Involuntary admission from the perspective of nurses and nursing auxiliaries at a mental health facility

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Dear Sir/Madam,

Thank you very much for all the comments from the reviewers, in order to improve our article **"Involuntary admission from the perspective of nurses and nursing auxiliaries at a mental health facility".** In this sense, we have done our best to follow all the recommendations provided by the reviewers:

1. On pages 2-4, Introduction/Background, we update the literature, including more recent references (Anokye et al, 2018; Brito & Ventura, 2019; Fistein et al., 2016; Moll et al, 2022; Ventura et al, 2020, Szmukler, 2019), following recommendations from Reviewer #1 and Editor.
2. On page 4, Method – We included a paragraph to describe the qualitative research approach, according to the suggestions from Editor and Reviewer #2.
3. On page 5, Materials and Methods – Data Collection, we emphasized how many interviewers were involved in the data collection (the principal researcher conducted one-to-one interviews) answering a question from Reviewer #2 "How many interviewers were involved in the data collection?
4. On pages 7-8, Results – Study Participants, we reorganized the section discussing RN/NA duties, using bulleted lists, as recommended by Reviewer #1.
5. On page 8, Results – we included a topic Participant Observation, detailing the participant observation stage, providing additional details on how observation occurred, according to the suggestions from Reviewer #1, Reviewer #2 and Editor.
6. On page 22, according to the suggestions from Reviewer #1, we included a section Relevance for Nursing Practice, discussing the implications for nursing practice.

In sum, these were the changes we made in the article according to the recommendations from the reviewers. All changes in the manuscript are highlighted in yellow We thank them very much for carefully reading the article and pointing out different possibilities to improve it. Therefore, we look forward to hearing their comments about the changes we have made and their evaluation of our article. If you need any other information and changes, please do not hesitate to ask them as our main goal is to strengthen our article and publish it in your journal.

With our warm wishes,

The authors

Involuntary admission from the perspective of nurses and nursing auxiliaries at a mental health facility

Abstract

This qualitative research study was conducted in a psychiatric hospital in the state of São Paulo, Brazil. The study aimed to identify nurses' and nursing auxiliaries' knowledge regarding different types of admission to psychiatric hospitals established by Brazilian legislation. Data was collected through semi-structured interviews with 21 registered nurses and nursing auxiliaries and analyzed through content analysis resulting in the following thematic category: "Gaps in the knowledge of registered nurses and nursing auxiliaries regarding the rules for admission" and five thematic subcategories: "Voluntary admission and the requirement of having a responsible person during admission"; "Involuntary admission occurring when the family is the one to hospitalize the patient"; "Involuntary Admission as a synonym to Compulsory Admission"; "Is there involuntary admission?", and "The Role of the Public Attorney in Involuntary Admissions". Results showed deficits in knowledge s about the different types of admissions to psychiatric hospitals. Therefore, authors suggest the development of policies to promote awareness of mental health nurses about the legal framework concerning psychiatric treatment enabling them to support patients' autonomy during involuntary admissions.

Keywords: Nurses' knowledge; Involuntary admission; Mental health legislation; Psychiatric Hospitals.

Introduction/Background

The development of protections for people with mental disorders is one of the main accomplishments of human rights legislation in recent decades. It emerged from two of the main large international social movements' joint efforts in the last sixty years: the human rights movement; and the movement for the rights of people with disabilities. The human rights movement has clarified and promoted fundamental principles to protect human beings'

rights and freedoms and the movement for the rights of people with disabilities has defended these rights in the national and international context, based on the foundational aspirations of human rights discourse, including equality, non-discrimination, right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment and the rights to information and participation (Gable et al., 2005; World Health Organization, 2005).

The fundamental right to mental health care is highlighted in different international agreements and directions, among which we emphasize the MI Principles (1991) and the International Convention on the Rights of Persons with Disabilities - CRPD (2006), which is the most up-to-date international legal instrument and is a potent platform for the protection of rights of the persons with disabilities.

In this context, the legal and ethical concerns regarding involuntary hospital admission are considered because admitting someone against their will is recognized to have the potential to violate a person's autonomy, liberty and their human rights (Brito et al., 2019; Patterson et al., 2015).

Despite these potential violations, many countries have approved mental health legislation that can authorize involuntary mental health admissions based on the 'risk of harm to self or others for assessment and treatment (Dey et al, 2019; Kelly, 2016). Brazil is one of these countries.

In Brazil, the Psychiatric Reform Movement emerged in the 1970s, proposing the deinstitutionalization of patients with mental illness, to facilitate their social rehabilitation. This movement was similar to other decarceration movements which were taking action around the world (Brito & Ventura, 2019). However, Law 10.216, redirecting the mental health care system to prioritize the rights of people with mental illness, only formally enacted this model in 2001 (Brazil, 2001). The Law states that admission to hospitals in any of its

forms will only be pursued when the outpatient resources prove insufficient. Since then, several legislative sources have been passed relating to inpatient psychiatric care and other mental health services (Brazil, 2002a; Brazil, 2003; Ministry of Health, 2004; Federal Council of Medicine, 2010; Federal Council of Medicine, 2013).

This study was based on the legal framework established by Law 10.216, as it is the standard source for psychiatric admission in Brazil.

The following table summarizes the articles of Law 10.216 related to psychiatric admission.

Table 1. Articles of Law 10.216/2001 related to involuntary admission

Thus, it is important to note that this legislation concerning psychiatric admission has provoked several key cultural changes. Professionals, patients with mental illness and their families are, however, often badly informed about these changes. In some cases, they may be provided with extensive information well, but they may not fully grasp the reasons for these changes and therefore do not act under the law (Anokye et al., 2018). This is particularly true when mental health legislation requires important adaptations to their habitual mental health practice (World Health Organization, 2005).

Studies show that the daily practice of mental health professionals is not comprehensively informed about the political changes taking place in the field of mental health (Anokye et al., 2018; Fistein et al., 2016; Moll et al., 2022). In these circumstances, research that examined the impact of involuntary admissions for psychiatric clinical nurses concluded that this profession "still holds a superficial knowledge of the constructs of the Brazilian Psychiatric Reform, the Reform Act and the implications of involuntary psychiatric admission for clinical psychiatric nursing" (Moreira & Loyola, 2011).

Considering that nurses are the professionals who provide direct care to patients, they are routinely faced with the pain and suffering of patients resulting from coercive treatments, such as involuntary hospitalizations. Thus, the role of nurses at psychiatric hospitals requires overcoming the conditions of being specialized technicians within the service, in order to play the fundamental and challenging role of constantly ensuring respect for the human rights of patients during their care (Ventura et al., 2020).

In that context, this research aimed to identify the knowledge of nurses and nursing auxiliaries at a psychiatric hospital in an inner city of the state of São Paulo about the differences and particularities of the types of psychiatric admissions.

Materials and Methods

Method

This qualitative research was based on the dialectical approach (Minayo, 2004). In this perspective, the qualitative approach aims at interpreting the meanings given by the research participants regarding multiple phenomena relevant to the field in which the health-disease process occurs. The researcher, when using the qualitative method, must consider the individuals with the objective of understanding what is "behind" the speeches and behaviours raised (Botega & Turato, 2006).

Participants and Site

This study was conducted with registered nurses and nursing auxiliaries from a psychiatric hospital in an inner city of the state of São Paulo. The inclusion criteria were for those who participate in the admission process and who provide direct care to hospitalized patients. Nurses and nursing auxiliaries nursing were chosen as study participants due to their potential role in ensuring patients' rights. From this perspective, to guarantee compliance with the law and to deliver care that considers the humanity of care receivers, the registered nurses

and nursing auxiliaries involved needed to permanently heed their patients' rights as health system users.

Ethical Considerations

The Research Ethics Committee of the XXX approved the study. Participants were identified with initials and their respective interview number. The following initials were used: Registered Nurse-RN; Nursing auxiliary-NA.

Data Collection

All the 72 nurses working at the hospital at the time of data collection were invited to participate in the study. Among them, 21 accepted to participate. There were no monetary incentives to participate.

Data was collected through semi-structured interviews, based on an interview schedule. The principal researcher conducted one-to-one interviews at a private office in the hospital. The interviews length varied from 30 to 60 minutes. The interviews were digitally recorded and transcribed. This technique enabled the authors to explore the theme through the search for the informants' information, perceptions and experiences. This study is part of a larger project. The interview schedule was based on the goals of this study, using the following questions: What types of admission can your patients be subjected to? What are their differences? What is the role of the Public Attorney in this process? What is the role of the medical doctor? What is your role?

Data was also collected through participant observation.

Participant observation is often used in qualitative research, as it enables researchers to reaffirm data obtained at the interviews, as the participant's reports are not always compatible with their behaviours (Queiroz et al., 2007). At this stage, the authors followed three steps 1ª) Researcher approximation to the studied group; 2ª) Researcher tries to understand the perspective of the participants regarding the subject of the study. This stage was accomplished

based on the study of official documents, understanding of the group and the hospital history, observation of daily life; search for key-informants and non-directive interviews with persons who could help understand the reality. This stage was developed during a month, four times a week during an average of three hours visits. Data was collected in the morning, afternoon and night shifts in different weekdays and in all wards of the studied hospital. Key informants, such as the Hospital Director and members of the administrative personnel were interviewed. Observation of daily practice at the hospital enabled an understanding of the reality as well as a greater approximation to the participants of this study. Data was registered in field notes. 3ª) Data systematization and organization (Queiroz et al., 2007).

Data Analysis

In order to analyze data, authors applied content analysis techniques through thematic categories (Bardin, 2009). The categories emerged from the analysis of their commonalities. The material was explored in three different stages: (i) pre-analysis, (ii) material exploration and (iii) treatment of the results.

During pre-analysis (i), data were transcribed and organized for the principal researcher observing pre-established rules, such as exhaustiveness, representativeness, relevance and exclusivity (Bardin, 2009). Pre-analysis was followed by (ii) material exploration, and in that phase all authors read and reread the data several times. Following this, each researcher, separately, explored and organized the data in thematic categories with the purpose of having an extensive description of the categories that represented the context, meanings, and interpretation of the identified themes. After this first coding, an iterative process was employed whereby researchers cross-checked codes and refined the core themes arriving into a consensus on the final categories. Lastly, the third phase (iii) aimed to understand and interpret the results for all authors, and the analysis was grounded in the literature as well as the observation data.

Strategies for Assuring Trustworthiness

Strategies for assuring trustworthiness were used to enhance the value of the research findings. Thereby, a law professor and a nursing professor, who had conducted several research studies in mental health, validated the relevance of the analyzed data. Two native English-speaking professors and a Brazilian English translator validated the translation of this study from the Portuguese language to English.

Results

Study Participants

This study was conducted with 21 nurses and nursing auxiliaries at a psychiatric hospital in an inner city of the state of São Paulo: seven registered nurses and 14 nursing auxiliaries. The majority were women (57.14%), married (52.38%), nursing auxiliaries (66.66%), years of nursing experience from one month to five years (76.19%), and working at the hospital from one month to five years (85.71%).

A registered nurse (RN) is a graduate nurse who has completed a Baccalaureate Nursing Program of four or five years and who has been legally authorized (registered) to practice by a regulatory authority, and who is legally entitled to use the designation RN.
It is the registered nurse's job to receive and look after patients and supervise, as a member of the healthcare team, participate in drawing up, executing and evaluating healthcare plans:

- prescribing medications only when the medication is previously approved by the health care institution and to specific public health care problems;
- participating in individual and group comprehensive health care programs and activities, especially for priority and high-risk patients;
- participating in health education programs and activities, aiming to improve the health of individuals, families and the population in general;

- participating in health care personnel training and development programs, especially in continuous education programs;
- participating in programs to promote health and safety and prevent work-related accidents and diseases;
- participating in patient referral and counter referral systems at different levels of health care and participating the development of technologies appropriate to health care (Brazil, 1987).

It is important to note that nurses' roles may differ in other countries, such as the possibility of prescribing medication. In Brazil, this role is restricted to specific situations explicitly described in the legislation.

A Nursing Auxiliary (NA) is a practitioner who has finished a technical program of two or three years, and is allowed to provide patient care linked to their hygiene and comfort, including:

- feeding or helping them to feed themselves;
- looking after cleanliness and tidying the health care unit's material, equipment and facilities;
- forming part of the health care team;
- participating in health care education, even giving patients post-consultation guidance about complying with nursing and medical prescriptions and carrying out routine work connected with patient discharge.

These activities are only conducted under the supervision, guidance and direction of the registered nurse (Brazil, 1987).

At the studied hospital, registered nurses participate in the admission process, from the moment the patient arrives at the hospital until the decision regarding the admission is made. The nursing auxiliaries participate in the process from the moment the patient is admitted to

one of the wards. In addition, in order to work at the hospital, registered nurses and nursing auxiliaries do not need to have any kind of specialization in psychiatric nursing.

Participant Observation

This stage was developed for a month. The observation was performed by the principal investigator, 4 times a week for approximately 3 hours for each visit. The researcher alternated the visits between the morning, afternoon and night shifts, between different days of the week and between the 7 wards of the hospital. The situations that occurred during the observation period were recorded in a field diary.

The participant observation made possible the immersion in the reality of the studied universe and a closer approximation with the study participants. During the entire duration of the research, the health team and the patients were receptive to the researcher's presence.

During this period, it was possible to follow: the procedures for the discharge and return of patients after weekend´s leaves, occupational therapy activities, social service consultations, visits, medication time, voluntary and involuntary hospitalizations and involuntary hospitalization after a escape.

In the interaction with the professionals, they talked about the difficulties experienced in the delivery of care, highlighting the hospitalization of minors, the hospitalization of people by court order, and the abandonment of people by family members.

The occupational therapy building is separate from the hospital and patients must cross the street, which can cause escapes. Therefore, only those patients who are not at risk of scaping participate. This building has a gym, volleyball court, soccer field, vegetable garden, and kitchen, and it is a very large space in which patients participate in sports, therapeutic and professional activities such as cutting and sewing, cooking, horticulture and woodwork. On the last Thursday of each month, employees organize a party for the birthdays of the month.

In addition, on commemorative dates such as Christmas, Easter, Mother's Day and others, lunches are organized with families.

A common criticism refers to compulsorily hospitalized patients. This is considered one of the major problems that the hospital faces, since judges often determine the hospitalization of minors (during the observation period there was a girl of about 13 years old hospitalized), and also patients convicted of serious crimes, placing the integrity of the patient, others and professionals at risk. The hospital provides care for adults only, but as there is no other suitable places in the region, the institution receives minors. When cases of this nature occur, the provider reinforces patient safety and challenges the judge's decision. This hospital-justice contact occurs only through correspondence.

The prosecutor of one of the municipalities in the region determines that the hospitalization is carried out in the private ward at a private room and that the municipality pays, but this is an isolated case among the 101 municipalities that integrate the network. The professionals highlighted that, although there is a lot to improve, there has been a positive evolution of the hospital in the last 10 years.

Thematic Categories

The analysis of the interviews demonstrated the participants' lack of knowledge about the differences and particularities of admission types. Although the study had been carried out with professionals with different educational backgrounds (registered nurses and nursing auxiliaries,) both professions demonstrated a lack of knowledge about the existing mental health legislation. As a result, thematic categories emerged from the analysis: "Gaps in the knowledge of registered nurses and nursing auxiliaries regarding the rules for admission", with five thematic subcategories: "Voluntary admission and the requirement of having a responsible person during admission"; "Involuntary admission occurring when the family is the one to hospitalize the patient"; "Involuntary Admission as a synonym to Compulsory

Admission"; "Is there involuntary admission?", and "The Role of the Public Attorney in Involuntary Admissions".

Gaps in the Knowledge of registered nurses and nursing auxiliaries regarding the rules for admission

Voluntary admission and the requirement of having a responsible person during admission

Concerning voluntary admission, Law 10.216 / 2001 provides that admission is only voluntary if the patient states in writing his/her acceptance (1). For this, he/she needs to have legal capacity. According to the study participants, in case of admission of this type, there is also the requirement for the presence of a guardian.

Voluntary is when the patient comes and contacts our institution. First, he comes to the psychiatric emergency and requests hospitalization, saying that he's not well, that he would like to be admitted, together with his family (RN1).

Voluntary the patient is... he freely goes to the Central Emergency. The companion always has to come, never alone, because when the patient has a mental disorder, he needs a person who is responsible for him because, even when he is the most oriented person in the world, it is considered that he needs someone responsible for him, because he has a psychiatric disorder, because he may be oriented at one moment but not be oriented soon afterwards (RN2).

Involuntary admission occurs when the family is the one to hospitalize the patient

Some confusion exists as to the study participants' understanding of involuntary admission. Involuntary admission was expressed in three ways, the first of which is

Involuntary admission where the family hospitalizes the patient.

[...] that the family hospitalizes (involuntary) (NA14).

Involuntary is when he comes, when it's the relative, someone who wants him to be hospitalized (NA18).

Involuntary is when the family signs a form, that the family is hospitalizing the patient, that he's in no condition to respond for himself so the family takes responsibility (NA8).

Involuntary is when the patient is brought against his will, with an ambulance, so the family requests an ambulance or the police to bring him to the hospital (RN1).

The participants called this type of admission, in which the family decides, **forced admission**, which in many cases may require police support.

Forced admission is when the family wants it (NA5).

Involuntary Admission as a synonym to Compulsory Admission

Involuntary admission was also identified as a **synonym of compulsory admission.**

[...] that the family admits, it's... not because they want to... (compulsory) (NA14).

Involuntary admission is the one when the hospitalization is ordered by the court, in spite of the patient' will (RN4).

Is there involuntary admission?

The participants believed that **no involuntary admission exists**, as patients are entitled to come and go.

The patient is entitled to come and go. As the admission is not mandatory, he is entitled to refuse hospitalization, if this hospitalization is not compulsory, he/she is... (RN1).

He finds out that he's going to be hospitalized, so, like, if he says that he doesn't want to, he is not obliged to enter (RN4).

The admission is not voluntary when the patient suffers from schizophrenia, or something deeper like he's not aware about what is happening around him, so it's not voluntary in that case (NA21).

In addition, in the observation process, there were situations in which health professionals used convincing strategies for patients to accept staying at the hospital.

When it is involuntary, then we talk, explain, try to convince him, try to make him enter voluntarily but, when that's not possible […] […] we have to mobilize the entire male staff, but he sees that bunch of men here and starts to enter, right, he enters easily (RN2).

Because, in fact, here at the hospital, we only admit voluntary patients, patients who want to be hospitalized, they have to be oriented, if the patients are not, then we can hospitalize if the family authorizes it, but if the patient is oriented and comes up to you and says I know where I am, I know what day it is, I know what time it is and I don't want to be hospitalized, you can't, the family may tell you, the physician may authorize it... [...] That's it. Only if he doesn't know where he is, what's happening, then we can hospitalize [...] We don't do it (involuntary hospitalization), we don't, we ask the family to talk to the patient, if the patient accepts fine, we admit, we even dialogue, look, you're gonna be hospitalized, you need to get treatment and so, but taking him and putting him in there no. [...] In most cases yes (they are able to convince the patient) (RN12).

Often no, often they are in no conditions to answer for themselves, often they do not know what it is

best for them, and then we override patients' rights, but for their own good (RN2).

The role of the Public Attorney in Involuntary Admissions

Participants showed lack of knowledge about the role of the Public Attorney in involuntary hospitalization.

What the function of the Public Attorney is in a psychiatric institution, I really cannot answer that question (RN1).

The Public Attorney? Laughs. You got me. Laughs. The Public Attorney is... […] but it's... their role itself is a very difficult question for me, I don't know what the role of the Public Attorney is (RN2).

[…] And the legal which is the Public Attorney, he determines on admission or not, so their only interference is concerning that, right, admission of a minor, of an under age, right, admission of people who represent a risk to society, they consider that it's a risk to remain out there, then they issue a court order to intern the patient (RN3).

The Public Attorney? If it's a minor, if it's a minor, right, and the judge is the guardian, he's the one who determines, we've had several, several girls under age here, which he determined (NA14).

Figure 1 summarizes the types of admission accordingly Law 10.216/01 and the study participants.

Figure 1 - Gaps in the Knowledge of registered nurses and nursing auxiliaries regarding psychiatric admission

In order to illustrate the gap of knowledge found in this study, Table 2 summarizes the percentage of misconceptions about the types of admission among the participants.

Table 2. Percentage of misconceptions found in the interview.

Discussion

In relation to voluntary admission, Law 10.216 / 2001 provides that admission is only voluntary if the patient is legally capable and confirms this in writing his/her acceptance (1). However, data showed that in cases of voluntary admission, there is also the requirement for the presence of a guardian. In this sense, it is important to note that there is no legal requirement for a guardian when it comes to voluntary admission of people with mental illness who are legally capable.

Concerning civil capability, "any person is capable of rights and duties in civil order" – article 1st of the Civil Law (Brazil, 2002b).

With the ratification of the CRPD by Brazil, some changes were made to the country's legislation. Thus, item III was added to Article 4 of the Civil Code, which provides that "are relatively incapable, those who, due to transient or permanent reasons, cannot express their will" (Brazil, 2002b).

When considering mental capacity, this is where the law defining capacity focusses on the patient's understanding of their disease and any associated consequences, the treatments that may be available and any associated risks and benefits. The process also considers the credibility of the information provided to the individual and their ability to process and act upon that information (Szmukler, 2019). Thus, in cases of voluntary admission, patients' decision-making ability is not considered to be impacted by the mental illness, so that no responsible person is needed. In contrast, if he/she is unable to decide on his/her health,

admission will be involuntary and the responsible person will be required, who will assume deliberations about his/her life, in line with the case of people under guardianship (Brito & Ventura, 2019).

According to Gable and Gostin (2009), the myth of incompetence relies on the false assumption that persons with mental illnesses cannot competently make decisions or grant consent. This myth was evident at the studied hospital, as participants did not recognize the possibility of an admission in which the patient totally chooses to be treated. Some confusion also exists as to the study participants' understanding of involuntary admission. Involuntary admission was expressed in three ways, the first of which is **involuntary admission when the family supports hospitalization.** This concept most closely approximates to the legal definition that establishes how the admission occurs in emergency situations or on the request of third parties, as the patient's clinical condition does not permit his/her consent. It is noteworthy that the request of the parent or guardian is not enough for the hospitalization as it also requires a physician, duly registered with the Regional Council of Medicine of the state to authorize it (Brazil, 2001). Involuntary admission was also identified as a **synonym for compulsory admission.** Thus, at first, it is important to highlight that compulsory admission is always a form of involuntary admission. The difference between both modes is that a court order is required to authorize admission (Brazil, 2001). One of the types of compulsory hospitalization is a safety measure that represents the legal form found by the court to treat would be criminal offenders with a mental illness (Brazil, 2001). These people cannot be legally considered criminals because they were, due to a mental illness, at the time of the criminal act, unable to understand the nature and quality of their actions. As a result judges apply, rather than a penalty, a safety measure that can be: stay in custody or treatment at a psychiatric hospital, and in the absence of this, in another appropriate institution; or outpatient treatment (Brazil, 2012).

At the hospital studied, there were several cases of patients hospitalized through safety measures. However, we note that hospitalization for these patients does not have the same characteristics of probation, since they are considered "dangerous" due to them having committed a crime and being detained for their own or others protection, they are not allowed to participate in any occupational therapy activity, in addition to being hospitalized for long periods, they are often awaiting judicial determination to leave the institution.

In this type of admission, the judges should "consider the safety conditions of the establishment, concerning the safety of the patient, other patients and employees" (Brazil, 2001). The participants reported that the hospital often experienced the compulsory admission of patients who had been imprisoned for severe crimes, as well as of children, without any structure to receive them thereby putting the safety of employees and other patients at risk.

During the observation period, there was no visit from the Public Attorney to the hospital, revealing a lack of concern with knowing the establishment before determining the validity or legality of the admission. Currently, the mode of compulsory hospitalization has also been widely used for cases of addiction. The state has promoted compulsory admissions of substance users as an effective form of contingency planning; especially those who are crack cocaine users, without observing the legal formalities for admission (D'Andrea et al., 2013). Thus, the services should be reviewed by the courts as in many of these cases of compulsory hospitalization, especially of psychoactive substance users; the hospital becomes a place of social exclusion. Therefore, there is an urgent need for more integrated work between the judiciary and health professionals and caregivers so that they can promote care in which the patient's rights are guaranteed.

In addition, according to some participants, involuntary admissions do not exist, as patients are entitled to come and go. This position, however, diverges from observations during the observation period and in the interviewees' discourse, which argues that admission

is not forced. In this sense, involuntary hospitalizations were observed as happening daily, and in some cases, it proved much more comfortable for the family who supported the admission.

It was also observed that the mental health network of the studied regional health sector is not well structured, lacks adequate community mental health services (CAPS) for the population which does not know about these and other replacement services and hospitalization is often seen as the best form of treatment for persons with a mental illness. Thus, the hospital-centred model still predominates in the region, a different reality from that observed in the country, where the number of beds in psychiatric hospitals has decreased since the enactment of the law.

It is noteworthy, in this scenario, that involuntary hospitalization, contrary to what the participants think, is defined by Law 10.216 / 01 as "one that happens without user consent" (Brazil, 2001). The requirements are: the existence of a serious mental illness and the imminent personal risk to the individual or others. If such requirements exist, the physician may, with the permission of the family or legal representative, authorize involuntary hospitalization. The right to liberty of patients who are unable to understand their disease and its consequences at that time, nor any treatment and its risks and benefits – will be resisted in this case to preserve other fundamental rights, such as the right to life, to health, to physical integrity and dignity (Brito et al., 2019).

Two registered nurses who said there was no involuntary admission commented that in cases where the patient does not want to stay, the nursing staff uses a range of techniques to persuade them to stay. Arguably this form of persuasion is coercive and such actions in the hospital could be considered a form of abuse of both authority and power, however, as this issue was not addressed directly in other interviews and appeared only on interviews with registered nurses as a way to explain the voluntary hospitalization, we concluded that any

unethical practice of potential coercion was more likely to be due to a lack of knowledge by professionals who may have insufficient specific education and training in psychiatric nursing. With this perspective in mind, it is important that nurses' knowledge of the types of admission would enable nurses to build a more trusting relationship with patients and ensure that the highest professional standards are met during this nursing care

Regarding forms of coercion used by staff and detailed in previous research, similar findings have reported the use of male nurses to coerce patients. The findings of such studies showed that male nurses could represent authority and power through patients' eyes who often wish to avoid any aggressive situations. The participants also stated that if there were any violent incidences they were more likely to call male nurses to the ward and in some cases their presence alone would calm a volatile situation (Kontio et al., 2010). Authors of this study believe, however, that “these manpower-orientated practices can exacerbate patients’ aggressive behaviour. This unofficial use of power is the grey area of free will in psychiatry and has long been considered (Foucault, 2014). Foucault perceived surveillance in psychiatry as a means of disciplining people to create useful citizens (Newton-Howes & Stanley, 2012). Therefore, there is a need for further discussion among nursing professionals about the use of power, whether consciously or unconsciously, as a way of finding better solutions to empower patients without compromising ward security (Kontio et al., 2010).

Studies also show that one in four individuals voluntarily admitted to a psychiatric hospital realizes they were coerced and half of these people continue to feel coerced after admission (Newton-Howes & Stanley, 2012; Katsakou et al., 2011). From this perspective, another study has demonstrated that a significant proportion of users admitted that any supposed voluntarily experience was actually perceived to be coercive and users unwittingly admitted that if a service user, voluntarily or involuntarily hospitalized, feels pressured or coerced, it is necessary to ensure that there is sufficient oversight of professional practice to

ensure that the individual rights of patients are respected (O'Donoghue et al., 2014). It certainly appears that a Public Attorney should conduct any review, under Law 10.216/01.

The 1988 Brazilian Constitution defines the Public Attorney as "a permanent institution, essential to the State's jurisdictional function, in charge of defending the legal order, the democratic regime and unavailable social and individual interests" (Brazil, 1988). The Public Attorney is responsible for supervising the execution and practice of fundamental, collective and social rights. In mental health, the Public Attorney's Office is the entity responsible for guaranteeing compliance with patients' rights through its activity and actions.

Involuntary admission can occur in both ordinary and emergency situations. In the former case, previous legal authorization needs to be requested and obtained. In emergency admissions, the case should be communicated to the Public Attorney within 72 hours (Brazil, 2001). Thus, in involuntary admission situations, a new actor is included with a regulatory function, which is the Public Attorney's Office, in an attempt to set "in movement a safety and protection device of patients' rights, when involuntarily admitted" (Newton-Howes & Stanley, 2012).

The person in charge of communication to the Public Attorney is the Clinical Director. Decree No. 2.391/02 from the Ministry of Health which includes a template of the Involuntary Admission Communication Form (Brazil, 2002a). Among compulsory information in this document, the following stands out: the type of admission (voluntary or involuntary), the reason and justification for the admission and the reasons for the user who is being admitted to disagree (Brazil, 2002a). The Public Attorney may demand additional information and also interview the patient and whoever is considered necessary and can authorize further examinations involving different professionals (Brazil, 2002a).

Law 10.2016/2001 requires the participation of the prosecution in the admission process, enabling patients with mental illness to have an institution to which recourse if their

rights are injured. However, nursing professionals' difficulty to express the role of the Public Attorney in cases of involuntary admissions reveals that interaction between the Public Attorney and the organization under analysis remains limited.

The lack of dialogue between health professionals and the courts, and the lack of action on the part of the latter on the procedures of health professional result in ethical, social and moral dilemmas, which suggests a broader debate about the search for solutions and partnerships aimed at promoting the citizenship of patients with mental illnesses. On the other hand, the necessity of involuntary admissions has been accepted as a necessary measure to protect patients, others, and society more widely. However, the balance between this protection and the promotion of service users rights remains controversial (Zhang et al., 2015). In some cases, when the patient is hospitalized, he is depersonalised, ceasing to be seen by others as a human being with rights and desires that must be respected.

In addition, hospitalization highlights feelings of vulnerability, isolation and powerlessness. Previous studies show that patients felt that they were incarcerated, trapped, dehumanized, stigmatized and treated punitively. They expressed feelings of boredom, alienation and loneliness (Alexander, 2006). Furthermore, particular treatment decisions may be contrary to deeply held social, medical, political or religious values of the person with a mental illness. If the treatment is coerced then this may violate an individual's sense of control over his/her life, health, and body. In addition when professionals override a person's decision about health care, treatment or services, this may deprive a person of a sense that he or she is respected by medical or other public authorities and "Once a person has been subjected to involuntary treatment in a mental health service, he or she may never again feel safe or trusting of mental health or other government services" (Rosenthal & Sundram, 2001). While it may be hard to quantify the subjective feelings of humiliation and degradation

caused by coercive treatment, there is no doubt that these feelings may prove very intense (Rosenthal & Sundram, 2001).

Relevance for Nursing Practice

This study offers an important perspective to nursing practice, especially nurses deal with involuntary hospitalizations. Thus, this study can help to disseminate the need for training nursing professionals to develop the capacity to understand and promote human rights, recovery and independent living in the community, improving the quality of care and services related to inpatients, as well as stimulating their autonomy and the practice of health advocacy.

Conclusions

Since 2001, guidelines for the mental health care model in Brazil proposed a network of services at all levels of care, which aims to provide comprehensive care. Within this network, the psychiatric hospital is designed to assist patients requiring exhaustive care, with admission being a last resort. Treatment should be directed to the social reintegration of the patient in his/her community, which is not possible when the patient is treated on-site isolated from family and social environment. In this scenario, for the consolidation of this model, it is necessary that registered nurses and nursing auxiliaries involved in patient care work are guided by ethical and legal principles and that they provide leadership to non-registered caregivers in this area. For this, they need to know the rights of their patients, and thus, through their practices, make the necessary interventions, guiding the outpatient services available on the network and offering a humanized care and rehabilitation services.

This study explored the understanding of registered nurses and nursing auxiliaries working at a psychiatric hospital about the and particularities of psychiatric admission modes. The results

suggest a lack of' knowledge about the legal aspects of psychiatric admission, suggesting that registered nurses do not adhere to guidelines in their professional code to be accountable, to keep up to date and to educate others. It is also important to emphasize that there is a limitation to the study the fact that it was conducted in only one psychiatric hospital. Accordingly, we suggest the development of further research that addresses psychiatric admission in other services and in other regions of the country, as this type of research linked to other policies may promote the awareness of mental health nurses about the legal framework concerning psychiatric treatment, enabling them to support patients' autonomy during involuntary admissions. These results may also be used to understand legislation and practices regarding psychiatric admissions in other countries of South America.

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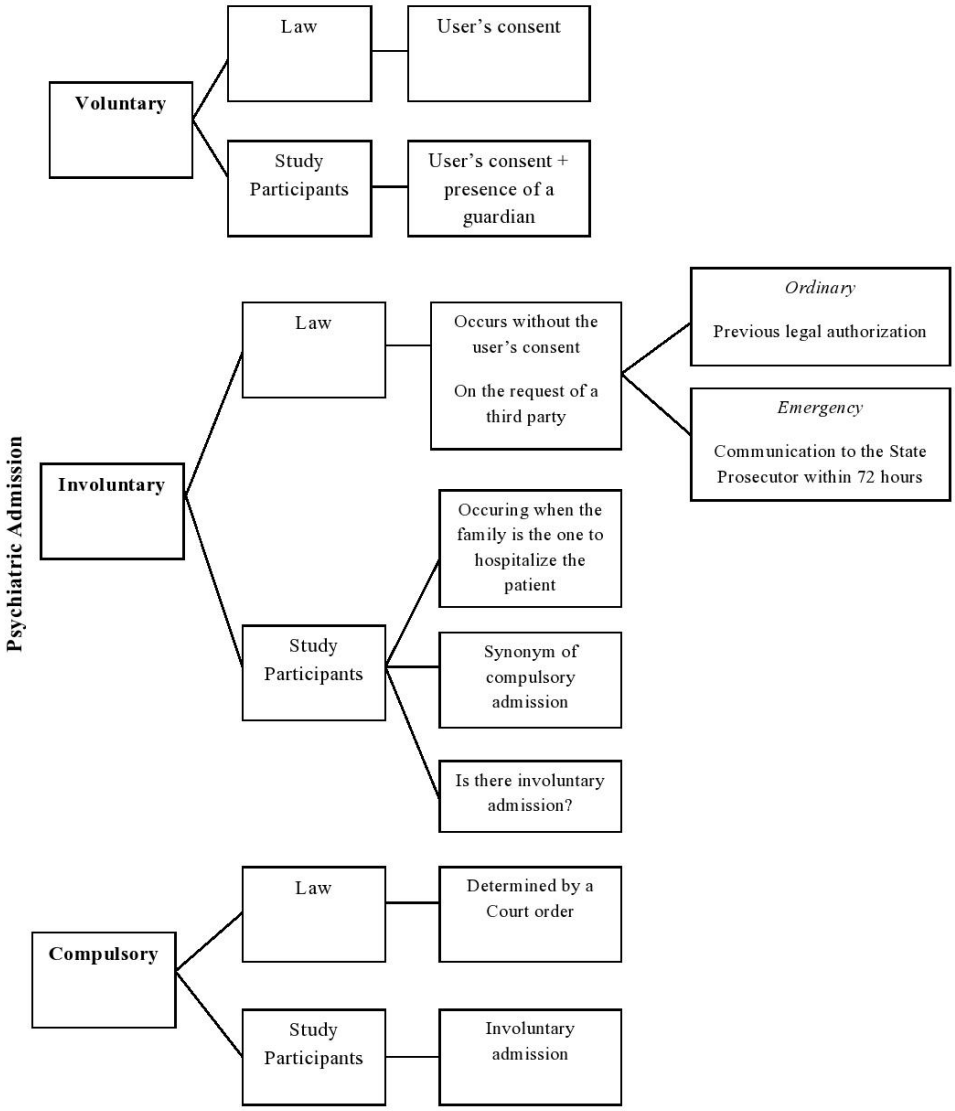
Table 1. Articles of Law 10.216/2001 related to involuntary admission.

Article of Law 10.216	**Content related to psychiatric admission**
Article 4th, paragraph 1	The admission will prioritize the social reintegration of the patient.
Article 4th, paragraph 3	Psychiatric admission is prohibited in institutions with asylums characteristics
Article 6th Types of admission to a mental health unit or hospital	I- Voluntary admission: occurs with the user's consent; II- Involuntary admission: occurs without the user's consent and on the request of a third party; and III- Compulsory admission: occurs upon legal determination
Article 8th Involuntary admission cases	Involuntary admission can occur in ordinary or emergency situations. § 1o Involuntary psychiatric admission shall, within seventy-two hours, be communicated to the Public Attorney's Office by the head of the establishment in which has occurred.
Article 9th Compulsory admission	The compulsory admission is determined in accordance with current legislation, by the competent court, which will take into account the security conditions for the establishment, for the safeguarding of the patient, other patients and staff.

Table 2. Percentage of misconceptions found in the interview.

Most frequent misconceptions found in the interviews	Number of participants	Percentage
"I do not know the types of admission"	9	42.8%
"Voluntary admission and the requirement of having a responsible person during admission"	21	100%
"Involuntary admission occurring when the family is the one to hospitalize the patient"	18	85.7%
"Involuntary Admission as a synonym to Compulsory Admission"	4	19.04%
"I do not know about compulsory admissions"	8	38.09%
I am not aware of the Role of the Public Attorney in Involuntary Admissions"	21	100%

Figure 1 - Gaps in the Knowledge of registered nurses and nursing auxiliaries regarding psychiatric admission


Psychiatric Admission
Voluntary
Law
User's consent
Study Participants
User's consent + presence of a guardian
Involuntary
Law
Occurs without the user's consent
On the request of a third party
Ordinary
Previous legal authorization
Emergency
Communication to the State Prosecutor within 72 hours
Study Participants
Occuring when the family is the one to hospitalize the patient
Synonym of compulsory admission
Is there involuntary admission?
Compulsory
Law
Determined by a Court order
Study Participants
Involuntary admission

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