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Comparison of Involuntary Hospitalization and Treatment Indications of Mentally Ill Across the EU

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Abstract

Involuntary psychiatric hospitalization (IH) is one of the most restrictive measures in mental health care. involving the admission and treatment of individuals without their consent. It is justified as mandatory measure to ensure patients own and other safety, IH raises ethical concerns regarding patient autonomy, human rights, and treatment outcomes. Across the European Union and non-Union states, involuntary admission (IA) is governed by very diverse legal frameworks. Inside Europe there is a lot of variation in admission criteria and especially concerning judicial oversight and its role relating to the treatment. Additionally, how much and in what ways, medical doctors have a role with IA, varies from country to country. This literature review examines the legal, medical, and ethical dimensions of involuntary hospitalization in the European Union context, with a particular focus on three countries with distinct approaches to IA: Finland, Germany, and Spain.

The findings show fundamental differences in how and when involuntary psychiatric treatment is being used. Finland's approach is quite medically centered in the international scale. They require several psychiatric examinations before involuntary admission is legally ratified. Spain, in some ways opposite of Finland when comparing in EU, has a system in place where the main emphasis is on judicial authorization. Spanish courts have a great role during the actual admission process and the decision of ordering the treatment. Germany with its decentralized system, gives responsibility about the specifics of indications and laws around IA to every German state. Most of the states lean towards a judicial centered approach. In this review ethical issues such as adverse

outcomes of IH are discussed. Also, alternatives for coercive involuntary treatment are brought up and reviewed.

Involuntary hospitalization has been and still is a complex and controversial topic in the medical world, by having many legal, medical, and ethical considerations. The variations observed across Finland, Germany, and Spain reflect broader debates on the extent to which coercion should be used in psychiatric care. Although efforts to minimize coercion and prefer alternative interventions continue, challenges persist in ensuring that IA policies balance patient rights with effective mental health treatment. Further research is needed to evaluate the long-term impact of involuntary treatment and to develop more effective, ethically sound alternatives to coercion in psychiatric care.

Abbreviations

Throughout this literature review, the following abbreviations are used:

IA – Involuntary Admission
IH – Involuntary Hospitalization
IT – Involuntary Treatment
WHO – World Health Organization
ICD – International Classification of Diseases
DSM – Diagnostic and Statistical Manual of Mental Disorders
EU – European Union
ECHR- European Convention on Human Rights

Keywords

Involuntary treatment, mental illness, involuntary hospitalization, coercion, European Union, psychiatric treatment

1. Introduction

The World Health Organization (WHO) has described mental health as a resource, built from one's emotions, behavior and cognition. During individuals' lives many adaptational challenges are faced, creating and modifying psychological resilience and influencing an individual's ability to cope with adversity. A general summation of mental health is that is a multidimensional construct having psychosocial functioning, personality maturity, cognitive and emotional skills, and the capacity to sustain well-being and optimism (1). If one of the previously mentioned disrupts, there is a possibility of mental disorder or mental illness, both referring to same thing. Mental illnesses generally present themselves with impairments in emotional regulation, cognitive processing, and behavior. In psychiatry disorders are mostly classified with two diagnostic systems: Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) (2).

The severity of mental disorders varies quite substantially like in somatic conditions. Patients may suffer from mild mood related symptoms or decrease in daily functionality to severe even life threating conditions which need urgent inpatient care. While psychiatric treatment is mostly always voluntary when considering all patients, several cases regularly present in which an individual's condition may be so severe that they need compulsory care. IA is typically justified in cases where patients lack a sense of illness, refuse treatment, and are a risk to themselves or others. Despite its clinical necessity in certain situations, it is often not a simple treatment decision. IA persists to be much debated topic among professionals, patients and patients' representative groups (2).

This literature reviews examines IT and treatment indications across the European Union. Main focus is particularly on legal aspects, treatment indications and ethical considerations as well. Treatment coercion, which is most often connected to psychiatry amid the medical specialties, is clearly heavily linked to IH itself, but includes other methods such as the forced administration of psychotropic medication and physical or mechanical restraints. These very liberty restrictive coercive measures are ideally done to keep patients and others safe. However, simply using forceful methods is sometimes counterproductive from the standpoint of long-term treatment results. Post hospitalization some patients report having negative feelings towards treatment, staff and the hospital due to a sense of being coerced. This may impact harmfully to cooperation regarding future outpatient care, and also treatment of somatic diseases. It is important to note that most of the patients treated involuntarily feel that they benefitted from the intervention. Additionally, many published works indicate that involuntary hospitalization can be associated with stress symptoms sometimes developing as severe post traumatic symptoms. These matters raise ethical concerns about its effectiveness and long-term implications (1).

Legal frameworks governing IA vary considerably across Europe, with significant differences in legislation on national level, details around the practical side of involuntary treatment, and procedural safeguards. The level of judicial involvement, the criteria for admission, and the role of medical professionals in decision-making differ between countries and depending on country between judicial areas. Some countries of the European union have developed a system where authorization from a court is needed pre-hospitalization. Other countries rely on examinations done after a patient has already been brought to the institution. This exemplary difference shows a value judgment among systems, between quick access to care and strong guarding on individual liberties. (3).

International guidelines have made efforts to support and protect the rights of patients subjected to IH. (ECHR) and the United Nations' Principles for the Protection of Persons with Mental Illness (1991), have had an agenda to ensure that IT complies and follows to ethical and human rights standards (4). However, challenges remain in unifying these principles with national mental health policies, and involuntary hospitalization continues to be a subject of debate.

A common trend in recent years has been to try to reduce coercion in psychiatric care. Many strategies based on studies have been executed or planned to be done. Improving patient-professional interactions, shared decision-making, and the implementation of de-escalation techniques, have been implemented in a effort to increase voluntary

treatment and cooperation (5). Currently involuntary treatment and coercive measures are undeniable needed, there is not enough comprehensive studies on the long-term effects of it on patients. Additionally, alternative open or semi-open care models such as community-based psychiatric services have been hypothesized and tried out in some countries to replace hospitalization in cases where it is possible. These treatment methods try to provide early intervention while minimizing the need for involuntary care. However, their effectiveness varies across healthcare systems, and their integration into mainstream mental health services has been slowed down due to skeptical attitudes, logistical and financial challenges (6).

The official stand of The EU is promoting deinstitutionalization and addition and relocation of resources to outpatient and community-based psychiatric care. The Mental Health Declaration for Europe and the Mental Health Action Plan for Europe (2005) advocate for reducing coercion, ensuring patient rights, and improving access to mental health services (7). The European Council has also stated that the diagnosis of mental illness can and must always be purely medical. This aims to eradicate misuse of psychiatric hospitalization for non-clinical reasons (1). Despite EUs endorsements and statements, the results among members of the Union are not unified in these matters. Many countries have developed and put resources towards outpatient and community-based care systems, on the other hand many have stayed with the more traditional mode and some even have added new institutions and hospital beds in them (8).

To gain better understanding of involuntary psychiatric treatment within Europe, this literature review examines the wide legislative aspects and medical view while taking a

more detailed look at three selected countries: Finland, Germany, and Spain. These countries were chosen due to their distinct legal frameworks and differences in how IA is being used in practice and justified. In comparison to these systems, variations and differences are highlighted. Differences can be distinguished between the role of medical professionals in decision-making and the ethical aspects of how coercive psychiatric care is viewed. Additionally, in this work alternative models for crisis interventions and the different ways attempts to reduce coercion in psychiatric treatment are reviewed. By providing a comparative analysis of IA policies, this review aims to provide knowledge and understanding to the wide discussion on how psychiatric systems can treat the most serious case requiring IA while simultaneously maintaining patient rights, clinical necessity, and public safety in the context of involuntary care.

2. Methodology for Literature Review

2.1. Research Design

The thesis has a narrative literature review methodology. It aims to study the current state of involuntary hospitalization and treatment practices in the European Union. A particular focus is on the criteria and legal frameworks governing involuntary admission. Also, the implications for patient rights and mental health care systems are studied. Additionally, the review compares the involuntary hospitalization practices of three

previously mentioned distinct countries of European Union: Finland, Germany, and Spain. These countries were selected due to the availability of relevant material and their significant differences. The three respected countries differ in legal frameworks, healthcare systems, and cultural approaches to mental health care.

2.2. Data Sources

In this review the main sources for searching data were Google Scholar and PubMed. As national legislation can change rather rapidly and new treatment methods and practices in psychiatry are developed. Articles from the last decade were the primary target of the search. In some cases, earlier articles were included if they provided essential historical information or if their data remained relevant to the review's topic.

2.3. Search Strategy

The search was done using keywords and phrases. The following search terms were used:

Psychiatry

Involuntary admission

Involuntary treatment

Involuntary treatment EU

Mental health care EU

Compulsory treatment of the EU

These search terms were used in various combinations. Boolean operators (AND, OR) were employed to connect these keywords, ensuring that the articles retrieved were as specific and relevant to the topic of involuntary hospitalization and treatment in the European Union context as possible.

2.4. Inclusion and Exclusion Criteria

Priority was given to studies, scholarly articles, official reports, and authoritative psychiatric textbooks that addressed involuntary hospitalization or treatment practices. Articles discussing ethical ja legal challenges were considered. Geographically primarily source material about topic inside EU, its member states were obtained or generally articles discussing Europe as previously mentioned Finland, Germany and Spain were selected as countries of special interest in this review. Journal articles, professional psychiatric publications, reports, and authoritative psychiatric textbooks were considered. The selection process aimed that all included sources held the proper academic and scientific standards.

This review specifically focuses on the involuntary hospitalization of adults. Involuntary psychiatric treatment for children and underage people (age depending on the country) has its separate judicial outlook and often different set of indications. In this review treatment aspects of minors were excluded, because the topic is broad on its own. Focusing just on the treatment of adults leaves more room to concentrate more carefully on the topic and especially on legal aspects. Studies, publications and articles that focused only on non-European regions were excluded. Language had also a part in

exclusion criteria. Only publications in English language or in some cases Finnish language publications were considered.

2.5. Article Selection and Review Process

The selected articles were reviewed to make sure that the information gathered was applicable to the research questions and as up to date as possible. Once articles were identified through the initial search, they were screened based on their titles and abstracts to assess their relevance to the topic. Articles that met the inclusion criteria were then obtained and reviewed. Key themes related to involuntary hospitalization, such as patient rights, legal criteria for involuntary admission, medical professional involvement, and the role of the judiciary, were highlighted. Articles that did not discuss relevant topics were excluded. The findings from these studies were then compared across Finland, Germany, and Spain to identify common trends and regional differences in involuntary hospitalization practices, alongside of other EU countries.

2.6. Data Analysis

Data analysis focused on identifying unilateral patterns, similarities and differences in the systems and processes concerning IA in the EU. Critical review was conducted to examine the outcomes, ethical dilemmas and unwanted effects of the treatment. International human rights were also compared to common practices and laws around IA in EU.

In addition, in this review, interest was paid in the role of medical doctors and other mental health professionals, in the procedure of deciding whether involuntary treatment is essential. Also, evaluation was done on what kind of impact other support mechanisms like for community-based care have on admission rates and satisfaction among patients.

2.7. Limitations

While the search strategy was designed to produce the most contemporary literature, the scope of available articles may have been influenced by language barriers, as previously mentioned. Additionally, the diversity of legal frameworks, healthcare systems, and cultural norms across Europe creates problems with creating general accurate findings including every EU member state. Studies covering all or the majority of the union states have been seldom done on the topic. Therefore, while the articles reviewed provide some insights, the findings may show the lack of articles on the topic and how vast the region itself is.

2.8. Summation on methodology

The methodology section of this literature review explains explaining the search strategy, inclusion and exclusion criteria, and data analysis methods. By aiming to gather up to date literature about treatment practices and procedures, this review intends to offer

deeper understanding about involuntary hospitalization in EU and especially within the three respected countries. The comparative focus on Finland, Germany, and Spain

3. Overview of illness and Involuntary Treatment

The base for mental health is made of genetic factors and biological structure. Psychosocial factors are strongly present as early as in the embryotic stage. The development of mental health in early childhood, adolescence and in adulthood are related to the development of structural changes of the brain, resulting from genetic and environmental factors. Mental health and its disturbances are inversely dependent on each other. Good mental health is related to low level symptoms. On the other hand, mental health disorder and mental balance are also independent dimensions. A severely and chronically ill person can adapt and despite it reach subjective balance with symptoms. During an individual's life span there are many different episodes which have their own developmental challenges. In various stages of life, new adaptational challenges occur. Experiences from those obstacles aid in creating psychological capital. Mental health can be described having multiple dimensions, which each have subdimensions of their own. These dimensions are presented in Table 1. Good mental health also entails sufficient cognitive, emotional, and social aptitude. A sense of satisfaction in one’s own life is another important aspect of mental health. Mental resilience is also reflected in positive expectations, an optimistic view on the future, and the ability to sustain hope. This concept, often referred to as resilience, can be understood broadly as overall psychological strength or more narrowly as the capacity to cope with stressful situations (1).

Table 1 Dimensions of mental health (1)

I.	*Psychosocial Functioning*
II.	Talents, Abilities, and Strengths
III.	Personality Maturity
IV.	Cognitive, Emotional, and Social Skills
V.	Life Satisfaction and Well-being
VI.	Resilience, Adaptability, Readiness for Change, and Optimism

Mental illness is generally understood as a disruption in thinking, emotions, behavior, or social relationships, which results in suffering, harm, or a loss of an individual's functional capacity. Diagnoses are based on international classification systems, (DSM) and by the (ICD). The root causes may be related to psychological or biological factors and with disruptions in the developmental process. Often the root causes overlap with each other and psycho pathogenesis can be traced to several comorbidities or predisposal factors. Mental disorders are catheterized by impairments with emotional regulation, cognitive processing and behavior (2).

The most numerous mental illnesses are substance abuse disorders, anxiety disorders and depressive disorders. Each disorder has a particular set of symptoms with their own diagnostic criteria (2).

One of the most prevalent treatment-associated elements for IA is often related to reduced or absent contacts with psychiatric outpatient care. Other factors include weak compliance with pharmacotherapy and previous IA treatment episodes, the two seem to be the most common factors related to IA. Patients admitted compulsory more often

present with symptoms such as positive psychotic and aggression while the symptoms of individuals with voluntary hospitalization tend to present with anxiety and depressive symptoms (3).

The majority of patients, regardless of whether their treatment was voluntary, later report having benefited from the intervention. The patient's subjective experience of the admission process plays a critical role in the overall success of treatment. In contrast if admission is seen as forced or coerced, it may play a part in creating negative attitude and sentiments towards the treatment. It is well established that non-consensual treatment can be traumatic for some patients, potentially leading to trauma-related symptomatology. Therefore, the experience of involuntary admission should be minimized by consistently adhering to best clinical practices throughout the admission process (1).

When comparing compulsory admission rates across Europe, big variations can be detected. Official data derived from national health reports and statistical bureaus are often compromised by differences in definitions and calculation methods. For example, early 1990s figures indicate that compulsory admission quotas ranged from as low as 1% in Spain to as high as 93% in Switzerland, with corresponding rates varying dramatically from 24.4 per 100,000 in Denmark to 248 per 100,000 in Sweden. Germany, with its decentralized federal system, shows even greater variability, with rates ranging from 9.4 to 108.8 per 100,000; a nationwide median of 28.8 per 100,000 and 10 preliminary detentions per 100,000 have been reported, though concerns regarding representativeness persist. Data from England reveal an increase in the compulsory admission quota from 7% to 12% between 1984 and 1995, while Italy has seen its rates nearly double from 26 to 49 per 100,000 over a decade. In Belgium, paradoxically, the adoption of more restrictive criteria was accompanied by a rise in compulsory admissions to 30% of all inpatient episodes. Although the study was based on data from a single hospital, which alone cannot be considered a nationwide trend. In contrast, after

reforming its commitment law, Sweden experienced a marked reduction in compulsory admissions, from 116 per 100,000 in 1979 to 19.7 per 100,000 in 1993. Denmark which has kept a national psychiatric case register, reported 24.2 compulsory admissions per 100,000 on the mainland compared to 43.5 per 100,000 in Greenland, an autonomous part of Kingdom of Denmark where different statutes are used. These greatly variable findings can show persistent challenges in obtaining internationally comparable data and highlight the continued need for methodologically sound studies (4).

While a statement for the usefulness of IT can be made and an argument that at times the only optional way to effectively treat an acute phase of mental illness, it also raises human rights concerns as well as problems from clinical point of view. Due to its' autonomy limiting and dismaying nature, patients may experience reduced self-esteem, loss of identity and lack of self-control. In post-treatment interviews with patients, major loss in functionality and self-guidance has also been reported. Hopefulness, one of the key elements with remission from depression, seems to be under threat, while patients have been treated involuntarily (9).

Effective interprofessional collaboration among healthcare providers is crucial for delivering optimal care to individuals undergoing involuntary treatment. By ensuring as smooth as possible cooperation psychiatric health care workers, mental institutions can ensure consumers receive high-quality care, minimize restrictive interventions, and promote recovery while involving actively patients into treatment and most importantly to the decision-making processes. Multiple studies around the globe provide evidence that highlight the benefits of staff training, multi-professional and patient involving decision-making interventions, and integrated care approaches in reducing coercive treatment in mental health services. The strongest evidence supports staff training to reduce the use of restraints and shared decision-making with consumers (4)

3.1. Role of Medical Professionals in Involuntary Hospitalization

IA as previously mentioned is one of the biggest restrictions an individual may experience in a lawful society. Consequently, it is highly regulated by laws, although they may differ a lot even in closely related countries such as inside the EU, as discussed in this literature review. In cases where IV is considered, the doctor responsible is placed in two roles, as they are required to contemplate the medical and judicial side of the case (10). Psychiatric treatment as a whole and especially during IT requires effective multiprofessional cooperation. Generally, care involves psychiatrists, psychiatric nurses, clinical psychologists, social workers, occupational therapists and sometimes specialized physical therapists (11).

3.2. A brief history of Mental health, mental illness and involuntary treatment and its legislation

The concept of mental illness has been referenced in historical texts trough human history. Cultural norms and customs have determined the model of normal behavior and definition of abnormality has varied a great amount depending on time period and geographical place. Historical treatments and etiological theories were mainly based on superstitions and religious dogma. One of the widely used historical treatment methods was trephination, where physicians used to drill holes into patients' heads with a goal to free a patient from evil spirits. Modern treatment methods for mentally ill, are regarded to have emerged around 16th century, when the first mental asylums were established. Patients admitted consisted of people authorities considered mentally ill, the poor, homeless, unemployed as well as criminals (12).

For the most part of its history, the aim of the involuntary hospitalization was not to give curative treatment, but rather to provide safety for communities from the mentally ill. From the 18th to the halfway point of the 20th century, psychiatric hospitalization resembled a prison sentence. The treatment methods of the era included e.g. heavy sedation and seclusion, which in today's view are seen rather counterproductive (2).

3.3. The transition from institutionalization to deinstitutionalization and its impact on mental health laws.

In Europe during the late renaissance and early industrialization psychiatrists argued between somatic and psychogenic root causes for mental illnesses. Hysteria was a particularly popular explanation for multiple sets of symptoms. In western countries generally, laws and legislation began to go through a thorough change in the latter half of the 19th century. The new attitude started to focus more on the patient's welfare rather than just shield the society from the mentally ill (1). In Spain the shift in legislation happened from 1980s and 1990s (13). and in Italy from late 1970s. Around that period a new psychopathological term “institutionalization syndrome” surfaced in mainstream psychiatry. It describes a syndrome where a patient admitted for a long period of time begins to suffer additional symptoms not related to original admission cause but the treatment itself. (1) Related symptoms include infantile emotional reactivity, emotional and cognitive regression and apathy towards the world outside of the hospital (3). These symptoms were present with many patients much earlier, but the change in attitudes brought it to limelight. (1)

Before 1850 in The United States of America mentally ill individuals were mainly considered suffering from spiritual deviations and treatment given left them facing grave limitations of human rights. Mental asylums were overflowing with patients and lacking staff. Doctors had no real restrictions concerning their decision-making power. This system produced illegal confinements, treatment methods such as lobotomies and all in all substandard prognoses for the patients (13).

In 1977, the World Psychiatric Association introduced the "Declaration of Hawaii," a code of ethics designed to guide clinical psychiatric practice. The World Health Organization (WHO) advocates for mental health treatments to be as effective as possible, emphasizing that hospitalization should be limited to the duration necessary to manage the risk caused by an acute situation and should only be used as a last resort when no alternative means of treatment are available. The ECHRs stand is that IT must be done always in accordance with Article 3's outlines. Those outlines ban inhuman and degrading treatment (2).

Two principles are the base for most of the contemporary laws governing mental health related issues. Principles: *parens patriae*, which grants the government or governing administration the authority to intervene on behalf of individuals who are incapable of taking care of their own safety or health and police or national security force the power, which is intended to maintain public safety. The state establishes legal provisions to promote welfare and safety to its citizens, and within this framework, involuntary hospitalization represents a compounded issue concerning the extent to which governmental intervention is justified, especially when it entails restricting individual liberty (2).

3.4. Involuntary Hospitalization: Legal and Ethical Foundations

Involuntary or compulsory psychiatric hospitalization can simply be described as a situation where patient is admitted against one´s will. It is one of psychiatry's most controversial topics. Compulsory inpatient treatment is bound to raise clinical, ethical and legal questions. The health care systems struggle often balancing how much forced treatment can be given and in which situations it should take place (14).

Generally, in medicine involuntary treatment can be prescribed under certain circumstances. Involuntary treatment includes some key characteristics which can be uniquely identified compared to regular care. By its nature it also involves restrictive practices ensuring patient safety (11). The circumstances, key characteristics and restrictive practices are listed in Table 2.

Table 2: Common characteristics of involuntary treatment (7)

Conditions under which involuntary treatment is typically applied	I. Patient is severely mentally ill II. Significant threat of harming oneself or another person III. There are no less restrictive measures accessible
Key characteristics of involuntary treatment	I. Coercive nature: treatment prescribed against individuals will II. Legislation framework: Specific law or legislation overseen by governing body III. Risk assessment: Decisions are based on evaluating the individual's perceived risk to themselves or others. IV. Therapeutic goals: The primary objective is to

	stabilize the individual's health and well-being while minimizing the risk of harm.
Restrictive practices	I. Seclusion: Isolating the individual in a secure space. II. Physical restraint: Using physical force to limit movement. III. Mechanical restraint: Applying devices such as straps or belts. IV. Chemical restraint: Administering medication to calm or sedate the individual.

3.5. Coercion

Involuntary treatment constitutes a fundamental form of coercion in psychiatric care, as it involves the examination of a patient and delivering patient to hospital without patient consent. In addition to involuntary hospitalization generally under the laws governing it, coercive measures in mental health settings primarily include the forced administration of psychotropic medication and the restriction of movement through physical or mechanical restraints or seclusion, presented in Table 2 (15). Restriction of electronic communication is one form that is not yet discussed as much; however, it could potentially become more universal in the future. It often entails limitations concerning the use of mobile devices. Limitations on communication may also include reduced visitations from family and friends as well as letters received and sent, however not used very often anymore in developed countries (2). Despite the widespread use of these measures, clear evidence of their long-term impact on treatment outcomes remains lacking in the number of studies and results. The concrete results from research on the

efficacy and ethical implications of coercion in psychiatric care emphasize the need for further investigation into its clinical justification, potential alternatives, and effects on patient well-being (15). It is noteworthy that inside the EU there are no countries where freedom to vote could be infringed during involuntary hospitalization (14).

Among the main forms of coercive interventions, forced medication seems to be the most significant reason causing negative experiences and sentiment towards the treatment. Research indicates that the use of coercion, in general, is correlated with extended hospitalization periods, with seclusion demonstrating a particularly strong link to longer stays. However, this relationship cannot be solely attributed to the severity of a patient's condition at the time of admission, suggesting that other factors related to coercion itself may contribute to prolonged hospitalization. Patients' new and previous diagnoses, social state and the healthcare system are all contributing factors (15).

In closed psychiatric wards situations arise where use of coercive measures is unavoidable. When such cases occur, a justification based on law ought always to be present. Alternative approaches have been explored and found to be ineffective, and the use of coercion is implemented to prevent harm to the patient, other patients, or staff (5).

Marginal use of coercion is of the most important qualitative measures on psychiatric health care, as well as one of the key factors leading to good treatment outcomes among hospital population. Evidence-based methods for reducing the use of coercion emphasize improving the quality of interaction between patients and professionals. The tension and disagreements often associated with psychiatric care can be solved through relatively simple measures where the patient is involved in the discussion and not just informed of the decision, thereby easing the patient's distressing situation (5).

The reduction of coercion is possible, and there are some researched and evidence-based methods to support this goal. However, the existing evidence on effective coercion-reducing interventions remains relatively slim (16). In studies evaluating programs aimed at reducing coercion, outcome measures typically focus on the prevalence of seclusion and restraint. While these interventions represent severe

infringements on patient autonomy and are very important critical indicators, they also leave out a wide range of less severe forms of restriction, which may, from the patient's perspective, be even more significant. One example is the restriction of freedom of movement, which is highly common in Finnish psychiatric care, as nearly all wards providing involuntary treatment operate as closed units. This restricts patients' ability to visit outside freely and can influence negatively one's state of mind (5).

3.6. Ethical and Human Rights Concerns

After World War II, around much of the globe and in almost all western countries, right and welfare of mentally ill have been tried to be protected. Particularly those subjected to involuntary hospitalization have gathered more attention. The United Nations formally recognized fundamental human rights in 1948. Following that the European Convention for the Protection of Human Rights and Fundamental Freedoms in 1950, was stated by the European Council. People are guaranteed liberty and personal safety. It allowed restriction of before-mentioned attributes under certain special conditions. Involuntary detention can be justified if an individual clearly presents with a severe mental illness, substance use disorders, vagrancy, or dangerous infectious disease. Detention needs to follow the letter of law in every step (4).

The Council of Europe has put in effort to make stronger legal protection for the mentally ill in IT. In 1983, the Committee of Ministers established guidelines on this issue (Recommendation R/83/2). In 1994 the Parliamentary Assembly enforced it (Recommendation R1235). 2000 White Paper intended to make further progression. It was developed by the Working Party on Psychiatry and Human Rights. New legal frameworks to safeguard the rights and dignity of involuntarily hospitalized individuals were outlined and brought up. It also contributed by addressing involuntary psychiatric

placements in its work. Internationally the United Nations introduced Principles for the Protection of Persons with Mental Illness (1991, gave common recommendations for daily methods and practice. The WHO established ten fundamental principles for mental health law (1996) (4).

3.7. Alternatives to Involuntary Hospitalization

Avoiding hospital admission whenever possible presents clear advantages, particularly given the high costs resulting from limited hospital bed availability, staffing and other costs associated with inpatient care. IA can also pose significant risks to patients, including institutionalization, dependency, anxiety symptoms from mandatory social contacts and proximity to other patients, being apart from social support networks, potential harm from staff or other patients, loss of employment or housing, and stigma. Additionally, IA may lead to the adoption of maladaptive coping strategies. Some of these negative effects can be reduced or avoided altogether through alternative crisis care settings. Providing outpatient care or treatment from homes setting during psychiatric acute situations offers distinct benefits, such as familiar surroundings, family and relative involvement, everyday chores and activities, creating adaptive coping mechanisms, and promoting a more active relationship between healthcare staff and patients (6).

Offering a variety of crisis services that allow for cooperative decision-making between patients and staff is clearly an advantageous from the standpoint of patient population and staff. Many community-based service models have demonstrated effectiveness compared to inpatient care. For instance, acute day hospitals can treat up to 20% of patients who would typically require admission with a more traditional system, producing comparable outcomes (16). Acute day hospitals generally are a setting where patients visit the ward during regular working hours but spend the night at their homes. The content of the treatment is mostly similar compared to closed ward care, with less

restrictions and most importantly it is based on voluntary agreement between the treatment team and patient. Treatment methods often include single and group therapy, as well as appointments with psychiatrists and nurses (1). In the same way crisis resolution teams have successful. Inpatient admissions and enhanced patient satisfaction have had better results with the crisis teams. The results have been promising, but obstacles have prevented them becoming fully mainstream options in psychiatric acute care. While crisis resolution teams are widely used, they have only been implemented nationally in countries like England and Norway which are outside of the EU, although being in Europe and doing close cooperation with the Union members. In EU countries, according to the cited literature there is no national use of these systems in a particular state. Politically and even for health care professionals these options may present as not that essential part of health care and therefore be given low monetary resources and be first to receive cuts (6).

3.8. Mental Health Systems in the EU

Across the EU there has been a trend preferring outpatient care rather than intensive institutional care. There is extensive variation in the extent of the role of psychiatric hospitals. The EU has officially ratified a de-institutionalist policy. Major pieces of legislation include the Mental Health Declaration for Europe, and the Mental Health Action Plan for Europe in 2005 (15). The action plan emphasized protection of patients' rights and social inclusion. It sited evidence for benefits from deinstitutionalization of mental health services in multiple member states while also acknowledging the current realities of less wealthy countries. In poorer member states and with the huge variety of cultures and their different views on mental illnesses, institutions still had a major role in mental health services (18).

According to the European Counsel the diagnosis for mental illness or disorder should always be done on medical grounds. Therefore, an individual's inadaptability to society's' moral, political or other values, ought not be considered as a diagnostic marker. Whether there is illness should be confirmed though thorough examination (1).

4. Comparative Analysis of Involuntary Hospitalization in the EU

In the EU several different countries have a system in place in which multiple doctors and nurses take part in the hospitalization of an involuntary patient. The respective system aims to minimize infringements on patients' rights and reduce the effect of individuals personal subjective beliefs and opinions. Often the second opinion is given by a psychiatrist, but it is not required in every country (3).

4.1. Finland

The Finnish constitution emphasizes the bodily autonomy and the right of self-determination of an individual. These rights can be limited only under special circumstances and according to the laws under the Finnish mental health act (2).

In Finland, the Mental Health Act prioritizes the general right to access care over individual civil liberties. Involuntary hospitalization is determined based on specific criteria. (see table 4). Notably, meeting the dangerous criterion alone is sufficient to justify involuntary admission. Before a decision is made, the patient's perspective on their need for treatment is considered and documented. Ultimately, the decision to proceed with compulsory hospitalization must be approved by three independent physicians (2).

In Finland IA and IT processes can be summarized in four steps. The steps are shown below (Table 3). The system is built around M-referrals, which require different attending physicians for each one. All the There are three types: observation referral M1, observation statement M2 and IT decision M3. All licensed doctors and medical students with drug prescription rights can make M1. For M2 doctors working directly for psychiatric hospital is required. M3 can only be done by a ward psychiatrist working in a hospital (1).

Table 3: The four steps of IA in Finland (2)

Step I.	M1	GP or ER-doctor, medical student working for the public sector, any licensed doctor
Step II.	Observation	Time period in psychiatric facility under observation, the decision is made by on call doctor of respective ward
Step III.	M2	At the latest on the fourth day of observation, attending gives written opinion if IA is justified
Step IV.	M3	Chief of psychiatry or if not, available attending psychiatrist makes the decision for IT

Table 4: Criteria for the involuntary admission in Finland

I. Presence of a mental illness
II. Serious threat to the individual's health or Dangerousness to others
III Insufficient or unavailable outpatient services

Getting a driver's license in Finland requires a medical assessment. Applicant's health needs to meet the necessary standards to ensure road safety. Certain mental disorders, particularly substance use disorders, and psychotic illnesses may disrupt individuals driving ability severely and it can produce fatal outcomes. In some cases, such impairments may be identified during a period of involuntary psychiatric treatment. The restriction or removal of a driving license is not a direct consequence of IT itself but rather a result of examinations done during the hospitalization. Therefore, the loss of a driving license cannot be considered a long-term consequence of involuntary hospitalization. However, the cancellation of a previously valid license remains a rare occurrence (4).

Table 5: Requirement for an independent medical expert (e.g., psychiatrist not working in the respective hospital) in the compulsory admission procedure of most EU countries (3)

Independent medical expert	Country
Yes	Austria; Belgium; Croatia; Denmark; Estonia; Finland; France; Hungary; Ireland; Italy; Netherlands; Malta; Romania; Slovenia

No	Bulgaria; Czech Republic; Greece; Iceland; Latvia; Lithuania; Poland; Portugal; Slovakia; Spain; Sweden;
Variation inside the country	Germany (varies between states);

Table 6. Categories of independent medical expert responsible for the compulsory admission process (5)

External medical experts	Countries
Psychiatrist	Austria; Belgium; Croatia; Finland; Germany; Hungary; Iceland; Ireland; Israel; Italy; Malta; Netherlands; Romania.
Court expert in psychiatry	Slovenia
Senior medical doctor	France
Medical doctor	Belgium; Denmark; Finland; Italy.

Table 7. Involvement of judges in making the decision about involuntary admission among most of Eu countries (3)

	Countries
Judge involved	Austria; Belgium; Bosnia and Herzegovina; Bulgaria; Croatia; Czech Republic; Estonia; France; Germany; Greece; Hungary; Iceland; Italy; Latvia; Lithuania; Netherlands; Poland; Portugal; Romania; Slovakia; Slovenia; Spain.
No judge involved	Denmark; Finland; Ireland; Malta; Sweden

4.2. Spain

The Spanish health care system is divided into 17 different systems according to the region their respective autonomous provinces. Each province has the responsibility to provide services for its communities. On a national level, mental health act is non-existent. The government was advised against it in the 1980s, Significant pieces of legislation include The Civil Procedure Act of 2000 and Act 41/2002. Ley de enjuiciamiento civil of (2000) oversees IA of the mentally ill when incapable of sound decision making. IA demands a preceding mandate from a judge apart from emergencies when the authorization can be applied 24h afterwards. Act 41 regulates autonomy, rights

and duties, except for emergencies and when there is risk for others, or a patient is incapacitated for decision-making (18). The law also requires attending physicians to file a report every six months and within shorter intervals if the courts have deemed it necessary. This is established in article 763 and it aims to enhance oversight concerning IH of the mentally ill (19).

In Spain the decision for involuntary hospitalization does not require the assumption of danger and decision can be made based on “need for treatment”. In Spain there also isn’t specified maximum period for the involuntary hospitalization by the law (Table 7). In Spain a temporary cessation of treatment can take place, for therapeutic or rehabilitory reasons. This applies also in the following EU countries: Belgium, Finland, France, Germany, Ireland, the Netherlands (20).

4.3. Germany

Germany as a nation is a federation of 16 states which in part have their own legal frameworks. In Germany regulations around coercive psychiatric treatment methods and constrictions are overseen by the guardianship legislation (Betreuungsrecht). It is a federal law and valid in all the states and can be compared to mental health acts in other nations (e.g. Finland) (10).

IA admission approaches vary among states. Diversity among the procedures takes place with the initial admission period and with the expertise needed for lawful

admission, as a demonstration. There are differences between maximum time (Table 7) and the requirement of independent expert (Table 5).

In 2018 Germanys' constitutional court ruled that the use of mechanic restraint can be considered as the most inhibitive method of restraint, therefore the use of it needs to be sanctioned by a judge, if continued more than half an hour (21).

State commitment laws specifically state that local authorities as the only entities authorized to apply for an involuntary placement order. Under the national guardianship law, only the legal guardian of the individual concerned has the right to submit such an application. Once an application has been filed, a medical assessment is required to verify that the criteria for involuntary admission are met. In most states, legislation mandates that these assessments be conducted by trained psychiatrists; however, in certain federal states, evaluations may also be carried out by physicians without specialized training in psychiatry. Based on the expert's evaluation, a judge issues the compulsory admission order, although judicial discretion allows for decisions that may deviate from the expert's testimony (4).

Table 8: Differences between IA procedures among three respective EU countries (4)

Country	Max. time (days)	Maximum duration of initial placement	Reapproval time points
Germany	Varies between states (1-14 days)	Preliminary detention, 6 weeks; regular placement,	Preliminary detention, 6 weeks; regular placement,

		12 months; in obvious cases, 24 months	6 months (Saarland only
Finland	3	9 months	3 months
Spain	Not defined	Not defined	6 months

Table 9: Differences between involuntary treatment legislations among the respective Eu countries for emergency Cases (4)

Country	Max. duration of short-term detention	Authorities for short-term detention
Germany	24 hours (15 federal states); 3 days (1 federal state)	Municipal public affairs office or psychiatrist
Finland	Regular procedures also in emergency cases	Psychiatrist or licensed doctor
Spain	24 hours	Psychiatrist

5. Discussion

IH remains a contentious yet essential component of psychiatric care, necessitating a careful balance between patient rights, public safety, and medical necessity. EU countries have an abundance of rules and regulations overseeing IH and it could argued that overall, the EU-area as a whole has one of the best systems in the field. However, all the systems have their strengths and weaknesses.

Comparing between involuntary care systems can be hard at times, when attempting to distinguish key factors affecting the process and criteria. Maybe the greatest variation among the three respected evaluated in this literature review was seen amid; legal frameworks, role of justice system, access to alternatives and medical decision making (Table 10). Clear variance can be detected where each country's system puts more importance or weight on.

Legal frameworks governing IH vary considerably which reflect differing national priorities. They differ regarding autonomy, medical practice and judicial involvement. Finland relies to a Mental Health Act. The act prioritizes medical decision-making through a multi-step evaluation process involving at least three physicians. This approach ensures comprehensive clinical assessment. At the admission stage legal oversight is practically non-existent apart from the standpoint that doctors act as officials in this matter (1). In contrast, Germany has the decentralized system where each federal state is mostly free to dictate specific IA criteria. This freedom obviously leads to procedural variations and in some cases inconsistency. Judicial oversight has a great role in most German states. Judges are making final admission decisions based on psychiatric assessments and while considering the other aspects (14). Spain lacks a dedicated national mental health law. Spanish rely instead on general civil legislation that mandates judicial authorization for all IH cases, except in emergencies (12). This court-centered model ensures good legal protections but may seriously delay necessary psychiatric emergency care.

Another point of differentiation is the role of the justice system. Finland’s physician-led model guarantees relatively quick intervention by minimizing legal barriers to hospitalization. As stated before, the system lacks immediate judicial review, relying instead on post-admission appeals. This system in theory ensures patients the right to fair appeal, but in practice an individual can be hospitalized for at least three months before the appeal is even processed. The slow paced and bureaucratic appeal process

seems to be one of the biggest flaws in the Finnish IT care system. However, cases of patients spending months in a closed ward or receiving forced medications without proper indications are extremely rare.

Germany integrates legal oversight more prominently, with judges playing a key role in IA authorization, thereby strengthening procedural safeguards. However, this model risks delaying urgent treatment when immediate psychiatric intervention is needed. Patients may have to wait for necessary treatment due to the bureaucratic steps or just to get the process forwards if there is a lack of proper officials. Night-time and holidays can cause major insufficiency with staffing and especially with an overcrowded judicial system. The strong role of judge in Germanys system, can also be questioned. When a consulting doctor presents the case to the court, does a judge have the professional knowledge to undermine physicians' opinion, or if a doctor is making recommendation on wrong indications, do the courts have expertise to notice that either.

Spain’s approach places the responsibility for IH decisions on both psychiatrist and judges, but major responsibility is put on the courts, trying to ensure legal scrutiny but potentially slowing access to care due to procedural constraints. All the involuntary hospitalizations need to approved by an appropriate judge. Exceptions can be made in cases of serious emergencies; however, they must be reported to a judge within 24 hours and ratified within 72 hours. The role of the judge is not simply to approve and ratify what psychiatrist recommends but consider critically the medical evaluation and hear court appointed physician, if necessary, before making a decision (22). The patient has also the right to appeal against the initial decision with legal representation. Spanish system safeguards patient rights strongly and guarantees clear chance to appeal in, individual is unhappy with the decision. On the other hand, a flaw with the manner of approach can be argued as well. The strong power of the courts and patients' ability to bring legal representation in early stage could make hospitalization of seriously ill patients without sense of illness. Problems may occur, for example because a judge is not medically

trained to examine psychotic symptoms, and an attorney doesn't necessarily recognize if an individual is capable of sound decision making. These variations follow broader European trends, where countries such as Austria, Belgium, and France require judicial authorization, while others, including Nordic countries, lean towards a more medicalized process.

The criteria for IH also have great differences. Finland requires an official psychiatric diagnosis, a significant risk to the individual or others, and a lack of viable outpatient care. This inclusion of dangerousness as a standalone justification highlights a preventive approach to mental health crises. Germany's criteria, while similar, differ by state, with varying standards for reassessment and discharge. Spain, on the other hand, follows a treatment-necessity model, where IA can be justified solely on the need for psychiatric care, without requiring dangerousness as a prerequisite. This aligns with other European countries that prioritize access to treatment over risk-based justifications.

The unique role of judicial intervention in psychiatry, as opposed to other medical specialties, has its foundation from the restrictions of liberty associated with IH. In this area of psychiatry, unlike other areas of medicine, where physicians independently determine treatment plans. Psychiatric involuntary treatment involves coercion, demanding legal oversight to protect individual rights. Spain's model exemplifies this legal-medical intersection, ensuring external review but potentially undermining the ability of psychiatrists to act swiftly in emergencies. Finland's approach, where psychiatric professionals retain primary decision-making authority, aligns more closely with general medical practice but may limit external supervision. Germany's hybrid system tries to balance legal and medical authority but is complucated by regional disparities in implementation.

Ultimately, the comparative analysis highlights the complexities of regulating IH while trying to uphold patient rights and ensure timely access to psychiatric care. Spain's judiciary-centric approach provides strong legal protections but may delay urgent treatment. Finland's physician-led model facilitates quick intervention but relies heavily on internal medical safeguards, which can be considered risky due to professional loyalty among them. Germany's decentralized system attempts to integrate both perspectives, yet its variability raises concerns about standardization and equity in patient outcomes. These differences highlight the obstacles and challenges of designing IH frameworks that harmonize legal protections with medical efficacy, emphasizing the need for continued evaluation and potential harmonization of European mental health policies.

Table 10: The differences of the legal framework and admission staff requirements of three respected countries

Country	Legal framework	Role of Justice system	Access to Alternatives	Medical Decision-Making
Finland	Mental Health Act; clear involuntary admission criteria	Judges oversee appeals but do not initiate admissions	Limited community alternatives available	Three-doctor system required for involuntary admission
Germany	State-specific laws, some variation in criteria	Judges play a significant role in approving detention	Community-based crisis care more developed than in Finland or in Spain	Psychiatrists required to conduct assessments, but general doctors may also be involved
Spain	Judicial oversight is	Judges often required to	Limited alternative	Mental health professionals

	stronger than in other countries	approve and oversee hospitalization	crisis care options	make initial recommendations, but courts have final authority

6. Conclusions

Involuntary hospitalization is a complex topic which has and probably will spark controversial dialogue among the medical professionals, legal experts, human and patient rights advocates as well as the general public. It is an extreme yet at times vital treatment method, when necessary, given that it is applied and timed correctly. Criteria and legal frame vary greatly around the world, which is quite rare compared to many other medical treatments. The EU has 27 member states and jurisdictions differ from country to country and even from province to province. There is no defying answer which country has adopted the most efficient system if its multiple layers are critically discussed. When comparing the systems, focus should be divided among several factors treatment outcomes, patient and staff satisfaction, legal standpoint and human rights. Each system has its own strengths and weaknesses depending on which direction the system has evolved in accordance with the priorities set by legislators and the medical community of each country, while also taking into account the nation's culture and shared values. Currently admission procedures vary greatly among EU countries, and this hinders accurate comparisons between systems related to scientific studies on treatment efficacy and outcomes. Unifying treatment criteria and admission procedures on EU-level could benefit patients and medical personnel in the future.

References

(1) *J., Lönnqvist, M., Henriksson (*8.12.2023). Tahdonvastainen hoito, Kustannus Oy Duodecim- Psykiatria

(2) Saya, A., Brugnoli, C., Piazzi, G., Liberato, D., Di Ciaccia, G., Niolu, C., & Siracusano, A. (2019). Criteria, procedures, and future prospects of involuntary treatment in psychiatry around the world: a narrative review. *Frontiers in psychiatry*, *10*, 271.

(3) Wasserman, D., Apter, G., Baeken, C., Bailey, S., Balazs, J., Bec, C., ... & Vahip, S. (2020). Compulsory admissions of patients with mental disorders: State of the art on ethical and legislative aspects in 40 European countries. *European psychiatry*, *63*(1), e82.

(4) Salize, H. J., Dreßing, H., & Peitz, M. (2002). *Compulsory admission and involuntary treatment of mentally ill patients: Legislation and practice in EU-member states* (p. 15). Mannheim, Germany: Central institute of mental health.

(5) Kuosmanen, L., & Laukkanen, E. (2019). Pakon käytön vähentäminen psykiatrisessa sairaalahoidossa.

(6) Lloyd-Evans, B., & Johnson, S. (2019). Community alternatives to inpatient admissions in psychiatry. *World psychiatry*, *18*(1), 31.

(7) Kovess-Masfety, V., Boyd, A., Van de Velde, S., De Graaf, R., Vilagut, G., Haro, J. M., ... & EU-WMH investigators. (2014). Are there gender differences in service use for mental disorders across countries in the European Union? Results from the EU-World Mental Health survey. *J Epidemiol Community Health*, *68*(7), 649-656.

(8) Killaspy, H., Cardoso, G., White, S., Wright, C., Caldas de Almeida, J. M., Turton, P., ... & King, M. (2016). Quality of care and its determinants in longer term

(9) Danzer, G., & Wilkus-Stone, A. (2015). The give and take of freedom: The role of involuntary hospitalization and treatment in recovery from mental illness. *Bulletin of the Menninger Clinic*, *79*(3), 255-280.

(10). Hotzy, F., Marty, S., Moetteli, S., Theodoridou, A., Hoff, P., & Jaeger, M. (2019). Involuntary admission for psychiatric treatment: Compliance with the law and legal considerations in referring physicians with different professional backgrounds. *International journal of law and psychiatry*, *64*, 142-149.

(11). Fariba, K. A., & Gupta, V. (2020). Involuntary Commitment.

(12) Walker, S., Mackay, E., Barnett, P., Rains, L. S., Leverton, M., Dalton-Locke, C., ... & Johnson, S. (2019). Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis. *The Lancet Psychiatry*, *6*(12), 1039-1053.

(13) Hernández-Viadel, M., Cañete-Nicolás, C., Bellido-Rodríguez, C., Asensio-Pascual, P., Lera-Calatayud, G., Calabuig-Crespo, R., & Leal-Cercós, C. (2015). Involuntary outpatient treatment (IOT) in Spain. *International journal of law and psychiatry*, *41*, 31-33.

(14) Georgaca, E., Machaira, S., Stamovlasis, D., Peppou, L. E., Papachristou, C., Arvaniti, A., ... & Vlachaki, A. (2023). Clinical determinants of involuntary psychiatric hospitalization: A clinical profile approach. *Journal of Clinical Psychology*, *79*(9), 2081-2100.

(15) U McLaughlin, P., Giacco, D., & Priebe, S. (2016). Use of coercive measures during involuntary psychiatric admission and treatment outcomes: data from a prospective study across 10 European countries. *PloS one*, *11*(12), e0168720.

(16) Marty, S., Jaeger, M., Moetteli, S., Theodoridou, A., Seifritz, E., & Hotzy, F. (2019). Characteristics of psychiatric emergency situations and the decision-making process leading to involuntary admission. *Frontiers in psychiatry*, *9*, 760

(17) Flammer, E., & Steinert, T. (2015). Involuntary medication, seclusion, and restraint in German psychiatric hospitals after the adoption of legislation in 2013. *Frontiers in psychiatry*, *6*, 153

(19) Lázaro-Mateo, J., Soldevila-Matias, P., & González-Ayuso, V. (2023). Internamiento involuntario vs. retención ilegal en pacientes con trastorno mental grave. *Papeles del psicólogo*, *44*(1), 22-27

(20) de Stefano, A., & Ducci, G. (2008). Involuntary admission and compulsory treatment in Europe: an overview. *International Journal of Mental Health*, *37*(3), 10-21.

(21) IFlammer, E., Eisele, F., Hirsch, S., & Steinert, T. (2022). Increase in coercive measures in psychiatric hospitals in Germany during the COVID-19 pandemic. *PLoS One*, *17*(8), e0264046.

(22) Serra, M. L. (2025). ‘If someone had stopped to talk to me’: A human rights analysis of Spain's mental health system. *International Journal of Law and Psychiatry*, *99*, 102069.