

Comparing International Rates of Involuntary Hospitalization on Psychiatric Grounds: A Case Study

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Abstract

In this study, we explored how rates of involuntary hospitalization on psychiatric grounds varied across 22 countries in Western Europe, Australia, and New Zealand between 2008 and 2017. Alongside this, we also compared national legislation and investigated whether variations in rates could be explained by national-level socioeconomic, demographic, and clinical factors. It was conducted by members of the NIHR Mental Health Policy Research Unit and was commissioned by the independent review of the Mental Health Act (1983) in England and Wales in 2017–2018. For us as researchers, this was an unusual project to work on: there are few other studies in this area, and we had to collect a large body of information about the different involuntary hospitalization legislations and their application in practice. We worked with a solicitor to do this, but there were still significant challenges, such as language barriers and understanding the technicalities of the different legislations. We relied heavily on the expertise of “key informants”: mental health law academics or practicing psychiatrists based in each of the countries. Meanwhile, the project also posed many other interesting research methods questions, such as how to analyze the relationship between rates of involuntary hospitalization and legislation. We also learnt a lot about the complexities of obtaining and using these types of publicly available data, especially in terms of its accessibility and limitations. Overall, this was an interesting project to work on, and one that we hope will help provide a platform for future work on this topic.

Learning Outcomes

By the end of this case, students should be able to

- Describe the benefits and challenges of this type of research
- Know how to obtain data on involuntary hospitalization rates, socioeconomic, demographic and clinical factors, and national legislation
- Identify some of the appropriate analytic methods when using these types of data

Project Overview and Context

I am a research fellow in the National Institute for Health Research (NIHR) Mental Health Policy Research Unit (Mental Health PRU). It was set up primarily as a collaboration between University College London and Kings College London, but it has a large network of collaborators across the United Kingdom. In October 2017, the government of the United Kingdom commissioned an independent review of the Mental Health Act 1983 (MHA) in England and Wales as amended. It was tasked with reviewing current practice and evidence and asked to make recommendations to improve legislation and practice. The final review report was submitted to the U.K. Government in December 2018 and further details can be found in the “further reading” section below. For that review, the MH PRU was commissioned with completing nine research projects. This case report describes how we conducted one of those projects. In it, we compared rates of involuntary hospitalization in England with those of other countries. We also compared the legislation

regulating involuntary hospitalization in those countries and explored potential social and clinical national-level factors driving those rates.

Previous Literature

In the past, there have been very few comparisons of rates of involuntary hospitalization internationally. To the best of our knowledge, only a few have explored them alongside a comparison of legislation ([Salize & Dressing, 2004](#); [de Stefano & Ducci, 2008](#)), and none have explored their relationship with national-level characteristics such as demographics. In the paper by Salize and Dressing, like in our own project, the authors obtained involuntary hospitalization data primarily from governmental sources. However, [de Stefano and Ducci \(2008\)](#) relied on previously published peer-reviewed data. Each took different approaches to exploring the relationship between legislation and rates of involuntary hospitalization, with the former using data analysis and the latter using a more narrative or descriptive approach. Furthermore, despite quite a bit of interest in these two publications, there have been no other papers published since 2008 that we are aware of. So while our own project provides an, perhaps overdue, update to this literature, it also makes a novel contribution by including data for more countries as well as an analysis of socioeconomic, demographic, and clinical predictors, which previous literature has not.

Section Summary

- This project was commissioned for the review of the Mental Health Act (1983) in England and Wales by the government of the United Kingdom in 2017.
- Few previous studies have explored this topic. So many of the research methods used in this project were developed by the research team.

Research Design

The study was initially conceived through discussion between the directors of the MH PRU with the MHA review working group. The exact study design was developed by the authors of the main project paper through discussion by email and in project team meetings. We also used the paper by [Salize and Dressing \(2004\)](#) to provide us with some rough guidelines during the initial stages of our own project and we were influenced by some of the aspects of their study. Through these discussions we decided on three research questions:

- How do rates of involuntary hospitalization in England compare with those in other countries?
- How does legislation regulating involuntary hospitalization (such as the MHA in England and Wales) vary and is there evidence of a relationship with rates of involuntary hospitalization?
- What are the social and clinical factors driving variation in rates of involuntary hospitalization?

To address these questions, we needed to obtain three categories of data at a national level:

1. Annual use of involuntary hospitalization orders per 100,000 population;

2. Details of legislation;
3. Socioeconomic, demographic, and clinical data per 100,000 population.

We included 22 countries: England, Northern Ireland, Scotland, Wales, Australia, Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, New Zealand, Norway, Portugal, Republic of Ireland, Spain, Sweden, and Switzerland. They were included because they have well-developed mental health care systems with substantial progress in deinstitutionalization, populations over 1 million people, and have involuntary hospitalization data available. It was thought by the project team that including countries with fundamentally different types of health care would introduce further complications into the interpretation of the results and make it more challenging to identify factors driving trends in the rates of involuntary hospitalization.

Involuntary Hospitalization Data

We obtained involuntary hospitalization data from national official organizations (e.g., government health or statistics departments), peer-reviewed literature, and the World Health Organization's (WHO) Mental Health Atlas. Details of the laws regulating involuntary hospitalization were collected directly from legislation, which has been made available online by each country.

Where the data were available, we obtained it for the previous 10 years (since 2008) because the di Stefano and Ducci paper was published then and because of the practical difficulties of obtaining data older than that. We agreed this decision after looking at online data repositories (e.g., the WHO Global Observatory and NHS Digital) and contacting various governmental (such as departments of health or statistics) or other relevant organizations (e.g., the WHO) to identify what data were available for us to use in our research. We found that only a small proportion of countries could provide data for years prior to 2008. This was often not because the data had never been recorded. In many cases, the data had been archived or had not been kept.

Legislation

We developed summaries of the mental health legislation regulating involuntary hospitalization for each country. These legislation profiles focused on eight legislative characteristics:

1. The essential criteria for involuntary hospitalization, including
2. The psychiatric condition the patient must have
3. Risk to self and others
4. Capacity
5. Treatability
6. Insight
7. Who and how many people are required for an involuntary admission order.
8. Any obligation to have a legal representative, independent advocate, or judge be present at the assessment or be consulted to authorize the admission, either prior to or immediately following it.

9. The legal requirement to consult the next of kin/nearest relative, and whether they have any power to block involuntary admission.
10. Details of distinct involuntary admission orders, such as for assessment or treatment, including requirements of each order and the maximum length of detention.
11. The arrangements for patients' right of appeal, such as through an independent tribunal.
12. The patients' legal rights, such as right to an independent advocate or legal representation; statutory right to aftercare.
13. What provisions there are to help protect the human rights of patients, based on UN Universal Declaration of Human Rights.

As the literature is sparse in this area, and there are certainly no standardized tools or other methods for recording data, we developed our own topics of interest. We chose these eight topics based on our view of what would be important for understanding how legislation regulates involuntary hospitalization between countries. We were principally interested in how changes to legislation may result in changes to rates of involuntary hospitalization, and so tried to identify what might be the key parts of the legislation that may affect clinical practice around involuntary hospitalization. For example, we considered the criteria under which someone could be hospitalized involuntarily, or whether it is a clinical or legal authority that issues an involuntary hospitalization order, to both be important in this regard. The research team featured two academic psychiatrists, including a very senior one, who lead the discussion of this issue. We then asked "key informants" to check that our legal profiles were accurate and comprehensive. Key informants were experts in mental health law in the countries they were based in and were psychiatrists or mental health law academics.

Socioeconomic, Demographic, and Clinical Data

We obtained data on the socioeconomic, demographic, and clinical characteristics of the different countries from international organizations such as the WHO, the Organisation for Economic Co-operation and Development (OECD), Eurostat, the European Social Survey, and the World Bank. These characteristics were as follows:

- Number of psychiatric beds per 100,000 individuals;
- Health care spending per capita in US dollars;
- Number of psychiatric staff (psychiatrists, mental health nurses, social workers, and psychologists) per 100,000 individuals;
- Gross domestic product (GDP) per capita at purchasing power parity (PPP) in US dollars;
- Income inequality (measured as Gini coefficients);
- Absolute poverty, defined as the proportion of the population with an income of less than \$550 per day;
- Relative poverty, defined as the proportion of the population with an income of less than 50% of the national median (data obtained from the OECD);
- Urbanization, measured as the proportion of the population living in urban environments;

- Foreign-born population, measured as the proportion of the population who were foreign born;
- BAME population, measured as the proportion of the population who identify as BAME.

Analyses

We planned four analyses:

1. A descriptive statistical analysis of how rates of involuntary hospitalization varied over time and between countries. For it, for each country included in the study we generated the mean change over time.
2. A description and comparison of legislation in those countries. We performed this as a discussion of some of the key features of legislation, particularly in terms of how legislation compares between countries and how these differences may impact rates of involuntary hospitalization.
3. A cross-sectional statistical analysis of the relationship between legislation characteristics and the most recent available number of annual involuntary hospitalizations per 100,000 population in each country. Based on the profiles we had created, we analyzed the relationship between rates of involuntary hospitalization and legislation using between group comparison of the average number of involuntary hospitalizations per 100,000 population. For example, countries that require patients to pose a risk to the safety of themselves or others before they can be involuntarily hospitalized were grouped, while those that do not were placed in a second group. We then compared whether rates of involuntary hospitalization differed between these groups using Wilcoxon rank-sum tests as the distribution of involuntary hospitalization data were non-parametric.
4. An analysis of the relationship between involuntary hospitalization rates and socioeconomic, demographic, and clinical characteristics internationally. We performed this analysis using up to 10 years of data, making it a longitudinal design. Since we would expect annual data from a single country to be more statistically associated with each other than those between countries (so to “cluster” within countries), we need to take that into account. We performed mixed-effects regression analyses using the rate of involuntary hospitalization as the outcome for each of the socioeconomic, demographic, and clinical predictors we included in our study. A mixed-effects or multilevel analysis allows for data to be hierarchical or have multiple levels and so to have groups or clusters. In our case, we had multiple years of data for each country and so the data had two levels: year and country. A multilevel model fits a regression line for the annual data for each country first and then generates an overall estimate of the relationship. We used a “random slopes” model, which allows the coefficients (or “slopes”) of the country-level regressions lines to vary between countries.

Where multiple years of data were not available for a social or clinical predictor, we performed a cross-sectional regression analysis using predictor and involuntary hospitalization data matched by year.

Section Summary

- Twenty-two countries were included from across Western Europe, Australia, and New Zealand. Data were obtained from governmental organizations, peer-reviewed literature, and other suitable sources.
- We summarized legislation for each country by creating “profiles,” which were checked by experts in mental health law based in the different countries.

Research Practicalities

The Research Team

Our research team was made up of researchers, clinical researchers, experts by experience, a statistician, and a solicitor. Having a solicitor contribute to a research study was certainly unusual for us as mental health researchers. However, their involvement was invaluable in creating the legislation profiles of the different countries as such information is often highly technical and can be difficult for a lay person to understand. Meanwhile, the clinical researchers were able to make use of their professional networks to help identify suitable clinicians in other countries to be key informants. But identifying experts using this method was not always possible and we also identified key informants through the peer-reviewed research literature on mental health legislation in the respective countries. Finally, having the contribution of people with lived experience of the mental health services and of being subject to the Mental Health Act was helpful and important. The NIHR Mental Health PRU has a “lived experience working group,” who are people with lived experience of the mental health services and who collaborate on our research projects. In the case of this project, two members of the working group were part of the research team and contributed especially to the interpretation of the results, both in the main text of the paper and through a “lived experience commentary.” Including Patient and Public Involvement (PPI) in the research process can be enormously beneficial in a wide range of ways, and many organizations, such as research funders, increasingly recommend or require PPI in the design, conduct, and dissemination of health and social care (Boivin et al., 2018). In the PRU, members of our lived experience working group are typically involved in the design, conduct, and interpretation of our research.

Obtaining Data

For this study, we sought to obtain publicly available data online, through peer-reviewed literature, and in some cases with the assistance of key informants. This is a very different process from conducting primary research with participants, but it certainly had its own challenges.

First, as few studies have been conducted investigating this topic, we needed to develop solutions to the challenges we encountered ourselves without the expertise of others in this field. We needed to find out ourselves how to obtain these types of data, how much or little such data were available and whether they were valid, and as there were no usable summaries of legislation available, we

had to summarize the legislation of different countries ourselves. As such, we did not need to recruit patients, obtain ethics approval, or go through the application processes often associated with large patient datasets. But we encountered many hurdles, many of which were novel to us, that we needed to find practical ways to overcome.

In terms of the data, at the start of the project we set out to obtain involuntary hospitalization data for as many potentially eligible countries and for as many years as possible. We began by searching for the websites of relevant government agencies for each country we wanted to include in the study. These included departments of health or statistics, such as NHS Digital in England. We downloaded data directly from the websites where it was available. However, many countries did not provide data readily available online. For those countries, we contacted the agencies by telephone and/or email to request the data or to ask where it could be obtained from. In some cases, we were unable to obtain data from government agencies, and so contacted academics who had published on this topic in those countries. In this way, for two countries (Greece and Cyprus), we were informed that the WHO Mental Health Atlas data were the most up to date so we used those. Not all websites were fully translated into English, and so one of the challenges of this study was to enlist people to help who could navigate the sites or contact the agencies in the relevant language. Moreover, it was often difficult for us to identify the correct source (e.g., website) for the data. We often needed to enlist the help of key informants familiar with how to obtain such data or with the relevant organizations in the different countries. As such we relied heavily on the assistance of many academics and psychiatrists from around the world to conduct this research. One of the key components of conducting this project then was establishing those connections and setting up good relationships with experts, without whom we would not have been able to complete it.

During the initial scoping process for the study, we found that national data were not collected for Canada, which is a country that we would otherwise have included. However, due to the lack of data, we had to exclude it from the study. We also decided to exclude the United States as we were concerned that available data were only for publicly funded mental health services, and so the data may not have accurately reflected the true rates of involuntary hospitalization, not least because of the use of private facilities and the relatively high numbers of people with mental illness in prison ([Bronson & Berzofsky, 2017](#)). As such, we thought that the data were unlikely to be directly comparable to those for other countries. Second, the United States contains 50 states that each have its own laws, and therefore summarizing the legislation would have created an unmanageable workload for our research team. Meanwhile, due to this variation in the legislation, we concluded that there was no good way to include the United States as a single country in our analyses of the relationship between legislation and rates of involuntary hospitalization. As such, we thought that the United States justified its own study. Indeed, if such a study was restricted to the United States, the potentially poor validity of the data may matter less as they are being compared to each other.

For the socioeconomic, demographic, and clinical characteristics of the countries, we focused on

publicly available data that we could obtain from the websites of international organizations such as the WHO and the OECD. We chose which data to use by first exploring what types of data were available (e.g., number of psychiatric beds per 100,000 population) and then considering which were of interest. This decision was based primarily on what previous literature had highlighted as associated with involuntary hospitalization, but clinical expertise was also important. This literature has been systematically reviewed in two other projects being conducted for the MHA review by the Mental Health PRU, one of which discusses the social and clinical predictors of involuntary hospitalization (Walker et al., 2019) and another role of ethnicity in the likelihood of being hospitalized involuntarily (Barnett et al., 2019).

Creating the Legislation Profiles

A significant amount of effort was dedicated to creating the legislation profiles of countries. We obtained the legislation for each country and searched for useful secondary sources, such as peer-reviewed papers, which described the legislation. We needed to translate the legislation of many countries, which we again did with the help of speakers of the different languages. We initially created a summary profile of the legislation for each of the countries. We then identified key informants based in each of the countries who could check the accuracy and comprehensiveness of the profiles for us. They also made notes for us about how the law is applied in practice. We did this by identifying legal academics specializing in mental health law or psychiatrists based in each country. One of the complications of this part of the project was that two countries (Germany and Australia) have multiple states, each with its own legislation. As such, legislation had to be summarized for each state, which was a very time-consuming process. Moreover, identifying suitable key informants was potentially tricky because a psychiatrist or academic may not be familiar with the laws of every state. As such, we identified mental health law academics and experts based in those two countries who could assist us. In both cases, they very kindly agreed to help and devoted a substantial amount of time to ensuring that our profiles were accurate.

Section Summary

- We had a multidisciplinary team of researchers, clinical researchers, a solicitor, and people with lived experience of mental health services. This broad range of skills was required to conduct this study effectively.
- But we also had contributions from a wide range of people, including academics, psychiatrists, and students to help us with language barriers, obtaining data, and with summarizing legislation.

Method in Action

There were many challenges, which were often fairly unique to us as researchers, in conducting this project. Two of the biggest that we encountered were to obtain involuntary hospitalization data

that were comparable between countries and completing our legislation profiles. Data were often not readily available, which made it difficult to obtain them. We often needed to rely on governmental sources or other organizations such as the WHO. Meanwhile, we were keen to identify the most recent and reliable data available. As such, we had to contact a lot of organizations, practicing psychiatrists, and academics based in the different countries to ask them for assistance. It could be difficult to engage them though as they were often very busy, and occasionally we had to be very persistent or ask several people in each country. Furthermore, as mentioned, we often faced a language barrier, which we tackled in correspondence with key informants with translation websites as well as enlisting the help of many researchers and students in our department who were native speakers.

Comparability of Data From Different Countries

A further difficulty was making sure the data were comparable. In England, for example, the involuntary hospitalization data available through NHS Digital are reported as the number of uses of the Mental Health Act (MHA) per 100,000 population per year. However, a patient can be subject to the MHA at the time they are admitted to hospital or subsequently after having been initially admitted “informally” (i.e., voluntarily and not under the MHA). So we could not compare English data to data for other countries if it only included patients hospitalized involuntarily on admission. Furthermore, many mental health legislations contain multiple orders, or “sections” in England, which can be applied to a patient and these typically differ in terms of the legal requirements placed on patients and professionals, such as how long a patient can be detained for or whether they are required to take medication. As such, we had to define what we meant by an instance of “involuntary hospitalization.” As it was the most common and clinically useful definition, we chose to focus on the number of hospital admissions in a year in which the patient was kept in hospital involuntarily for at least some of the time. We had to be mindful though that the data in some countries, such as the Netherlands, may include every instance of a use of the mental health legislation and therefore at a patient could be subject to multiple uses in a single admission, and so there could be an issue with a single admission counting multiple times in the data. In England, while every effort is made to avoid such “double counting,” it is possible that a patient who moves from a privately owned hospital to an NHS hospital will be counted twice (however, this is only a small number of people). But as we do not have access to patient-level data in any country, so we cannot eradicate this possibility ourselves.

Second, we wanted to focus on only inpatient involuntary admissions. However, some countries by default count community treatment orders (CTOs) in their involuntary hospitalization data. CTOs are orders that require patients currently receiving treatment while living in the community to comply with their treatment plans, such as with their prescribed medication regimen. Most countries provided involuntary hospitalization data without CTOs. But some, such as Scotland, could not. As such, this was another limitation on making the data straightforwardly comparable between all countries.

Third, in some cases, it can be difficult to find comprehensive definitions of what is or is not included

in the data in some countries. So we needed to spend quite a lot of time discussing this with the organizations publishing it. Where there were known issues with the data, or limits on the comparability of data from different countries, which we could not overcome we acknowledged them in the limitations section of our paper. For example, the data in England for 2016–2017 are known to undercount the number of involuntary hospitalizations as not all NHS providers reported their figures in time to be included. As such, although we report the 2016–2017 figure in our paper, we acknowledge that it is under-reported and we do not include it in our analyses.

National-Level Characteristics

There were also limitations with the socioeconomic, demographic data, and clinical data we used. We obtained it from organizations, such the WHO or OECD, which typically request it from individual government organizations. However, there can be issues with the data governments give them. For example, the number of psychiatric beds in Australia is actually quite a bit lower than we initially included in our paper. However, this only became apparent after the paper was published and once WHO Europe received revised data from Australia. This topic is discussed in a letter to the editor regarding our paper ([Allison, Bastiampillai, Copolov, & Castle, 2019](#)) and our reply to it ([Rains & Johnson, 2019](#)).

Legislation

The legislative profiles posed their own difficulties. It took a long time to create comprehensive profiles of legislation because of the complexities associated with trying to understand the different legal systems, as well as language barriers and that some countries have multiple states, such as Australia and Germany, and each state required their own summary. Furthermore, we needed to identify suitable key informants who were familiar with the different legislations. We focused on identifying academics who were experts in mental health law and psychiatrists with web searches or through contacts the research team had. But they were often very busy people, and in some cases, people did not have the time to assist with the project. However, everyone we contacted were very happy to contribute if they could, and their input was invaluable.

Section Summary

- We faced many challenges in obtaining and analyzing the data. Some of these challenges include difficulties in identifying appropriate sources for the data and obtaining comparable data for every country, language barriers, and finding experts based in the different countries to check our legislation profiles.
- Summarizing the legislation and obtaining the data in particular were both very time-consuming tasks. However, we now have information about the legislation of each country that we can use in future studies.

Practical Lessons Learned

Conducting this type of work is tricky because of the difficulties in obtaining data, the limitations of that data, and because it is very time consuming and challenging to understand so many different legislative systems, especially if they are many different languages. In a sense, it is difficult to draw definitive conclusions about socioeconomic, demographic, and clinical drivers of international variations in rates of involuntary hospitalization. But it nevertheless provides an interesting comparison and does suggest the importance of some factors for understanding why some countries have much higher rates than others. However, the limitations of the data perhaps obscure the true nature of the relationships to some degree. But one of the most important outcomes of the analysis was that much of the variation in international rates could not be explained by the factors we decided to include. That includes legislative differences, at least in our analysis. Therefore, there is still enormous scope for exploring what the key reasons are. As we speculate in our paper, it may be that how clinical practice differs between countries is more important than specific elements of legislation. For example, patients who would be hospitalized on the grounds of presenting risk in some countries might instead be hospitalized for urgent treatment in others. The threshold for deciding when to hospitalize someone involuntarily may be less the result of variations in legislation than it is to do with variations in clinical culture.

However, whether to perform a statistical analysis on this topic was something that we struggled with. An alternative would have been to provide only a narrative analysis and not include a statistical analysis at all. This is because a statistic analysis in this context may not be sensitive enough to pick up on differences. Instead, a nuanced narrative analysis may be preferable. With either of these approaches, however, this is an extremely complex topic and it was always going to be impossible for us to provide definitive answers. Instead, we hoped to contribute to the discussion on this issue by providing some data and analyses. There had never been a study that had summarized the legislation for all of the countries we included, nor an international comparison of mental health legislation that summarized the topics we did.

During this process, as a research team we learnt a lot about how to conduct analyses with publicly available data, where and how to obtain it, and about the limitations of such data. We also obtained a large body of information about the legislation of different countries that we may be able to use in future publications. However, perhaps the key thing we learnt is the need to do more to improve research in these slightly unconventional, but important, policy-related topics. More can be done to consider the real-world impact of different mental health policy and legislation choices. However, the practical reality of such research is often far from straightforward at the moment. It is important that more is done by governments and other organizations to ensure that the data they report are valid and comprehensive and that there is a growing consensus on which data should be collected and made publicly available.

Section Summary

- We learnt a lot about how to obtain these types of data and about their limitations.
- We struggled with how to analyze the relationship between legislation and rates of involuntary hospitalization. The two previous papers on this topic have taken different approaches: one performing a statistical analysis and the other a purely narrative analysis.

Conclusion

In this project we investigated variations in the rates of involuntary hospitalization internationally and explored their relationship with national mental health legislation and socioeconomic, demographic, and clinical characteristics. In this article, I have described the process of conducting the project. Overall, it was an interesting and fairly unique project to work on, which posed some unusual challenges.

We were a fairly small research team, but we relied on the input from a large group of clinicians, academics, and students, without whom this project would not have been possible. The project took roughly a year to complete. This timeframe was dictated to a degree by the schedule of the U.K. government's independent review of the MHA (1983) as amended, which had been commissioned in late 2017 and needed to be finished by late 2018. As this project was intended to inform that review, we had to ensure that we completed the final report for the review's working group in time. Much of this time was occupied with contacting organizations and key informants, summarizing legislation, and ensuring we had obtained the most up-to-date and accurate involuntary hospitalization data we could.

However, there were several challenges that we needed to overcome while conducting this project, and we were sure to catalog the ones that may affect interpretation of the study's results in the limitations section. Indeed, due to journal word limit restrictions, we needed to move a full discussion of some of these limitations to the supplementary material. While we cannot say that this project could provide definitive answers on the topic of how involuntary hospitalization rates vary internationally, it presents the best data that were available and makes an important contribution to the literature. However, much of the variation in rates remains explained. Our hope is that further work can build on this study and shed more light on why rates vary so much internationally.

Section Summary

- We completed this project in about 9 months, which was a schedule dictated by the review of the MHA.
- There were several, fairly unique, challenges to completing this project, but it was an interesting project to work on.

Classroom Discussion Questions

Classroom Discussion Questions

1. How can research like this help inform a review of mental health law?
2. What do you think are some of the difficulties when interpreting the statistical results of this study in relation to (a) legislation and (b) socioeconomic, demographic, and clinical factors?
3. What were some of the challenges of conducting this research project and do you have any potential ways of addressing them that were not discussed in this report?
4. How would you examine the relationship between legislation and rates of involuntary hospitalization?
5. What do you think are the next steps for research in this topic?

Declaration of Conflicting Interests

The Author declares that there is no conflict of interest.

Further Reading

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