fisher et al., 2001). In Greece, for involuntary admission an individual must meet certain criteria: to suffer from a mental illness; due to the mental illness, the patient must not be capable to take care of oneself; the mentioned illness must need treatment, otherwise it might result in danger for oneself (Carter et al., 2006) or for others (Douzenis et al., 2012).

Almost one quarter of patients with mental disorders needed mechanical restraint in order to ensure his/hers protection. The ratio of subjects that needed coercive measures, like mechanical restraint, were generally part of those involuntary admitted for symptoms like self-harm (58%). Of the coercive measures, mechanical restraint is the most traumatizing one (Perkins et al., 2012) but it is sometimes necessary especially in emergencies with aggressive potential. Coercive measures (Høy er et al., 2002) are procedures considered necessary and justified from an ethical point of view in psychiatry.

VIII.5. PARTIAL CONCLUSIONS

The increase in number of the involuntary admissions in 2007 appears consecutively to the period in which all norms of application of the law for mental health and protection of people with mental disorders were approved.

Transport of patients with mental disorders needed the involvement of the police due to the aggressive potential of mentally ill patients. Thus, a quarter of patients were escorted by the police when admitted, and one third of psychiatric patients that were transported by ambulance needed also the police support in order to be taken to the psychiatric hospital.

In the analyzed lot of mentally ill patients, admitted involuntarily, one can notice the high frequency of patients without a job, this highlighting the difficulty that these people have in order to function or social reinsertion, due either to the alteration of the cognitive, affective and motivational, behavioral functions, either to the stigmatization and marginalization of the psychiatric patient.

In the lot studied, one third of the mentally ill patients are uninsured, a very important aspect due to this vulnerable category’s necessity to access a complete medical assistance, these patients being exposed to a high risk of discontinuing their treatment.

The studied lot highlights a high frequency of unmarried patients, and of those married, half of them are separated from their partner, thus underlying their difficulty of family integration.

According to the ICD 10 diagnosis criteria, almost 2/3 of patients that were admitted by involuntary admission are part of the diagnosis category schizophrenia or other psychotic disorders, this exposing a lowered disease conscience in this diagnosis category. The diagnosis category mentioned was followed by a high number of patients admitted involuntarily in the psychiatric hospital that were part of another diagnosis category mental and behavioral disorders due to psychoactive substance abuse.

Likewise, in patients who were at first admission in the psychiatric hospital, the admission diagnosis was mainly found in the diagnoses category schizophrenia or other psychotic disorders, this highlighting yet again a small insight in this diagnoses category.

The involuntary admission criteria according to the law for mental health and protection of people with mental disorders refer to symptoms that imply symptoms with
aggression potential (self-harm, harm of others) and psychotic disorders (specially delirious symptoms). These admission criteria were followed in all patients involuntary admitted.

Between the number of meetings of the involuntary admission committee and the number of admission days one can find a direct link, thus the large number of gatherings can be significantly associated with a large number of admission days.

Mechanical restraint during hospital admission, measure taken for psychiatric patients’ protection is usually found most frequently in patients from the diagnosis category schizophrenia or other psychotic disorders, this highlighting a small insight in this diagnosis category.

The recommended medication at discharge underlines the necessity of treatment continuation for a patient with mental disorders also after one was discharged from the psychiatric hospital.

**CHAPTER IX. STUDY ON MEDICAL PERSONNEL PART OF PATIENT THERAPY**

**IX.1. INTRODUCTION**

According to psychiatrists’ opinion, the decision for admission of a patient with psychiatric disorders varies significantly according to their diagnosis. Likewise, studies referring to involuntary admission that included judicial personnel, like lawyers, underlined the necessity of involuntary admissions of patients with a high danger risk (Luchins et al., 2006). Coercive measures like involuntary admission of patients with psychiatric disorders are traumatizing experiences, humiliating, that put a stigma on the patient, but also on their families (Crisanti, 2000). Some studies show that coercive politics have a negative impact on the mentally ill patient, these triggering stigmatization and self-stigmatization in significant percentages (Link et al., 2008). Although contention is a measure sometimes necessary in psychiatric medical care, specially in aggressive patients (Ghebaur et al., 2012), medical personnel must encourage the psychiatric patients’ autonomy (Grant, Briscoe, 2002) during hospitalization in order to reduce in time, self-stigmatization. Studies show that, unfortunately, that patients’ experience and the perception of the medical personnel regarding the necessity of the enforced treatment is different (Haglund et al., 2003).

Although multiple studies show that patients with mental disorders do not have a high number of antisocial acts, in comparison with individuals without mental disorders, these ones are unjustly rejected socially and stigmatized (Damir, Toader, 2007). Society’s perception concerning individuals with mental disorders imply fear, fury, disgust, hostility, negative emotional experiences that materializes in social discrimination (Pădurariu et al., 2011). Likewise, in the opposite corner, feelings of stigma include: depression, anxiety, guilt, awkwardness, avoidance, fury with negative consequences for the mentally ill patients’ quality of life (Dinos et al., 2004, Verhaeghe et al., 2008). Stigma linked to mental disorders is an important barrier in the quality psychiatric medical assistance (Zalar et al., 2007). Self-stigmatization refers to internalization of feelings like inferiority, guilt, shame (Gray, 2002).

External stigma refers to discrimination of others, engaging an unfair attitude towards the patient (Stuart, 2005). Internal stigma, but also external stigma results in social isolation (Suciu, Ardelean, 2007) and decrease in social support (Gray, 2002). Stigma is seen as a form of social oppression (Arboleda-Flórez, Stuart, 2012). In Greece, according to some studies, the publics’ attitude (Evans-Lacko et al., 2013) towards discrimination, disapproves to the extent of their living near the mentally ill patient (Economou et al., 2009).
social stigma and self-stigma there is a contiguity relation that results in a decrease in self-image and in self-efficacy (Watson, Corringan, 2002).

Theoretical principle, but also practical obligation, medical confidentiality is a stringent requirement in medical assistance (Chiriţă et al, 1994). Confidentiality is an ethical necessity both in medical assistance, but also in research (Jones, 2003). According to Hippocrates’ oath, the medical professional is obliged to maintain the medical data’s and patients’ confidentiality (Moskop et al., 2005, O’Brien, Chantler, 2003). By trespassing confidentiality, the integrity of the doctor-patient relation is broken and the patient becomes much more vulnerable (Ţirdea, Gramma, 2007). The psychiatrist is frequently found in situations of ethical tension, but also in intermissions of trespassing medical confidence (Chiriţă et al., 1994). The psychiatrists’ ethical responsibility is keeping and protecting the data confidentiality of the mentally ill patient (Bloch, Chodoff, 2000). The borders regarding medical confidentiality has many ethical challenges for the XXI century, in the press (Cănănău, Astărăstoae, 2012), medical assistance and also research (Ferguson, 2012).

Psychiatric disorders are a category of illnesses in which obtaining a valid informed consent is a challenge (Amer, 2013). A signed informed consent signed by a patient considered incompetent is invalid from a legal point of view (Appelbaum, 2007).

**IX.2. MATERIAL AND METHOD**

The second study is prospective, realized with the help of questionnaires, on medical staff involved in the medically ill patients’ care. The knowledge of psychiatric patients’ rights by the staff involved in therapy and the way these are perceived, had a research population of 217 members of personnel involved in the therapy of the mentally ill patient: psychiatrists, psychologists, family doctors, clinicians from other specialties, in medical centers from Iaşi, Suceava, Botoşani, Vaslui. The study is prospective, descriptive, questionnaire-type and was realized during the period July 2012 – July 2013. The studied factor referred to the knowledge and respecting psychiatric patients’ rights and the ways of protecting them regarding legislation restrains. The main criteria of appreciation was the lack of knowledge or minimizing the importance of respecting patients’ rights that can influence the mentally ill patients’ voluntary addressing to psychiatric medical assistance and implicitly to admission and/or psychiatric care.

The questionnaires followed all stages of pretesting, revising, validation and their application as final form. The results were statistically adapted for each item, having done after this also the correlation of answers to questions according to different characteristics of the studied lots.

**IX.RESULTS**

**Study lots**

**Psychiatrists lot** – 57 psychiatry physicians

**Other specialties physicians lot** – 50 doctors physicians from other specialties (ex. – neurology, cardiology, emergency medicine) involved in the treatment of patients with mental disorders

**Family doctors lot** – 50 physicians

**Psychologists lot** – 60 psychologists

In the physician lots, the analysis of the frequency distribution according to their specialty highlights the majority of the resident physicians (54%) in the lot of physicians from other specialties and of the specialist physicians (66%) in the family physicians lot, while in the psychiatrists lots one can underline the homogenous distribution according to each specialty. When put to practice the unparametric intergroup Kruskall-Wallis test, it is
highlighted the significant statistical differences between the specialties of the doctors who answered to the questionnaire (Chi-Square = 15.22; df=2; p=0.001).

**Questionnaire evaluation**

**Question 1:** “The law for mental health and protection of people with mental disorders is:”

a. Law 487/2002
b. Law 129/2012
c. Law 487/2002 and Law 129/2012
d. I don’t know.

Comparing by studied lots, the answer concerning the actual legislation that deals with the protection of people with mental disorders highlights the following aspects:

**Table 4. Distribution by studied lots concerning question 1**

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Psychiatrist</th>
<th>Other specialty</th>
<th>Family doctor</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Law 487/2002</td>
<td>12</td>
<td>21.1%</td>
<td>12</td>
<td>24.0%</td>
</tr>
<tr>
<td>Law 129/2012</td>
<td>1</td>
<td>1.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td>27</td>
<td>47.4%</td>
<td>2</td>
<td>4.0%</td>
</tr>
<tr>
<td>I do not know</td>
<td>17</td>
<td>29.8%</td>
<td>48</td>
<td>96.0%</td>
</tr>
<tr>
<td>Mean rank</td>
<td>83.01</td>
<td>155.80</td>
<td>104.47</td>
<td>98.47</td>
</tr>
</tbody>
</table>

By applying the significance intergroup Kruskall-Wallis test, one can underline significant differences from a statistical point of view between the answers from the first question, referring to the legislation of people with mental disorders (Chi-Square = 48.60; df=3; p=0.001):

- The psychiatrists’ answer highlights the fact that both Law 487/2002 and Law 129/2012 are the legal background on which one must deal with the mental health and protection of people with mental disorders (47.4%);
- For the physicians with other specialties than psychiatry, one can take note of the fact that by not knowing the legislation (96%), they are not advised in order to monitor people with mental disorders;
- 54% of family doctors do not have information on The law for mental health and protection of people with mental disorders;
- From psychiatrists, 48.3% are up to date concerning The law for mental health and protection of people with mental disorders, while 40% of those do not have knowledge on this matter.

**Question 2:** “Do you consider that mentally ill patients must be informed before commencing treatment, regarding its benefits and adverse reactions?”

a. Yes, the psychiatric patient has the right to an adequate informed consent that must be respected;
b. In the particular case of a patient with mental disorders, I would offer a minimum of information;

c. The mentally ill patient must not be informed;

d. I don’t know.

Referring to the answers given at question 2, by comparing the studied lots, it was noted the high number of affirmative answers in all lots analyzed.

**Table 5. Answer distribution in question 2, by studied lots**

<table>
<thead>
<tr>
<th>Question 2</th>
<th>Psychiatry</th>
<th>Other specialty</th>
<th>Family doctor</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>55</td>
<td>96.5%</td>
<td>41</td>
<td>82.0%</td>
</tr>
<tr>
<td>Min. of informations</td>
<td>2</td>
<td>3.5%</td>
<td>7</td>
<td>14.0%</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>4.0%</td>
<td>2</td>
<td>4.0%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>2</td>
<td>4.0%</td>
<td>1</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

The mean rank of associated answers at question 2, did not highlight significant statistical differences between the questioned lots (Chi-Square = 6,88; df=3; p=0.076):

- Only 3.5% of psychiatrists consider that in the particular case of a mentally ill patient they would ensure a minimum of information regarding the therapeutic approach;
- This aspect is found at 13-14% of other questioned people;
- In the family physicians group, a percentage of 4% do not consider that mentally ill patients need to be informed regarding the benefits or the adverse reactions of their treatment, while in the psychologists’ group, 1,7% did not know what to answer regarding this matter.

**Question 3:** “Do you consider that the social attitude in relation with the mentally ill patient is that of:”

a. Acceptance and/or tolerance;

b. Discrimination and/or intolerance;

c. Other........

Answers to this question found significant ratio differences from the statistical point of view between the studied groups (Chi-Square = 8,01; df=3; p=0.046).

A percentage of 56.1% of psychiatrists and 48% of physicians from other specialties, in comparison with 38% of family doctors; considered that the social attitude in relation with the mentally ill patient is that of acceptance and/or tolerance.

Although, a percentage of 60% of psychologists and 52% of family doctors, in comparison with 42.1% of psychiatrists and 46% of doctors from other specialties considered that the social attitude in relation to the patient with mental disorders is that of discrimination and/or intolerance.
Table 6. Answer distribution in question 3 by studied lots

<table>
<thead>
<tr>
<th>Question 3</th>
<th>Psychiatrist</th>
<th>Other specialty</th>
<th>Family doctor</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Acceptance and/or tolerance</td>
<td>32 56.1%</td>
<td>24 48.0%</td>
<td>19 38.0%</td>
<td>20 33.3%</td>
</tr>
<tr>
<td>Discrimination and/or intolerance</td>
<td>24 42.1%</td>
<td>23 46.0%</td>
<td>26 52.0%</td>
<td>36 60.0%</td>
</tr>
<tr>
<td>Other</td>
<td>1 1.8%</td>
<td>3 6.0%</td>
<td>5 10.0%</td>
<td>4 6.7%</td>
</tr>
<tr>
<td>Mean rank</td>
<td>93.81</td>
<td>104.70</td>
<td>117.34</td>
<td>120.07</td>
</tr>
</tbody>
</table>

Question 4: “Supposing that the personal data of the mentally ill patient wouldn’t be considered confidential and would be disclosed, do you consider that he/she would suffer from prejudice?”

a. He/she would not suffer from prejudice;
b. Yes, but not major prejudice;
c. Yes, the social and professional reinsertion of the patient would be compromised;
d. I don’t know.

Regarding the registered answers in question 4, it was underlined the high ratio of affirmative answers in all analyzed lots, 91.2% of psychiatrists and 93.3% of psychologists consider that social and professional reinsertion would be compromised if the personal data of the mentally ill patient would be disclosed. This aspect can be found also in the frequency of the answers from the family doctors (74%) or doctors from other specialties (70%) that can be in contact with mentally ill patients.

The mean rank associated with question 4, has highlighted significant statistical differences between the questioned lots (Chi-Square = 13.97; df=3; p=0.003).

Table 7. Answer distribution from question 4 by studied lots

<table>
<thead>
<tr>
<th>Question 4</th>
<th>Psychiatru</th>
<th>Alta specialitate</th>
<th>Medec de familie</th>
<th>Psiholog</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>No prejudice</td>
<td>1 1.8%</td>
<td>2 4.0%</td>
<td>1 2.0%</td>
<td></td>
</tr>
<tr>
<td>Yes, but no major prejudice</td>
<td>4 7.0%</td>
<td>13 26.0%</td>
<td>11 22.0%</td>
<td>4 6.7%</td>
</tr>
<tr>
<td>Yes, social and professional reinsertion would be compromised</td>
<td>52 91.2%</td>
<td>35 70.0%</td>
<td>37 74.0%</td>
<td>56 93.3%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>1 2.0%</td>
<td>1 2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean rank</td>
<td>116.89</td>
<td>93.98</td>
<td>102.51</td>
<td>119.43</td>
</tr>
</tbody>
</table>
ETHICAL AND LEGAL ASPECTS CONCERNING VOLUNTARY AND IN VOLUNTARY ADMISSION OF PATIENTS WITH MENTAL DISORDERS

**Question 5:** “Do you consider that divulging information about the mentally ill patient inside the treating services can be allowed in certain situations to the medical team in regard to:”

a. The family/legal representative;
b. Police/judicial institution (Tribunal/Court);
c. Other variants (define);
d. I don’t know.

- 70% percent of family doctors and 54-56% of psychiatrists or physicians from other specialties consider that the breach in confidentiality should be allowed in regards to the family but also to the police and judicial institution;
- The percentage of psychologists that are compliant with this permission to breach confidentiality was of 45%, but to this one will add a ratio of 30% of psychologists that consider a breach in confidentiality should be allowed only in regards to the family/legal representative.

The mean rank associated to the answers from question 5 did not find significant statistical differences in the questioned lots (Chi-Square = 3.39; df=3; p=0.335).

**Table 8. Answer distribution in question 5 by studied lots**

<table>
<thead>
<tr>
<th>Question 5</th>
<th>Psychiatrist</th>
<th>Physician from other specialties</th>
<th>Family doctor</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Family/legal representative</td>
<td>9</td>
<td>15.8%</td>
<td>12</td>
<td>24.0%</td>
</tr>
<tr>
<td>Police/judicial institution</td>
<td>15</td>
<td>26.3%</td>
<td>9</td>
<td>18.0%</td>
</tr>
<tr>
<td>Both</td>
<td>32</td>
<td>56.1%</td>
<td>27</td>
<td>54.0%</td>
</tr>
<tr>
<td>Press</td>
<td>2</td>
<td>3.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.0%</td>
<td>2</td>
<td>4.0%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>1</td>
<td>1.8%</td>
<td>2</td>
<td>4.0%</td>
</tr>
<tr>
<td>Mean rank</td>
<td>105.82</td>
<td>104.06</td>
<td>121.87</td>
<td>105.41</td>
</tr>
</tbody>
</table>

**Question 6:** “Do you consider that the law should impel any psychiatric patient to involuntary admission and treatment?”

a. Yes, because its goal is to cure the patient and an authority (paternal) figure from the psychiatrist is needed in this field;
b. No, the law should impel the psychiatric patient to obligatory admission and treatment, only in emergency psychiatric situations (self-harm, harm to others);
c. No, the patients’ right to decide for himself is being trespassed and involuntary admission and obligatory treatment will reduce the addressability of the patient to the psychiatric medical care;

d. I don’t know.

Concerning the registered answers to the number 6 question, by comparing the studied lots, the following studied lot distribution was found:

- With ratios varying from 64% physicians from other specialties that are in contact with mentally ill patients, up to 72% of family doctors, consider that the law should impel the patient to obligatory admission and treatment only in emergency psychiatric care (self-harm, harm to others).

The mean rank associated with the answers from question 6, significant statistical differences were found between the answers from physicians from other specialties and the opinion of psychiatrists, psychologists or family doctors (Chi-Square = 8.83; df=3; p=0.032).

Table 9. Answer distribution from question 6 by studied lots

<table>
<thead>
<tr>
<th>Question 6</th>
<th>Psychiatrist</th>
<th>Physicians from other specialties</th>
<th>Family doctors</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Da</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>No, the law should impel the patient in emergency situations</td>
<td>4</td>
<td>7.0%</td>
<td>14</td>
<td>28.0%</td>
</tr>
<tr>
<td>No, the patients’ right to decide is trespassed</td>
<td>48</td>
<td>84.2%</td>
<td>32</td>
<td>64.0%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>3</td>
<td>5.3%</td>
<td>3</td>
<td>6.0%</td>
</tr>
<tr>
<td>Mean rank</td>
<td>118.83</td>
<td>93.17</td>
<td>107.56</td>
<td>114.05</td>
</tr>
</tbody>
</table>

**Question 7:** “Do you consider that the mentally ill patient, in comparison with other patients, are discriminated?”

a. Yes, they are discriminated;

b. No, they are not discriminated;

c. I can not appreciate.

Answers to this question highlighted significant statistical ratio differences between the analyzed lots (Chi-Square = 25.63; df=3; p=0.001):

- The opinion of the medical personnel that the patient with mental disorders is discriminated in comparison with other patients is found in 93% of psychiatrists and 81.7% of psychologists, while only 52% of doctors from other specialties and 72% of family doctors answer affirmative to this question;

- 30% of physicians from other specialties can not appreciate the matter of discrimination of the mentally ill patients and 18% consider that patients with mental disorders are not discriminated in comparison with other patients;

- Of family doctors, 14% can not appreciate the matter of discrimination of the mentally ill patients and 14% consider that the patients with mental disorders are not discriminated in comparison with other patients.
Table 10. Answer distribution to question 7 by studied lots

<table>
<thead>
<tr>
<th>Question 7</th>
<th>Psychiatrist</th>
<th>Other specialty</th>
<th>Family doctor</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>53</td>
<td>93.0%</td>
<td>26</td>
<td>52.0%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>1.8%</td>
<td>9</td>
<td>18.0%</td>
</tr>
<tr>
<td>Can not appreciate</td>
<td>3</td>
<td>5.3%</td>
<td>15</td>
<td>30.0%</td>
</tr>
</tbody>
</table>

Mean rank 90.42 135.09 112.25 102.20

IX.4. DISCUSSIONS

The research was structured as a descriptive study based on a questionnaire with seven questions, addressed to the medical personnel involved in the medical assistance of the patient with mental disorders (psychiatrists, family doctors, physicians from other specialties, psychologists).

The study refers to the relationship medical team – psychiatric patient from the point of view of the health professionals. The main factor of study refers to the knowledge and respect of mentally ill patients’ rights and the ways in which they can be protected in regards to the legal restraints. The main appreciation criteria refer to the lack of knowledge or minimizing the importance of patients’ rights, aspect that can influence the voluntary addressability of psychiatric patients to treatment and therapeutic success.

The lot of this study had a number of 217 subjects from which are part psychiatrists, family doctors, physicians from other specialties and psychologists, who work in therapy centers and hospitals from the following counties: Iași, Botoșani, Suceava, Vaslui.

The medical professionals’ opinion regarding the mentally ill patients is that of discrimination or intolerance. Psychologists are the most convinced ones by this unethical attitude in regards to the patients with mental disorders. The social attitude in regards to the psychiatric patient, according to the literature, is one that can bring them major prejudice, leading in many cases to discrimination, intolerance, stigma, marginalize, labeling. To these one can add the coercive measures by involuntary admission in the psychiatry hospital, mandatory treatment, mechanical restraint and mentally ill patient isolation.

Discrimination of patients with mental disorders include, according to the field literature, difficulties at hiring, to a better health insurance, when buying a home, etc. The opinion that the mentally ill patient is discriminated in comparison with other patients is found in 93% of psychiatrists and 81.7% of psychologists, while only 52% of physicians from other specialties and 72% of family doctors answer affirmatively to this question. Likewise, the patient with mental disorders is stigmatized by the members of society, the profile literature supports by other studies the social stigmatization attitude of these vulnerable category of patients. Studies made in Germany (Seifert et al., 2002) and England have shown a negative perception of the medical personnel involved actively in the care of psychiatric patients. Psychiatrists have, though, a similar perception of the involuntary admission process (Lepping et al., 2004).
Regarding the answers registered to question number 6, the following distribution by studied lots was observed: ratios varying from 64% of physician from other specialties that are in contact with mentally ill patients, up to 72% of family doctors, consider that the law should impel the patient to mandatory admission and treatment only in emergency psychiatric situations (self-harm, harm to others). Some opinion polls applied to some psychiatrists from the U.S.A. have found that these hold as being necessary the involuntary admission of mentally ill patients with the risk of self-harm, harm to others, but also in those with severe disabilities (Brooks, 2006). The perception of the medical personnel referring to the necessity of involuntary admission of a patient with mental disorders sends only to emergency situations in which there is a risk of prejudice both for the patient, but also for others (Luchins et al., 2004).

IX. PARTIAL CONCLUSIONS

As a conclusion of the characteristics of the lot studied made of medical representatives involved in therapy, one can find the dominance of young female persons, and as a profession the doctors are the majority.

By age groups, the age category 30-39 years included half of the participants in the study. From the medical personnel that was in the study, almost half of psychiatrists and psychologists, know both the old law, and also the new law of mental health and protection of people with mental disorders.

A considerable number of doctors from other specialties do not know the health law of people with mental disorders, and half of the family doctors do not know any of the mental health laws and protection of people with mental disorders.

The majority of personnel members involved in therapy admits the right to information of patients with mental disorders. There is though a small number of participants among medical employees, namely family doctors, that invalidate this right.

A high number of psychologists and psychiatrists consider that the social attitude towards the patient with mental disorders is of discrimination and intolerance. This perception towards the discrimination of mentally ill patients versus other patients is high among all study participants.

The majority of the personnel members involved in therapy admit the importance of maintaining confidentiality in the therapeutic relationship, these considering that trespassing it can create major prejudice to the mentally ill patient, going up to their incapability of social reinsertion.

Divulging the mentally ill patients’ private information can be allowed in regards to the family and judicial institutions, according to the opinion of the majority of medical personnel involved in the psychiatric patients’ therapy.

Likewise, the medical personnel involved in therapy argues that one must not have a parental attitude towards the mentally ill patient, with some acceptable exceptions: emergency situations (aggressive potential).

CHAPTER XI. FINAL CONCLUSIONS

1. Coercive measures in the psychiatric medical assistance by means of involuntary admission of the mentally ill patient are justified from an ethical and legal point of view in psychiatric emergencies that imply self-harm and harm of others.
2. The dual nature of the obligations of medical personnel involved in the therapy of patients with mental disorders – legal obligations towards authorities and ethical ones
towards the patient can transform the relationship with the patient, sometimes with negative consequences on the therapeutic success.

3. The value of confidentiality in the therapeutic relationship with the mentally ill patient is admitted by the majority of members from the medical personnel as being fundamental in psychiatric care.

4. In psychiatric care, there are though situations where divulging medical information to a third party becomes necessary. These situations were mentioned by the members of the medical personnel who consider as being necessary divulging medical information to the patients’ family members by the role of support and help for this vulnerable population and in some situations generated by the legal obligations towards the judicial and police institutions.

5. The fundamental value of the medical acts’ confidentiality that implies the psychiatric patient, resides also in social consequences like marginalization, stigma, discrimination, that can be caused by its lack of respect, fact also supported by the members of the medical personnel and of which further unfolds a reduction in the patients’ self-esteem, the difficulty or even impossibility of social reinsertion and an impact on the function level of the patient.

6. The police presence at the psychiatric evaluation at the moment anterior to admission is considered to be an unethical aspect in the psychiatric medical assistance because police members do not have the obligation to maintain confidentiality of the psychiatric patient.

7. Professionals involved in the therapy of the psychiatric patients consider that the circumstances of the therapeutic success are met by ethical fundaments like communication and trust.

8. The results of studies on the personnel involved in therapy shows that the majority of the medical personnel members consider that admission of a mentally ill patient can not be required for any patient that suffers from a psychiatric disorder, thus the paternal attitude towards them would breach the patients’ autonomy.

9. The medical personnel involved in therapy consider to be necessary an authority attitude towards the mentally ill patient only in situations of emergency that imply self-harm and harm to others.

10. Beginning from these considerations and continuing with a comparative analysis of legislations from different countries of the world, one will consider to be put to change, addition and revising, the following aspects:
- Implementing in advance directives in the legislation system by which the patient can express his/hers future wishes regarding his/hers psychiatric care
- Involuntary admission of the mentally ill patient can be made according to admission criteria that include only injuriousness criteria

SELECTIVE BIBLIOGRAPHY


ETHICAL AND LEGAL ASPECTS CONCERNING VOLUNTARY AND INVOLUNTARY ADMISSION OF PATIENTS WITH MENTAL DISORDERS


ETHICAL AND LEGAL ASPECTS CONCERNING VOLUNTARY AND INVOLUNTARY ADMISSION OF PATIENTS WITH MENTAL DISORDERS


Segal SP, Burgess P. Factors in the selection of patients for conditional release from their first psychiatric hospitalization. *Psychiatr Serv* 2006; 57(11): 1614-1622.


**ANNEX 1**

PAPERS PUBLISHED DURING THE DOCTORAL STAGE


