



Insights into involuntary hospital admission procedures for psychiatric patients: A 3-year retrospective analysis of police records

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ABSTRACT

The procedure of involuntary hospitalization has been an ongoing subject of study. Its implementation requires the systematic co-ordination between the Justice and Health Care systems around the globe. In the case of Greece, the procedure under discussion is regulated by Law 2071/1992, which designates the Police as the agent that links the aforementioned systems together. The present study aims to shed light upon the procedure of involuntary hospitalizations, regarding the preparatory stage and the Police involvement up to the individuals' admission to the on-call hospital for a mental health assessment (MHA). The entry data of two police stations in Athens was recorded by the respective Duty Officer responsible for each case. The police records were retrospectively inspected and information on socio-demographic, clinical and parametric characteristics was extracted. The data collection took place between March and July 2020 and included 324 cases, 80.3% of which referred to involuntary hospitalizations; 17.6% of sample cases did not meet the criteria of the procedure, as opposed to 1.9% of the cases in which the patients eventually ended up being voluntarily admitted and afterwards hospitalized for treatment. There was a statistically comparison of socio-demographic, clinical and parametric variables in relation to the status of hospitalization groups (involuntary, voluntary and no hospitalization). Additionally, statistical comparisons were made between parametric and clinical variables in relation to the type of prosecution order (written: standard route, oral: emergency route). Acute mental health deterioration accounted for around 45% of the total data and it has been identified as the main factor for informing the Hearings Prosecutor office mainly by the patient's family and subsequently proceeding to the issuance of an order (in either written or oral form) to the Police. This enables the Police to escort the individuals and lead them to a psychiatric unit for mental health assessment (MHA) and based on this, for involuntary hospitalization if deemed necessary. In 87.9% of the cases, the individual was transported by police vehicles over a time span ranging from the very same day to 22 days. In total, the written prosecution orders (63.6%) outnumbered the oral ones (36.7%). The findings of the present study demonstrate that the Prosecution order type varies significantly depending on the causes that instigated the involuntary hospitalization procedure. The psychiatric decision whether there should be hospitalization or outpatient therapy also significantly varies depending on the diagnosis. Lastly, the results point out that the need for improvement and further clarification of the aforementioned Greek Law is absolutely essential.

1. Introduction

The European legislative framework regarding the management of involuntary admission procedures for compulsory treatment varies from country to country. In Belgium, it is imperative that there be a mental disorder as well as the fact that no other recommended therapy is

available and that either the public's safety or the patient's physical integrity is in jeopardy. The situation in France, it requires that the individual has to be in no condition to give their consent and that their state of mental health necessitates immediate care and medical monitoring either in hospital or on an outpatient basis. In addition to this, a crucial factor is that the individual is at risk of harming themselves

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(Coldefy, Fernandes, & Lapalus, 2017). In the United Kingdom, involuntary hospitalization is implemented only in emergencies, when a person is in grave danger of harming themselves or others and when one displays signs of mental disorder in public, as stated in Warrant 135 and 136 respectively (NHS, 2019). In Denmark, the procedure in question is enforced in cases where patients experience a psychotic episode as a result of which they might be at a high risk of harming either themselves or others; it is also implemented in cases where any prospect of therapy or significant and effective improvement of their condition could be seriously compromised without hospital admission (Beadle-Brown, Finn, Nyman, Petri, & Turnpenny, 2017). In the case of Italy, the law does not outline any criteria regarding the degree of risk directed to others or patients themselves as a precondition for involuntary hospitalization. Be that as it may, the involuntary hospital admission is allowed when deemed justifiable due to an ongoing mental health condition, paired with the need for therapeutic intervention. Enforced therapy can be administered only in state hospitals and more frequently so in general intensive care units with a capacity of fifteen patients (Amaddeo, Barbui, & Tansella, 2012; De Girolamo & Cozza, 2000).

In recent years, the involuntary hospitalization therapies are regulated within community settings. In particular, in 75 countries there exist legal procedures which are used to regulate the compulsory community mental health care provision to individuals with severe mental disorders. However, there are simultaneously notable variations in both legal criteria and practices (Dawson, 2005; Rugkasa, 2016). Thus, in countries such as the United Kingdom, Norway and Denmark as well as Canada and Sweden, community therapy orders may be initiated by a clinic recommendation; on the contrary, in the U.S.A. they are typically initiated by court order (Rugkasa, 2016). Such an order can be justified by the need for treatment and/or a risk for the patient or even others and can be initiated either at psychiatric unit discharge or within the community (Kisely et al., 2013; Løvsletten, Haug, Granerud, Nordby, & Smaaberg, 2016; Rugkasa et al., 2019). The main obligations for such cases are that these patients are required to take their medication and sustain their contact with the clinicians (Dawson, 2005; Morandi, 2016). As Light (2019) points out, in Australia, the therapeutic rates of community treatment orders in 2016 & 2017 fluctuated between 40 residents/100.000 in Western Australia and 112.5/100.000 in Northern Australia. Regarding the United Kingdom, it appears that, from 2010 until 2012, the therapeutic rates within communal settings rose from 74 to 82 residents/100.000 (Manning, Molodynski, Rugkåsa, Dawson, & Burns, 2011; Prior & Behan, 2013) and there is evidence for a similar increase in Canada (Malatest, 2012).

Concerning Greece, the legislative framework has undergone many changes since 1862 up until the active Law 2071/1992. This law assumes that the procedure can be applied in cases where the person is considered to be suffering from a mental health disorder or is not competent to reach a decision on their health welfare or the lack of treatment is likely to lead to the impossibility of their cure or the aggravation of their health. Finally, the procedure is activated when hospitalization is considered to be necessary to deter patients from violent acts against themselves or third parties. Prior to Law 2071/1992, it appears that 97% of hospital admissions were involuntary in nature (Bilanakis, 2004) and, even after its enforcement, only minor amendments were made (Pehlivanidis, Politis, Economou, & Trikkas, 2001). For several years, no research has been conducted in Greece to record the frequency of involuntary hospitalizations. In fact, no study exists to shed light on the parametric data of the procedure from the moment the law is being enforced until the individual is admitted to the psychiatric unit. In 2010, however, Douzenis et al. demonstrated that there had been crucial violations of the legislative framework on civil detentions. Similarly, in 2017 Stylianidis et al. showed that between June and October 2011, 57,4% of patients were involuntarily admitted to the Psychiatric Hospital of Attica, thus demonstrating that the procedure of involuntary hospitalizations is deeply-rooted in the clinical practice. What also emerges from an exploration of the experiences of individuals,

who went through the stages of involuntary hospitalization, is that civil detention is a traumatic experience, which elicits a range of negative emotional responses and ambivalent attitudes towards the family and the mental health care providers (Stylianidis et al., 2018). Consequently, many patients are unwilling to repeat such an experience. It is therefore reasonable to argue that the hospitalization experience might be one of the causes of the individual's alienation from the mental health care services, which in turn can initiate the process of involuntary hospitalization anew. Alternatively, treating patients with respect, results in the development of more positive attitudes towards the notion of hospital admission. Actually, the aforementioned findings fit perfectly with the research of Gilbert, Rose, and Slade (2008). The latter emphasized the important role of communication, safety, cultural sensitivity and absence of coercion, for a positive hospitalization experience regardless of the status of each patient. Furthermore, the literature review shows that, once patients realize that a part of their autonomy remains intact as a result of their participation in the decision-making process of a care plan, they can find it easier to embrace the idea of their confinement (Katsakou & Priebe, 2007).

According to Stylianidis et al. (2017), the procedure of involuntary hospitalization in Greece complies with the European standards. In general, two routes are available: the normal one and the emergencies. In practice, both routes are much more complex mainly because the involuntary hospitalization procedure can be initiated by either first or second-degree relatives as well as by legal guardians and/or judicial supporters. If none of the above applies to the patient or if they fail to present themselves to the Public Prosecuting Authorities, then the procedure can be initiated by the Police, the branches of the National Hellenic Center for Social Solidarity or even by citizens upon witness testimony enlisting the reasons for requesting the initiation of the procedure in question.

The prosecution order, instructing Police Authorities to safely escort the individual to the on-call psychiatric clinic, needs to be given in written form. Sequentially, a psychiatric assessment is conducted and soon after if deemed necessary, involuntary hospital admission ensues.

As an exception to this rule, the order can be given in oral form when the Prosecuting Authorities opt for an emergency route, in which case they are being notified by the Police that the individual is in urgent need of transfer to a psychiatric unit. Even in this case, however, the issuing of the oral form of the order is mentioned in writing in the Referral document that accompanies the person. After the psychiatric evaluation and decision for hospitalization, a duplicate of the Referral document is returned to the police station, usually compiled with the diagnosis and the psychiatrists' decision regarding the hospitalization for each patient. This procedure is followed even if the patients eventually agree to be hospitalized voluntarily despite their denial at the beginning or if the psychiatrists decide that there are no reasons for hospitalization. However, it is noteworthy that that no police protocol exists requiring the Duty officer to record potentially certain information.

Given all the aforementioned points, it can be argued that, up to now, the majority of studies in Greece, up to now have exclusively focused on both the clinical part and the wider legislative framework pertaining to the rights of patients for whom the involuntary hospitalization procedure is activated. The present study intends to shed light on the factors of pivotal importance, relevant, not only to the clinical but also specifically to the legislative parts of the preparatory procedure on a practical basis, wherein the Prosecutor as well as the Police and the Public Health authorities co-operate across two indicative municipalities. To this end, apart from the exploration of socio-demographic characteristics, this study has aimed to examine the association of the clinical diagnosis with the status of hospitalization (involuntary/voluntary/no hospitalization). As far as the parametric points are concerned, the relation of preparatory factors -such as the people ore services who initiated the procedure, the reasons for MHA and the patient's age- with the type of prosecutor's order (written = standard pathway/oral = urgent pathway) as well as the relation between the type of order and the time required for

execution by the police stations, has been explored.

2. Methods

2.1. Sample setting

Data collection took place in the Police Stations of Ambelokipi and Dafni-Hymettus. Both of which are policing two sizeable communities in Athens, working alongside the Hellenic Police Headquarters. More specifically, the sample included 324 cases, which were only linked with MHA incidents occurring from January 2017 to December 2019.

As far as the rationale behind the choice of these two specific police stations is concerned, they were chosen for practical facilitation purposes (convenience related to information access). In addition, both police stations are situated in the centre of the Greek capital, however, compared to the Dafni-Hymettus Police Station, the Ambelokipi Police Station is in closer proximity to the Greek Pentagon (Hellenic Headquarters buildings of the National Defence, Public Order & Citizen Protection) and Public Health Services.

Furthermore, the data was held in the electronic police records system called "Police On line-Book of Incidents" and in order to be given electronic data processing, Panteion University being the scientifically responsible body of the study requested the access. In turn, the Police Headquarters permitted the admission to the police stations system, under the Law 4624/2019 terms and conditions with the ultimate prerequisite that the personal identification details of each case would be protected. As a case in point, the first of the authors -who accessed the records to extract the useful information- was overseen by two police officers who were assigned by the Police to supervise the process of data extraction, regarding the identification anonymity compliance. It is worth noting that both the extraction and the individuals' identities anonymity process, were conducted within the police premises.

2.2. Data collection and classification

The sample consisting of the cases from 01/01/2017 to 31/12/2019 was divided into three groups: Involuntary hospitalization group, Voluntary hospitalization group and No hospitalization group (see Tables 1, 2, 3) and in order for the required information to be written down, socio-demographic, parametric and clinical traits were recorded. The following subsections were included:

2.2.1. Socio-demographic characteristics

Gender, nationality (Greek vs Immigrant), age, area of residence (Athens centre, Regional and Homeless).

2.2.2. Parametric characteristics

In order to describe the preparatory initiation above, the variable "MHA to the Hearing Prosecutor Office"(Family, Neighbors, the Police,

General Hospital Doctors, Strangers and National Center for Social Solidarity) was added, to describe the agent starting the procedure. We also recorded the reasons for initiating the procedure (Acute mental health deterioration, Relational conflicts, Suicidality, Psychoactive substances such as misuse, withdrawal, intoxication, Psychosocial maladjustment and malfunction, Non-compliance in medication, Bad hygiene & Inadequate self-care and Mental Health Services escape). Alongside the above, the type of Prosecution order (written vs. oral) based on what the procedure gets to be classified as either standard or emergency, wherein the former is given in written form and the latter is commanded orally. Finally, the time duration from the issuing of the order to the date of its execution by the Police -in days- and the vehicle used for the individual's transfer (Paramedic ambulance, Police vehicle, Private car, Unknown means of transport).

2.2.3. Clinical characteristics

Diagnosis and First request (yes-no). The diagnosis was formed by psychiatrists who were on duty in the mental health unit, and it was based on the ICD-10 Classification of Mental and Behavioral Disorders. In fact, it was this particular classification system that constituted the scientific basis for classifying-grouping each psychiatrist's written clinical diagnosis. Accordingly, each diagnosis was subsequently categorized into 7 (seven) greater groups of disorders by the authors for statistical reasons and these were Dementia, Schizophrenia schizotypal & delusional disorders, Affective disorders, Disorders of adult personality and behaviour, Organic including symptomatic mental disorders, Neurotic stress-related and somatoform disorders and Others. It is worth noting that the information on the diagnosis was recorded in the police records in most cases. The "First request" was a binary variable in order to depict in which of the cases the procedure was activated for the first time or more than once, during each year from January 2017 to December 2019.

2.3. Statistical analysis

For descriptive statistics, frequencies were calculated for nominal variables whilst the mean and standard deviation was used for continuous variables. For bi-variable analysis (nominal variables), we used the Fischer's exact test since some cells had an expected count of less than 5. Moreover, the pairwise z test was implemented in combination with Fischer's exact test in order to illustrate which percentages were significantly different between two columns on Table 4. For the statistical comparison between the type of prosecutor's orders and continuous variables (age and days for the execution of prosecutor's order), independent samples t-test were used. Additionally, ANOVA was used for the comparison of three groups of hospitalization status regarding the age. Statistical significance was regulated on the $p < .05$ level. The analysis was conducted using the SPSS statistical software package for social sciences (version 26).

Table 1
Socio-demographic characteristics for the sample in relation to hospitalization groups status.

Variable	Sample	Involuntary hospitalization group	Voluntary hospitalization group	No hospitalization group	Statistical test results
Gender	N = 315	N = 253	N = 6	N = 56	Fischer's exact test
Male	167 (51.5%)	129 (51%)	3 (50%)	31 (55.4%)	Not significant
Female	157 (48.5%)	124 (49%)	3 (50%)	25 (44.6%)	
Nationality ^b	N = 313	N = 253	N = 6	N = 54	Fischer's exact test
Greek	284 (90.7%)	233 (92.1%)	4 (66.7%)	47 (87%)	$\chi^2 = 5.57,$
Immigrant	29 (9.3%)	20 (7.9%)	2 (33.3%)	7 (13%)	$ip = .06$
Residence ^b	N = 280	N = 225	N = 6	N = 49	Fischer's exact test
Athens Centre	246 (87.9%)	198 (88%)	6 (100%)	42 (85.7%)	Not significant
Regional	27 (9.6%)	22 (9.8%)	0 (0%)	5 (10.2%)	
Homeless	7 (2.5%)	5 (2.2%)	0 (0%)	2 (4.1%)	
Age ^a	N = 288	N = 237	N = 3	N = 48	ANOVA
	46.5 (SD = 16.7)	46.5 (SD = 16.3)	42.3 (SD = 20.3)	46.8 (SD = 18.9)	Not significant

^a Descriptive Statistics are mean value and standard deviations in the parenthesis.

^b For the gender 9 missing values, for the Nationality 11 missing values, for the Place of Residence 44 missing values.

Table 2
Clinical diagnoses and first request for psychiatric assessment in relation to hospitalization groups status.

Variable	Sample	Involuntary hospitalization group	Voluntary hospitalization group	No hospitalization group	Statistical test results
Diagnosis Cluster ^a	<i>N</i> = 179	<i>N</i> = 164	<i>N</i> = 1	<i>N</i> = 14	
Dementia	8 (4.5%)	3 (1.8%)	0 (0%)	5 (35.7%)	
Schizophrenia, schizotypal & delusional disorders	88 (49.2%)	86 (52.4%)	1 (100%)	1 (7.1%)	
Affective disorders	47 (26.3%)	47 (28.7%)	0 (0%)	0 (0%)	Fischer's exact test
Disorders of adult personality and behaviour	5 (2.8%)	2 (1.2%)	0 (0%)	3 (21.4%)	$\chi^2 = 53.8$
Organic including symptomatic mental disorders	13 (7.3%)	12 (7.3%)	0 (0%)	1 (7.1%)	$p < .001$
Neurotic stress-related and somatoform disorders	4 (2.2%)	2 (1.2%)	0 (0%)	2 (14.3%)	
Other	14 (7.8%)	12 (7.3%)	0 (0%)	2 (14.3%)	
First Request/year ^b	<i>N</i> = 312	<i>N</i> = 253	<i>N</i> = 6	<i>N</i> = 53	
Yes	283 (90.7%)	230 (90.9%)	6 (100%)	47 (88.7%)	Fischer's exact test
No	29 (9.3%)	23 (9.1%)	0 (0%)	6 (11.3%)	Not significant

Note: a. 145 missing values (no clinical assessment recorded), b. 12 missing values.

2.4. Ethics

Owing to the fact that the sample in question contained sensitive personal data, there was full compliance with the measures in the Law 4624/2019 on personal data protection giving the right to scientists conducting research which includes personal data process by article 30. The research request -in order to be given access to such sensitive data- was eventually accepted by the Police Lieutenant General-Chief of Staff to Hellenic Police provided that the identity of citizens would be sustained anonymous, as mentioned above (Section 2.3). The overall purpose was to secure the anonymity of every single person and also to avoid potential stigma, whilst respecting the individual's right to privacy. To this end, apart from gender, nationality, place of residence and age, all other personal identification details from the data extraction process were deleted under police supervision, respecting the law requirement.

3. Results

3.1. Proportions of admissions (socio-demographic and clinical)

Initially, the results of the descriptive statistics analysis indicated that out of the total sample 80.3% of cases referred to involuntary hospitalizations; 17.6% of cases did not meet the criteria of the procedure, as opposed to 1.9% of the cases which eventually ended up being voluntarily admitted to the hospital and afterwards hospitalized for therapy.

Out of a total of 324 cases recorded in the police stations by the Duty Officers between 01/01/2017 and 31/12/2019, 167 (51.5%) of incidents involved males whereas 157 (48.5%) of incidents involved females. Regarding the gender, we found that there was no statistically significant difference among the sub-groups of hospitalization, ($p = .89$).

Greeks were prevalent in all sub-groups (90.7%) in contrast to Immigrants (9.3%) with statistically non significant differences among three groups, ($\dagger p = .06$).

Concerning the place of residence mentioned to the police stations either from the individuals or their relatives, the highest percentage among three sub-groups live in the Center (87.9%) followed by those who live in the Regional areas (9.6%), and Homeless people (2.5%) following to a lesser extent respectively, with statistically non significant difference among three groups, ($p = .80$).

The age of our sample ranged from 15 to 93. The average age was 46.5 years, with the oldest patients being placed in the "No Hospitalization group" ($M = 46.8$, $SD = 1.16$) followed by "Involuntary hospitalization group" patients ($M = 46.5$, $SD = 16.3$) and those who were slightly younger chose to be hospitalized in the "Voluntary

hospitalization group" ($M = 42.3$, $SD = 20.3$). However, one-way ANOVA indicated that there was no significant association between the three sub-groups and the age, $F(2, 285) = 0.104$, $p = .90$.

It is worth mentioning that there were some missing values in the variables above. This issue probably stemmed from the fact that some Duty Officers may have neglected to write down all the details. (See Table 1).

As far as the clinical characteristics are concerned, it appears that 145 of the 324 police records (45%) lacked either data or vital information regarding the first clinical assessment. In accordance with the police protocol for recording data, in such incidents, there was no tangible mandated regulation compelling the Duty officer to write down the conclusion of the first clinical diagnosis of psychiatrists. As a result, in the sample there are 145 missing values regarding the "Diagnosis Cluster" and 12 regarding the variable "First request", which have been removed for statistical reasons.

The psychiatric diagnoses included in the Police files were grouped into seven categories for statistical reasons. With respect to the seven categories, a statistically significant difference in distribution is displayed relating to the status of hospitalization (involuntary/voluntary hospitalization/no hospitalization) and the diagnosis cluster, $\chi^2 = 53.8$, $p < .001$. Schizophrenia, schizotypal and delusional disorders (52.4%) as well as affective disorders (28.7%) were the most common diagnoses in involuntarily hospitalized patients among 164 cases; one case was recorded as voluntarily hospitalized in which a person suffered from psychotic disorders and agreed to receive nosocomial treatment; dementia (35.7%) was most prevalent among 14 patients who were recorded as not hospitalized. Regarding the first request for psychiatric assessment, no statistical differences were observed among the sub-groups ($p = .78$). (See Table 2).

Furthermore, the outcome of the involuntary hospital admission procedure was analyzed on the basis of the final police report found in the electronic system "Police on Line" of the two police stations. Specifically, in 238 (75.1%) cases the patient was admitted to the psychiatric unit where the diagnosis had been formed, whereas in 7 (2.2%) cases the patient was admitted to a different public health system hospital unit, whilst in another 7 cases (2.2%) the patient was admitted to a private psychiatric unit. In 27 (8.5%) cases the psychiatrists on call, assessed that people did not need admission and so they were not hospitalized, whereas in 12 (3.8%) cases, the request for psychiatric examination was repealed; in addition, in 13 (4.1%) cases the individual was sought by the police but was not found, while 1 (0.3%) case involved a person who was found deceased and 3 (0.9%) cases involved the termination of the procedure because the Prosecutor found that, given the testimonies, there were no legal grounds for granting authorization; additionally, in 5 (1.6%) cases the patient remained hospitalized in a General Public

Hospital for a 48-h monitoring period as well as in 4 cases (1.3%) where the patient remained in a Public Psychiatric Hospital for a 48-h monitoring.

3.2. Parametric proportions

With reference to the parameters involved in the preparatory procedure of involuntary hospitalizations in Greece, the present study drew upon the country's existing legislative framework to investigate the agent that initiates the procedure as well as the causes for that initiation and the means of transfer of these individuals among the three groups. Out of the total number of the police records, it emerged that 132 cases provided either insufficient or non-existing data. Thus, they were not accounted for the "Request for MHA to the Hearings Prosecutor Office" variable and the same applied to 133 cases that failed to be included in the "Reasons for MHA" variable.

Referring to the means of transport and the three groups of hospitalization a statistically significant difference was noted, $\chi^2 = 113.89$, $p < .001$. In particular, police cars were the most frequent means of transport of the cases (87.9%) with a percentage of 97.2% in Involuntary hospitalization, 16.7% in Voluntary and 53.6% in No hospitalization groups. In some cases, the means of transport to the hospital was unknown (8.3%) with a percentage of 33.3% in the voluntary hospitalization, 42.9% in the no hospitalization group. The means of paramedic ambulances followed accumulating the percentage of 3.5%, with 50% of the cases in Voluntary hospitalization, 3.6% in No hospitalization and 2.4% in the Involuntary hospitalization groups. However, there was only one case (0.4%) in which the involuntarily hospitalized patient was transferred by a private car.

Regarding the person or service informing the legal authorities in such cases and the status of hospitalization, no significant differences were remarked ($p = .39$). Nonetheless, it is worth mentioning that the most frequent initiator among the others was a family member (49.7%).

In the same vein, no statistical differences occurred between the subgroups of hospitalization and the reasons for invoking the initiators of the procedure ($p = .45$). (see Table 3).

With respect to the type of the prosecution order, in general, the results of the descriptive statistical analysis showed that out of the total

of cases, 67.4% concern those in which the prosecutor gave a written order to the police (standard route); whereas, for 32.6% of them, the prosecutor ordered orally the police to carry out the MHA procedure (emergency route).

In particular, the present study examined thoroughly the differences between the cases that followed the standard procedure via a written order for the MHA and those that followed the emergency route via an oral one. Fischer's exact test displayed statistical differences between the two types of orders from the Hearings Prosecutor Office in relation to the agent initiating the procedure and the reasons for the MHA, with $p < .001$. Nonetheless, upon closer inspection an attempt was made to detect any potential statistical differences between the two columns related to the aforementioned variables and their subgroups. To this end, pairwise z test was implemented to display precisely, which percentages differed significantly from each other. As a result, it appeared that when the prosecutor was informed by the family the standard routes (60.5%) significantly outnumbered those of the emergencies (31.9%) and conversely, when the request was submitted by the police, the emergencies (44.9%) were significantly predominant in contrast to those of the standard routes (8.4%). Likewise, such differences were also found in certain reasons for MHA. When the prosecutor was informed about the fact that a primary reason for MHA was acute psychopathology deterioration, the standard routes (55.9%) significantly exceeded those of the emergencies (27.5%); when the relationship conflicts were a primary reason for MHA requests then -conversely- the emergencies (43.5%) significantly dominated compared to the standard routes (13.6%). Furthermore, the differences related to Diagnosis were statistically nonsignificant ($\dagger p = .06$).

Additionally, *t*-tests were implemented for independent samples with a view to comparing the individuals' ages as well as the period needed for the Prosecution order to be carried out. The analysis demonstrated that there were statistically significant differences between emergency and regular cases with reference to age, $t(290) = 2.55$, $p = .011$. The people to whom the standard procedure was followed ($M = 48$, $SD = 16.7$) were found to be significantly older than those involved in the emergencies ($M = 42.8$, $SD = 16.2$). Also, the same analysis has shown that there have been significant differences between the two paths concerning the time span that had lapsed for the execution of the Public

Table 3

Parametric characteristics of the sample in relation to hospitalization groups status.

Variable	Sample	Involuntary hospitalization group	Voluntary hospitalization group	No hospitalization group	Statistical test results
Means of transport	<i>N</i> = 315	<i>N</i> = 253	<i>N</i> = 6	<i>N</i> = 56	
Paramedic ambulance	11 (3.5%)	6 (2.4%)	3 (50%)	2 (3.6%)	
Police vehicle	277 (87.9%)	246 (97.2%)	1 (16.7%)	30 (53.6%)	
Private car	1 (0.3%)	1 (0.4%)	0 (0%)	0 (0%)	Fischer's exact test $\chi^2 = 113.89$
Unknown means of transport	26 (8.3%)	0 (0%)	2 (33.3%)	24 (42.9%)	$p < .001$
MHA request to Prosecutor ^a	<i>N</i> = 191	<i>N</i> = 143	<i>N</i> = 6	<i>N</i> = 42	
Family	95 (49.7%)	74 (51.7%)	3 (50%)	18 (42.9%)	
Neighbors	7 (3.7%)	4 (2.8%)	0 (0%)	3 (7.1%)	
Police	44 (23%)	32 (22.4%)	3 (50%)	9 (21.4%)	Fischer's exact test
General Hosp. Doctors	16 (8.4%)	14 (9.8%)	0 (0%)	2 (4.8%)	Not significant
Strangers	22 (11.5%)	13 (9.1%)	0 (0%)	9 (21.4%)	
National Center for Social Solidarity	7 (3.7%)	6 (4.2%)	0 (0%)	1 (2.4%)	
Reasons for MHA ^b	<i>N</i> = 185	<i>N</i> = 154	<i>N</i> = 6	<i>N</i> = 25	
Acute Mental Health deterioration	83 (44.9%)	70 (45.5%)	2(33.3%)	11(44%)	
Relational Conflicts	46 (24.9%)	40 (26%)	3 (50%)	3 (12%)	
Suicidality	19 (10.3%)	16 (10.4%)	0 (0%)	3 (12%)	Fischer's exact test
Psychoactive substances (misuse, withdrawal, intoxication)	14 (7.6%)	9 (5.8%)	1 (16.7%)	4 (16%)	Not significant
Psychosocial maladjustment and malfunction	15 (8.1%)	11 (7.1%)	0 (0%)	4 (16%)	
Medication non-compliance	5 (2.7%)	5 (3.2%)	0 (0%)	0 (0%)	
Bad hygiene & Inadequate self-care	2 (1.1%)	2 (1.3%)	0 (0%)	0 (0%)	
Mental Health Services escape	1 (0.5%)	1 (0.6%)	0 (0%)	0 (0%)	

Notes: a. 132 cases were not accounted for "MHA request to the Hearings prosecutor office", b. 133 cases were not accounted for "Reasons for MHA". c. MHA stands for Mental Health Assessment.

Prosecutor's command, $t(201.2) = 8.56, p < .001$, with regular cases ($M = 2.18, SD = 3.2$) lasting more than emergency ones ($M = 0.12, SD = 0.5$). (See Table 4).

Table 4
Parametric & Clinical characteristics in relation to the type of Prosecution order.

Variable	Sample	Type of		Statistical test results
		Written (Standrad)	Prosecution order Verbal (Emergency)	
MHA request to the hearings prosecutor office ^a	$N = 188$	$N = 119$	$N = 69$	
Family*	94 (50%)	72 (60.5%)	22 (31.9%)	Fischer's exact test
Neighbors	7 (3.7%)	4 (3.4%)	3 (4.3%)	
Police*	41 (21.8%)	10 (8.4%)	31 (44.9%)	$\chi^2 = 37$
General Hosp. Doctors	16 (8.5%)	9 (7.6%)	7 (10.1%)	$p < .001$
Strangers	23 (12.2%)	18 (15.1%)	5 (7.2%)	
National Center for Social Solidarity	7 (3.7%)	6 (5%)	1 (1.4%)	
Reasons for MHA ^b	$N = 187$	$N = 118$	$N = 69$	
Acute psychopathology deterioration*	85 (45.5%)	66 (55.9%)	19 (27.5%)	
Relationship Conflicts*	46 (24.6%)	16 (13.6%)	30 (43.5%)	Fischer's exact test
Suicidality Psychoactive substances (misuse, withdrawal, intoxication)	18 (9.6%)	9 (7.6%)	9 (13%)	
Psychosocial maladjustment and malfunction	15 (8%)	10 (8.5%)	5 (7.2%)	test
Medication in adherence	5 (4.2%)	11 (9.3%)	4 (5.8%)	$\chi^2 = 31.25$
Bad hygiene & Inadequate self-care	2 (1.1%)	5 (2.7%)	0 (0%)	$p < .001$
Escape from Mental Health Facility	1 (0.5%)	0(0%)	2(2.9%)	
Diagnosis Cluster ^c	$N = 185$	$N = 127$	$N = 58$	
Dementia	8 (4.3%)	2 (1.6%)	6 (10.3%)	
Schizophrenia, schizotypal & delusional disorders	91 (49.2%)	69 (54.3%)	22 (37.9%)	Fischer's exact test
Affective disorders	50 (27%)	33 (26%)	17 (29.3%)	test
Disorders of adult personality & behaviour	5 (2.7%)	2 (1.6%)	3 (5.2%)	$\eta p = .06$
Organic including symptomatic mental disorders	13 (7%)	9 (7.1%)	4 (6.9%)	
Neurotic stress-related and somatoform disorders	4 (2.2%)	3 (2.4%)	1 (1.7%)	
Age		48	42.8	t test $t(290) = 2.55, p = .011$
Prosecutor's order execution delay (days)		SD = 16.7	SD = 16.2	t-test $t(201.2) = 8.56, p < .001$
		2.18	0.12	
		SD = 3.2	SD = 0.5	

Notes: * $p < .001$ (z test), a. 136 cases were not accounted for MHA request to the Hearings Prosecutor office, b. 137 cases were not conducted for Reasons for MHA, c. 139 cases were not accounted for Diagnosis cluster.

4. Discussion

The results of the present study relied on data extraction and analysis which was focused on two specific communities in Athens, showing that 80.3% of police interventions followed prosecution orders related to involuntary hospital admissions. A finding, which means that in most cases there was an actual need for mental health treatment despite the refusal of each individual for whom the procedure was activated. In very few cases after the activation of the involuntary procedure, the individual agreed to be voluntarily examined and afterwards admitted to hospital for inpatient treatment (1.9%). In 17.8% of the cases, no hospital admission took place as the psychiatrists found that the criteria had not been met pertaining to Law 2071/1992.

In the present study and in contrast to the existing literature (Curley et al., 2016; Hwang, Jung, Lee, & Kim, 2020; McManus, McDonnell, & Whitty, 2015) males slightly outnumbered females in involuntary hospitalization. Regarding those who were not hospitalized, males again accounted for a higher percentage than females. Nonetheless, no significant difference in the frequency of males and females occurred among all the types of three hospitalization sub-groups.

With reference to the other socio-demographic variables, the majority of the patients were native Greeks followed by Immigrants, which was in line with similar findings of Di Lorenzo, Vecchi, Artoni, Mongelli, and Ferri (2018). These results are in complete contrast to past practises where psychiatrists admitted disproportionate number of immigrants compared to natives in state hospitals (Mulder, Koopmans, & Selten, 2006), however, the non-statistical significance could not lead to reliable conclusions.

Unlike the research undertaken in the past (Douzenis et al., 2010; Stylianidis, Peppou, Drakonakis, Douzenis, et al., 2017), the present study analyzed the reasons for MHA meticulously as well as the agents who initiated the procedure on a more practical basis. In particular, regarding the main outcomes and specifically the age of patients who were involved in the two routes, the results indicated a statistically significant difference; the route of emergency was followed by younger patients on average. This route of involuntary psychiatric assessment was activated mostly by the police and mainly in response to relationship conflicts as well as the subgroup of schizophrenia, schizotypal and delusional disorders, was the most frequent diagnosis in such cases. On the contrary, the standard route was activated for older people on average, which was activated mostly by their family for acute psychopathology deterioration as the most common reason. Additionally, schizophrenia, schizotypal and delusional disorders were at higher percentage than other sub-groups of the diagnosis cluster in this route, likewise the emergencies. It is necessary to say that even if the aforementioned spectrum of disorders was more prevalent than other sub-groups of disorders, the differences between the type of prosecution orders and the diagnosis cluster sub-groups were not significant.

The clinical results in combination with hospitalization group status, lead us to point out that schizophrenia and in general, psychotic disorders were the most frequent diagnoses for admission to hospitals. This finding is in agreement with Barnett (2018), Di Lorenzo et al. (2018), Feeney, Umama-Agada, Gilhooley, Asghar, and Kelly (2019) and Stylianidis, Peppou, Drakonakis, Douzenis, et al. (2017). However, this study did not restrict itself to the exploration of two hospitalization groups (involuntary/voluntary), but was extended by the addition of another group comprised of individuals for whom psychiatrists diagnosed a disorder but also decided that they did not meet the criteria for hospitalization. Despite the few cases in this group, the prevailing diagnosis leading to these patients not being hospitalized, was dementia (35.7%). This finding is encouraging, as multiple negative outcomes have been associated with the admission of older people in general and people with dementia in particular, including high risk of delirium (Whittamore et al., 2014), functional decline (Hartley et al., 2017), fall-related injuries (Cameron et al., 2018), nosocomial infections and an elevated risk of mortality (Dwyer, Gabbe, Stoelwinder, & Lowthian,

2014). Additionally, in our sample despite the missing values, only one entry has existed as a voluntarily hospitalized patient, after the clinical diagnosis and this was classified in the Schizophrenia, schizotypal & delusional disorders sub-group; a finding which would be by chance to lead us to a valid conclusion that patients suffering from psychosis spectrum disorders, are more likely to be hospitalized voluntarily than involuntarily or even not being hospitalized, owing to the fact that roughly half of the records did not include a clinical assessment and the total of the recorded voluntary hospitalizations which included a clinical assessment was only one case.

Furthermore, the present study highlighted that the average time for the order execution was delayed by 2.18 days on average when the standard route was activated. In contrast, regarding the emergency route, the orders were executed on the same day. This finding can be explained by the fact that only two or three Police Officers are on duty in the police stations at any given time because the majority of the station force is occupied with external service related duties, in accordance with each Police Directorate internal orders and regulations. To this end, in the preparatory stage of the procedure, it is common for the Commanders to request an extension regarding the execution duration of the Prosecutor's written order, so as to detect and detain the person in order to accompany them to hospital. As a consequence, the police personnel end up escorting the individuals to psychiatric facilities after a delay.

In addition, the research into the cases indicated that throughout every single year a request to the prosecutor had been submitted for the first time, for the majority of the total cases (90.7%), in contrast to a minority where more than one requests has been noted. Roughly, the same proportion was displayed for the involuntarily hospitalized patients and those who were not hospitalized. Nonetheless, all the cases in which the patients eventually were hospitalized voluntarily, were initiated for the first time, a finding which may reflect that those patients, despite their primary refusal, were more likely to understand that they needed treatment and consequently agreed to be hospitalized in contrast to other two groups of hospitalization. Perhaps, the more easily the patients are convinced they need hospital treatment, the more they reduce the possibilities of reactivating the MHA procedure during an annual period. Nevertheless, these findings were statistically non significant.

Also, it is apparent that only a small percentage of the sample was redirected to another psychiatric unit. However, the extremely low percentage of admissions in private clinics leads us to understand that due to the wider financial crisis experienced by the average Greek family in recent years, psychiatric help is sought within the public health sector whose service is free of charge.

According to the present study, in Greece, there continues to be a staggering percentage of people with mental health problems who are transferred to the psychiatric facilities by police cars and end up being hospitalized involuntarily (97.2%). This is a finding which is in alignment with the research conducted by the [Greek Ombudsman \(2007\)](#) and is mostly likely due to the fact that, even though Article 96 Section 5 of the law 2071/1992 states that such transfers must be made with due respect to the patient's dignity, it does not clarify the exact procedure. Owing to a somewhat vague legislative point, once apprehended, the person with mental health issues is treated in the same way as criminal offenders are, up until their delivery to the medical staff, since the police are not prepared to deal with the individuals who meet such problems, as are paramedical and medical practitioners who have been trained in the management of such crucial circumstances with appropriate medical equipment. These practices can lead to the stigmatisation of such patients, even by some medical personnel for instance, nurses who may label them negatively ([Koekkoek, Van Meijel, & Hutschemaekers, 2006](#)) and sometimes characterise them as the "worst" patients, knowing that they have been admitted to the hospital by the police, as [Maharaj, O'Brien, Gillies, and Andrew \(2013\)](#) pointed out in their study. The matter of the transportation of individuals with mental health issues, needs to be amended under the Greek psychiatric reform bill, so as to

ensure that the first intervention in the preparatory phase is conducted by qualified mental health practitioners. Only in cases when an individual is considered violent by the aforementioned practitioners (harmful to themselves or others), the police assistance should be requested. Additionally, the police -who are the first responders- should be trained in such cases by mental health professionals. However, the police should not be held accountable given the ambiguity of the current legislation.

If it is taken into consideration that there is a high rate of prosecutor's orders enabling individuals to be involuntarily admitted to a hospital, a conclusion can be drawn that these people despite their denial they have an actual need for mental health treatment. However, in Greece, there is no legislation including an option for compulsory treatment that can be provided outside hospitals as a "less restrictive" alternative choice to involuntary hospitalization; similar to other countries like Italy, Sweden, the United Kingdom, France, Australia and Canada whose law encompasses legal procedures authorising mandatory community mental health care to people affected by severe mental disorders. To this end, the Greek psychiatric reform needs to be amended immediately in order to achieve the quality of mental health care of the countries above. The ultimate goal should be to offer patients care and provide them with the opportunity for inclusion and treatment within the community (this is a common practice by law in 75 countries worldwide) rather than perpetuating stigma and marginalization which is strongly associated with involuntarily hospitalized patients.

The present study was not without its limitations. Firstly, many records contained insufficient data and therefore all parameters could not be mapped for all cases. Secondly, the data is not representative of the entire country since the information was sourced from two police stations situated in the capital of Greece and in turn this might reduce the property of generalisation. Thirdly, clinical diagnoses lacked coding and consensus was reached through documented psychopathology. Additionally, it is worth noting that there was a great number of missing values in some variables which occurred due to the absence of strict internal police regulations and protocols for data documentation regarding this procedure. As a consequence, even though we tried to compare clinical characteristics, such as mental disorders, to the three-divided hospitalization status among the cases, there was only one record where the person agreed to be hospitalized voluntarily, for whom psychiatrists diagnosed that he suffered from psychotic disorders. Therefore, there is no clear insight regarding those people who eventually agreed to be hospitalized voluntarily after police intervention and their escort by them to the on-call public hospitals regarding their mental disorders. Finally, the electronic system of the Hellenic Police "*Police on Line*", lacks a database that categorizes information pertaining to the involuntary hospital admissions procedure. Here, there could have been an opportunity to establish an authorized observatory to monitor how the procedures operate in Greece in relation to police interventions. However, this was not taken advantage of.

5. Conclusion

The present study offers a new window on the preparatory procedural aspects of involuntary hospitalization. We have attempted to offer insight with respect to the practicalities involved in the procedure by focusing on two distinct regional areas. It places particular emphasis on the time interval from the moment that the procedure is activated, with the involvement of both the prosecutor and police authorities -as well as their co-operation with health services- up until the moment of the psychiatric assessment giving the green light to the procedure of hospitalization.

Our results highlight that Law 2071/1992 needs to be further clarified especially concerning the criteria of involuntary hospitalization regarding the risk of danger or aggressiveness which are mostly seen in relationship clashes; the latter seemed to be a principal point, as a reason for MHA, where the prosecutor specifically instructed verbally the police

to follow the emergency route. Relationship clashes and disputes usually within a domestic environment are an important reason for the MHA initiation and if it is deemed necessary for inpatient therapy, are not necessarily connected with the psychopathology of a person. In contrast, they possibly can be attributed to a combination of reasons including the subjective perceptions of their families about the mental health condition of their relatives for whom the procedure is activated, the legislative system shortages which render the mental health care system incapable of handling such cases outside hospital facilities in order for these people to avoid a restriction and also the deficiency of continuity concerning the mental health care within a community (Stylianidis, Peppou, & Drakonakis, 2014). In today's practice, the transfer of an individual to a medical facility for psychiatric assessment is frequently delayed as a result of police station workload, apart from emergency incidents. This should be taken into consideration amid the ongoing reform. The goal ought to be that primary health care professionals (i.e. paramedical staff, psychiatrists, psychologists and specialised nursing personnel) should assume most roles currently conducted by the police, such as the first responding, the exploration of reasons relating to MHA as well as potential psychiatric history. The police could have an ancillary role only in the cases of potentially violent individuals who are clearly aggressive and at risk to themselves or others in order to intervene with the ultimate purpose of providing safety only.

Future research could usefully explore similar variables in the Greek rural areas, where the Justice, the local Health Care facilities and the police are involved; since it is quite possible that a considerable number of results might be different compared to our study which was focused on two urban municipalities in Athens.

In conclusion, this study should be followed up with a broader and more in-depth exploration of the attitudes and perceptions of first-line staff towards mental health patients with the respective systems which will be of value to policy makers.

References

- Amadeo, F., Barbui, C., & Tansella, M. (2012). State of psychiatry in Italy 35 years after psychiatric reform. A critical appraisal of national and local data. *International Review of Psychiatry (Abingdon, England)*, 24(4), 314–320. <https://doi.org/10.3109/09540261.2012.694855>.
- Barnett, B. (2018). Factors associated with the use of seclusion in an inpatient psychiatric unit in Lilongwe, Malawi. *Malawi Medical Journal*, 30(3), 197. <https://doi.org/10.4314/mmj.v30i3.12>.
- Bilanakis, N. (2004). *Psychiatric care and human rights in Greece*. Athens: Odysseas.
- Cameron, I. D., Dyer, S. M., Panagoda, C. E., Murray, G. R., Hill, K. D., Cumming, R. G., & Kerse, N. (2018). Interventions for preventing falls in older people in care facilities and hospitals. *The Cochrane Database of Systematic Reviews*, 9(9), Article CD005465. <https://doi.org/10.1002/14651858.CD005465.pub4>.
- Coldefy, F., Fernandes, S., & Lapalus, D. (2017). Compulsory Psychiatric Treatment: An Assessment of the Situation Four Years After the Implementation of the Act of 5 July 2011. (Assessment, The Institute for Research and Information in Health Economics IRDES, 2017). Retrieved from <https://www.irdes.fr/English/issues-in-health-economics/222-compulsory-psychiatric-treatment.pdf>.
- Curley, A., Agada, E., Emechebe, A., Anamdi, C., Ng, X. T., Duffy, R., & Kelly, B. D. (2016). Exploring and explaining involuntary care: The relationship between psychiatric admission status, gender and other demographic and clinical variables. *International Journal of Law and Psychiatry*, 47, 53–59. <https://doi.org/10.1016/j.ijlp.2016.02.034>.
- Dawson, J. B. (2005). *Community treatment orders: International comparisons*. University of Otago Faculty of Law.
- De Girolamo, G., & Cozza, M. (2000). The Italian psychiatric reform. A 20-year perspective. *The International Journal of Law and Psychiatry*, 23(3–4), 197–214. [https://doi.org/10.1016/S0160-2527\(00\)00030-3](https://doi.org/10.1016/S0160-2527(00)00030-3).
- Di Lorenzo, R., Vecchi, L., Artoni, C., Mongelli, F., & Ferri, P. (2018). Demographic and clinical characteristics of patients involuntarily hospitalized in an Italian psychiatric ward: A 1-year retrospective analysis: Characteristics of patients involuntarily hospitalized in an Italian psychiatric ward. *Acta Bio Medica Atenei Parmensis*, 89(6–S), 17–28.
- Douzenis, A., Michopoulos, I., Economou, M., Rizos, E., Christodoulou, C., & Lykouras, L. (2010). Involuntary admission in Greece: A prospective national study of police involvement and client characteristics affecting emergency assessment. *The International Journal of Social Psychiatry*, 58(2), 172–177.
- Dwyer, R., Gabbe, B., Stoelwinder, J. U., & Lowthian, J. (2014). A systematic review of outcomes following emergency transfer to hospital for residents of aged care facilities. *Age and Ageing*, 43(6), 759–766. <https://doi.org/10.1093/ageing/afu117>.
- Feeney, A., Umama-Agada, E., Gilhooley, J., Asghar, M., & Kelly, B. D. (2019). Gender, diagnosis and involuntary psychiatry admission in Ireland: A report from the Dublin involuntary admission study (DIAS). *International Journal of Law and Psychiatry*, 66, 101472. <https://doi.org/10.1016/j.ijlp.2019.101472>.
- Gilbert, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, 8(92). <https://doi.org/10.1186/1472-6963-8-92>.
- The Greek Ombudsman (2007). *Ex officio research by the Greek Ombudsman on involuntary hospitalization of psychiatric patients: Special report*. Athens: Greek Ombudsman.
- Hartley, P., Gibbins, N., Saunders, A., Alexander, K., Conroy, E., Dixon, R., ... Romero-Ortuno, R. (2017). The association between cognitive impairment and functional outcome in hospitalized older patients: A systematic review and meta-analysis. *Age and Ageing*, 46(4), 559–567. <https://doi.org/10.1093/ageing/afx007>.
- Hwang, T. Y., Jung, G., Lee, C. J., & Kim, H. Y. (2020). Analysis of involuntary admissions in Korea through the admission management information system. *International Journal of Law and Psychiatry*, 68, 101542. <https://doi.org/10.1016/j.ijlp.2020.101542>.
- Katsakou, C., & Priebe, S. (2007). Patient's experiences of involuntary hospital admission and treatment: A review of qualitative studies. *Epidemiologia e Psichiatria Sociale*, 16(02), 172–178.
- Kisely, S., Preston, N., Xiao, J., Lawrence, D., Louise, S., Crowe, E., & Segal, S. (2013). An eleven-year evaluation of the effect of community treatment orders on changes in mental health service use. *Journal of Psychiatric Research*, 47, 650–656. <https://doi.org/10.1016/j.jpsychires.2013.01.010>.
- Koekoek, B., Van Meijel, B., & Hutschemaekers, G. (2006). 'Difficult patients' in mental health care: A review. *Psychiatric Services*, 57, 795–802.
- Light, E. (2019). Rates of use of community treatment orders in Australia. *International Journal of Law and Psychiatry*, 64, 83–87. <https://doi.org/10.1016/j.ijlp.2019.02.006>.
- Løvsletten, M., Haug, E., Granerud, A., Nordby, K., & Smaaberg, T. (2016). Prevalence and management of patients with outpatient commitment in the mental health services. *Nordic Journal of Psychiatry*, 70, 401–406. <https://doi.org/10.3109/08039488.2015.1137969>.
- Maharaj, R., O'Brien, L., Gillies, D., & Andrew, S. (2013). Police referrals to a psychiatric hospital: Experiences of nurses caring for police-referred admissions. *International Journal of Mental Health Nursing*, 22(4), 313–321. <https://doi.org/10.1111/j.1447-0349.2012.00881.x>. Epub 2012 Sep 25. PMID: 23009594.
- Malatest, R. A. (2012). The legislated review of community treatment orders (final report). Retrieved from http://www.health.gov.on.ca/en/public/programs/hepatitis/docs/cto_review_report.pdf.
- Manning, C., Molodynski, A., Rugkåsa, J., Dawson, J., & Burns, T. (2011). Community treatment orders in England and Wales: National survey of clinicians' views and use. *Psychiatrist*, 35, 328–333. <https://doi.org/10.1192/pb.bp.110.032631>.
- McManus, S., McDonnell, B., & Whitty, P. (2015). Rate of involuntary admission in Dublin south west: A 5-year retrospective review. *Irish Journal of Psychological Medicine*, 32(4), 341–345. <https://doi.org/10.1017/ipm.2015.3>.
- Morandi, S. (2016). Descriptive and epidemiological studies. In A. Molodynski, J. Rugkåsa, & T. Burns (Eds.), *Coercion in community mental health care: International perspectives* (pp. 47–74). Oxford: Oxford University Press.
- Mulder, C. L., Koopmans, G. T., & Selten, J. P. (2006). Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands. *The British journal of psychiatry : the journal of mental science*, 188, 386–391. <https://doi.org/10.1192/bjp.188.4.386>.
- NHS. (2019). *Mental health Act. England: NHS*. Retrieved from <https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-act/>.
- Pehlivaniadis, A., Politis, A., Economou, D., & Trikkas, G. (2001). Evaluation of civilly committed patients: Comparative study of two chronological periods (1977–1997). *Psychiatriki*, 12, 283–289.
- Prior, D., & Behan, D. (2013). *Monitoring the mental health act in 2011/12*. Newcastle upon Tyne. Retrieved from http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_final_web.pdf.
- Rugkasa, J. (2016). Effectiveness of community treatment orders: The international evidence. *Canadian Journal of Psychiatry*, 61, 15–24. <https://doi.org/10.1177/0706743715620415>.
- Rugkasa, J., Nytingnes, O., Simonsen, T. B., Benth, J. S., Lau, B., Riley, H., & Hoyer, G. (2019). The use of outpatient commitment in Norway: Who are the patients and what does it involve? *International Journal of Law and Psychiatry*, 62, 7–15. <https://doi.org/10.1016/j.ijlp.2018.11.001>.
- Stylianidis, S., Peppou, L. E., & Drakonakis, N. (2014). Moral and ethical issues related to involuntary psychiatric hospitalization. In A. Douzenis, & E. Lykouras (Eds.), *Moral and ethics in mental health*. Athens: BETA Medical Publications.
- Stylianidis, S., Peppou, L. E., Drakonakis, N., Douzenis, A., Panagou, A., Tsikou, K., et al. (2017). Mental health care in Athens: Are compulsory admissions in Greece a one-way road? *International Journal of Law and Psychiatry*, 52, 28–34.
- Stylianidis, S., Peppou, L. E., Drakonakis, N., Iatropoulou, G., Nikolaidi, S., Tsikou, K., & Souliotis, K. (2018). Patients' views and experiences of involuntary hospitalization

- in Greece: A focus group study. *International Journal of Culture and Mental Health*, 11 (4), 425–436. DOI: 1080/17542863.2017.1409778.
- Whittamore, K. H., Goldberg, S. E., Gladman, J. R., Bradshaw, L. E., Jones, R. G., & Harwood, R. H. (2014). The diagnosis, prevalence and outcome of delirium in a cohort of older people with mental health problems on general hospital wards. *International Journal of Geriatric Psychiatry*, 29(1), 32–40. <https://doi.org/10.1002/gps.3961>.
- Beadle-Brown, J., Finn, A., Nyman, M., Petri, G., & Turnpenny, Á. (2017). *Mapping and understanding exclusion: Institutional, coercive and community - based services and practices across Europe (report)*. 26 p. 1050). Brussels: Mental Health Europe Mundo B- Rue d'Edimbourg (Bruxelles).