

Title: Feelings experienced at hospital admission by Inpatients Involuntarily Admitted
Under Japan's System of Psychiatric Care

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Abstract

Background & Aims: The purpose of this study was to gain insights into how patients experience involuntary admission under Japan's system of psychiatric care. To this end, patients who had been involuntarily admitted and were scheduled for discharge were interviewed about their experiences at hospital admission to clarify the feelings of such patients' experience on the day of admission.

Method: Semi-structured interviews were conducted among 12 inpatients who had been involuntarily admitted to the hospital and consented to participate. The interview data was analysed qualitatively and descriptively.

Results: Feeling of involuntary admitted patients were summarised into five thematic categories: [Life/work commitments are bigger priorities than admission], [Surprise and anger at being deceived by family], [Recognising one's emotionally driven behaviour], [Resigning to and accepting intangible exogenous forces], and [Unconvinced of explanation by health care professionals on admission].

Conclusion: Even after visiting to the hospital, patients remained clearly committed to their life/work, which were their bigger priorities than admission. The patients also felt that they had been deceived by their family. Issues regarding decision-making regarding hospitalization emerged. As they were aware of their own situation, they resigned to and accepted the inpatient treatment. As an initiative for outpatients at the time of non-voluntary hospitalisation, our results suggest that support is required for deciding treatment plans while sharing the opinions of both patients/family members and health care professionals while respecting what is important for the patients.

Keywords:

Psychiatric care, involuntary admission, at hospital admission, patients' feelings

I Introduction

According to a 2017 report by Japan's Ministry of Health, Labour and Welfare,¹ the number of psychiatric patients in the country has exceeded 4.19 million, of which 270,000 are hospitalised in psychiatric units. Another report by the Ministry highlighted issues that must be addressed to promote the transition to community-based care.² The issues to be addressed by a new community-based mental healthcare system include how to: 1) ensure that communities can care for psychiatric patients, 2) ensure that the healthcare system covers the diverse needs of these patients, and 3) increase functional differentiation in psychiatric units.² All three issues remain outstanding.

Of particular importance is the third issue, the functional differentiation of psychiatric units. Hirata (2013) analysed shifts in emergency psychiatric units legally established under a 2002 law: As of 2013, the number of these units had risen to over 100 since the first was established in 2002.³ This finding denotes a sharp rise in these units, which are informally known as 'super emergency wards'. Alongside this trend, the number of psychiatric patients kept in seclusion increased by 30% in the decade from 2004 to 2014. Over the same period, the number of patients subjected to physical restraint more than doubled. Moreover, involuntary admission accounts for 33% of psychiatric admissions in Japan, compared to the European average of 12.1%. Since 2000, only Japan has seen a sharp increase in the rate of involuntary admission.

In Japan, projects on health outreach and community-based comprehensive care are being actively undertaken, but they are still in the process of developing. The national guideline is to be improved with regard to the response of acute exacerbations of persons with mental disabilities and outpatient care. In reality, patients have no intention of receiving medical treatment, that is, inpatient medical care in a non-voluntary manner is the main response to acute exacerbations of mental illness.

The literature on involuntary admission in Japan has explored the issue from perspectives such as medicine, law, human rights, and ethics. Of these, the protection of human rights has been highlighted as a particularly problematic aspect of involuntary admission.⁴ Studies have also examined nurses' attitudes on the topic. One of these studies revealed the stress experienced by nurses working in emergency psychiatric units,⁵ while another revealed the confusion and anxiety experienced by those new to emergency psychiatric care.⁶ However, only four medical studies in the past 10 years have examined the perspectives of patients and families. Ito (2011)⁷ highlighted the problem of how to connect patients with medical services when they refuse to see a doctor. He also argued that the perspective of the psychiatric patient is often ignored. After interviewing psychiatric patients, Ogino⁸ identified ethical issues in psychiatric care concerning relationships and noted that patients require opportunities to make self-determined decisions. Kajiwara and Endo (2017)⁹ examined the initial stages of the psychiatric nursing process from the perspective of both nurses and patients. They found that interventions performed against the patient's will be perceived as coercive by the patients and that this runs counter to the principle that patients should positively appraise the experience of care. The authors concluded that the patient's autonomy should be respected while ensuring safe treatment.

As for the literature outside Japan, Wynn (2018) conducted a systematic review of articles on involuntary admission into Norwegian facilities.¹⁰ He reviewed 74 articles and arranged them into six thematic categories, one of which was 'patients' experiences, satisfaction, and perceived coercion'. The results suggested that involuntarily admitted patients perceive the involuntary admission as coercive. However, the literature Wynn reviewed reflected the particularities of Norwegian legislation and Norwegian health services, meaning that the findings may not be directly applicable to psychiatric care in Japan. In an Irish study, O'Donoghue et al. (2009)¹¹ interviewed 81 involuntarily admitted

patients and found that 86.4% of them were aware that they had been admitted involuntarily. Therefore, whereas the international literature has shown interest in the attitudes of involuntarily admitted patients, this perspective has been largely ignored in the Japanese literature. Moreover, Japan's system of psychiatric care differs in some ways from those of other countries, making general comparisons difficult. Accordingly, it is necessary to gain more data on involuntary hospital admission and treatment in Japan.

Therefore, the purpose of the present study was to gain insights into how patients experience involuntary admission under Japan's system of emergency psychiatric care. To this end, we asked individuals who were involuntarily admitted, either by administrative order (*sochi nyūin*) or under the auspices of medical care and protection (*iryō hogo nyūin*), and who were subsequently scheduled for discharge, to recall their experiences at hospital admission to clarify the feelings such patients experience on the day of admission.

II Methods

1. Nomenclature

1.1 Involuntary Admission

Admission of patient to the hospital without his/her consent, according to Articles 29 and 33 of the Mental Health and Welfare Act (the abbreviated title of the Act on Mental Health and Welfare for Persons with Mental Disabilities), provides for four categories of involuntary admission: admission for medical care and protection (*iryō hogo nyūin*), admission by administrative order (*sochi nyūin*), emergency admission (*ōkyū nyūin*), and admission by administrative order for crisis stabilisation (*kinkyū sochi nyūin*).

1.2 Admission

A process that begins the moment the patient first checks into a hospital and ends when the patient is admitted to a psychiatric unit. This period does not include transportation time.

2. Research Design

This study adopted a qualitative, descriptive design.

3. Data Collection

3.1 Participants

This study was conducted with individuals who had been involuntarily admitted, either by administrative order (*sochi nyūin*) or under the auspices of medical care and protection (*iryō hogo nyūin*), and who fulfilled the following eligibility requirements:

- Does not have dementia.
- Regardless of gender, aged at least 20, the age of legal adulthood in Japan had been admitted to a secluded unit.
- Regardless of how he/she was accompanied to hospital (by family, police, or private or public emergency services).

- Residing in a general psychiatric unit (as opposed to a secluded unit).
- Capable of managing their medication themselves.
- Permitted to go outside the hospital grounds.
- Have been scheduled.
- Be able to recall their experiences at hospital admission and discuss their experiences on the day of admission.
- Has the permission of their principal doctor to participate in the interview.
- Lived at home before hospitalisation.

3.2 Study period

The study was conducted from January 2015 to May 2017.

3.3 Methods

Semi-structured interviews were conducted using an interview guide. In the interview, researchers with more than 10 years of clinical experience in psychiatry conducted one-on-one interviews with research participants. Since the participant may remember during the interview something that he/she does not want to remember, the researcher stopped the interview immediately in the case the participant feels sick, to minimize the burden on the participant. In order to do so, the interview time was not extended, and considering the risk of relapse of symptoms of the participants, an attending physician was staying in the ward at the time of the interview. Recording was performed on an IC recorder using an interview room in the ward where privacy could be ensured, with consents from participants. Data were also collected by writing down about the observations during the interviews when needed. This time, since 2 out of 12 people did not agree to the recording, it was recorded in handwriting. The interviewees were prompted to discuss the topic freely with three questions: 1) Could you recount your experiences in the time leading up to your admission? 2) How did you feel during that time? 3) What do you

think should be improved?

4. Analytical Method

The purpose of this study was to analyse the nature of involuntary admission as experienced by patients in emergency psychiatric care. The study therefore required an analytical method that could qualitatively interpret and describe the meaning of patients' experiences and feelings. Sato's case-code matrix¹² was adopted on the basis that it is effective and capable of accurately deciphering both the patients' narratives themselves and the contexts surrounding them. The case-code matrix involves the following processes. A verbatim transcript of the interview is read repeatedly and qualitatively coded. Next, sections of text are classified according to meaning and content. Where multiple sections share the same meaning or content, these sections are classified as a single qualitative code (like a heading) to form segments of text. Segments of text grouped under the same code are then arranged to form a matrix chart. Referring to this matrix chart, the researchers analyse the similarities and differences between the codes and sections of text, making corrections as necessary. Finally, qualitative codes similar to each other are grouped together into subcategories. These subcategories are then grouped into core codes (categories). The relationships between categories were examined and schematized with respect to the flow of admission process.

To ensure objectivity, the categories were generated by the researcher with three co-researchers (one of whom is a designated mental health doctor). To ensure accuracy, a pre-interview was conducted, then the interview content and method were reviewed and amended as necessary. To ensure faithfulness, the transcripts were read multiple times, and the process of grouping and interpreting the data was supervised by a researcher experienced in qualitative research. Decisions were reached after consensus between all the researchers.

5. Ethical Considerations

This study was approved, following a review of the proposal, by the ethics committee of the participating institution. The participants were informed verbally and in writing of the following: 1) that they were free to choose whether to participate in the study, 2) that they could decline to participate or withdraw midway through the study, and 3) that they would not be penalised in any way as a result of declining to participate or withdrawing midway. After being informed of these matters, those consenting to participate signed a consent form. The audio recordings of the interviews were stored in a locked location. The names of the speakers were anonymised in the transcript. The study was also approved, following a review of the proposal, by the ethics committee of The Jikei University School of Medicine (No. 30-061: 9082).

III Results

1. Participants' Basic Attributes

Table 1 shows the basic attributes of the 12 participants. Regarding the age breakdown, the 40-49 range represented the largest share (five participants), followed by the 30-39 range (four participants). The gender breakdown was roughly even between men and women.

Insert Table 1: Participants' Basic Characteristics

2. Categories Generated

After extracting and analysing content concerning the participants' experiences and feelings following admission, 100 codes, 22 subcategories, and five categories we extracted. Table 2 shows the categories. Herein square brackets indicate categories, angle brackets indicate subcategories, and inverted commas indicate qualitative codes.

Insert Table 2: Participants' Feelings At Hospital Admission

3. Narratives

The participants' feelings at hospital admission were represented by the following five categories: [Life/work commitments are bigger priorities than admission], [Surprise and anger at being deceived by family], [Recognising one's emotionally driven behaviour], [Resigning to and accepting intangible exogenous forces], and [Unconvinced of explanation by health care professionals on admission].

3.1 Life/Work Commitments are Bigger Priorities than Admission

This category consisted of four subcategories: <Things that are more important than admission>, <Work problems that admission entails>, <Unable to handle life commitments due to admission>, and <Feeling that one had been managing life well>. The patients who experienced involuntary admission gave statements such as the following: 'My family can step in without delay, but deadlines are fast approaching', 'I want to be

with my dog’, ‘What really mortified me was missing my appointment with a friend scheduled for the day of admission’, ‘As head of my alumni association, I felt guilty at having to cancel the reunion meeting’, ‘I wanted to celebrate Granddad’s birthday’, ‘I couldn’t even take phone calls,’ and ‘The sudden admission ruined one important plan after another’. These narratives indicate that the patients, even after admission, felt that they had more important things to concern themselves with than admission. During the admission process, the patients experienced the following feelings: The staff doesn’t deal with me, but my family is stealing my money and I’m in great trouble in my life. Other narratives included the following: ‘I lost my job as a result of admission’ and ‘My job’s on the line if I don’t get out of here in three months’. Admission to hospital was also associated with the feeling that it created ‘misunderstandings about me’. The participants believed they were ‘sane and ready to live in the community’ and, ‘until admission, living normally with advice from a friend’; yet, their situation was apparently not respected.

3.2 Surprise and Anger at Being Deceived by Family

This category consisted of three subcategories: <Surprise at being deceived by family>, <Anger towards parents>, and <Anger at violation of human rights (desiring for legal recourse)>. The patients gave statements such as the following: ‘I was reeling from the surprise; my wishes were ignored’ and ‘I felt that my human rights were violated’. In response, one patient tried to seek legal recourse, going so far as to demand ‘access to a third party (lawyer) immediately’. These and other narratives indicated that the surprise the patients experienced at being tricked into admission by parents or other family members soon gave way to anger. Despite ‘having made plans on the day of admission’, a patient ‘ended up getting tricked by family into getting an evaluation’. At hospital admission, the patient was ‘astonished to see my parents ahead of me at the outpatients’ and even more ‘looked different from how they normally did’. Though unconvinced of the need for

admission, the patient ‘could not really take action against my family’. One patient, on ‘discovering that my family had been consulting with the doctor without my say in the matter’, felt that the family ‘had disregarded me and duped me into being admitted to hospital’.

3.3 Recognising One’s Emotionally Driven Behaviour

This category consisted of six subcategories, which included <Having knowledge based on experience>, <Recognising one’s manic state>, and <Was in emotional disarray>. The patients recalled their abnormal behaviour, saying that ‘I was being incoherent’ and ‘I kept spouting gibberish’. One patient reported knowing at the time of admission that ‘making a commotion around the entrance would result in me being admitted by administrative order. The patients recalled how they were ‘in emotional disarray’ and were ‘talking abnormally’. One patient mentioned that he/she was ‘so manic that I couldn’t sense my (imaginary) world’. The situation was such that the patients expressed the following feelings: ‘I felt a little more manic than normal’, ‘At hospital admission, I couldn’t control myself’, ‘I grabbed onto the health care professionals’, ‘I was over the top’. Other feelings included the following: ‘I had a manic episode when a large group of nurses surrounded me in outpatients, ‘I lost it when I realised that this wasn’t the hospital I thought it was’, and ‘I was not all there’.

3.4 Resigning to and Accepting Intangible Exogenous Forces

This category consisted of five subcategories, including <Taking issue with the very idea of involuntary admission>, <No way back>, and <Accepting the inevitability of admission>. The patients expressed feelings such as the following: ‘At hospital admission, I felt it would be futile to resist, so I didn’t put up a fuss’, ‘I have no memory of resisting at hospital admission’, ‘I wasn’t really opposed to going to hospital per se’, and ‘I gave up and signed, as the paramedics wouldn’t go back otherwise’. Other recollections of

resignation included the following: ‘They might explain my symptoms, but without sensing the symptoms myself, I would just have to accept it’, ‘I wanted to be convinced of the reasons for my admission’, and ‘I just don’t get it; why don’t they accept what I’m saying?’. One patient recalled that ‘refusing and resisting led the nurses to surround me en masse’, causing the patient to accept ‘that I would be inside for three months’. The patient felt ‘treated like a criminal’ and ‘like I was being put in prison’.

3.5 Unconvinced of Explanation by health care professional on Admission

This category consisted of four subcategories: <Wanting to be treated the same as others are>, <The doctor’s explanation was polite and thorough but unconvincing>, <Wanting to break free from being surrounded by nurses>, and <Wishing to have heard the truth, not lies>. One patient remarked that the ‘doctor explained in a sensitive way’ but that his explanation was ‘inadequate’ and that ‘he should have considered the condition and justified why the admission was necessary’. Another patient said, ‘I was entirely unconvinced of the doctor’s explanation of the condition and diagnosis’. One patient said, ‘I was aghast when they told me at outpatients that I would be admitted’, which led to ‘a suspicion that I was being lied to’. Additionally, one patient said ‘I would have accepted it had the paramedics told me the truth (that I would be admitted), not lies’ and that ‘I wanted honest answers, even for small matters’.

3.6 Relationships Between the Five Categories

Figure 1 shows the schema of relationships between the five categories illustrating the emotional process involuntarily admitted patients undergo at hospital admission.

Insert Figure 1: Relationships Between the Five Categories

The cup shows the inside of the patient’s heart. The underlying sentiment is that one’s [Life/work commitments are bigger priorities than admission]. It represents the

patients' perceptions of themselves— that they were fulfilling the basic requirements to function as adult members of society.

Then, in the process of admission, the following three feelings arise: [Surprise and anger at being deceived by family], [Recognising one's emotionally driven behaviour], and [Unconvinced of explanation by health care professionals on admission]. These three feelings shake about and form a volatile mixture in the patient's mind. The exact way they mix and play out depends on the person in question, but, as a general pattern, the person feels deceived by the family and recognises their emotionally driven behaviour, and this emotional maelstrom culminates in a sense of resignation amid the overwhelming forces at outpatients. These three categories emerge from the base category— the importance the patient places on life and work commitments. Some of the patients evidently wanted to return to their normal lives and were seeking a way out. With such sentiments, these patients felt subjected to intangible, exogenous forces and therefore felt unable to accept any explanations from staff. The patients did also try to put their feelings in order and look at the situation dispassionately. However, this was insufficient to make them feel convinced by the explanations.

IV Discussion

From the interviews with the involuntarily admitted patients on their experiences at hospital admission, 22 subcategories, and five categories were extracted regarding the patients' feeling on admission. Discussed below are the implications of the five categories, and the relationships between the categories.

1 . Implications of the Five Categories

1.1 Life/Work Commitments are Bigger Priorities than Admission

According to the interview data, the patients believed that they had been successfully managing their daily lives (<Feeling that one had been managing life well>) and that this fact was not respected at hospital admission. To the patients, the admissions were unexpected. Systems of involuntary admission exist in Europe too, but rates of such admission per million people are two digits lower than in Japan. In other countries, it seems that psychiatric patients are rarely admitted involuntarily.¹³ Around 60% of the participants had schizophrenia, and the sample was relatively young, with those aged 30-49 representing the largest share. Being in middle adulthood, they were part of the working-age population. Hence, while some would experience symptoms such as auditory hallucinations and delusions, all of them had been living their lives in the community. It is unsurprising, then, that they should prioritise work over admission, resulting in the category [Life/work commitments are bigger priorities than admission]. This finding underscores the importance of one of the clauses in the UN's principles for the protection of persons with mental illness and the improvement of mental healthcare: that 'all persons with a mental illness, or who are being treated as such patients, shall be treated with humanity and respect for the inherent dignity of the human person'. In light of this principle, the patients' insistence that [Life/work commitments are bigger priorities than admission] means that the patients also have a normal life as a person, and they value them. Involuntary

hospitalisation is based on these assumptions, which require sufficient consideration for conducting such treatment.

1.2 Surprise and Anger at Being Deceived by Family

Much of the shock the patients experienced seemed to be stemmed from the behaviour of their family; they gave statements suggesting that the family ‘had been consulting with the doctor without my say in the matter’ and were ‘ahead of me at outpatients’. It is nevertheless worth considering the perspective of the family members who had lived with the patients. A study by Tanaka and Nakagawa (2008) revealed that such family members experience various forms of mental strain. They also revealed that the families harbour hope for the patient (in the authors’ English abstract, this is expressed in the category [Existence of hope]) while making an effort to make allowances for practical realities.¹⁴ Therefore, it is likely the families acted out of desperation, believing there was no other option for ensuring the patient’s best interest than to get the patient into hospital, even if it meant deceiving them. Given such sentiments, the involuntary admissions were arguably unavoidable. However, the sentiments themselves have seemed a product of Japan’s inadequate support system for families. As a consequence of their families’ actions, the patients felt <Anger at violation of human rights> in that their wishes were not respected. This anger resulted in a desire for legal recourse, with one patient demanding ‘access to a third party (lawyer) immediately’. On the other hand, there were also signs of consideration towards the family (‘I cannot really take action against my family’). The patients, it seems, experienced an unexpected emotional turn in their astonishment and subsequent anger at being duped into hospital by trusted family members. One participant felt that the family ‘had disregarded me and duped me into hospital’. This sentiment, too, was triggered by the admission, forming another component of the [Surprise and anger at being deceived by family] the patient had long trusted. These findings, coupled with data

indicating that 28% of involuntary admissions harm the patient's family relationships,¹¹ underscore the need to provide family support as part of emergency psychiatric care. They also highlight the human rights issue of planning admission in a clandestine way, without informing the patient. We have found that there are challenges in patient decision making.

1.3 Recognising One's Emotionally Driven Behaviour

Our results revealed that some of the patients, while acknowledging their impulsivity at hospital admission ([Recognising one's emotionally driven behaviour]), also recognised that family and health care professionals had deceived them. Inpatient care undoubtedly offers a benefit to patients in terms of improving their symptoms. Since patients with mental illness may lack the ability to consent to inpatient treatment, the paternalism model, which medical professionals decide their treatment plans, overrides the patients' wishes in some cases. This is unavoidable in the event of an emergency, which requires an immediate decision. The neurological domain includes psychomotor ability, cognitive processing, and memory. The participants experienced symptoms of psychomotor agitation. Of these, they recognised that they were experiencing mania (<Recognising one's manic state>) and exhibiting abnormal behaviour at hospital admission. Patients were able to talk about how they felt once the symptoms calmed down. To support patients to make decision at the time of admission, if the environment is created to allow the patients express what they aware of and convey the situation/circumstance to health care professionals, the patients may less likely be hurt.

1.4 Resigning to and Accepting Intangible Exogenous Forces

The subcategory <Feeling imprisoned> likely reflects the participants' basic attributes: Three of the 12 participants had been admitted by administrative order. Once they arrived at outpatients, the patients felt trapped, having <No way back>. They felt powerless in the face of overwhelming force ('refusing and resisting led the nurses to

surround me en masse’). They even saw their family members as part of the overwhelming forces. It is likely that the patients felt cornered and isolated. Feeling ‘treated like a criminal’, they gave in and allowed the forces to take them away. This sentiment is especially evident from the statement, ‘At hospital admission, I felt it would be futile to resist, so I didn’t put up a fuss’. It also explains the following feelings: ‘They might explain my symptoms, but without sensing the symptoms myself, I would just have to accept it’, ‘I recognised that I would be inside for three months’, and the feeling of being ‘imprisoned’. These sentiments echo what Kallert, Glöckner, and Schützwohl (2008)¹⁶ found in a review— that patients feel humiliated by involuntary admission. They also underlay emotions such as the following: ‘I wanted to be convinced of the reasons for my admission’, ‘I just don’t get it; why don’t they accept what I’m saying?’. Johansson and Lundman found that the ‘loss of liberty and ... violation of integrity’ associated with involuntary admission are seen as profound losses by patients.¹⁷ However, our results suggest that even in the situation where the patients ‘resigned’ as their own decisions, the patients were able to choose the positive coping behaviour to ‘accept’ without trying to resist. It can be interpreted as a sign of the patients’ willingness to understand themselves and accept admission. Given the circumstances in which the patients in our study ultimately decided to ‘give in’, the way they referred to ‘violation of human rights’ must have reflected the idea that their human dignity was not being respected. This finding implies that there are ethical issues in the current process of admission.

1.5 Unconvinced of Explanation by health care professionals on Admission

On the question of how to deal with patients at hospital admission, the Japanese Psychiatric Nurses Association’s guidelines state that nurses should brief to the patient conscientiously and empathetically.¹⁸ Similarly, the Japanese Association for Emergency Psychiatry states the following in its guidelines: ‘When a patient is to be involuntarily

admitted or placed under constraints, doctors should not just notify the patient via the prescribed paperwork; they should proactively explain the situation to the patient, taking into account the patient's decision-making capacity and confidence in medical services'.¹⁹ Even if health care professionals discharge this task diligently and conscientiously, the patient may still react with surprise, which would explain why the patients in our study acted defiantly towards the doctor and felt 'aghast when they told me at outpatients that I would be admitted'. This reaction likely reflected a desire for 'answers, even for small matters'. According to Kajiwara and Endo (2017), around 27% of involuntarily admitted patients are negatively affected in their relationship with the doctor.¹¹ When the explanations given by health care professionals fail to convince a patient, it creates a gap between patient and health care professionals, and this may lead to a unilateral, paternalistic health care professionals –patient relationship. Daily life matters weighed heavier on the patients' minds than did the need for inpatient care, and the patients were admitted without having the chance to sort these matters out. Coerced into hospital, their right to self-determination was violated. From an ethical and human rights standpoint, it is necessary to reconsider Japan's approach to admission in psychiatric care. It is important to be open to listening to patients about small things (who will take care of my pets, what will happen to the contents of my refrigerator, etc.). Once important things have been solved, it may be possible to decide on inpatient treatment together while sharing both parties' opinions such as providing sufficient information from health care professionals and making requests from patients.

2. Implications for Practice

2.1 Decision making at hospital Admission to Psychiatric Care

As shown in the figure, patients felt subjected to intangible, exogenous forced and therefore felt unable to accept any explanations provided in the process of involuntary

admission. In such circumstances, the patients were obliged to accept admission against their own wills; their self-determination was quashed. If the patient had previously experienced involuntarily admission in the past, they might be even more likely to accept admission in a resigned manner. This situation runs counter to the UN's principles for the protection of persons with mental illness and the improvement of mental healthcare. To uphold these principles, it is necessary to be sensitive to the fact that the patient will likely be emotionally torn between the need for treatment and the need for self-determination. What is also important is to support for their decision-making regarding inpatient treatment.

In a set of guidelines composed by the Japanese Society of Psychiatry and Neurology, informed consent is treated as essential at hospital admission to a psychiatric unit. The guidelines state that it is essential, even if it is necessary, in some cases, to modify the briefing according to the stage of treatment and the patient's condition and cognitive faculties.²⁰ In line with this principle, the Japanese Psychiatric Nurses Association and Japanese Association for Emergency Psychiatry included in their own guidelines the previously mentioned stipulations: 'Nurses should brief to the patient proactively and empathetically'¹⁸ and 'When a patient is to be involuntarily admitted or placed under constraints, doctors should not just notify the patient via the prescribed paperwork; they should proactively explain the situation to the patient, taking into account the patient's decision-making capacity and confidence in medical services'.¹⁹ Despite such guidance, our results suggest that problems remain; the patients felt that their human rights and right to self-determination had been violated, that their relationship with their family had been damaged, and that their inherent dignity as a human person was not respected. We have no doubt that health care professionals sincerely endeavour to uphold the four principles of medical ethics: autonomy, non-maleficence, beneficence, and justice. Nevertheless, it is important to monitor staff to ensure that, whatever the scenario, they always stop to think

about whether they are following the principles. Unquestionably, safeguarding life will always come first, but even in doing so, health care professionals should always try to find a solution that avoids depriving the patient of the things they value in life. It is also necessary to consider specific ways that allow both patients and health care professionals to make decisions regarding the inpatient treatment required for the patients.

Our results highlighted a concerning reality that patients experience: Betrayed, as they see it, by long-trusted family members, the patients experience astonishment and anger and an undermining of their self-esteem. It is necessary to reconsider the ways in which such patients are treated in emergency psychiatry. In particular, in the absence of the patient, the decision to be hospitalised should not be one-sided. The hospitalisation system itself, including the current guidelines, must be reviewed to enable the patients who are the parties concerned to participate.

2.2 How health care professionals Should Treat Patients at hospital Admission

Admission by administrative order is often carried out because the patient has been deemed to be at risk of harming themselves or others, and it is by no means rare for the police to be involved. During this form of admission, the patient tends to exhibit relatively unstable psychological behaviour. By contrast, in cases of admission for medical care and protection, the patient is less likely to exhibit extreme behaviour (although it does depend on the circumstances). When the patient is relatively stable, health care professionals should ascertain the patient's life and work situation and develop an inpatient treatment plan judiciously, with the participation of the patient, not just the family or caregiver. The patient's condition may pose an obstacle to ascertaining the patient's situation, and the medical information may be inadequate to form a clear picture. Additionally, the patient may also have diminished decision-making capacity. Moreover, the disease may be one that the patient is unable to control. In such cases, there is always a tendency for the

professional to make a treatment decision on the patient's behalf. We should bear in mind that even when the patient presents extreme symptoms at hospital admission, they may, in some cases, be able to view their symptoms and situation objectively. Accordingly, health care professionals should make sustained efforts to interact with the patient calmly using tools such as the Comprehensive Violence Prevention and Protection Programme (CVPPP). It is also essential that health care professionals, in addition to upholding the above guidance on briefing the patient proactively and empathetically, gently inquire, at opportune moments, as to whether the patient has any life, work, and social circumstances that would make admission problematic for them. If the health care professionals take the time to inquire into these matters, then patients may feel more assured about their admission than they do under the current admission measures. Kajiwara and Tanaka⁹ argued that multiple staff members should have a one-on-one dialogue with the patient first, rather than surrounding the patient, and that assistance in line with the patient's will is needed. To avoid a situation in which the patient is coercively surrounded by nurses in outpatients, it is necessary to approach the patient sensitively and establish emotional resonance.

V. Limitations of the Study and Future Challenges

The first limitation of this study concerns the small sample size.

Second, our sample was somewhat biased, in that it consisted entirely of inpatients from a single facility in Tokyo, and the narratives were all obtained after the patients had progressed to a stable stage. The high rate of schizophrenia suggests a bias towards disease. 75% of the total were in their 30s and 40s, biased toward adulthood. Given that some emergency psychiatric patients present extreme symptoms at outpatients, our findings are not applicable to all psychiatric patients. Additionally, since we analysed only the patients' narratives, the results present only one side of the picture. In a future study, it would be desirable to analyse such narratives alongside those of family members and health care

professionals.

Another limitation concerns the fact that only one of the 12 participants had been involuntarily admitted for the first time. Some of the narratives from this patient were distinctive; they differed from those of the other patients. It is possible that we would have found similar narratives had we gathered data from other patients who were involuntarily admitted for the first time. Nevertheless, although our data on first-time cases may be rough, we did identify some themes that are common to patients who had a prior experience of involuntary admission. Although the size of our sample might be insufficient, we concluded that publicising the experiences of the participants would contribute to the betterment of emergency psychiatric care.

In the current study, we examined the experiences of involuntary admitted patients focused at the time of hospital admission and clarified the process of their feelings at the point. It is likely that patients' feelings would be shaped in various ways by factors occurring over the period leading up to the time when their symptoms eased. In the future, the challenge is to expand investigation to other time periods.

Further research is required to address these limitations and provide further insights for improving emergency psychiatric care.

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Conflict of Interest Statement

We have no conflict of interest to declare.

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