COMPULSORY ADMISSIONS IN EUROPE

TROND HATLING

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LEGAL REGULATIONS

- Varies considerably across Europe – 22 countries included (Rains et al., 2019)
  - Is it a judicial and/or clinical process?
  - Diagnostic criteria or not (but mostly mental illness)?
  - Does the person need to be at risk for him-/herself or others (mostly yes)?
  - Is treatment required?
  - Does the condition need to be treatable?
  - Etc (9 items mapped)
  - But all have included a right to repeal or a tribunal
- Main findings
  - Observed no relationship between annual involuntary hospitalisation rates and any characteristics of the legal framework
- In other words
  - Radical changes in the legal regulations – in accorance with the CRPD – are probably rquired for substantial changes in each country's compulsory admission rates

FREQUENCY OF COMPULSORY ADMISSIONS ACROSS EUROPE (RAINS ET AL., 2019)

- Includes data from 22 countries over a 10 year period
- The rates – annual incidence of CA per 100 000 individuals - varies from 14.5 (Italy) to 282 in Austria (most recent year).
  - The median 106.4
- The same picture found in a number of other studies in the last 20 years
- And it is not declining
  - 4 countries with an increase of 4% or more during this period,
  - Only 2 countries with a decrease of more than -2%
  - The rest more or less stable
  - And this in a period of raised attention to reduction of coercion against persons with a mental illness

FREQUENCY – WHAT COULD EXPLAIN THE DIFFERENCES?

- It is (weakly) positively associated with
  - A larger number of beds
  - Higher GDP per capita PPP
  - Health care spending per capita
  - Proportion of foreign-born
- Inversely (weakly) associated with
  - Proportion of the population living in absolute powerty
- No association between rates of CA and
  - Relative poverty, inequality (GINI-coefficient), proportion of BAME-population, number of mental health clinicians or urbanization

FREQUENCY – WHAT COULD EXPLAIN THE DIFFERENCES?

- How to understand some of these findings – and still only one of many hypothesis:
  - Are «affluent» countries also those who earlier built up a high capasity of psychiatric hospital beds – and remain in a culture of coercion as «the way to do it»?
- Conclusion
  - «Variations between countries were large and for the most part unexplained»
    - And although the sample is only 22 this indicates that the answer to What can explain the diffences? lies only to a very modest degree in these indicators
    - Not to say that these elements are not important – but being rich is not the same as using them wisely (to the benefit of those CA)

RISK FACTORS FOR BEING COMPULSORY ADMITTED

- These studies often focus on characteristics of the patient, and the most frequently found assosiations are (Walker et al., 2019) (but findings differs beween studies of moderate and high quality):
  - Male gender
  - Being single/previously married
  - Unemplyment
  - Receiving wellfare benefits
  - Being diagnosed with a psychotic or bipolar disorder
  - Previous involuntary hospitalisation
- Also factors like perceived risk to others (scant use of formal scales), positive symptoms of psychosis, reduced insight into illness (but how is it measured?), reduced adherence to treatment before hospitalisation and police involvement in the admission seems to be associated with CA.

RISK FACTORS CONT. ETHNIC VARIATIONS IN CA (BARNETT ET AL., 2019) (MOSTLY UK STUDIES):

- BAME (Black, Asian and minority ethnic groups) increased risk of CA.
  - Compared to white ethnic groups
- The primary studies come up with a range of explanations for this,
  - Some «supported by evidence»:
    - Increased prevalence of psychosis, increased peceived risk of violence, increased police contact, absence og or mistrust in GPs and ethnic disadvantages
  - Some «unsupported»
    - Higher comorbid drug use in BAME group, language barriers, poorer detection of mental illness and greater stigma than in majority groups
- «we are no closer to understanding or effectively adressing these ethnic inequalities in psychiatric care»
  - calling for longitudinal studies and multisectoral, intersectional aproaches

RISK FACTORS FOR BEING COMPULSORY ADMITTED – CONT.

- A number of the individual factors show CA as being more frequently used towards persons with a low social status – and the question of the causes of social inequality is relevant:
  - is their social status a result of their mental health problems, or do their low social status contribute to their mental status (or both)?
- And economic deprivation both on an individual level and on the population level is associated with increased risk of CA.
- Preventing CA thus also have to adress social conditions; jobs, housing, social networks etc., etc
  - And these topics are usually of little concern for hospitals, requiring close collaoration with community mental health services, the social services, voluntary sector and others.

RISK FACTORS CONT.

- And if a previous involuntary hospitalisation is strongly associated with CA,
  - Is this at least in part due to the persons experiences – and thus waiting to seek help until a CA is «unavoidable»?
  - And how do the services work with these experiences in order to learn and re-establish trust?
  - And how do the services work with crisis planning – together with the user and across services and with family/network – with the aim of establishing other alternatives in periodes of increased distress/symptoms?
    - As a note to the legality – in Norway sharing this type of information across services without consent is illegal
- And on a system level
  - Could this association – at least in part – explain the rise in CA we now see in many countries?

THE COMPLEXITY OF STUDYING CA

- So far litte is known about the mechanisms behind the differences in use of CA – between and within countries – here just a few factors:
  - Is it the laws?
    - Or is it the implementation of the laws?
  - Is it the societal conditions (jobs/housing/economic conditions/culture etc.)?
  - Is it the user?
    - But what is the most important aspects?
    - And how do they interact?
    - And here to remember Sidsel (and bearing in mind studies of ethnic variations - being from Jamaica does not mean that you have to be CA)
      - Each user has to be met and understood individually

THE COMPLEXITY OF STUDYING CA

- Is it the composition of the services as a whole?
  - The division of responsibility between mental health services and the criminal system
- Is it the hospitals?
  - Staffing (composition/number)/ number of beds/culture/treatment philosophy
  - Existence of other services (outreach services etc.) and collaboration within spesialist services
- Is it the community services
  - Staffing (composition/number)/services available (housing, jobs/economic support)
- Is it the collaboration between specialist and community services?
  - Content of and degree of intergration of services offered – and «eqality» between service levels

- And the answer is yes – to some degree (of which we know close to nothing) – to all these elements

- And lastly
  - how do all these elements interact?

HOW TO REDUCE CA?

- Barbui et al., 2021 (Umbrella review of meta analysis):
- Contributing to reduced involuntary admissions:
  - Shared descision making – Weak association - GRADE rating Moderate
  - Integrated care – Weak association - GRADE rating Low
- Not contributing
  - Community treatment orders
  - Adherence therapy

A CLOSER LOOK AT THE POSITIVE FINDINGS

- What is the outcome measure:
  - Involuntary admissions (but not specified if this is quota, number of incidents, number of patients or length of stay) – and they differ - Hofstad et al., 2021
    - Reducing each of these measures will probably involve different agents, and are influenced by CMH to varying degree
- What is Integrated care?
  - Two types included under this cathegory – Crisis resolution teams (a type of 24/7) and a team providing a combination of CBT, family therapy and psychoeducation
  - Not exactly the same – what to choose from a clinical/organizational perspective?
- And what happened to the two other studies included in the Integrated treatment category in de Jong (2016) – one of the 3 meta-analysis in the umbrella review?

AN EVEN CLOSER LOOK AT THE FINDINGS

- The limitations of the method (Barbui et al., 2021):
- The effect on coercive practices of legislation, policies, service organization models and population-level interventions, such as interventions based on advocacy, awareness-raising campaigns, moral persuasion and public engagement, cannot be assessed by means of randomized trials, and therefore these factors were not included in the systematic reviews that met criteria for this study.
- Similarly, complex multicomponent actions that are considered active ingredients of community mental health services, such as ensuring comprehensive responsibility in all phases of treatment, working on the environment and the social fabric, and fostering service accountability toward the community are difficult to evaluate in formal studies.
- However, absence of randomised evidence for these interventions does not mean that they are ineffective. Law 180 in Italy remains a paradigmatic example of the potential impact of legislative measures on coercive practices,

HOW TO REDUCE CA – CONT.

- Gooding et al., (2020) – scoping review
  - Identified a total of 121 studies – only a few of them on CA
  - And only about 1/3 explicitly aiming at reducing coercion
- With the aim to identify studies within the area of coercion reduction – not to systematically evaluate the effect of each method/effort.
  - It is thus mostly – at least in the field of CA - a listing of potentially promising methods to reduce coercion, but where most of them need to be further investigated to decide their effect
    - And preferably also up against each other
- Mesasured outcomes in some of the studies are psychopatology and consumer satisfaction, not reducing CA.

THE SCIENTIFIC HIERACHY – IS IT USEFUL?

- Ioannidis (2016): The mass production of redundant, misleading and conflicted systematic reviews and meta-analysis
  - «Few systematic reviews and meta-analysis are both non-misleading and useful»
    - Useful in the meaning useful for clinical descisionmaking and policymaking
  - "A very common conclusion, in particular for meta-analysis, is that the evidence is weak or insufficient, thus the review is not informative on what is the best interventions are in terms of patient care or health policy."
    - "We found that the evidence base is still not optimal, especially in terms of strength of associations, but it is nevertheless suggestive that coercive treatment may be reduced without major shortcomings." Barbui et al., 2021.
  - But:
    - «It is irrational not to perform systematic reviews of what is already known before deciding to perform a new study.»
    - And his critique of SR/MA is «not an argument for going back to Non-systematic reviews» ☺

WHAT RESEARCH DO WE NEED?

- Intervention studies
  - How can we reduce CA – and most effectively – and in different contexts?
- Studies of causation
  - In order to inform intervention studies
- Implementation studies
  - How to transform services – effectively
  - In different contexts
  - In this also fidelity – are they adhering to the described models/methods
- Co-creation studies – professionals/consumers/researchers
  - To what extent does that hinder theöry-driven studies?
- And we need larger studies
  - To try out all the inventive small scale studies identifying new methods
  - Across countries – to grasp more of the influence of context - and in\crease strength of findings
- And a combination of qualitative and quantitative designs – mixed methods

RESEARCH INFORMING CLINICAL GUIDELINES AND POLICY

- "Within a general legislative, policy and organisational framework, implementing specific interventions to reduce coercive treatment would probably require their inclusion in existing guidelines for mental health conditions. The present umbrella review provides the background evidence for such an inclusion".
  - Does it?
  - Apart from abolishing CTO?
- External advisor national clinical advice (not guidelines) on reducing coercion
  - Draft criticized for lack of solid research foundation
  - Status of research will make National clinical advice impossible
    - We are thus back to local culture and practice
- In the area of coercion the EBM movement is thus a hinder for developing less coercive services
  - Due to their adherence to RCT's as the golden standard

IN THE WORDS OF X-FILES

- The truth is – still – out there
- It is up to you to discover it ☺
- Good luck