

# Involuntary Psychiatric Hospitalization: Current Status and Future Prospects

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## SUMMARY

The general aims of this article are: a) to cover the current status of research on the important clinical and human rights issue of involuntary psychiatric hospitalization, and b) to discuss some factors which might influence future developments in this area of mental health care provision. Firstly, the article will outline main results from two literature reviews on outcomes of involuntary hospital admission. Secondly, selected results from the clinical part of a recent European multi-site research project on coercion in psychiatry (Acronym: EUNOMIA) will be presented in detail on the following issues: the association of patients' views of involuntary hospital admission and differences in legislation, patient characteristics associated with more or less positive outcomes of coerced hospital admission, coercive measures (e.g. mechanical restraint, seclusion and forced medication) used during these hospitalizations. Thirdly and finally, the article will shed some light on future prospects of this topic. Thus, some recommendations for best clinical practice in the use of involuntary hospital admission will be discussed, and arguments for two future scenarios, increase vs. decrease of involuntary psychiatric hospitalizations, will be contrasted and analyzed.

**Keywords:** involuntary psychiatric hospitalization; coerced admission; coercion; human rights; mental health legislation; best practice recommendation

## INTRODUCTION

Acute admissions to psychiatric hospitals are sensitive clinical procedures, in particular if performed on the legally defined basis of involuntariness [1]. In many national mental health service systems, they are still more frequent than desired. A time series of the 1990s in 15 member states of the European Union indicated an overall tendency towards more or less stable rates of 10 to 20% in most countries [2]. Recent international studies showed that involuntary hospital admission of general psychiatric patients is performed in 3% (Portugal) to 30% (Sweden) of all psychiatric inpatient episodes [2]; these significantly varying rates lead to speculations about the impact of specific features of national mental health service configuration and mental health legislation. In addition, an inconsistent increase of involuntary admissions is among the indicators (increasing placements in homes and in institutions of forensic mental health care, increasing rates of imprisoned persons) suggesting a new era of re-institutionalization of providing mental health care in several European countries between 1990 and 2006 [3, 4].

Against this background, this article will cover the current status of research on the important clinical and human rights issue of involuntary psychiatric hospitalization, and discuss some factors which might influence future developments in this area of mental health care provision. Firstly, the article will outline main

results from two literature reviews on outcomes of involuntary hospital admission. Secondly, selected results from the clinical part of a recent European multi-site research project on coercion in psychiatry (EUNOMIA) will be presented, in detail on the following issues: the association of patients' views of involuntary hospital admission and differences in legislation, patient characteristics associated with more or less positive outcomes of coerced hospital admission, coercive measures (e.g. mechanical restraint, seclusion and forced medication) used during these hospitalizations. Thirdly and finally, the article will shed some light on future prospects of this topic. For this, some recommendations for best clinical practice in the use of involuntary hospital admission will be discussed, and arguments for two future scenarios, increase vs. decrease of involuntary psychiatric hospitalizations, will be contrasted and analyzed.

## RECENT SYSTEMATIC REVIEWS ON OUTCOMES OF INVOLUNTARY HOSPITAL ADMISSION

In contrast to the frequency of this clinical procedure, data on potential effects of involuntary hospital treatment are rather scarce. The first of recent systematic reviews on outcomes of involuntary hospital admission reported findings from no more than 18 studies [5]. Results demonstrated that most involuntarily admitted patients showed substantial clinical improve-

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ment, and that a significant number of patients did not feel retrospectively that the admission was justified or beneficial. The second recent systematic review included 41 references on the outcome of acute hospitalization for adult general psychiatric patients admitted involuntarily as compared to patients admitted voluntarily [6]. Results on clinical and subjective outcomes showed that involuntary patients demonstrated lower levels of social functioning, and equal levels of general psychopathology and treatment compliance; they were more dissatisfied with treatment and more frequently felt that hospitalization was not justified. The authors concluded that acute involuntary hospitalization may not be automatically associated with a higher risk for overall negative outcome, but might bear specific risks on selected outcome domains that might be therapeutically influenced.

Both reviews demonstrated a generally low methodological level of research, the most important shortcomings being insufficiently large sample sizes, and the limited use of standardized instruments for any of the relevant clinical and subjective outcome domains. Future research should also clarify if the dichotomized criterion of legally voluntary and involuntary admission is adequate for differentiating and predicting outcome of hospitalization. In this respect, new concepts of coercion in which the patient's perspective plays a more dominant role should be explored [7]. This seems to be urgently needed because there is no clear clinical and statistical correlation between the legal and subjective concept of coercion, because up to 30-50% of patients admitted to psychiatric acute wards report high levels of perceived coercion, and because there are controversial results if such high levels of perceived coercion have an impact on the outcome of acute hospitalization.

#### **FURTHER ARGUMENTS FOR RESEARCH ON INVOLUNTARY PSYCHIATRIC HOSPITALIZATIONS**

The need of methodologically sound empirical research in this sector of mental health care is further stimulated by the increasingly prominent view that coercive measures in psychiatry are an important human rights issue. Recent internationally binding documents like the UN Convention on the Rights of Persons with Disabilities [8] emphasize this position, most pointedly expressed by international organizations of patients/(ex-)users and survivors of psychiatry [9], but also supported by high-ranking political bodies such as the Council of Europe [10].

A high variation of legal regulations in the area of mental health laws might be seen as another source for concern in terms of patients' rights. The lack of clear, internationally accepted standards for such regulations not only opens up opportunities for injustice and inequality in the field of mental health laws in general, but may also influence the important field of clinical practice as demonstrated by recent international research on involuntary hospitalization [11, 12].

A standardized legal analysis of civil law issues associated with involuntary hospitalization in psychiatric

establishments, performed within the framework of the EUNOMIA project [11, 12, 13], revealed major differences among the twelve European countries studied. Variations appeared in regard to basic conditions as well as additional criteria for involuntary admission, time periods for making decisions, the association between involuntary placement and treatment, patients' rights to register complaints, roles of relatives, and safeguard procedures of these processes.

#### **SELECTED RESULTS FROM THE EUNOMIA PROJECT**

So far, there has been no cross-national research initiative having used the same prospective research protocol that addresses the issue of legally involuntary hospital admission to acute general psychiatry units. Further, no international clinical study has explicitly included voluntarily admitted patients who felt coerced to admission into the study design. The research protocol of the clinical part of the EUNOMIA project [13] covered both modes of coerced admissions to psychiatric hospitals and has overcome the mentioned methodological shortcomings of studies in this area.

The EUNOMIA project was carried out in the years 2002 to 2006 at 13 centres in 12 European countries: Dresden, Germany; Sofia, Bulgaria; Prague, Czech Republic; Thessaloniki, Greece; Tel Aviv, Israel; Naples, Italy; Vilnius, Lithuania; Wroclaw, Poland; Michalovce, Slovak Republic; Granada and Malaga, Spain; Örebro, Sweden; and East London, UK (for detailed descriptions of the study design of the clinical part, of the participating catchments areas, and of the participating hospitals, e.g. staff, and modalities of care, see [13]).

The clinical part of the project was supplemented by a standardized legal analysis of civil law issues associated with involuntary hospitalization in psychiatric establishments, and by the development of national and international good clinical practice recommendations on involuntary hospital admission and on individual coercive treatment measures.

#### **Patients' views of involuntary hospital admission and differences in legislation**

In the clinical part of the EUNOMIA project 2326 consecutive patients admitted involuntarily to psychiatric hospital departments were interviewed within one week after admission; 1809 were followed-up after one month, and 1613 were interviewed three months later. One outcome criterion was whether the patient viewed the admission as appropriate [14]. In the different countries, after one month between 39% and 71% found the admission appropriate, and between 46% and 86% after three months. Female patients, those living alone, and those with a diagnosis of schizophrenia had more negative views. Adjusting for confounding factors, differences between countries were significant. Patients' views on the appropriateness of their involuntary admission showed significant differences between sites in different countries, even when adjusted

for other predictor variables. The post-hoc comparisons showed that not all differences between sites at different countries were statistically significant, but the more substantial ones were. For example, the patients' views in England are significantly less favourable than those in Bulgaria, Greece, Spain, the Czech Republic, Italy, Germany, and Slovakia, whilst patients' views in Slovakia are significantly more positive than in all sites other than those in the Czech Republic, Italy and Germany.

Can the identified differences of patients' views of involuntary admission be linked to characteristics of the given legislation? There is no straightforward answer. The legislation in all countries is complex and has many features which are of potential importance. One possible criterion to classify the national regulations is the extent to which they protect the rights and interests of the patients concerned. Seven criteria that vary between countries and may be seen as relevant for the protection of the interests of the patients are as follows (note: the first option in each question is seen as more protective of the interest of the patients): 1) Is involuntary admission possible only when patients pose a risk to themselves and/or others, or also to avoid a more general threat to the patients' health? 2) Can the admission be initiated only by authorities and medical doctors or also by other stakeholders? 3) Does involuntary admission require the decision of a court or not? 4) Is the period of time for which the hospital can decide to keep patients involuntarily on the wards without a formal decision for involuntary treatment shorter or longer than 24 hours? 5) Is legal support guaranteed or not? 6) With respect to appeal procedures to independent bodies, are there binding time periods for a response, and are people and/or institutions other than the patient authorised to appeal, or not? 7) Is the decision for involuntary treatment measures separate from the decision for involuntary admission or not? Although the answers to the questions are not always clear cut, the authors of this study established the number of criteria for each country.

The resulting ranking has similarities with the order of outcomes in the multivariate analysis of this study (with the most protective legislation and most positive patient views in Slovakia and Germany, and the least protective legislation and most negative views in England), but the criteria still leave many of the differences in patients' views unexplained. Another possible factor accounting for differences could be clinical practice (the behaviour of professionals towards involuntary patients and the methods employed to support and treat them) which is likely to vary across Europe and impact on outcomes.

### **Patients' characteristics associated with outcomes of coerced hospital admission**

The patients (N=3,093) were predominantly male (55.7%), single (75.4%), and unemployed. They had a mean age of about 40 years and most suffered from psychosis (63.4%). Most of them (71.1%) had been previously admitted to psychiatric hospitals. With respect to the current admis-

sion, one quarter of them were voluntarily admitted and three quarters legally involuntarily. The sample that was followed up three months later had similar characteristics as the total sample. At the time of the follow-up, 87% had been discharged from inpatient treatment.

Associations with perceived coercion [15] at admission were found as follows: In a multivariate analysis, only four variables remained in the model. Female gender, legally involuntary admission, poorer global functioning and more positive symptoms were independently associated with more perceived coercion, explaining 10.4% of the variance.

Changes of perceived coercion, global functioning and symptoms: On average, patients showed improvements in perceived coercion (Cantril Ladder sum score ( $\pm$ SD): 6.3 (3.4) vs. 4.5 (3.3)), global functioning (GAF sum score ( $\pm$ SD): 33.1 (15.1) vs. 52.1 (17.3)) and all (BPRS) symptom subscales (e.g. positive symptoms sum score ( $\pm$ SD): 13.7 (6.1) vs. 8.1 (3.8)). The differences were statistically significant on each scale.

Associations of changes in symptoms and global functioning with changes in perceived coercion: In the multivariate analysis only the reduction of positive symptoms and improvements of social functioning were correlated with changes in perceived coercion.

The finding that involuntarily admitted patients have higher levels of perceived coercion is consistent with data reported in other studies carried out with smaller samples. That female patients tend to feel more coerced is probably due to the fact that they feel more vulnerable in the often rough atmosphere of acute in-patient settings or to a higher tendency to report coercion as well as other types of psychological discomfort.

Perceived coercion tends to improve over time. This can be partly due to a recall bias effect, with patients "forgetting" the coercion they had perceived in hospital, while feeling better. On the other hand, the positive effects of treatments during hospitalization may have improved patients' insight of the illness and fostered patients to acknowledge the usefulness of received coercive measures and treatments.

Patients with a better global functioning have less perceived coercion. This is probably due to the fact that these patients are more willing to be treated in order to regain their functioning level. Thus, the perception of coercion into treatment may be linked to the functioning level that patients expect to regain at admission and, at a later stage, to the functioning level they actually achieve during treatment. In addition to the functioning level, symptoms have also been identified as relevant. Out of the tested subscales of the BPRS, positive symptoms were the only ones significantly associated with perceived coercion. One can only speculate about the reasons for the importance of positive symptoms for the perception of coercion during in-patient treatment, e.g. patients with such symptoms may feel particularly distressed in a contained ward environment, with usual coping strategies of avoidance and withdrawal being difficult on often crowded and busy inpatient wards.

Perceived coercion into treatment is likely to undermine patients' motivation to treatment and impair positive thera-

peutic relationships. Thus, strategies should be developed to reduce perceived coercion, both at admission and over time. Female patients deserve particular attention in such efforts as they perceive more coercion. It remains unclear for the time being what type of settings or gender sensitive interventions may improve their perception. Findings of this study showed that improving functioning and positive symptoms is also likely to be an effective way to reduce perceived coercion. Further, they demonstrated that this is independent of the influence of various other patient characteristics, such as the diagnostic category, previous hospitalization and the formal legal status of the current hospitalization, and independent of the country of treatment in Europe.

### Coercive measures during hospitalization

In 10 study sites the EUNOMIA group could analyze data from 2,030 legally involuntarily admitted patients [16]. 1,462 events of coercive measure that were applied on 770 patients (35% of the whole sample) were recorded during the first four weeks of the index hospitalization. Variability between individual sites (21% of these patients in Granada and Malaga and 59% in Wroclaw) was high.

When comparing basic characteristics of subgroups of involuntarily admitted patients without ( $N=1,260$ ) and with ( $N=770$ ) coercive measure no significant differences regarding gender, age, employment and living situation were found. However, in the group with coercive measure use, there were more patients diagnosed with schizophrenia (69% resp. 63%,  $p=0.004$ ) and the BPRS score at the end of the first week in hospital was significantly higher (58 resp. 53,  $p<0.001$ ).

The frequency of various coercive measures used in individual sites showed high variation across sites. The application of a single coercive measure per patient was the typical pattern in Sofia, Naples and Vilnius, whereas in Wroclaw, London, Granada and Malaga two and/or more measures per patient were frequently applied. Amongst the entire group forced medication was the most frequently used intervention (56%), followed by restraint (36%) and seclusion (8%). The most commonly prescribed drugs in these cases were typical antipsychotics, especially haloperidol (in 229 cases) and zuclopenthixol (in 120 cases). Also benzodiazepines (diazepam in 111 cases, clorazepate in 92 cases, clonazepam in 82 cases) were often used separately or in combination with antipsychotics.

The most frequent reasons for coercive treatments were aggression against others (59%), threat to his/her health (27%), auto-aggression (22%), aggression against property (24%), prevention of escape (13%) and inability to care for one's self (11%).

In most cases the decision to apply coercive measures was made by a physician (91% of cases) in a written form (71%). Only in London, more often nurses had the right to order coercive measures (41%). In addition, verbally expressed decisions were most frequently acceptable in London (71%) and in Naples (52%). Almost all patients

were informed about the reason (98%) and the type of the coercive measure being used (96%).

Age, gender, and severity of psychopathological symptoms in the first week of the hospitalization were significantly different according to the type of coercive measure being used. Seclusion was used more often on younger men. Forced medication was applied to older male patients with a higher appearance of psychopathological symptoms. The frequency of restraint was equally used on both men and women.

Referred to the "technical" characteristics of the individual EUNOMIA study sites [13] vast differences existed regarding the number of psychiatric hospital beds per 100,000 (4.6 in Naples and 63.7 in Dresden), the number of staff per bed (4 in Michalovce and 2.0 in Örebro and Naples) and the average number of beds per room (1.2 in Örebro and 8.0 in Vilnius). There were no significant correlations among used coercive measures and these technical characteristics.

Nonetheless, the influence of an individual site was obvious. Therefore, the EUNOMIA group would like to emphasize the position of other authors [17] that a country's socio-cultural traditions, as well as their customs in treatment, in individual psychiatric facilities play a decisive role in this very sensitive issue. However, this very important area of psychiatric care is still rarely addressed in mental health services research. Future projects could help us to identify the factors in legislation and clinical practice, including important staff-patient interactions [18], which could be specifically relevant to achieving a more constructive cooperation of all parties involved. Even at present, it is necessary to introduce programs and practice guidelines that would rationalize and minimize the use of coercive measures in psychiatric facilities.

### CROSS-NATIONAL HARMONIZATION OF LEGAL REGULATIONS AND BEST PRACTICE RECOMMENDATIONS: A WAY FORWARD TO IMPROVE PATIENTS' RIGHTS WITHIN THE PROCESS OF INVOLUNTARY HOSPITALIZATION?

As a result of the standardized legal analysis of civil law issues associated with involuntary hospitalization in psychiatric establishments in 12 European countries, performed within the framework of the EUNOMIA project, specific issues with the potential or even need for cross-national harmonization appeared. In the opinion of the EUNOMIA group the following issues deserve special attention when revisions of (national) mental health laws address the process of involuntary hospitalization [11, 12]:

- The legal basis for treatment decisions (including the treatment setting) and the decision process itself must be simplified to the greatest extent possible.
- The powers of decision have to be clearly subdivided and assigned to different professional roles; standards of professional competency for these roles need to be defined.

- Time periods for the judicial decisions and performance of judicial authorities should be standardized across nations.
- Laws should be adapted with consideration for the clinical reality of high rates of emergency involuntary hospital admissions.
- During each stage of the judicial proceedings mandating involuntary hospitalization and coercive treatment measures, the patient should have the right to a legal representative.
- Regulations regarding the appeals process have to be as simple and transparent as possible.

Currently, no solid evidence base addresses whether and in which way such changes in the legal definitions would influence the practice of involuntary admission and stay in psychiatric hospitals, and if these would increase the acceptance of such coercive interventions by the patients or if they would then evaluate their rights as better respected.

Another important and so far insufficiently addressed issue of cross-national harmonization is the development of best practice recommendations in the field of coercive measures in psychiatry. Using (mostly) local expert groups (of 10 to 15 individuals 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), the EUNOMIA research group aimed to establish recommendations for improving the clinical practice in the field of individual coercive measures in twelve European countries [1, 13]. These expert groups ran semi-structured discussions or focus groups to develop unanimous agreement on national suggestions. Within a second phase of the work, all centres in which local expert groups were established asked different national professional organisations (e.g. psychiatrists, lawyers or judges, patients and relatives, ministries) for comments on their suggestions. These comments were collected using structured or non-structured questionnaires, or discussions in specific thematic workshops; the expert groups modified the text of the local suggestions based on the comments received. All national suggestions were translated into English. The centre coordinating EUNOMIA in Dresden performed a qualitative analysis of the content to produce common suggestions, and by involving the whole EUNOMIA research team developed a final version of the suggestions for best clinical practice in the use of involuntary hospital admission and individual coercive measures (e.g. mechanical restraint) valid for eleven project centres (not for the UK site because of the already existing Code of Practice).

The following example on the issue of involuntary hospital admission [1] demonstrate what was able to be achieved – and not achieved – by such an approach “*Behaviour of judges in the process of involuntary admission to a psychiatric hospital*”: The judge, before formulating any decision about the patient's admission, must collect information from the patient her-/himself, 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 re-examined. If national legislation stipulates that a hearing is required (e.g. in the 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.

To date, many open questions remain concerning the content of such guidelines or recommendations and their implementation into clinical practice. As documented above, in particular when a broader consensus is sought, recommendations seem to be rather generalized and not adequately specific. Further, effects of implementing such guidelines or recommendations on complex situations into clinical practice are unknown. Thus, the potential of such documents to improve patients' rights remains unclear.

## TWO FUTURE SCENARIOS

At the moment, mental health care analysts are not in a position to clearly foresee how frequencies of involuntary psychiatric hospitalizations will develop across Europe. Therefore, the following paragraphs will present arguments for two future scenarios, i.e. increase vs. decrease of such hospitalizations. It is up to the individual reader to weigh the probability of each argument against his own regional or national background of mental health care and to decide which of the two scenarios seems to be the more realistic context-specific option.

Frequencies of involuntary psychiatric hospitalizations might increase (in the opinion of the author) because of the following trends and developments:

Re-institutionalization seems to be a widely spread and unbroken tendency of mental health service provision, meanwhile existing for the last decade at least in Western European countries. In several countries further increase of capacities in prisons and forensic mental health care institutions is already decided on the political level, and several countries face the challenge that, due to current overcrowding, general psychiatric hospitals have asked for an increase of their capacity.

Mostly due to economic constraints, some countries have reduced their budgets for community mental health services and thus decreased the availability of such services. Others face the challenge that qualified staff in such services (mostly psychiatrists and nurses) is rare, because working conditions in this field do not meet the expectations of the younger generation. Some countries struggle with both problems, and with an increasing dissatisfaction of patients and their relatives due to long waiting periods and lists. Such developments enlarge the pressure on hospital-based services to care for a number of patients that clearly exceeds their current resources.

This situation is even more worrying because of the well-known future increase of persons with dementia, and some deficits regarding quality of care and staffing in long-stay homes for this population, e.g. to successfully deal with situations like hetero-aggressive behaviour and psychomotor disturbances like pacing. Some research results on a national level [19] demonstrate that persons with dementia are at a high and constantly increasing risk for coercive measures like involuntary psychiatric hospitalization and (mechanical) restraint when being hospitalized.

Should mental health legislation be shifted from the common approach that an involuntary psychiatric hospitalization is motivated by either the mentally ill patient's dangerousness to others (for the prevention of harm to the society), dangerousness to self (for the prevention of harm to the patient) or by the need for treatment (for the good of the patient) towards an approach that incapacity regarding mental health care decisions [20] combined with dangerousness to others and/or to self could be the basis for such hospitalization, a further increase of legally involuntary psychiatric hospitalizations might be envisaged.

And finally, if the future public attitude towards the mentally ill is dominated by fears of risks these persons might impose on society and by increasing social distance, and if societies are not willing to start promising initiatives which could diminish the prevailing social exclusion of the mentally ill, such tendencies will empower movements like re-institutionalization.

Frequencies of involuntary psychiatric hospitalizations might decrease (in the opinion of the author) because of the following trends and developments:

Human rights of mental health patients are of increasing importance and a huge number of nations are now committed to a sufficient guarantee and respect of these rights. They showed their commitment e.g. by the ratification of the UN Convention on the Rights of Persons with Disabilities (13 December 2006) [8]. The Convention's definition of persons with disabilities (Article 1) clearly states that this includes "those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." Focusing on health related issues of these persons, and dealing also with the issue of involuntary psychiatric hospitalizations, the following regulations in this Convention deserve special attention because they have to be guaranteed by States Parties: "States Parties shall ensure that persons with disabilities, on an equal basis with others:... b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty" (Article 14); Article 15 outlines that "... 2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment"; and, "States Parties recognize

that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation" (Article 25). As has been discussed recently in more detail [21], the field of psychiatry in its current state should be deeply concerned that these rights, in their complexity and comprehensiveness that clearly exceeds the issue of coercive treatments, are, at least, inadequately addressed and respected, and might even be severely endangered.

## CONCLUSION

To improve this situation, the establishment of regular and effective monitoring processes focusing on involuntary psychiatric hospitalizations would be an important step forward. However, a recent general impression from twelve European countries is that activities of existing supervision authorities are largely performed as a formal routine [11]. Supervision refers to checking duly filled-in and signed paperwork, but does not stimulate or demand practical changes. Despite of the complexity of the regulations, or perhaps because of that, the face-to-face interview between the person with the mental illness and the supervising authority is exceptional. Changes to the patient's legal status dictated by an authority and not previously suggested by the health professionals are extremely rare. Although appeal proceedings of the patients are foreseen by most of the laws, they rarely occur. Most of the regulations do not contemplate other coercive measures by which the patient might be affected while staying in hospital. It seems that once the patient is placed in the hospital, the authority delegates the responsibility to the health professionals, assuming that they will always act in the best interests of the patient.

Further, re-definition of national mental health care policies and consequent re-allocation of the respective financial means in the direction to stimulate the establishment of care approaches which provide alternatives to hospitalization might decrease the frequencies of involuntary psychiatric hospitalizations. Acute day care is an example for such service provision. Most recent research demonstrated that the highest site-specific percentage reduction of inpatient admissions of general psychiatric patients which could be achieved by acute day care is up to ca. 70% [22]. To achieve such a reduction treatment concepts and professional qualifications of the staff in day care facilities need to be adapted in a way that such facilities could deal not only with the full spectrum of mental disorders (e.g. not exclude substance abuse disorders), but also with all degrees of severity and immanent clinical risks of these disorders (e.g. suicidal risk, need for 1:1-supervision, comorbid somatic disorders). To realize a further increase of such feasibility rates (i.e. percentage reduction of inpatient admissions of general psychiatric patients) would force

acute day care units to treat legally involuntarily admitted patients, an option which would not only require clarification in many national mental health laws, but would further significantly change currently established clinical practice (i.e. there would be a need to offer 24-hour home treatment including the option to provide constant 1:1-supervision) in day care units.

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## Принудна психијатријска хоспитализација: садашње стање и изгледи за будућност

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### КРАТАК САДРЖАЈ

Општи циљеви овог чланка су: а) да прикаже садашња истраживања о важним клиничким и питањима људских права у вези са присилном психијатријском хоспитализацијом; и б) да анализира одређене факторе који могу утицати на будући развој у пружању услуга у овој области менталног здравља. У чланку ће бити описани главни резултати из два прегледна рада о исходима присилног пријема у болницу. Изабрани резултати клиничког дела новог европског мултицентричног истраживачког пројекта о принуди у психијатрији (EUNOMIA) биће представљени детаљније у вези са следећим питањима: ставови удружења болесника о присилној хоспитализацији и разлике у законодавству, одлике

болесника повезане с мање или више позитивним исходима присилног пријема, принудне мере (нпр. механичко ограничавање, издвајање и принудна медикација) које се користе током ових хоспитализација. Коначно, чланак ће расветлити будуће перспективе ове теме. Због овог, неке препоруке за најбољу клиничку праксу у коришћењу присилне хоспитализације биће продискутоване, а аргументи за два будућа сценарија – повећање против смањења броја присилних психијатријских хоспитализација – биће супротстављени и анализирани.

**Кључне речи:** принудна психијатријска хоспитализација; принудни пријем; принуда; људска права; регулатива у домену менталног здравља; најбоље препоруке за праксу