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Compulsory psychiatric treatment checklist: Instrument development and clinical application

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ABSTRACT

Instruments designed to evaluate the necessity of compulsory psychiatric treatment (CPT) are scarce to non-existent. We developed a 25-item Checklist (scoring 0 to 50) with four clusters (Legal, Danger, Historic and Cognitive), based on variables identified as relevant to compulsory treatment. The Compulsory Treatment Checklist (CTC) was filled with information on case ($n = 324$) and control ($n = 251$) subjects, evaluated under the Portuguese Mental Health Act (Law 36/98), in three hospitals. For internal validation, we used Confirmatory Factor Analysis (CFA), testing unidimensional and bifactor models. Multilevel logistic regression model (MLL) was used to predict the odds ratio (OR) for compulsory treatment based on the total scale score. Receiver Operating Characteristic analysis (ROC) was performed to predict compulsory treatment. CFA revealed the best fit indexes for the bifactor model, with all items loading on one General factor and the residual loading in the a priori predicted four specific factors. Reliability indexes were high for the General factor (88.4%), and low for specific factors (<5%), which demonstrate that CTC should not be performed in the subscales to access compulsory treatment. MLL reveals that for each item scored in the scale, it increases the OR by 1.26 for compulsory treatment (95%CI 1.21–1.31, $p < 0.001$). Based on the total score, accuracy was 90%, and the best cut-off point of 23.5 detects compulsory treatment with a sensitivity of 75% and specificity of 93.6%. The CTC presents robust internal structure with a strong unidimensional characteristic, and a cut-off point for compulsory treatment of 23.5. The improved 20-item version of the CTC could represent an important instrument to improve clinical decision regarding CPT, and ultimately to improve mental health care of patients with severe psychiatric disorders.

1. Introduction

Compulsory psychiatric treatment (CPT) of individuals with mental disorders is characterized by a conflict of opposing interests and moral values (Simonović, Nenadović, & Momcilović, 2011), due to the deprivation of liberty and intrusion of the personal integrity of an individual who has not committed any crime (Simonović et al., 2011). However, families and physicians consider CPT beneficial, and some patients subjected to CPT consider this a positive step (Wyder, Bland, Herriot, & Crompton, 2015), suggesting that there is no single definitive experience or view of Compulsory Outpatient Treatment (COT) (Canvin, Rugkåsa, Sinclair, & Burns, 2014). Therefore, it remains a controversial and complex ethical and legal problem, raising human rights concerns (Bartlett, 2011; Brown, 2016).

Whether CPT reduces health service use, and/or improves outcomes, remains an unresolved question and there is a lack of standards and proof of effectiveness (Jacobsen, 2012). The few studies available have shown contradictory results (Høyer, 2008; Kallert et al., 2011; Okai et al., 2007; Prinsen & van Delden, 2009; Sibitz et al., 2011), with observational studies showing positive effects (Bursten, 1986; Durst, Teitelbaum, Bar-El, Shlafman, & Ginath, 1999; Fernandez & Nygard, 1990; Geller, Grudzinskas, McDermeit, Fisher, & Lawlor, 1998; Hiday & Scheid-Cook, 1989; Munetz, Grande, Kleist, & Peterson, 1996; Preston, Kisely, & Xiao, 2002; Zanni & deVeau, 1986), whereas higher levels of evidence have failed to demonstrate benefits, namely for COT regarding service use, symptom levels, social functioning or quality of life as

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compared with patients treated on standard voluntary care (Kisely & Campbell, 2015).

The frequency of CPT varies considerably between countries and regions (Kallert et al., 2011; Steinert et al., 2010), mainly due to differences in legislation. Official statistics on CPT are scarce, with rates varying from as low as 3.2% in Portugal, to as high as 30% in Sweden, yielding a median value of 13.2% (Kallert et al., 2011). Moreover, considerable differences exist even within the country, and sometimes even from psychiatrist to psychiatrist, in the same hospital. In fact, local treatment culture and staff attitude may contribute to variations (Feiring & Ugstad, 2014; Lepping, Steinert, Gebhardt, & Röttgers, 2004; Steinert et al., 2010). In addition, extralegislative factors stemming from the setting, the patient, the decision-maker, and the availability of resources are likely to influence the decision (Engleman, Jobes, Berman, & Langbein, 1998). The values and beliefs of the decision-maker may then become an important determining factor, and considerable variation in how the law is understood, interpreted and operationalized may occur (Davidson et al., 2016; Feiring & Ugstad, 2014).

In this sense, psychiatrists need to better define and characterize the criteria for initiating and/or maintaining CPT (Braitman et al., 2014). If compulsion is to be justified, much clearer evidence should be required as to how it is currently used, and the circumstances in which it is necessary, rather than merely convenient (Bartlett, 2011). A proposal of monitoring guidelines for involuntary measures has been proposed to improve the situation (Jacobsen, 2012), since such a standard is absent, the imposition of treatment becomes a matter of luck as to who is the responsible clinician, and human rights become a lottery (Bartlett, 2011).

Although attempts have been made to standardize rules and instruments (Priebe et al., 2005), only limited data is available on procedures for CPT of patients with mental disorders in Europe (Quirk, Lelliott, & Seale, 2004); thus, there is an urgent need to find an international consensus on clinical conditions and procedures regulating it (Kallert, 2008). This was also the conclusion of EUNOMIA, a study funded by the European Commission, in order to develop European recommendations for good clinical practice in involuntary hospital admissions (Kallert et al., 2011).

2. Objectives

In face of the need to develop instruments to standardize the clinical evaluation for the decision to initiate and/or maintain CPT, we developed a Compulsory Treatment Checklist (CTC) to guarantee that all relevant factors are taken into consideration during the psychiatric clinical evaluation. We present the results regarding the Checklist's validation in a sample of patients using mental health services.

3. Methods

3.1. The Portuguese Mental Health law

The Portuguese Mental Health Law (36/98) (Mental Health Act, n.d.) establishes the general principles of the mental health policy in Portugal and governs the compulsory detention of persons with mental disorders, namely persons with *serious* mental disorders. It establishes that a person may be compulsorily detained in an appropriate (official) institution when suffering from a *serious* mental disorder, which creates a situation of danger to legally protected rights of relevant value, whether his/her own or those of others, of a personal or patrimonial nature, and refuses to submit to the necessary medical treatment (Article 12, number 1). Moreover, patients who lack the necessary discernment to evaluate the implications of non-consent, may also be compulsorily detained in cases where the absence of treatment can result in a significant deterioration of their condition (Article 12, number 2). The detention is substituted by compulsory outpatient treatment (COT), whenever such treatment can be performed under conditions of freedom; whenever the stipulated conditions of outpatient treatment are not met by the patient, this is reported to the court and detention (i.e. compulsory hospitalization) is resumed.

Compulsory detention may be petitioned by the legal representative of the person suffering from a mental disorder, by the Public Health authorities and by the Public Prosecution Service. Nevertheless, whenever a doctor in the exercise of their duties, detects a mental disorder with the effects stipulated in Article 12, he/she may communicate such information to the competent Public Health authority for the purposes of the needed provisions. When the person has been voluntarily admitted and requests discharge, but remains eligible for compulsory detention, the clinical director of the institution is eligible to apply for compulsory detention.

The psychiatric assessment is referred to the official psychiatric assistance services, of the patient's area of residence and should be carried out within a period of 15 days, by two psychiatrists, with the possible assistance of other mental health professionals (Article 17). The services forward their report to the court, within a maximum period of seven days. The clinicians' technical scientific assessment inherent to the psychiatric assessment, is not subject to the judge's free appraisal.

After receipt of the psychiatric assessment, the judge designates a date for the joint session, of which the patient to be detained, the defence attorney, the applicant and the Public Prosecution Service are informed (Article 18). Although this should be the rule, persons wtih a *serious* mental disorder may be subject to an emergency compulsory detention in cases where, given the provisions of Article 12 (number 1), there is *imminent danger* to the legally protected values referred therein, namely due to an acute deterioration of the person's state. When this is the case, the police or Public Health authorities may determine, officiously or by application, through a warrant, that the person with a mental disorder is escorted to the nearest psychiatric emergency department to be submitted for an urgent formal psychiatric assessment and provided with the appropriate medical assistance (Article 24). In cases where, due to the urgency of the situation and the dangers of delay, a warrant may not be previously issued, and any police officer may proceed with the immediate escort of the patient for urgent evaluation (Article 23).

When the psychiatric assessment determines the need for detention and such a measure is opposed to by the patient, the institution immediately communicates the compulsory admission of the patient to the competent court, with copy of the assessment report (Article 25). When the psychiatric assessment does not determine the need for detention, the entity which presented the person with a mental disorder sets him/her immediately free (Article 25, number 2). Any doctor in a psychiatric emergency service may initiate this process, and for that they only have to communicate the need for compulsory admission to the competent court, with a copy of the clinical evaluation report.

Upon receipt of the report, the judge issues a decision regarding whether detention should or not be maintained, within a maximum time limit of forty-eight hours from the deprivation of freedom, pursuant to articles 23 and 25.

Upon receipt of the communication, the judge begins the compulsory detention process based on the principles stipulated in Article 12 and shall therefore order a new psychiatric assessment to take place within five days by two psychiatrists not involved in the previous assessment and with the possible assistance of other mental health professionals (Article 27).

Compulsory detention (either during hospitalization or on an outpatient basis) terminates once the factors which have originated it have ceased (Article 34). This is done based on a psychiatric assessment report by two psychiatrists of the health service where the detention took place, and it is immediately communicated to the competent court. The review of the patient's situation is mandatory, independently of whether it is requested, two months following the beginning of the detention, or the decision to extend it (Article 35).