



Voluntary or involuntary acute psychiatric hospitalization in Norway: A 24 h follow up study



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ABSTRACT

The Norwegian Mental Health Care Act states that patients who are involuntarily admitted to a hospital must be reevaluated by a psychiatrist or a specialist in clinical psychology within 24 h to assess whether the patient fulfills the legal criteria for the psychiatric status and symptoms. International research on the use of coercive hospitalization in psychiatry is scarce, and an investigation of Norway's routine re-evaluation of involuntarily referred patients may expand knowledge about this aspect of psychiatric treatment. The aim of this study was to investigate the extent to which Involuntarily Hospitalized (IH) patients were converted to a Voluntary Hospitalization (VH), and to identify predictive factors leading to conversion. The Multi-center Acute Psychiatry study (MAP) included all cases of acute consecutive psychiatric admissions across twenty Norwegian acute psychiatric units in health trusts in Norway across 3 months in 2005–06, representing about 75% of the psychiatric acute emergency units in Norway. The incident of conversion from involuntarily hospitalization (IH) to voluntary hospitalization (VH) was analyzed using generalized linear mixed modeling. Out of 3338 patients referred for admission, 1468 were IH (44%) and 1870 were VH. After re-evaluation, 1148 (78.2%) remained on involuntary hospitalization, while 320 patients (21.8%) were converted to voluntary hospitalization. The predictors of conversion from involuntary to voluntary hospitalization after re-evaluation of a specialist included patients wanting admission, better scores on Global Assessment of Symptom scale, fewer hallucinations and delusions and higher alcohol intake. **Conclusion:** The 24 h re-evaluation period for patients referred for involuntary hospitalization, as stipulated by the Norwegian Mental Health Care Act, appeared to give adequate opportunity to reduce unnecessary involuntary hospitalization, while safeguarding the patient's right to VH.

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1. Introduction

Involuntary hospitalization (IH) is a controversial issue in psychiatry due to the ethical complexity of admitting a person for treatment against his/her will. The Madrid Declaration on Ethical Standards for Psychiatric Practice from August 25th 1996 states in article 4 (World Health Organization, 2005): “...No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or the life of others. Treatment must always be in the best interest of the patient.” International law bodies like the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment focus on how IH is performed in countries, the patient's right to information about use of coercion, and how

national supervisory bodies function with inspections practice (Ministry of Justice and Public Security, 2000).

1.1. Background

The autonomy of the psychiatric patient is a complicated construct. In situations where the patient might lack insight about the illness and is believed by health care professionals to suffer from psychosis, major depression or to be in a manic state, the balancing of patient autonomy with the right and need for treatment may be challenging. Patients with psychosis often lack insight – a capacity to gain an accurate and deep understanding of someone or something including awareness of a mental disorder and understanding social consequences of the disorder, the need for treatment and awareness of specific signs and symptoms of the disorder (McCormack, Tierney, Brennan, Lawlor, & Clarke, 2014). A study on the “patient's perspective”, and “family burden of coercion” showed that IH often is associated with a feeling of being excluded from participation in the treatment (Kallert, 2008).

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Due to differences in mental health legislature both across Europe and in the rest of the world, levels of IH are difficult to compare (Kallert & Torres-Gonzales, 2006). EU-countries have been recorded varying rates from 3.2% in Portugal, to 21.6% in Finland. France has reported IH rates of 10.5–12.5% (1988–1999), UK 11.7–13.5% (1976–1999) and German reports range from 3.9 to 44.8% in 1978 and 17.7% in 2000 (Riecher-Rossler, 1993).

On a general level patients' may experience unaccountability or incompetency to give consent for hospitalization as a consequence of young age, or disturbance of consciousness caused by a serious medical condition. In some cases necessary treatment may conflict with religious beliefs, for example refusal to receive blood or blood products, or refusal to break off an ongoing hunger strike (Norwegian Ministry of Health and Care Services, 1999; Yate, Milling, & McFadzean, 2000). In these circumstances physicians have to make choices for the patients based on best practice and the need to save lives. Under the Norwegian Act of Health Personnel, necessary health care shall be given, even if the patient is incapable of granting his consent thereto, and even if the patient objects to such treatment (Ministry of Health and Care Services, 1999a).

In Norway, family members are commonly the ones making contact with the primary health care system if they believe a person to be in need of psychiatric hospitalization. The family doctor/the general practitioner (GP) is often the first port of call, or alternatively, the local afterhours emergency clinic might perform an evaluation of the patients' mental health status. The physician then determines whether or not there is a need for hospitalization as IH or VH.

1.2. Norwegian law

The Norwegian Mental Health Care Act follows the principles of the World Health Organization's checklist which states that IH and involuntary treatment may only be given when 1) there is evidence of a mental health disorder of specified severity 2) a serious likelihood exists that the person might do harm to him/herself or others, 3) substantial likelihood exists that serious deterioration might occur in the patient's condition if treatment is not given and 4) admission is for therapeutic purposes (World Health Organization, 2005).

1.2.1. The Norwegian Mental Health Care Act process

In order to be admitted to an acute psychiatric unit in Norway the patient must be evaluated by a physician (in most cases a GP) outside the hospital (Ministry of Health and Care Services, 1999b). The referring physician decides, based on the Mental Health Care Act, if a patient should be referred as voluntary hospitalization (VH) (§ 2–1), involuntary observation (IH) up to 10 days (§ 3–2) or involuntary hospitalization (IH) with unlimited duration (§3–3). To fulfill the IH observation criteria, the physician must suspect that the patient is suffering from a serious mental disorder. IH patients may be referred through a court decision, and adolescents can enter the hospital under the law of child protection or the law of social services. While the vast majority of IH is by referral from a physician, VH should always be considered first if the present condition of the patient does not clearly preclude this.

When the patients are admitted to the psychiatric acute emergency unit at a psychiatric hospital, they are immediately met by a physician or a resident physician for a first evaluation. The IH patient is re-evaluated by a psychiatrist or a psychologist with special authorization within 24 h. This is commonly done in the morning following the admission. This re-evaluation assesses whether the patient is in further need of IH. If IH is not indicated the patient can be treated as VH or discharged. Follow as indicated is performed by their GP and/or outpatient clinic or local municipality services. The 24 h observation period is intended to allow for more accurate decisions to be made regarding the need for IH. Given that patients are admitted, additional information regarding their condition and behavior may then be gathered from their GP, relatives, and other relevant sources like district psychiatric centers

or municipality mental health teams. The observation of patients by health care staff at the acute psychiatric emergency unit is also valuable in this decision process. Competent psychiatric staff, a quieter environment, reduction of stress, contacts with relatives and detoxification of drugs combines to allow for a more thorough re-evaluation. Especially in cases of substance abuse, the acute crisis might be over within this 24 h period. There is no claim that the Voluntary Hospitalized (VH) patients have to be re-evaluated within 24 h by a specialist since there is no process of changing their legal status of admission.

1.2.2. Conversion from VH to IH

Conversion from a VH to IH was not legal in Norway during 2005–2006. Under this act, if a VH patient required IH due to worsening of his/her condition he or she was required to return to the GP/or the local afterhours emergency clinic for a new "first" evaluation. In severe cases the GP could be called to the hospital, but this was rarely done in practice. A new Parliament revision took place June 30th 2006 and legalized January 1st 2007 (Mental Health Act § 3–4). From that time on it has been legal to convert a seriously ill patient from VH to IH on order of a specialist, if there was an imminent serious danger to the patient or others, but even so a second physician has to assess the patient.

1.2.3. Patients' rights

The patient is entitled to be informed about their opportunity to contest IH. Referring physicians (GPs or a physician at the local afterhours emergency clinic), the resident receiving the patient and the psychiatric specialist reviewing their cases are all obliged to inform the patient of his/her legal rights. If the patient does contest an IH, he/she are also entitled to free legal services by an independent lawyer. The patient may direct the complaint to the Supervisory Commission (The Norwegian Social Affairs Committee, 1998–99), which in many ways is similar to the lowest court level in the Norwegian legal system. It consists of four members chaired by a lawyer qualified to serve as a magistrate. The remaining members are a physician not affiliated with the hospital, a former patient or next of kin to a patient, and a person from a community related profession, such as a social worker or psychiatric nurse. The Supervisory Commission is autonomous in its activity, and may overrule the psychiatric specialist decision for IH.

According to the Norwegian Mental Health Care Act, referrals for IH can only be made to psychiatric inpatient units in hospital departments or community mental health centers (District Psychiatric Centers) certified for this (Ministry of Health and Care Services, 1999b, 2012). Independent psychiatric forensic hospitals do not exist in Norway. The referring physician is required to have seen the patient in person within 10 days prior to hospitalization (Fig. 1). Other Nordic countries like Finland (Turunen, Valimaki, & Kaltiala-Heino, n.d.) and Denmark have similar laws (Jepsen, Lomborg, & Engberg, 2010).

1.3. Review of earlier studies

We have identified one national report and four studies from Norway describing the IH to VH conversion process. One study was based on large samples while three were minor projects. However, we identified no international studies.

The national report represented 54% of the admissions from Norwegian psychiatric hospitals in 2001 ($N = 10,553$) and 78% in 2006 ($N = 15,721$). A respective 40% and 39% of admitted patients were referred for IH, and 88% and 75% stayed involuntary after specialist reevaluation (IH → IH) (Bremnes, Hatling, & Bjørngaard, 2008). Due to incomplete data from several sites in 2001 and improved admissions data recording in 2006, the number of included admission rose of nearly 50%. Hospital wards treating patients aged 15 and over (acute psychiatric emergency units, high security units and long term units) were included. The report found that patients with a diagnosis of schizophrenia had higher risk of IH than other diagnostic groups, and patients age 50–59 had a higher odds ratio than all other age groups for IH.

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