



Involuntary admission for psychiatric treatment: Compliance with the law and legal considerations in referring physicians with different professional backgrounds



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ABSTRACT

Background: Involuntary admission (IA) for psychiatric treatment is a massive restriction of human rights. Therefore, its execution is regulated by law. During executing IAs referring physicians find themselves in a dual role: support of patients in the recovery process but also safe-keeper of society. In Zurich, Switzerland the law stipulates that physicians regardless of their medical specialization may admit patients who suffer from a mental disorder, mental disability or severe neglect involuntarily if care cannot be provided otherwise, regardless of their decision-making capacity. The referring physician is obliged to examine the patients, hear their views on the IA, inform them about the following steps and about their right of appeal at the civil court. We aimed to assess whether referring physicians can comply with those legal requirements for an IA. Additionally, we examined whether legal considerations differed according to the physicians' professional backgrounds and attitudes towards coercion in general.

Methods: We invited physicians from different in- and outpatient settings who executed IAs to the University Hospital of Psychiatry Zurich to participate in a newly developed online survey. We used correlation analysis, chi-square and *t*-tests to analyze the responses of 43 psychiatrists with those of 64 other physicians.

Results: In about 1/3 of the IAs referring physicians were not able to hear the patients' views on the IA, to inform the patients about the following steps and about their right of appeal. Psychiatrists felt more certain with the legal basis of IA compared to physicians other than psychiatrists. Nevertheless, the latter stated that the assessment of the risk for suicide and danger should not be restricted only to psychiatrists. Both groups differed in their attitudes towards coercion with psychiatrists being more critical.

Conclusions: Interventions should be developed to facilitate a compliance with legal requirements during IA. Physicians who execute IAs must have a thorough knowledge of the clinical and legal basis for their actions. We recommend specialized consultation teams for the assessment of PES and regular training including ethical discussions, especially for physicians other than psychiatrists.

1. Introduction

Some of the most widely discussed and ethically challenging interventions of psychiatric practice are those when the mental health professional must intervene against the will of the patient for his or her own supposed benefit or/and that of society at large (Giacco, Conneely, Masoud, Burn, & Priebe, 2018; Salize & Dressing, 2004). Ideally, the

psychiatrist and the patient cooperate and build up a trusting relationship. However, given the nature of some psychiatric disorders, this is not always possible and, in some situations, whilst deeply controversial and ethically problematic, coercion has to be used.

In the outpatient setting, physicians with different professional backgrounds are more or less regularly confronted with psychiatric emergency situations (PES) (Downey, Zun, & Burke, 2012; Fulbrook &

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Lawrence, 2015; Vu et al., 2015). Some of these PES can lead to involuntary admission (IA) of patients.

IA restricts an individual's freedom, which is a rare occurrence for an individual who has not been accused of committing a crime. This illustrates the ethical and legal challenges which are connected to IA. Due to the massive restriction of a person's freedom, legal regulation is necessary. This is especially important because it was shown that patients perceive IA and treatment against their will as humiliating, aversive and isolating (Bergk, Flammer, & Steinert, 2010; Greenberg, Moore-Duncan, & Herron, 1996; Naber, Kircher, & Hessel, 1996). As a result, most nations have strict codes about the criteria that must be met for a person to be denied the right to physically leave a given location and refuse treatment (Legemaate, 1998; Salize & Dressing, 2004). The criteria for IA, the professional background of those who may initiate an IA, but also the course after IA (i.e. maximum duration of IA, involvement of a court hearing, free legal support) differ internationally (Dressing & Salize, 2004; Steinert & Lepping, 2009). Most frequently, IA may be exerted to prevent patients from hurting themselves and/or others (Gilhooley & Kelly, 2018; Rotvold & Wynn, 2015b). Countries like Austria, Belgium, France, Germany, Luxembourg, the Netherlands, China and most countries of the USA stipulate that a person must suffer of a mental illness and be endangering for self or others. In Denmark, Finland, Greece, Ireland, United Kingdom and Portugal a mental illness must be accompanied by endangerment or a need for treatment. Italy, Spain, Sweden and Switzerland demand a mental illness and need for treatment (Federal Assembly of the Swiss Confederation, 2018; Dressing & Salize, 2004; Jiang et al., 2018; Testa & West, 2010).

In Switzerland, IA is regulated by a federal law which is implemented differently in the 26 Swiss cantons (states) (Art.429) (Federal Assembly of the Swiss Confederation, 2018). Article 426 of the Swiss Civil Code states that “a person suffering from a mental disorder or mental disability or serious neglect (...) may be committed to an appropriate institution if the required treatment or care cannot be provided otherwise”.

Given the aspect that patients in a crisis can induce relevant distress in the patients' environment (Foldemo, Gullberg, Ek, & Bogren, 2005) the law further stipulates, that “the burden the patient places on family members and third parties and their protection must be taken into account” (Art. 426). In contrast to other countries (Federal Assembly of the Swiss Confederation, 2018; Dressing & Salize, 2004; Jiang et al., 2018; Testa & West, 2010), endangerment to self or others and disturbed decision making capacity is not required explicitly for an IA. Thus, distinct to other countries, a patient can be involuntary hospitalized without meeting the danger criterion and although the decision-making capacity is not disturbed.

Besides these criteria which focus on the clinical findings, the law also requires that “the doctor shall examine and interview the patient in person”, provide information about the following steps and the right to appeal at the civil court (Art. 430).

In contrast to other cantons of Switzerland, in Zurich every physician who is entitled to practice medicine in Switzerland independently, or works under the supervision of a physician is authorized to refer patients involuntarily if he or she is not affiliated to the hospital the patient is referred to. The child and adult protective services (Kindes- und Erwachsenenschutzbehörde, KESB) is also entitled to execute an IA and, in contrast to physicians, has the authority to prolong an IA if the maximum of 42 days of a physician's IA is exhausted and its prolongation seems necessary (Zuercher Einfuehrungsgesetz, 2012).

To ascertain a structured process, the Canton of Zurich provides a commitment document which helps the referring physician to cover all relevant aspects (Gesundheitsdirektion Zuerich, 2013). Nevertheless, some referring physicians use other commitment documents with differences in structure and scope.

Although not considered by the Swiss law, there is an ongoing and controversial discussion if the lack or presence of a patient's decision-making capacity should be a criterion to determine an IA (Trachsel &

Huerlimann, 2017). In contrast to Switzerland, the decision-making capacity is taken into account by the German law which stipulates that the person committed involuntarily must lack in the capacity to recognize the necessity of examination and/or treatment (Steinert, Weissenau, & Hirsch, 2018).

While there is growing literature on the perspective of patients towards this coercive intervention (Gardner et al., 1999; Lucksted & Coursey, 1995; Nicholson, Ekenstam, & Norwood, 1996; Priebe et al., 2009; Priebe et al., 2010), little is known about the perspective of the referring physicians who are caught in the characteristic dual-role of psychiatry (Robertson & Walter, 2008). Compared to other medical disciplines mental health care is in the unique position to offer treatment for patients who are in need and who want to receive psychiatric care on one side. On the other side, it is assigned by society with the authority to hold back and treat patients against their will for the patients' wellbeing. Previous studies found that some referring physicians felt uncertain about applying the legal criteria for IA (Rotvold & Wynn, 2015a, 2015b) and that in some commitment documents the information on the right to appeal, the information of the patient on the following steps and the purpose of the IA was lacking (Jaeger et al., 2014; Kieber-Ospelt et al., 2016). Besides that, it was shown that there are differences in the course after IA linked to the working background of the referring physicians (Cutler et al., 2013; Fuglseth et al., 2016; Hotzy, Kieber-Ospelt, Schneeberger, Jaeger, & Olbrich, 2018; Johansen, Mellesdal, Jorgensen, & Hunskaar, 2012). Differences in levels of certainty about the legal requirements might play a role in these variances (Rotvold & Wynn, 2015b).

Taking into account the specifics of PES, the clinical symptoms of a person are relevant in the decision-making process for/against IA. Besides that, the evaluation of endangerment to self and or others is essential but might induce thoughts about legal consequences of a decision for or against an IA. Fears of being sued in the case of a suicide of the patient or harm to others might play a role during the decision-making process. Uncertainties with the legal regulation might foster the decision for an IA to be legally on the safe side. Nevertheless, to our knowledge until today no study examined in detail the legal considerations of referring physicians with different medical specializations during an IA.

In this study we aimed to answer the questions to what extent the referring physicians were able to comply with the legal requirements for IA and how legal considerations influence the decision-making process for an IA. Additionally, we examined whether legal considerations differed according to the physicians' professional backgrounds and whether they were associated with attitudes towards coercion in general.

We developed a structured online questionnaire and invited a defined group of physicians who had referred patients for IA to the University Hospital of Psychiatry Zurich to participate in the study.

2. Material and methods

2.1. Setting and study population

This article is based on data collected at the University Hospital of Psychiatry Zurich, Switzerland. The hospital provides acute and semi-acute inpatient treatment for adults and elderly patients. With its affiliated departments, the clinic constitutes the largest psychiatric clinic in Switzerland, providing mental health services for a catchment area of nearly 500'000 inhabitants from a mostly urban region. The canton of Zurich with its broad range of mandating physicians was suitable to this type of study as it enabled comparison of physicians with different specialization and working experience.

During the study period (October 2016 – September 2017) 560 physicians exerted 1242 IAs. Thus, some physicians accounted for more than one IA. We had to exclude 196 physicians due to missing or unclear contact information, job changes (physicians were not tracked

Table 1
Overview of the referring physicians and their affiliated institutions.

	% All referring physicians (n = 560)	% Invited physicians (n = 364)	% Participating physicians (n = 107)
Outpatient psychiatric office	19	24	31
Psychiatric institution	14	14	10
General practitioner	19	14	11
Outpatient emergency doctor	8	11	10
Hospital physician	34	32	30
Other	6	5	8

This Table shows the proportion of the affiliated institutions in all referring physicians, in those who were invited and in those physicians who participated in the study.

down if they no longer worked at the institution from where the patient was referred), admissions from other cantons of Switzerland, or because the physicians refused to be invited for participation. Of the 364 invited physicians, 107 (29%) completed the questionnaire sufficiently and were included in the data analysis. An overview on the referring physicians and their affiliated institutions is shown in Table 1.

The participants were working in the canton of Zurich in in- and outpatient settings. Psychiatrists accounted for 40% (n = 43) and other physicians for 60% (n = 64) of the completed questionnaires.

2.2. Procedures and measures

For this study, the study team developed a structured online questionnaire. A draft of the questionnaire was reviewed and discussed with experts in the field of PES and IA. We informed the 364 referring physicians about the study via telephone and invited them to participate in the online survey.

The questionnaire assessed the physicians' socio-demographic data (gender, age, years of working experience, education level), their professional background (medical specialization, working field), the number of IAs they exert per year. We also assessed characteristics of the PES leading to IA which are described and discussed in detail elsewhere (Marty et al., 2018). We then asked the participants about their fulfillment of the legal requirements during their last IA. More precisely, we asked if they were able to hear the patients' view on the IA, to inform the patients about the following steps and about their right of appeal at the civil court and if they had been able to inform a next of kin about the IA (Federal Assembly of the Swiss Confederation, 2018). Participants could choose categorized answers (yes/no). If they chose the answer "no", they were asked to provide a short explanation. In addition, we asked if the patients' decision-making capacity was assessed before executing the IA. We further asked the referring physicians to rate their agreement on statements about legal considerations on a five-point likert scale. Statements included concerns about being prosecuted (i.e. "I have concerns about being prosecuted for my decisions") and the ability to comprehend the legal basis (i.e. "I find it challenging to comprehend the legal basis for my actions in PES"). Further statements included the tendency to mandate an IA to be legally safeguarded (i.e. "When indecisive, I'd rather mandate an IA to be on the safe side legally") and the opinion who should assess risk factors in patients (i.e. "The assessment of the risk of suicide and danger to others should be performed by a psychiatrist" and "An experienced, non-psychiatric physician can assess the risk of suicide and danger to others well").

We used the Staff Attitude to Coercion Scale (SACS) (Husum, Finset, & Ruud, 2008) to assess the participants' attitudes towards coercion. This scale encompasses three subscales describing different aspects of coercion: "Coercion as offending", "coercion as care and security" and "coercion as treatment".

2.3. Statistical analysis

We used descriptive statistics such as proportions of the specific

answer categories and standard errors as well as means and standard deviations to describe the participants' attitudes and considerations about legal requirements during mandating an IA. We searched for differences regarding the physicians' professional background with chi-squared tests or, in case of low cell counts, with Fisher-Freeman-Halton exact tests for categorical data and *t*-tests for continuous data. We assessed the relationship of the participants' legal considerations, with their attitudes and professional experience with Spearman rank correlation coefficients.

If the legal requirements were not met, we checked the open-answers in a qualitative analysis. To examine the reasons for not complying with the legal requirements we categorized the open answers into three main categories depending on the specific statements ("organic", "psychiatric other" and "non-compliance", respectively, "no next of kin", "rejection of the patient" and "others informed"). We performed statistical analysis with SPSS 23.0 (IBM Corp. Released 2011. IBM SPSS Statistics for Windows, Version 23.0. Armonk, NY: IBM Corp.) for Windows. We chose a significance level of $p < .05$.

3. Results

3.1. Descriptive analysis

The participants had a mean age of 46 years, a mean professional working experience of 18 years, and 39% were female. The majority (86%) stated that they had conducted more than one IA during the last 12 months.

According to the socio-demographic background, psychiatrists were significantly older (50.5 vs. 43.3 years) and had significantly more professional working experience (22.1 vs. 14.3 years) than other physicians. Both groups did not differ in their gender and number of IAs during the last 12 months. About two thirds of the consultations took > 60 min and about half of the participants stated that other parties were involved in the PES (most often police or next of kin were named). The majority (79%) did not know the patient from a prior treatment. Characteristics of the PES and the decision-making process for IA are described in detail elsewhere (Marty et al., 2018).

3.2. Fulfillment of legal requirements

In 35 (33%) PES resulting in an IA, it was not possible to hear the patient's view on the IA. In most of these PES (29 out of 35) the patient's clinical condition (mostly organic disorders, psychotic disorders or danger to self or others) did not allow for such a hearing. The others named a lack of motivation or compliance of the patient and other reasons.

Informing the patient about the following steps after the IA was not possible in 37 (35%) PES. Again, the clinical condition of the patient was named most frequently (30 out of 37), followed by lack of motivation or compliance and one reason otherwise specified.

In 38 (36%) PES it was not possible to inform the patient about his/her right to appeal against the IA. The patient's clinical condition again was named most frequently (30 out of 38 cases), followed by lack of

Table 2
Fulfillment of legal requirements of last PES leading to an IA.

Legal requirement	Fulfilled		Reasons for not complying with the legal requirements summarized in categories						p
	(all physicians)		Psychiatrists			Other physicians			
	n	%	n (se) organic	n (se) psychiatric other	n (se) non-compliance	n (se) organic	n (se) psychiatric other	n (se) non-compliance	
Hear the patient's view	69	64.5	4 (-0.5)	8 (1.0)	1 (-0.8)	10 (0.4)	7 (-0.8)	5 (0.6)	.243
Information about the IA	67	62.6	5 (-0.4)	8 (1.6)	0 (-1.6)	12 (0.3)	5 (-1.2)	7 (1.2)	.018
Information about the right to appeal	65	60.7	4 (-0.8)	9 (1.7)	1 (-1.1)	12 (0.6)	5 (-1.3)	7 (0.9)	.031
Inform patient's next of kin	65	60.7	no NOK 10 (0.1)	patient rejected 3 (-0.1)	others informed 1 (-0.1)	no NOK 17 (-0.1)	patient rejected 6 (0.1)	others informed 2 (0.1)	1.000

Note. IA = Involuntary admission, PES = Psychiatric emergency situation, NOK = next of kin; Total n = 107 participants; se = standardized residuals; missing values of closed answers are below 2%; One person did not answer to the open questions and two of them were unclear and not categorized. Due to the small sample, we used Fisher's exact test for group comparison. Open answers were such as "the patient was: demented, very confused, intoxicated with alcohol and drugs (organic); acute psychotic, a danger to self or others (psychiatric other); uncooperative, not listening, difficult (non-compliance)".

motivation. In 1 case a language barrier was named.

A total of 39 (36%) participants were not able to inform a patient's next of kin about the IA. Of that 39, 27 stated that no next of kin was available (e.g. because the patient was not able to name anybody, or he/she could not be reached in the situation), in 9 cases the patient did not want a next of kin to be informed, in 3 cases someone else (nurse or patient) informed a next of kin.

When we compared the statements about the fulfillment of the legal requirements between psychiatrists and other physicians we found that psychiatrists named psychotic symptoms and danger to self or others significantly more often as barrier to inform the patients about the following steps and the right to appeal. Other physicians more often named organic reasons (e.g. dementia, intoxication, disorientation) and lack of compliance. The statements of the participants did not reveal in detail in how they were hindered in their duty to comply with the requirements. Details are shown in Table 2.

Out of 107 participants, the majority stated that the patient would not have agreed to a voluntary admission. Nevertheless, 17 (16%) participants stated that the patient also would have agreed to a voluntary admission. The reasons to refer those patients involuntarily can be grouped into four categories: 1. the patient was ambivalent and could therefore have changed his/her mind (n = 7). 2. the patient was intoxicated, and IA should prevent self-endangerment (n = 5). 3. the psychiatrist at the receiving hospital requested an IA (n = 3), 4. other reasons.

The evaluation of the patient's decision-making capacity (DMC) was conducted conclusively in 79 PES and determined as impaired in the majority of those situations. Details are shown in Table 3. We found that an impaired DMC was significantly associated with the inability to hear the patients' view ($\chi^2(2) = 6.72, p = .035, n = 103$) and to inform about the right to appeal ($\chi^2(2) = 6.8, p = .033, n = 102$), but not with the inability to inform the patients about the following steps after IA ($\chi^2(2) = 5.21, p = .07, n = 103$) and a next of kin ($\chi^2(2) = 1.75, p = .417, n = 101$).

3.3. Legal considerations during involuntary admission and attitudes towards coercion

Twenty participants (19%) agreed with the statement "I have concerns about being prosecuted for my decision". Such concerns were more frequent among physicians other than psychiatrists. Nevertheless, the difference was not significant compared to psychiatrists.

We found a significant difference in the agreement with the statement "I find it challenging to comprehend the legal basis for my actions in PES". Among psychiatrists 1 (2%) agreed, compared to 19 (28%) of the other physicians.

Concerning the statement "When indecisive, I'd rather mandate an

Table 3
Perceived voluntariness and decision-making capacity of patients.

Perception	All referring physicians		Psychiatrists	Other physicians	p
	n	%	n (se)	n (se)	
Patient was willing to admit voluntarily					.002
Yes	17	15.9	6 (-0.3)	11 (0.3)	
No	69	64.5	35 (1.4)	34 (-1.1)	
Could not be elicited	21	19.6	2 (-2.2)	19 (1.8)	
Decision making capacity of the patient					.260
DMC not impaired	18	16.8	4 (-1.2)	14 (1.0)	
DMC impaired	61	57.0	27 (0.6)	34 (-0.4)	
Evaluation was not possible / made	24	22.4	10 (0.1)	14 (-0.1)	

Note. DMC = Decision-making capacity; Total n = 107 participants; Missing values below 4%; Due to the small sample, we used Fisher's exact test for group comparison.

IA to be on the safe side legally" 24 participants expressed agreement. The agreement was higher among physicians other than psychiatrists, but the difference was not significant.

The statement: "The assessment of the risk of suicide and danger to others should be performed by a psychiatrist" found agreement in 29 (69%) psychiatrists, whereas only 26 (41%) of the other physicians agreed. In contrast, the statement "An experienced, non-psychiatric physician can assess the risk of suicide and danger to others well" found agreement in 39 (61%) other physicians, whereas psychiatrists 23 (52%) disagreed.

Regarding the participants' attitudes towards coercion (Husum et al., 2008), psychiatrists viewed coercion significantly more as "offending" and less often as "treatment" compared to other physicians.

All results remained the same when controlled for years of professional experience. Details are shown in Table 4.

We used a correlation analysis to assess associations between the attitudes towards coercion, the working experience and legal considerations. Higher ratings (implying agreement) of the SACS-subscale "Coercion as treatment" (Husum et al., 2008) were significantly correlated with higher agreement to the statements "I find it challenging to comprehend the legal basis for my actions in PES" and "When indecisive, I'd rather mandate an IA to be on the safe side legally". Participants with more years of working experience agreed significantly less to the statements "I have concerns about being prosecuted for my decision" and "I find it challenging to comprehend the legal basis for my actions in PES". Interestingly, we found a positive correlation

Table 4
Differences in attitudes towards legal aspects? between psychiatrists and physicians with other specializations.

	Psychiatrists		Other physicians		T value or χ^2	p	Cohen's d
	M or %	SD	M or %	SD			
Legal aspects							
I have concerns about being prosecuted for my decisions	2.14	1.21	2.25	1.23	0.47	.637	
I find it challenging to comprehend the legal basis for my actions in PES	1.56	0.73	2.56	1.15	5.06	.000	1.00
When indecisive, I'd rather mandate an IA to be on the safe side legally	2.16	1.23	2.34	1.26	0.73	.465	
The assessment of the risk of suicide and danger to others should be performed by a psychiatrist	3.90	1.17	3.09	1.38	3.15	.002	0.62
An experienced, non-psychiatric physician can assess the risk of suicide and danger to others well	3.21	1.05	3.72	0.83	2.76	.007	0.55
SAC Scale							
Coercion as offending (SAC subscale 1)	3.51	0.60	3.19	0.59	2.73	.007	0.54
Coercion as care and security (SAC subscale 2)	4.26	0.70	4.23	0.61	0.18	.861	
Coercion as treatment (SAC subscale 3)	1.95	0.78	2.27	0.77	2.08	.040	0.41
Personal characteristics							
Male gender	60.5		61.9		0.02	.881	
Age in years	50.47	7.93	43.31	13.67	3.10	.003	0.61
Professional experience in years	22.12	7.55	14.35	12.19	3.71	.000	0.74
≥ 5 IA during the past 12 months (%)	44.2		40.6		0.134	.714	

Note. IA = Involuntary admission, PES = Psychiatric emergency situation; Attitudes were measured on a rating scale ranged from 1 to 5 while higher values indicate more agreement; Missing values of all variables are below 1.9% (43 psychiatrists and 63 other physicians); T value (df = 105) or Chi-square value (df = 1).

Table 5
Relationship of attitudes towards coercion and legal considerations determined by Spearman rank correlation coefficients.

	1	2.	3.	4.	5.	6.	7.	8.
1. I have concerns about being prosecuted for my decisions	–							
2. I find it challenging to comprehend the legal basis for my actions in PES	0.52**	–						
3. When indecisive, I'd rather mandate an IA to be on the safe side legally	0.43**	0.53**	–					
4. The assessment of the risk of suicide and danger to others should be performed by a psychiatrist	0.24*	0.24*	0.20*	–				
5. An experienced, non-psychiatric physician can assess the risk of suicide and danger to others well	0.03	–0.03	–0.08	–0.43**	–			
6. Coercion as offending (SAC subscale 1)	0.09	–0.08	0.15	0.10	–0.12	–		
7. Coercion as care and security (SAC subscale 2)	–0.14	–0.18	–0.01	0.02	0.11	–0.16	–	
8. Coercion as treatment (SAC subscale 3)	0.10	0.29**	0.45**	0.17	–0.06	–0.10	0.27**	–
9. Professional experience, years	–0.26**	–0.42*	–0.13	–0.05	–0.09	–0.05	0.26**	–0.00

Note. IA = Involuntary admission, PES = Psychiatric emergency situation.
* Significant at 0.05 (two-sided).
** Significant at 0.01 (two-sided).

between working experience and the rating of “Coercion as care and security”. Details are shown in Table 5.

4. Discussion

Nearly 1/3 of the participants stated that they were not able to fulfill some of the legal requirements which were implemented by the legislation to strengthen the patients' autonomy during the exertion of IA (Federal Assembly of the Swiss Confederation, 2018). Most often, the patients' clinical condition was named as a reason to omit hearing the patients' view, providing information about the following steps and the right to appeal. Psychiatrists were more familiar with the legal basis for their actions in PES compared to other physicians. The latter viewed coercion more often as treatment.

To our knowledge, this is the first study to examine the referring physicians' subjective perspectives on legal aspects of IA in detail. IAs are not only clinically challenging, they also restrict fundamental rights of the patient (i.e. “the right to liberty and security of person” (OHCHR, 1966)) and are therefore regulated by law (Federal Assembly of the Swiss Confederation, 2018; Dressing & Salize, 2004). Thus, PES and the exertion of IAs do not only require psychiatric skills of the physicians involved. They also require a profound knowledge of the legal basis and awareness about the importance to preserve the rights of the patient (Federal Assembly of the Swiss Confederation, 2018; OHCHR, 1966). We found that about one third of the physicians felt not able to comply with some of the legal requirements. In contrast to previous studies (Jaeger et al., 2014; Kieber-Ospelt et al., 2016), psychiatrists and other physicians did not significantly differ in their fulfillment of the legal

requirements during IA in our study. The patients' clinical condition was most often named as the reason for not complying with the legal requirements. Future studies should aim to develop strategies which help to increase the compliance with the legal requirements during the IA. These could be the standardized use of the commitment document provided by the Canton Zurich (Gesundheitsdirektion Zuerich, 2013). Also, specific training in the handling of PES and de-escalation-skills or supported decision-making (Davidson et al., 2015) might be helpful to establish a basis for a reciprocal interaction between patient and physician. Consultation teams specialized in the assessment and handling of PES could be established. This might be a helpful support for physicians other than psychiatrists.

Nevertheless, the receiving hospital physicians have to be aware that the patients clinical condition makes a compliance with the requirements impossible during some PES. In such cases they should aim to fulfill the legal requirements as soon as the patients' condition allows for it (Fiorillo et al., 2011).

There is a growing debate about the decision-making capacity in psychiatric patients and its role during the application of coercion (Davidson et al., 2016; Trachsel & Huerlimann, 2017). We showed that an impaired decision-making capacity can be associated with the inability to fulfill the legal requirements during the IA. Nevertheless, our findings also indicate, that some participants felt able to comply with the legal requirements although they determined an impaired DMC. Until today, a standardized assessment of the DMC is rarely used in clinical practice. The decision to refrain from an impaired DMC as a criteria for IA in Switzerland (Federal Assembly of the Swiss Confederation, 2018) was critically discussed (Trachsel & Huerlimann,

2017) and more knowledge on the standardized assessment of the DMC during a PES is necessary. Different tools are available for this purpose, but most of them need further evaluation (Dunn, Nowrangi, Palmer, Jeste, & Saks, 2006).

According to the referring physicians, there was a small group of patients who may have gone to the hospital on a voluntary basis. They were referred involuntarily due to different reasons. Situations like ambivalence or intoxication are challenging for the physician in charge because they raise the question if the patient – even though not refusing in the moment of examination- is competent to formally consent for treatment. Also, pressure from the environment or even the receiving physicians may leverage the referring physician to exert an IA. Such IAs are not in line with the legislation which stipulates that a patient must refuse the treatment on a voluntary basis (Federal Assembly of the Swiss Confederation, 2018). Future studies should aim to merge medical, ethical and legal considerations and establish guidelines which help during the decision-making process in such situations. The more critical attitude of psychiatrists towards coercion compared to other physicians might have been one reason that a higher number of patients referred by the latter might also have gone for inpatient treatment on a voluntary basis. Most ethical discussions on “potential side effects” and trainings on the exertion of coercion in psychiatric patients take place in a psychiatric setting and have a limited interdisciplinary audience, although the amount of psychiatric patients in a non-psychiatric setting (e.g. emergency departments) is high (Downey et al., 2012; Fulbrook & Lawrence, 2015; Vu et al., 2015). Furthermore, psychiatrists might be more often confronted with the “damage” coercive interventions can cause in their patients. Due to experiences of coercion, some patients refuse treatment in a future crisis (Smith, 1995; Swartz, Swanson, & Hannon, 2003) and are skeptical or even hostile towards psychiatry (Mielau et al., 2018). This can end up in a vicious circle with an increased risk for IA in another crisis (Montemagni et al., 2011; Van der Post et al., 2014). These negative effects should be taken into account when the dual role of psychiatry is discussed (Robertson & Walter, 2008). We found that a less critical attitude towards coercion was also associated with an attitude to rather mandate an IA to be on the safe side and uncertainty about the legal basis for IA. In our study, about a third of the other physicians found it challenging to comprehend the legal basis for their actions in PES. This is less compared to a Norwegian study which found that about half of the GP's found the criteria in the law difficult to apply (Rotvold & Wynn, 2015a). Nonetheless, only one out of 43 psychiatrists in our study had difficulties to comprehend the legal basis for PES. The number of IAs per year – previously discussed as a reason for uncertainties (Rotvold & Wynn, 2015a) – did not differ between psychiatrists and other physicians in our study. Thus, besides the quantity of PES and IAs, also other aspects have an impact on the certainty with the legal basis for one's actions in PES.

Lack of certainty on the legal basis for one's actions and concerns about being prosecuted were correlated. Therefore, it is comprehensible that other physicians had more concerns about being prosecuted for their decisions. Nevertheless, compared to psychiatrists, they more often disagreed to the statement that only psychiatrists should assess the risk of suicide and danger to others and agreed more often to the statement that a non-psychiatric physician can assess the risk of suicide and danger. Other physicians, although sometimes struggling with uncertainties about the legal basis during PES and IA, want to maintain the authority to assess the risk in their patients. This underlines the importance of regular training and education in the handling of PES – including legal but also ethical perspectives – in those physicians who are authorized to admit patients involuntarily to a clinic.

4.1. Limitations

This study assessed solely the perspective of the referring physicians. Future studies should also aim to assess and compare the perspectives of patients and their next of kin.

The data presented are representative for one region in Switzerland. Due to differences in the legal regulation and organizational structures of other regions, the generalizability of the results is limited. Therefore, future studies should compare the perspectives from stakeholders in regions with different legal and organizational backgrounds.

It was not possible to invite all physicians who referred patients for IA during the studied period. Furthermore, the questionnaire was completed by about one third of the invited physicians. Due to the anonymized study design a comparison of the group of responders and non-responders is limited. As shown in Table 1, the affiliation of the referring physicians is slightly different in the whole group of referring physicians, in those invited to participate and in those who actually participated in the study. Psychiatrists in own office might be higher represented due to a higher interest in the psychiatric topic. However, the distribution of the professional background in the responders is comparable to the distribution of all referring physicians who conducted IAs in previous studies (Kieber-Ospelt et al., 2016). Furthermore, those who participated in the study might be interested in the topic of IA and therefore have a more grounded opinion. The lower response-rates of other physicians and the high response rate of psychiatrists indicates that the differences between the two groups might be even more pronounced in all referring physicians.

5. Conclusion

The fulfillment of the legal requirements for IA is not always possible for the referring physicians. Physicians who do not meet some of the legal requirements for an involuntary admission report that this is mostly due to the patients' clinical symptoms. Strategies to enhance the compliance with the law during IA should be developed. Nevertheless, it is mandatory that the receiving hospital aims to complete those legal requirements which are lacking, as soon as possible.

The correlation of a reduced certainty with the legal basis of IA and a rather positive attitude towards coercion implicates the importance of good training and awareness on medical, ethical and legal aspects of PES in referring physicians.

To gain a deeper and generalizable knowledge on the background of PES and the decision-making process during IA, future studies should assess the perspectives of the referring and receiving physicians in regions with differing legislations and compare them to those of patients and their next of kin.

Compliance with ethical standards

In this study no patient data were analyzed, therefore it was not subject to the Swiss Human Research Act (Humanforschungsgesetz) and waived by the Cantonal Ethics Commission of Zurich, Switzerland.

This study has been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. The authors informed the respondents (referring physicians) about the study in a cover letter. They assured the participants of the confidentiality and anonymity of the data, and the voluntariness of participation. Participation and completion of the questionnaire was constituted as confirmation of their consent. The data collection was anonymously, and no identifying factors were collected to ensure privacy.

Conflicts of interest

Florian Hotzy declares that he has no conflict of interest.
 Silvan Marty declares that he has no conflict of interest.
 Sonja Moetteli declares that she has no conflict of interest.
 Anastasia Theodoridou declares that she has no conflict of interest.
 Paul Hoff declares that he has no conflict of interest.
 Matthias Jaeger declares that he has no conflict of interest.

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Authors' contributions

Study conceptualization and data collection: FH, SMA, MJ.
 Analysis and interpretation of data: FH, SMA, SMoe.
 Drafting the article and/or revising it critically for important intellectual content: FH, SMA, SMoe, AT, pH, MJ. Final approval of the version to be published: FH, SMA, SMoe, AT, PH, MJ.

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Differences in legal aspects and SAC Scale also appeared when controlled for age and experience.

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