Sistema Socio Sanitario
Regione Lombardia
ASST Melegnano e Martesana

The right [and opportunity]
to have a [whole]
life
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Compulsory Treatments and the Patient's Rights

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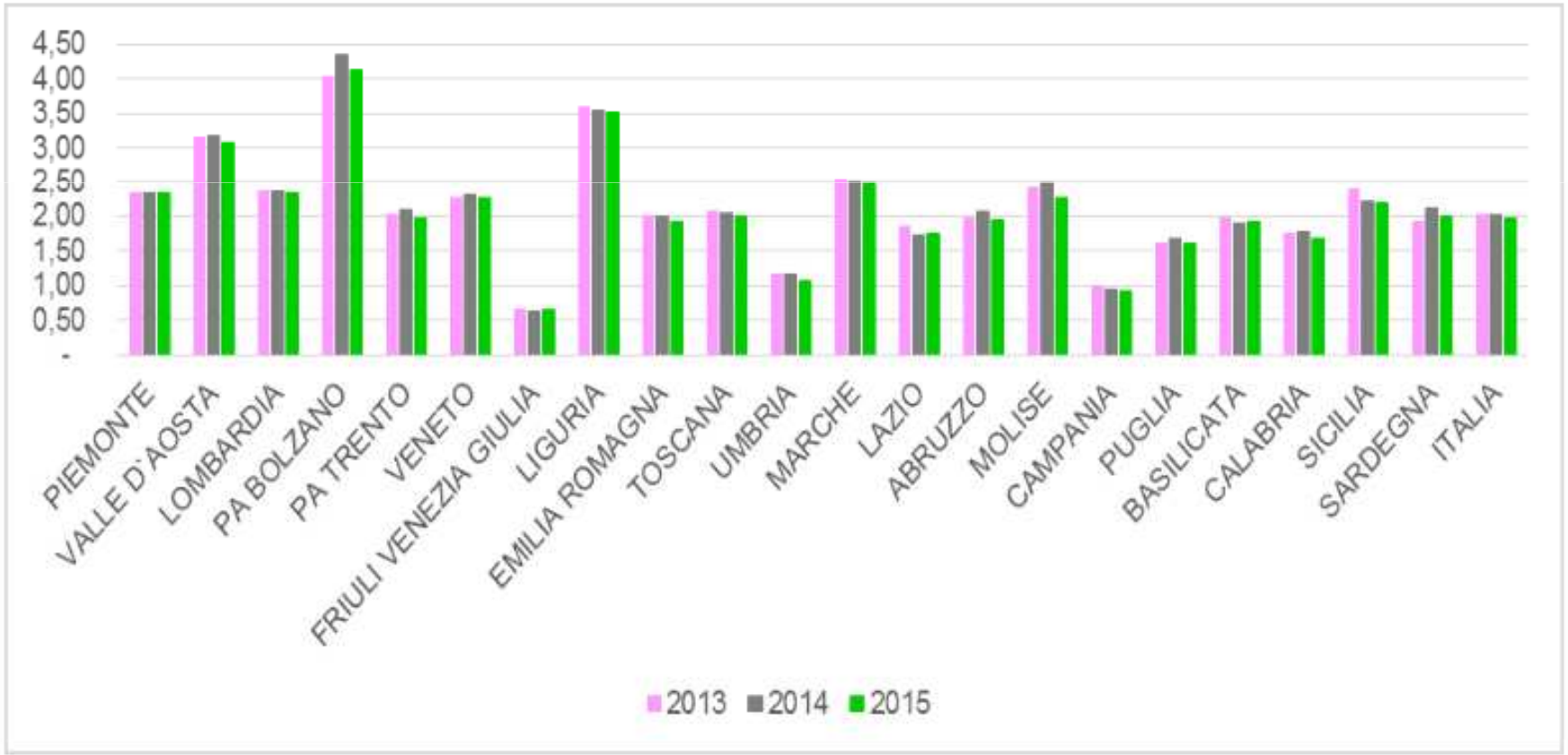
Admission rate in General Hospital Psychiatric Units/1.000 inhabitants



Hospital Stay

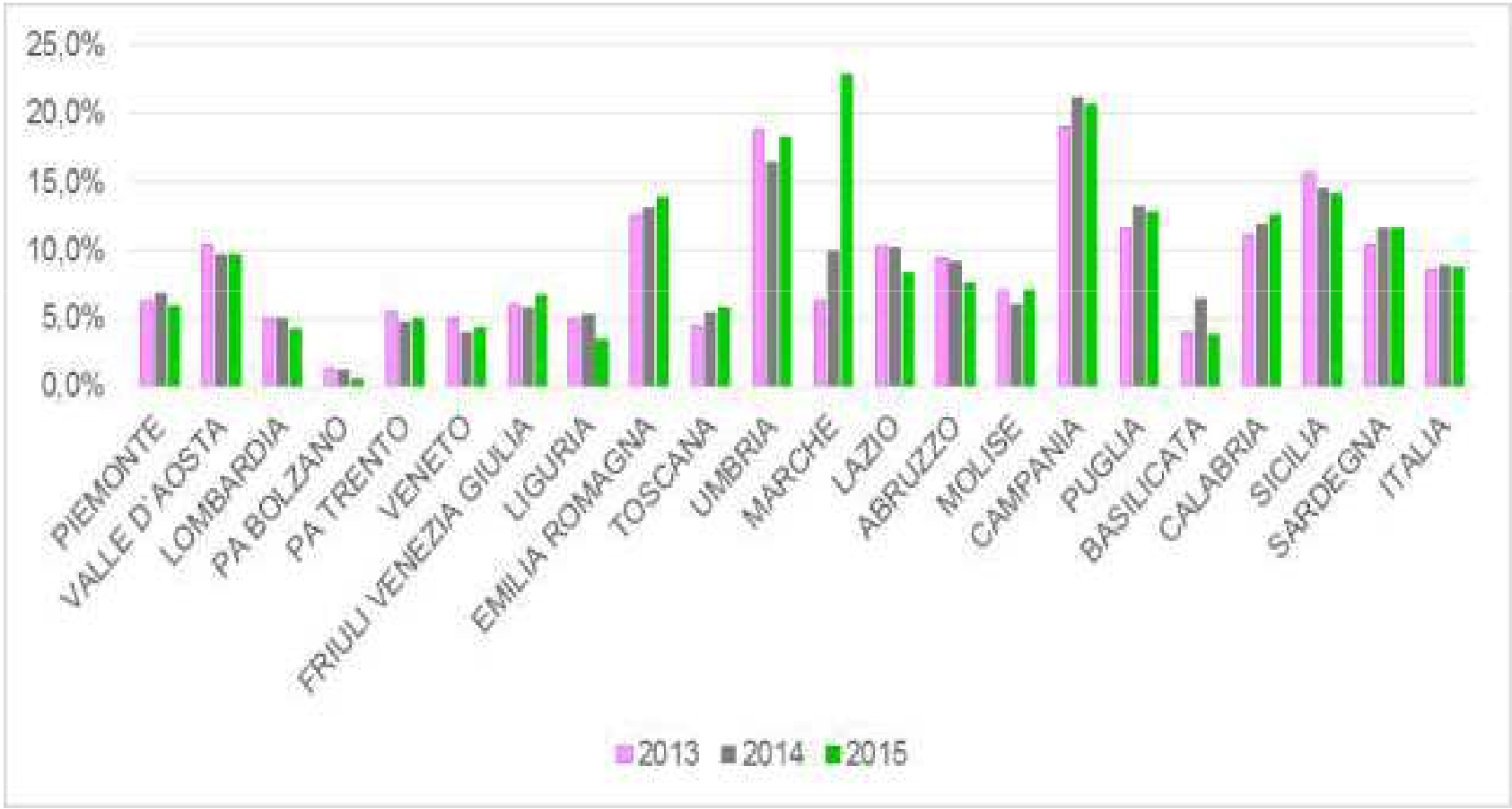
	2013	2014	2015
Days of hospitalization	1,433,774	1,419,328	1,398,211
Average hospital stay	12,6	12,5	12,6

Compulsory Treatments

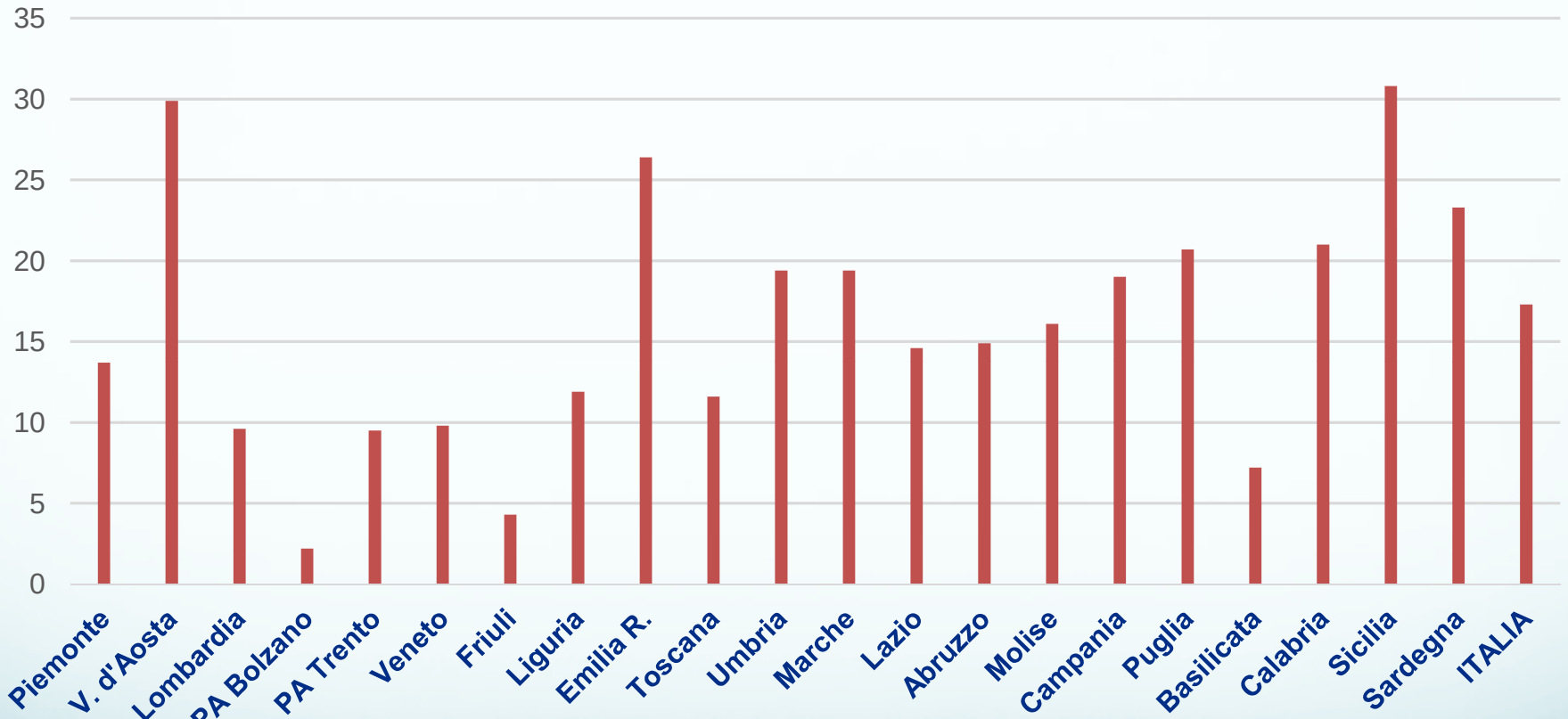
Years 2013 - 2015

	2013	2014	2015
ITALY	8950	9067	8777

Compulsory admissions on the total admissions in General Hospital Psychiatric Units



Compulsory Admission Rates in Italy year 2015



Compulsory admission rate in some EU countries

Country	n.	Involuntary admissions /100,000 in.
Belgium	4,799	47
Denmark	1,792	34
Finland	11,270	218
France	61,063	11
Germany	163,551	175
Italy	*8,777*	*17**
Portugal	618	6
England		65**
UK	23,822	48

*Year 2015
**Year 2008

(European Commission, 2002)

- **Admission rate varies greatly region by region**
- **There are different procedures to implement the order of admission**
- **There hasn’t been any *implementing regulation* in 40 years**
- **A significant relationship – statistically established – can be seen between staff availability and the number of involuntary treatments (*Starace*, 2017).**

Necessary conditions to carry out a Compulsory Health Treatment

- Mental disorders severe enough to require immediate treatment.
- The patient refuses the treatment.
- It’s impossible to treat the patient in an appropriate and immediate way outside the hospital.
- All three conditions have to be present.

Procedure of C.H.T. (1)

- ✓ A doctor (not necessarily a psychiatrist) writes a proposal of C.H.T.
- ✓ The proposal has to be confirmed by another N.H.S. doctor.
- ✓ The proposal has to be presented to the municipal offices and the Mayor shall issue the order of admission.
- ✓ The Local Police carries out the order.
- ✓ The order has to be notified to the competent judge within 48 hours after admission.
- ✓ The judge has to confirm or cancel the order within 48 hours.

Procedure of C.H.T. (2)

- ✓ The length of a C.H.T. is 7 days maximum, but the Head of the psychiatric unit may prolong the hospitalization by request to the mayor.
- ✓ Anyone can ask the mayor to withdraw or amend the C.H.T. (Administrative Objection).
- ✓ The patient or someone who is interested may appeal to the court against the judge's decree which confirmed the Mayor's order (Legal Objection).

Court of Milan

	Total C.H.T.	Not confirmed	%
2015	166	17	10.2
2016	113	14	12.4

Medical model

- **The dangerousness is not the main condition of the admission.**
- **The dangerousness is adopted in all the countries of EUNOMIA study (*Fiorilllo et al.*, 2010).**
- **C.H.T. is not a judicial proceeding but an activity of care.**
- **The loss of freedom is not decided by judges, since the judicial authority plays just a controlling role.**
- **The doctor is responsible and free to decide.**
- ***Ex post*, doctors' decisions can be subjected to a judicial investigation.**

Health Treatment

- Before 1978 all treatments were involuntary because the lack of consensus was assumed.
- Under the new law:
  1) the responsibility of the care was given back to the patient,
  2) the patient is an adult who decides if he wants a treatment and which treatment.
- What had to be done:
  1) Focusing on the patient's refusal to treatment.
  2) Transitioning from an authoritarian relationship to a contractual relationship.
  3) Questioning the true nature of this therapeutic relationship: contractual or paternalistic?

Advice of “Comitato Nazionale di Bioetica” on Council of Europe’s “White paper”

- Involuntary treatment does not always mean involuntary hospitalization.
- The law should provide for the possibility of using therapeutic alternatives to the patient’s clinical situation.
- During an involuntary hospitalization the patient can not be treated in any case against his will, because the patient’s capacity to decide has dynamic character.
- Compulsory admissions should be decided by the Judicial Authority as an independent institution, with the mandatory opinion of a Psychiatrist.
- In emergency situations, hospitalization can be decided by doctors without the order of the competent authority. The authority must, however, confirm the admission.

Art. 54 Codice Penale. – Non è punibile chi ha commesso il fatto per esservi stato costretto dalla necessità di salvare sé od altri dal pericolo attuale di un danno grave alla persona, pericolo da lui non volontariamente causato, né altrimenti evitabile, sempre che il fatto sia proporzionato al pericolo.

Article 54 establishes the following necessary criteria:

- **Present danger**
- **Severe harm (not only physical injury, but also of the personal and sexual freedom).**
- **Adequacy and proportionality between act and danger.**

Mental Capacity for the Informed Consent

- **The capacity to understand the essential information.**
- **The capacity to rationally process information.**
- **The capacity to assess the situation and the likely consequences of a choice.**
- **The capacity to communicate a choice.**

Mental Capacity in psychiatric in-patients

Psychiatric in-patients	**5-90%**	**(*Okai D. et al*, 2007)**
Involuntary in-patients	**16%**	**(*Cairns R. et al*, 2005)**
Involuntary in-patients	**53%**	**(*Poythres N.G. et al*, 1996)**

- The majority of psychiatric in-patients have capacity to make treatment decisions.

- Some studies indicate that a sizeable proportion of involuntary in-patients have capacity to accept or refuse admission to hospital.

- Only dementia may cause a static incapacity.

- The capacity to express the consent is a dynamic and evolving process within the therapeutic relationship.

The five principles

1) A person must be assumed to have capacity unless it is established that he lacks capacity.

2) A person is not to be treated as unable to make decision unless all practicable steps to help him to do so have been taken without success.

3) A person is not to be treated as unable to make decision merely because he makes an unwise decision.

4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

(*The Mental Capacity Act*, 2005)

The quality of informed consent

Knowledge of the reason for admission or outpatient treatment	R.F.	C.M.H.C.	G.H.P.U
Sufficient	53.9	85.1	68.8
Totally inadequate	46.1	14.9	31.2

Knowledge of posology	R.F.	C.M.H.C.	G.H.P.U.
Complete	47.9	63.1	31.2
Restricted	18.3	24.1	23.4
Absent	33.8	12.8	45.4

Knowledge of drug function	R.F.	C.M.H.C.	G.H.P.U.
Absent	56.3	20.2	52

(*Catanesi et al.*, 2010)

Psychiatric Law and informed consent

- Even during the involuntary hospitalization, patients prove decision-making and self-determination capacities.
- Nevertheless, the law does not refer to informed consent and patient decision-making capacity in relation to their treatment.
- The total incapacity is therefore presumed.

The informed consent should be:

1) *not* as an act inspired by an abstract and formal legalism.

2) a useful *process* to promote personal autonomy and to encourage an equal and participative doctor-patient relationship.

3) a *way* to communicate within the relationship.

Involuntary vs. voluntary hospital admission

- Equal or longer length of stay
- Higher risk of involuntary readmission
- Less satisfaction with their treatment
- No group differences in medication compliance
- No group differences in terms of general psychopathology

(*Kallert T.W. et al.*, 2008)

Subjective experiences of compulsory treatment (1)

- 2326 involuntarily admitted:
  At 1 month 55% (39-71%) thought their admission was right
  At 3 months 63% (46-86%) thought their admission was right
  Male patients and those living with others tended to find the admission more often right
- Can the identified differences of patients' views of involuntary admission be linked to characteristics of the given legislation?
- 7 criteria that can be seen as relevant for the protection of the interests of the patients.
- The authors found most positive patients' views in the countries with the most protective legislation *(Priebe S. et al., 2010).*
- Patients who expressed a lower satisfaction with hospital care are more likely to be involuntarily readmitted within 1 year
  (Priebe S. et al., 2008).

Subjective experiences of compulsory treatment (2)

- Those who believed that involuntary hospitalisation was wrong thought that their problems could have been managed through less intensive and/or coercive community interventions.
- They experienced the admission as an unjust infringement of their autonomy and as a threat to their social position and to their sense of themselves as autonomous individuals.
- Evidence indicates that when patients believe that their opinions are taken into account and that decisions are made with their best interests in mind, they feel less coerced, even when treated against their will (*Katsakou C. et al.*, 2011).

Subjective experiences of compulsory treatment (3)

- **Shame and self-contempt may render individuals involuntarily admitted more vulnerable to increased self-stigma and impaired empowerment, reducing their quality of life and self-esteem.**

- **The number of lifetime involuntary hospitalizations was not associated with self-stigma or empowerment: it is less the quantity of coercive experiences than their perceived emotional and cognitive quality that determine their impact (*Rüsch N. et al.*, 2013).**

What do the users ask?

- Users demand improvements in two key areas:
  - the way mental health professionals relate to users
  - alternative forms of treatment and a variety of service options.

- Users indicated that the compulsory treatment would be improved by better access to advocacy to ensure more people fully understand their rights and participate in decisions about their care and compulsory treatment *(Ridley J. et al., 2013)*.

Why do some voluntary patients feel coerced into hospitalisation?

Three factors leading to perceived coercion:

- **viewing the hospital as ineffective and other treatments as more appropriate**
- **not participating in the admission and treatment**
- **not feeling respected**

Perceived coercion is significantly linked to patients' satisfaction with their treatment.
Therefore treatments interventions, improving patients' satisfaction, may in turn lead to overall more positive outcomes.

(*Katsakou C. et al.*, 2011)

Coercion in Psychiatric Care: Systematic Review of Correlates and Themes

- ✓ **There is, potentially, an element of coercion in every clinical encounter.**
- ✓ **Coercion is associated with negative concepts, such as feeling dehumanized and unheard.**
- ✓ **The patient's lack of a "voice" in treatment decisions is repeatedly associated with perceived coercion.**
- ✓ **The studies found a negative association between coercion and improved outcomes.**

(*Newton-Howes G. et al.*, 2011)

Advance Statement

If a person is ill, it is important that the people who look after him/her know about:

- **the treatment that works for him/her**
- **the treatment that does not work for him/her**
- **the treatment he/she do not want**
- **why some treatments are better for him/her than others.**

The person should write this when he/she is well enough to say what he/she wants.

Independent advocacy

- ✓ **Independent advocacy helps patients make your voice stronger and to have as much control as possible over their life.**
- ✓ **It is called independent because advocates and advocacy workers are *separate from services.* They do not work for hospitals, social work or other services.**
- ✓ **Some people need support to speak up, to understand what is being said and to make decisions.**

Named Person

A named person can help to protect patient's interests if he has to be given care or compulsorily treated.

The named person has the right:

- **to be consulted when certain things happen – such as when a short- term detention or an application for a compulsory treatment order (CTO) is being considered;**
- **to make applications or appeals to the Mental Health Tribunal;**
- **to receive copies of certain records or information;**
- **to consent to two medical examinations taking place at the same time, if the patient is not capable of giving his consent to this;**
- **to ask for an assessment of patient's needs from the local authority and/or Health Board.**

What's the difference between a named person and an independent advocate?

- **An independent advocate can come with you to a Tribunal hearing to support you but does not have the same rights as a named person to be consulted, informed or to make applications and representations to the Tribunal.**
- ***An independent advocate cannot make decisions on behalf of the patient in the way that the named person can.***
- **A patient can have both an independent advocate and a named person if he finds it helpful, but because their roles are different they cannot be the same person.**

Conclusioni

- **Clinch**
- **Solitude of the main characters**
- **An enlargement of the scene**

Thanks !

Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health Act *(Ridley J., et al., 2013)*

- Sample of 49 service users.
- Semi-structured qualitative interviews conducted face-to-face by pairs of interviewers: a professional researcher and a peer researcher who was mental health service user.
- 42% judged compulsion “completely unnecessary”
- 52% judged compulsion a “necessary evil”.
- Community compulsion equated with a “medication order”.
- Users demand improvements in two key areas:
  - the way mental health professionals relate to users
  - alternative forms of treatment and a variety of service options
- Users indicated that the compulsory treatment would be improved by better access to advocacy to ensure more people fully understand their rights and participate in decisions about their care and treatment under the MHCT Act.

Patients' views and readmission 1 year after involuntary hospitalisation

(Priebe S., et al., 2008)

- Sample of 1570 involuntarily admitted patients. At 1 year, 15% of patients had been readmitted.
- Within the first week after admission data had been gathered with semi-structured qualitative interviews conducted face-to-face by pairs of interviewers: a professional researcher and a peer researcher who was mental health service user.
- Initial satisfaction with treatment is associated with both objective and patient-rated outcomes 1 year after the index admission. Patients who express a lower satisfaction with hospital care
  - are more likely to be involuntarily readmitted within 1 year;
  - are less likely to feel that the index admission was justified.
- Users indicated that the compulsory treatment would be improved by better access to advocacy to ensure more people fully understand their rights and participate in decisions about their care and treatment under the MHCT Act.

Secluded and restrained patients' perceptions of their treatment

(Soininen P., et al., 2013)

- **Sample of 90 secluded/restrained patients.**
- **Data were collected with a specific questionnaire (S/R-PPT)**
- **Patients perceived that they received enough attention from staff and they were able to voice their opinions, but their opinions were not taken into account.**
- **Patients denied the necessity and beneficence of seclusion and restriction.**
- **Women and older patients were more critical than men and younger patients regarding the use of restriction.**

Patients' views of involuntary hospital admission after one and three months: a prospective study in eleven European countries (1)

(Priebe S., et al., 2010)

- 2326 involuntarily admitted
- At 1 month 55% thought their admission was right (39-71%)
- At 3 months 63% thought their admission was right (46-86%)
- Italy:
- At 1 month 71%
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- At 1 month 55% thought their admission was right (39-71%)
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- Male patients and those living with others tended to find the admission more often right.

Patients' views of involuntary hospital admission after one and three months: a prospective study in eleven European countries (2)

(Priebe S., et al., 2010)

- Can the identified differences of patients' views of involuntary admission be linked to characteristics of the given legislation?
- 7 criteria that can be seen as relevant for the protection of the interests of the patients.
- "Is legal support guaranteed or not?"
- "Can the admission be initiated only by authorities and medical doctors or also by other stakeholders?"
- The authors found most positive patients' views in the countries with the most protective legislation.
- The criteria still leave many of the differences in patients' views unexplained.

Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study (1)

(Katsakou C., et al., 2011)

- ✓ The study explore involuntary patients' retrospective views on their hospitalisation.
- ✓ Service-user researchers were involved.
- ✓ The great majority of patients believed that they were mentally unwell before their admission. They also experienced involuntary hospitalisation as a time when they felt powerless and lost control over their lives, as they thought that they were not involved in the admission and treatment process and felt forced to comply with professionals' decisions.
- ✓ 3 Groups: Positive (47%), Negative (32%), Ambivalent (21%)

Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study (2)

(Katsakou C., et al., 2011)

- ✓ **Those who believed that involuntary hospitalisation was wrong thought that their problems could have been managed through less intensive and/or coercive community interventions.**
- ✓ **They experienced the admission as an unjust infringement of their autonomy and as a threat to their social position and to their sense of themselves as autonomous individuals.**
- ✓ **Evidence indicates that when patients believe that their opinions are taken into account and that decisions are made with their best interests in mind, they feel less coerced, even when treated against their will.**
- ✓ **Patients ask to be involved in their care. They ask for greater control over their own care and life.**

Emotional reactions to involuntary psychiatric hospitalization and stigma-related stress among people with mental illness

- Shame and self-contempt may render individuals involuntarily admitted more vulnerable to increased self-stigma and impaired empowerment, reducing their quality of life and self-esteem.
- The patterns observed appeared to be independent of psychiatric symptoms and diagnoses.
- The number of lifetime involuntary hospitalizations was not associated with self-stigma or empowerment: it is less the quantity of coercive experiences than their perceived emotional and cognitive quality that determine their impact.

(Rüsch N. et al., 2013)

Conditions conducive to perceived coercion in mental hospital admission

1. Patient's belief that he or she is not mentally ill
2. Motives of other suspect
3. Force used or threats made
4. Admission resembles criminal arrest (e.g handcuffs)
5. No opportunity to have voice in admission decision
6. Not treated
7. Dealt with in bad faith (e.g. deceived)
8. Inadequate information provided
9. Decision making seen as unfair
10. Treatment is unsuccessful

(Monahan J. et al., 1995)

Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study

Three themes leading to perceived coercion:

- **viewing the hospital as ineffective and other treatments as more appropriate**
- **not participating in the admission and treatment**
- **not feeling respected**

Perceived coercion is significantly linked to patients' satisfaction with their treatment.
Therefore treatments interventions, improving patients' satisfaction, may in turn lead to overall more positive outcomes.

(Katsakou C. et al., 2011)

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Some people need support to speak up, to understand what is being said and to make decisions.

Named Person

A named person can help to protect patient's interests if he has to be given care or treatment under the new Act.

The named person has the right:

- to be consulted when certain things happen – such as when a short- term detention or an application for a compulsory treatment order (CTO) is being considered;

- to be notified when certain changes happen – for example if the short-term detention is revoked;

- to receive copies of certain records or information, including the record made if treatment has been given which conflicts with the advance statement;

- to make applications or appeals to the Mental Health Tribunal, and to speak and give or lead evidence at a hearing;

- to consent to two medical examinations taking place at the same time, if the patient is not capable of giving his consent to this;

- to ask for an assessment of patient's needs from the local authority and/or Health Board.

What's the difference between a named person and an independent advocate?

Under the Act anyone with a mental disorder has the right to access independent advocacy services, whether or not the person is receiving compulsory treatment. An independent advocate is able to give support and help the person to express his own views about care and treatment.

But an independent advocate cannot make decisions on behalf of the patient in the way that the named person can.

An independent advocate can come with you to a Tribunal hearing to support you but does not have the same rights as a named person to be consulted, informed or to make applications and representations to the Tribunal.

You can have both an independent advocate and a named person if you find it helpful, but because their roles are different they cannot be the same person.