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Original article

How to improve clinical practice on involuntary hospital admissions of psychiatric patients: Suggestions from the EUNOMIA study

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ABSTRACT

Number and procedures of involuntary hospital admissions vary in Europe according to the different socio-cultural contexts. The European Commission has funded the EUNOMIA study in 12 European countries in order to develop European recommendations for good clinical practice in involuntary hospital admissions. The recommendations have been developed with the direct and active involvement of national leaders and key professionals, who worked out national recommendations, subsequently summarized into a European document, through the use of specific categories. The need for standardizing the involuntary hospital admission has been highlighted by all centers. In the final recommendations, it has been stressed the need to: providing information to patients about the reasons for hospitalization and its presumable duration; protecting patients' rights during hospitalization; encouraging the involvement of family members; improving the communication between community and hospital teams; organizing meetings, seminars and focus-groups with users; developing training courses for involved professionals on the management of aggressive behaviors, clinical aspects of major mental disorders, the legal and administrative aspects of involuntary hospital admissions, on communication skills. The results showed the huge variation of involuntary hospital admissions in Europe and the importance of developing guidelines on this procedure.

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1. Introduction

Involuntary hospital admission of patients with mental disorders is a controversial but sometimes necessary medical procedure. A recent review [23] showed that involuntary

placement of mentally ill people is not associated with a higher risk of negative outcome; however, it may have a strong impact on specific outcome domains, such as satisfaction with treatments and quality of life.

Available epidemiological data show that rates of involuntary hospital admissions are significantly different across Europe, ranging from 12.4/100,000 inhabitants in Italy to 232.5/100,000 in Finland, and also within the same countries [12,44]. The clinical conditions requiring an involuntary hospital admission are also

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very different in the various European contexts, being severe psychotic or affective disorders, suicide risk, marked cognitive impairment, behaviour disorders with aggression and agitation, severe danger for patients' own and for others' life, urgent need for patients' psychiatric treatments [6,25].

However, only limited data are available on procedures for involuntary hospital admission of mentally ill patients in Europe [37], although several attempts have been made to standardize rules and instruments [1–3,35], such as the publication of the volume "Mental health legislation and human rights" by the World Health Organization in 2003 [41], in which the issue of compulsory hospital admissions was specifically addressed from a legal and a technical perspective rather than from a clinical one.

Family associations and political bodies recently asked for the development of European guidelines and/or for the dissemination of good clinical practice recommendations on involuntary hospital admission [21], thus emphasizing the urgent need to find an international consensus on clinical conditions and procedures regulating it [18]. Such consensus would be in line with one of the general goals of the European Union, that of harmonizing opportunities of health care for EU citizens [18].

From 2002 to 2006, the European Commission, within the Fifth Framework Programme of Research, funded the study "European evaluation of coercion in psychiatry and harmonisation of best clinical practice – EUNOMIA" [20], coordinated by the University of Dresden and carried out in 11 European countries (Dresden – Germany; Sofia – Bulgaria; Prague – Czech Republic; Thessaloniki – Greece; Naples – Italy; Vilnius – Lithuania; Wrocław – Poland; Michalovce – Slovakia; Granada and Malaga – Spain; Örebro – Sweden; London – United Kingdom) and in Tel Aviv – Israel.

This study aimed to:

- a) clinically assess all involuntarily admitted patients living in the 13 catchment areas of the participating centres and a sub-group of voluntarily admitted patients who felt coerced at admission [20]. To identify this second study group, a randomly selected sample of at least 375 voluntarily admitted patients was screened according to their subjective experience of feeling coerced at admission using the perceived coercion scale from the MacArthur Admission Experience survey [15]. Patients reporting perceived coercion in three or more out of the five questions on the instrument were asked to participate in the study;
- b) produce standardized reports on the national legal situations on coercive treatment measures in psychiatry, on the basis of the original national legal texts [19];
- c) develop suggestions of good clinical practice on involuntary hospital admission;
- d) develop suggestions of good clinical practice on coercive treatment measures.

In this paper we report the development of suggestions for a good clinical practice on involuntary hospital admission, while information on point a), b) and d) have been reported elsewhere [19,22,36].

2. Materials and methods

Within the period January 2003 – December 2005, eleven EUNOMIA centres – with the exception of the London site, acting on the already established UK Code of Clinical Practice [11] – worked out local suggestions. Because of different centre-specific resources, a range of methods was used. Several centres (Dresden, Prague, Naples, Wrocław, Michalovce, Granada, Örebro) established regional expert groups of 10 to 15 persons representing all parties potentially involved in the administration of coercive

treatment measures (e.g. psychiatrists and nurses, municipal and police officers, members of patients' and relatives' organisations). These expert groups run semi-structured discussions or focus-groups to develop unanimously agreed upon national suggestions.

In some other centres (Sofia, Thessaloniki, Tel Aviv) a written survey of selected national representatives of all parties involved in these treatment measures was carried out; the produced material was amended according to the results of personal interviews.

Within a second phase of the work, all centres in which local expert groups were established asked for comments on their suggestions to different national professional organisations (e.g., psychiatrists, lawyers or judges, patients and relatives, ministries). These comments were collected by means of structured or non-structured questionnaires, or by discussions in specific thematic workshops; modifications of the text of the local suggestions according to the comments received were inserted by the expert groups.

All national suggestions were translated into English, and collected by the coordinating EUNOMIA – centre in Dresden at the end of 2005. By use of a qualitative content-analytical method, this centre established a system of categories aiming to produce common suggestions. The following main categories for involuntary hospital admission were developed:

- clinical conditions and legal pre-requisites for involuntary hospital admission;
- professionals involved in involuntary hospital admission procedures;
- relationship with the patient;
- relationship with the relatives;
- ethical aspects;
- therapeutic plan;
- proposals to improve patients' health care.

The information obtained from the national suggestions was extracted independently by two researchers from the Dresden centre who crosschecked their assignments afterwards. For further analyses, "summary tables" were developed. Subsequently, three researchers from the Dresden centre integrated the information into a proposal valid for all participating centres in each category. After completing the summary, the tables were sent to each centre for reviewing the validity, comprehensiveness and completeness of each summary with regard to the situation in the respective countries.

In the final step (July/August 2006), researchers from the coordinating centre revised the summaries according to the annotations of the other centres. Thereby, all information in which the centres differed was omitted. Thus, a final version of the suggestions for best clinical practice in the use of involuntary hospital admission valid for 11 EUNOMIA project centres was developed.

3. Results

3.1. Clinical conditions and legal pre-requisites for involuntary hospital admission

An involuntary hospital admission should be performed only if the following clinical pre-requisites are simultaneously present:

- the patient is suffering from a serious mental disturbance;
- the patient needs urgent therapeutic hospital-based interventions;
- the patient does not agree to such care, so that the care cannot be given with his or her consent.

Involuntary hospital admissions should be ordered and performed according to the current national Mental Health Laws, other relevant laws and regulations relating to mental health care [15]. The herein defined basic criteria of mental health condition, as well as additional criteria (e.g. dangerousness) legitimating involuntary admission, must be fulfilled.

3.2. Professionals involved in involuntary hospital admission procedures

3.2.1. Community mental health team

The physician first visiting the patient should collect all potentially useful information regarding the patient's situation from all available sources, such as relatives, friends, colleagues, social workers, police officers, other professionals.

The first clinical examination should take place in a safe and quiet place, preferably in a four-eyes-situation or in the presence of very few persons (such as a nurse or a person whom the patient trusts), if needed. The physician should then issue a certificate, in which the mental disturbances and other relevant elements causing the need for hospitalisation should be clearly reported, including a statement that the necessary pre-requisites are fulfilled. After this preliminary clinical examination, the physician can involve the paramedical professionals, defining clear tasks for each of them.

The patient can be moved to a first aid station if there is the need of a general medical check, or for ascertaining the presence of alcohol/drug intoxication, which may have contributed to the development of psychiatric symptoms.

Information on patient's sociodemographic and clinical characteristics must be transferred to the hospital team before his/her arrival.

3.2.2. Mental health team in the hospital

Upon patient's arrival at the hospital, a full mental status examination should be performed by the ward psychiatrist. After having carefully examined the patient, the psychiatrist is responsible of the final decision about patient's involuntary hospital admission. Information about patient's hospital admission must be provided by the psychiatrist to the relevant authorities as soon as possible.

Nurses and other paramedical professionals must prepare the room and the bed before patient's arrival. If the ward psychiatrist agrees, they can take part in the clinical evaluation; they must check the patient's personal belongings and they must guarantee a direct daily contact with him/her while maintaining calm, active and supportive behaviours. Finally, they must inform the patient about the ward's rules and report on the patient's physical monitoring in the appropriate records.

3.2.3. Police

The physician can ask for police involvement in patient's examination and/or when taking the patient to the hospital only when all alternatives have been considered and upon his written documented request, the police can be requested to participate in the patient's examination and/or to take the patient to the hospital for involuntary admission.

The need for police involvement is to avoid patients' aggressive and disruptive behaviours to ward, doctors, other mental health professionals, and other involved persons (i.e. relatives), and not to protect the patients against illegal and humiliating treatments by psychiatrists.

Police officers should explain to the patients about their role and reasons for their intervention in the procedure and should

inform the patients about their rights, avoiding aggressive physical and verbal behaviours toward them.

All applied coercive measures should be reported in the patient clinical record, including reasons for their applications and a clear description on how they have been performed. The record should always be at the judge's disposal.

3.2.4. Judges

The judge, before formulating any decision about patient's admission, must collect information from patients, relatives and community mental health professionals, enquiring about the patient's actual clinical situation directly from the ward psychiatrist.

In cases where orders that led to an involuntary hospitalization were not carried out within 48 hours, the circumstances under which the orders were issued should be reexamined.

If a hearing is required by the national legislations (e.g., in Czech Republic, Lithuania, Slovakia, Spain and Germany), this should take place in a comfortable and safe room, possibly located within the ward. During the hearing, the judge should involve the ward psychiatrist in order to integrate the available information with clinical details. The judge's decision should be made only after all persons participating in the involuntary admission procedure have been heard.

3.3. Relationship with the patient

Before being admitted to the hospital, the patient should receive the relevant information about his/her admission as well as about diagnostic and therapeutic measures that have to be undertaken.

The patient is allowed to bring to the hospital documents and personal belongings, and he/she should be granted the possibility of staying in contact with his/her relatives and with the relevant authorities. Moreover, the patient can receive visits and use the telephone. If the patient's mental status is significantly influenced by his/her delusions or hallucinations, or by threats to others, the use of the telephone should be anyway allowed but only in the presence of a mental health professional.

The contacts of the patient with people outside the ward cannot be limited by anyone; in particular, letters written by the patient cannot be censored.

If necessary, cultural brokers can support the patient to reduce possible linguistic and cultural differences, which can influence the duration of hospitalisation and the needs for care.

3.4. Relationship with the relatives

Unless expressly prohibited by the patient, relatives can be involved in the procedures of involuntary hospital admission (e.g., in order to get valid information about the clinical manifestations of the disorder before the admission) and should receive the relevant information about the current admission, its presumable length and prescribed treatments, by phone or face to face, by the physicians.

If the patient agrees, close relatives can be involved in the initial clinical assessment; during hospitalisation, the patient should be granted the possibility of daily contact with his/her relatives.

3.5. Ethical aspects

During the involuntary hospital admission procedures and the admission itself, patient's rights should be granted; interventions must be provided according to the principle of the "least restrictive alternative".

During the procedure, the following issues should always be considered:

- it is necessary to find a quick and clear decision about the hospitalization, in the patient's interest;
- the patient can ask to be taken to the hospital with his/her relatives, and he/she should be ideally admitted to the closest hospital;
- the whole procedure should have a limited time-frame; overly long waits should always be avoided;
- nobody can be involuntarily hospitalized without being assessed by a psychiatrist;
- this assessment should be carried out in the most comfortable conditions while ensuring the necessary level of safety for both the examining physician and for the patient.

If at all possible, the admitted patient should be firstly located in a single room, in order to guarantee him/her a safe and calm environment. He/she should have regular contacts with mental health professionals, which should be held with reciprocal respect and understanding.

Communication must be adequate for the clinical state of the patient, and information should be clearly given during each step of the procedure: patients should be clearly informed about their rights, diagnosis, prognosis and treatment. If the patient does not provide his/her informed consent, it is forbidden to convey information on his/her clinical conditions to others.

The involuntarily admitted patient must have the opportunity to use his/her right of lodging an appeal with the relevant court and consult a trustworthy lawyer.

Coercive measures should always be considered as last resort, and only when all other possible specific strategies for aggression management failed. They are allowed only in the framework of existing legislation, national standards, and relevant ethical norms and policies. Applied coercive measures (e.g., mechanical restraint, forced medication, seclusion) must be recorded in the patient's clinical file by the physician; in this file, information about persons ordering coercive measures and those executing them, duration of coercive measures, patient's physical and mental conditions should be reported.

3.6. *Therapeutic plan*

Community mental health team, ward professionals and social workers should always develop a "shared" therapeutic plan for the patient even he/she has been involuntarily hospitalized.

This plan should be worked out after a careful evaluation of patient's sociodemographic and clinical characteristics, possibilities of care, personal strengths and weaknesses, as well as his/her life expectations. The therapeutic plan should be agreed upon with the patient, if his/her mental status is healthy enough to provide informed consent. If the patient is not able to provide it, the therapeutic plan should be agreed upon with his/her key-relatives or with significant others; however, during the hospitalization the physicians should continuously try to obtain patient's informed consent.

The therapeutic plan should be elaborated for patients who have been involuntarily hospitalized.

3.7. *Proposals to improve patients' health care*

Community and hospital-based mental health teams should organize periodical meetings, seminars and focus-groups with users' involvement on the main aspects of major mental disorders and of involuntary admissions.

Moreover, training courses for the different professionals involved in this procedure should be regularly planned, taking into account management strategies for aggressive or disturbing behaviours, diagnosis and treatment of most frequent mental disorders, legal and administrative aspects of involuntary admissions, as well as specific communication skills and problem solving strategies.

4. Discussion

To our knowledge, this was the first international multi-site project, which aimed to investigate quantitative and qualitative data of involuntarily admitted patients in 12 European countries. The differences emerging across the countries did not allow the working group to formulate more in-depth suggestions; however, they may represent a first basis for discussion at a policy-making level.

The development of this consensus document in 11 countries allowed a synthesis of the most significant national aspects regarding involuntary hospital admissions, and the identification of the main different and common aspects of the procedure. In particular, it seems that cross-national differences are mostly related to legal and policy-making aspects, rather than to clinical situations.

While comparing legal and clinical conditions necessary for an involuntary hospital admission, two main models emerged as influencing the procedure, the medical and the legal model [12,44,19]. The former, adopted in countries like Italy, Greece and Sweden, assumes that the involuntary hospital admission is a health procedure, and the administrative authorities have the function of control and validation of the proposal. The latter, in force e.g. in Germany and Spain, reduces the role of the health authority, as the preconditions are already well coded by the law, and outlines the fact that the deprivation of personal freedom can be decided only by judges. The practical implication of this model is the direct involvement of legal professionals in the procedure, making necessary the hearing with the judge or with special committees. Although these differences represent an obstacle for the development of shared guidelines in the different countries, common clinical strategies have been identified. While in the Bulgarian law the clinical conditions (psychosis, severe personality disorder, salient permanent disability due to mental illness, moderate or severe mental retardation, dementia) requiring an involuntary hospital admission are analytically reported, in all other EUNOMIA countries broader diagnostic categories are used. At one end, general low threshold definitions (such as the "psychological alterations" reported in the Italian law) lack a clear definition of the nature of impairments, disturbances or illnesses which should be included in this definition. Most countries (Czech Republic, Germany, Greece, Poland, Slovak Republic, Spain) use the term "mental disorder" or "mental illness", but only a few detail what is intended under these terms. Moreover, some countries also include substance intoxication (Czech Republic) and mental retardation (Poland) among the criteria for involuntary hospital admissions.

The low level of clinical definition, as well as the tendency to use broad and generic diagnostic categories, reflect the national situations and the difficulties of physicians in identifying predictive factors for involuntary hospital admissions of mentally ill patients. However, this situation may also represent a practical advantage for professionals, in particular as regards the actual difficulties in formulating valid and reliable psychiatric diagnoses in emergency situations [38].

In some centres (Czech Republic and Bulgaria) it has been highlighted the need to admit patients with drug or alcohol abuse disorder in wards dedicated to patients with these disorders. The

admission of these patients in dedicated wards has raised an in-depth debate among the centres. In fact, mental health professionals often face difficulties in working with patients with abuse disorders due to:

- the diagnostic complexity of these patients, often reporting physical and psychiatric comorbidities;
- the different psychopathological basis of these conditions, which may blur the clinical aspects of their presentations;
- the lack of training of professionals to treat these disorders;
- the need for specific treatments of these patients, who often report low levels of compliance with medications and high rates of hospitalization.

The establishment of dedicated centres providing integrated health care for these patients would be an optimal solution; however, this is unrealistic in some of the countries participating in the study, because the distinction of drug addiction and mental health centres is still very sharp and has long clinical and even socio-legal traditions.

Moreover, availability of staff with a specific training in both settings and with the needed clinical skills would require a significant reform of training programs; thus, pragmatic short-term improvements within the health care systems are needed. These could comprise the following:

- to establish constantly available consultation services between drug addiction and mental health centres;
- to implement staff rotation models between these centres;
- to organize clinical conferences and supervision with staff working in both settings;
- to define clear criteria for admission to each setting, which must be communicated to emergency departments and to general hospitals.

It has long been debated whether social dangerousness has to be listed as a condition requiring an involuntary hospitalization. Although all the participating centres agreed that involuntary hospital admission is a medical procedure, the presence of social dangerousness was explicitly reported by all participating countries, with the exception of Italy. This criterion was adopted in all the other countries on the basis of two main assumptions:

- the existence of a real or actual and considerable danger (in the form of self-destructive behaviour) for a person's own life and health in Bulgaria, Czech Republic, Germany, Greece, (to some extent) Lithuania, Poland, Slovak Republic and Sweden;
- and/or the prevention of a real or actual and considerable danger (in the form of dangerous behaviours) for legally-protected important interests (including health and life, but also properties in Lithuania) of other people (Bulgaria, Czech Republic, Germany, Greece, Lithuania, Poland and Slovak Republic).

In Israel and Greece, the same criteria for danger to society are used, but with a more specific focus on the protection of patients themselves or of society (i.e., "protection from inflicting bodily harm on themselves or others"). In Italy this criterion was not endorsed in accordance with the mental health reform law of the 1978 (833/1978 law), which abolished social dangerousness among the criteria for involuntary hospital admission and highlighted the health aspects of this procedure. Moreover, this difference between Italy and the other countries may be also due to the differences concerning the historical development of the civil commitment legislations and the present state of the mental health care systems in the respective countries. The medical and

legal models of civil commitments procedures seem to be of extreme importance in this context. A better understanding of these issues could provide the basis for a Europe-wide harmonisation of clinical practice on involuntary hospital admissions.

However, the criterion of dangerousness of mentally ill persons represents one out of two settling criteria for involuntary hospital admission according to the WHO definition ("there is likelihood of self-harm or harm to others and/or of a deterioration in the patient's condition if treatment is not given", the other being "the evidence of a given mental disorder of specified severity as defined by internationally accepted standards" [41]) and to the recommendations of the Council of Europe [10].

The right to lodge complaints against decisions of an involuntary hospitalization was explicitly reported by all participating centres, highlighting the importance to guarantee patients' rights.

As far as role and skills of the different involved professionals are concerned, the following needs emerged:

- the improvement of the cooperation between mental health community and hospital teams. This may guarantee a continuity of care for patients and should lead to the definition of a therapeutic plan shared with patients, caregivers and professionals. Since this study focused on involuntary hospital admissions only, it was not possible to analyze in more detail the therapeutic plan and treatments provided against patients' will;
- the establishment of well-defined and clear tasks for each professional, particularly for nurses, whose role should include administration of drugs, emotional support, observation and daily contact with the patients, as well as an active collaboration with physicians in reaching the highest quality levels of care [13];
- the development of training courses for all involved professionals, including the police. These courses should aim at improving knowledge of clinical and psychopathological features of the main mental disorders, the legal and administrative aspects of the procedure for an involuntary admission, the improvement of communication skills, the management of possible aggressive behaviours in psychiatric inpatient settings.

Moreover, these courses should highlight the importance of gender, racial, cultural, social and religious/spiritual differences, in order to facilitate the mitigation of disturbed/violent behaviors [34], and the involvement of cultural brokers [24,7].

As far as the relationship with users and relatives is concerned, the following aspects emerged:

- the need to develop initiatives aimed at obtaining patient's consent to treatments, avoiding overly long hospital stays and transforming the admission into a voluntary one as soon as possible [14]. The fact that patients give their informed consent to treatment and to the voluntary hospitalization can reduce the risk that they insist on discharge immediately after having accepted the voluntary stay. However, this risk cannot be completely avoided, and it basically depends on the relationship of physicians and nurses with patients;
- the importance to provide relatives with information on reasons for admission and presumable length of stay, unless explicitly forbidden by the patient. If patients have been brought into hospital because of aggressive behaviors against their relatives, professionals should facilitate the relationship among family members through gradual and sheltered meetings, teaching communication skills and using psychoeducational techniques [28];

- the usefulness of meetings, seminars and focus-groups on clinical and legal aspects of involuntary hospital admission with the involvement of users and relatives. Even if patients' families may prefer not to be involved in the mental health care of their ill relative, available data suggest that a close involvement of users and relatives can improve patients' acceptance of treatments and create a general feeling of being more highly considered and being regarded as well [8,9,16,27–29,32,33];
- the routine application of strategies aimed at promoting relatives' involvement. Families represent an important resource, which should be helped by the availability of support groups and of psychoeducational intervention in order to improve their knowledge about mental disorders and to reduce levels of burden and expressed emotions [4,30,31].

In agreement with the existing laws in the different countries and in accordance with the Helsinki Declaration [42] and with the European Convention on Human Rights [26], the EUNOMIA team agreed that users should be treated as any other person. In particular, the following principles have been reported:

- health care provided to patients should respect the principle of the “least restrictive alternative” and the relationship between patients and physicians should be based on reciprocal respect, in agreement with points 1 and 3 of the ethical standards approved by the Madrid declaration of the World Psychiatric Association [43], and subsequently listed by the WHO among the “key areas” to be included in mental health legislations [41];
- the protection of users' civil rights and personal freedom, which represents a fundamental achievement of psychiatry;
- the protection from physical and psychological violence and abuses, as reported in the 1994 Recommendation No. 1235 on psychiatry and human rights of the European Union [5], and as ratified in the basic principles of the Oviedo Convention [17], as well as in the most recent statements of the Convention on disabled persons' rights adopted by the UN General Assembly [39].

5. Conclusion

The work carried out by the EUNOMIA group can be considered the first attempt to harmonize practical health care and procedures existing in different European countries on involuntary hospital admissions [21].

From a methodological viewpoint, this work contains the following positive characteristics:

- the involvement of different professionals in the drawing up of the national documents;
- the participation of 11 countries with different geographic, political and health contexts.

However, the following limitations must be reported:

- the lack of a rigorous and standardized methodology in the development of national suggestions;
- the involvement of users' and relatives' associations in the drawing up of the final consensus document, which has not been uniform in the different countries;
- the exclusion of patients with more than 65 years of age.

This population represents an under researched group, which often behaves violently and consequently is involuntarily hospitalized [40].

The results of this study can be useful to:

- develop European good clinical practice recommendations or guidelines on involuntary hospital admission;
- improve mental health care during psychiatric hospitalizations;
- guarantee patients' rights during involuntary hospital admission;
- increase patients' satisfaction with this procedure;
- promote collaboration among the different professionals involved in the hospital admission;
- improve knowledge about current laws and appropriate behaviours, with meetings and seminars for all involved parties and professionals.

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