AN ICELANDIC PERSPECTIVE ON ETHICAL AND PRACTICAL ASPECTS OF FORCED TREATMENT

Dr. Pall Matthiasson MD MRCPsych PhD
Topics of talk

- Ethical aspects of coercion
- The UN convention
- Different types of coercive measures
- The Icelandic experience
- How to reduce coercion in psychiatry
My background
The Icelandic mental health model - features

- Landspitali – the National Hospital, covers 85% of 2. and 100% of 3. care (mental health part of general hospital system)
- No long-term patients (excl. one forensic ward w 2 yrs av. length of stay)
- Law on capacity – no special MH law – (72 hrs – 21 days – prolonged for 12 weeks - courts)
- Very low involuntary admission rate
- No physical restraints
Why are there so few involuntary admissions?

How do we cope without mechanical restraints?
How can we calm someone who is agitated / aggressive?
Can we FORCE those at serious RISK?
HUMAN RIGHTS FIRST

TIME 4 TRUTH
WAIT! WE NEED TO CONSIDER ALL OUR STAKEHOLDERS!
Stakeholders

1. Medicine/psychiatry
2. Law
3. Legislative bodies
4. Executive branch of government
5. The Police
6. Accrediting bodies
7. Lay advocacy organizations
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Law vs. Medicine

1. Conflict — consensus
2. Formal — informal
3. Error
4. Free will — determinism
5. Least restrictive setting — reducing suffering
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How do we best help unwell and vulnerable people?
Arguments against coercion

1. Problems with living – should not be seen as mental illness
2. Mental illness exists but coercion is wrong
3. Mental illness exists - treatment can be helpful – coercion is unethical and ineffective
4. Mental illness exists - treatment can help - coercion can help – but if society offered decent clinics coercion wouldn’t be necessary
Arguments for coercion

- Mental illness exists
- Treatment can be beneficial
- Coercion is often humane and effective
- Attractiveness and accessibility of treatment facilities cannot always replace involuntary treatment
Parens patriae
“As we examined these forced-treatment situations we found repeatedly that initial coercion can lead to greater freedom in the long run. ...Coercion should not be viewed in terms of presence of absence, but in terms of degree and source.”
(The Group for Advancement of Psychiatry)
In summary, systematic data about the benefits of involuntary treatment at times, is convincing enough to make involuntary treatment acceptable, within a legal framework, with careful scrutiny, in most countries.
Is there a need for involuntary treatment?

If so – should the treatment decision be made by someone other than the prospective patient?
The paternal view of past...

Trust me.
I’m a doctor.
“The jury in its wisdom always commits”
Abuses of involuntary treatment

1. Unnecessary hospitalization
2. Mistreatment during the period of admission
The UN convention on the rights of persons with disabilities
UN convention (2007)

Article 14 - Liberty and security of person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

a) Enjoy the right to liberty and security of person;

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 12 & 25

article 12 recognizes equal right to enjoy legal capacity in all areas of life, such as deciding where to live and whether to accept medical treatment.

article 25 recognizes that medical care of persons with disabilities must be based on their free and informed consent.

Thus, in the case of earlier non-binding standards, such as MI principles the Special Rapporteur (Novack) noted that the acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention.
Types of coercion

- Involuntary admission
- Seclusion
- Holds
- Mechanical fixation (belts, straightjackets)
- Forced medication/rapid tranquillisation
Consequences of coercion

- Coercion can leave long-lasting marks on patients, families and staff (Bonner 2002, Mesquita 2016)
- Patients sometimes later believe force was necessary at the time (O´Donoghue 2013, Olofsson 2001)
- How force was used and justified is very important (Recupero 2011)
Main reasons for coercion

- Threatening behaviour
- Violence
- Damage to property
- Refusal of medication

(Baker 2009, Oster 2015, Smith 2015)
Involuntary admission

Definition:
Formal admission to hospital against the will of the person or restriction on a patient’s wish to leave hospital.
Rate of admissions under coercion
Source: Nordic Minister Council 2004-2005

Admissions under coercion were 3.7% of all admissions between 2003-2010.

2014:
- 3.2% of admissions
- 4.95% if 48hr adm. included
Seclusion

- **Definition:** The confinement of a patient in a locked room or in a clearly defined area within a ward
- **Rates and length vary widely** (Janssen 2008)
- **The incident on John Meyer Ward, London**
- **De-escalation suites**
A de-escalation suite – an alternative to seclusion
Holds and mechanical restraints
Notes on Mechanical Restraint

- Practice varies widely
  - Rates of inpatients restrained:
    - from 0% (UK, Iceland), 3% (Finland) to 22% (Poland).
      Average for Europe is 11%
    - USA 11%, Japan 18%
    - Huge variation within countries as well
    - In a Japanese study 24% were restrained for over 15 days

- Reasons for restraint include
  - “prevention of excitement” in 47% (Odawara et al. 2005)

(Stewart 2009, Lepping 2016)
## Restraint Use in Inpatient Psychiatric Facilities

*Hours per 1,000 patient hours; top 3 facilities.*

<table>
<thead>
<tr>
<th></th>
<th>ALL AGES</th>
<th></th>
<th>AGE 65 AND OVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRIDGEPORT HOSPITAL</td>
<td>46.0</td>
<td></td>
<td>38.0</td>
</tr>
<tr>
<td>MASONIC HOME AND HOSPITAL</td>
<td>34.0</td>
<td></td>
<td>36.0</td>
</tr>
<tr>
<td>DANBURY HOSPITAL</td>
<td>3.61</td>
<td></td>
<td>9.19</td>
</tr>
<tr>
<td>STATE AVERAGE</td>
<td>1.0</td>
<td></td>
<td>7.69</td>
</tr>
<tr>
<td>U.S. AVERAGE</td>
<td>.39</td>
<td></td>
<td>1.01</td>
</tr>
</tbody>
</table>

*Source: Centers for Medicare & Medicaid Services, 2012-13*

*WebKazoo graphic*
The EUNOMIA project

Coercive measures used among 770 involuntary admitted patients in ten European countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Seclusion</th>
<th>Restraint</th>
<th>Forced medication</th>
<th>Number of coercive measures applied</th>
<th>Number of coercive measures applied per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>p&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Germany</td>
<td>0</td>
<td>—</td>
<td>51</td>
<td>55</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>4</td>
<td>4</td>
<td>17</td>
<td>15</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>9</td>
<td>6</td>
<td>50</td>
<td>33</td>
<td>ns</td>
</tr>
<tr>
<td>Greece</td>
<td>0</td>
<td>—</td>
<td>131</td>
<td>69</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Italy</td>
<td>19</td>
<td>19</td>
<td>24</td>
<td>24</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Lithuania</td>
<td>0</td>
<td>—</td>
<td>9</td>
<td>27</td>
<td>ns</td>
</tr>
<tr>
<td>Poland</td>
<td>0</td>
<td>—</td>
<td>83</td>
<td>32</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Spain</td>
<td>10</td>
<td>5</td>
<td>82</td>
<td>37</td>
<td>ns</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>79</td>
<td>30</td>
<td>68</td>
<td>26</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Sweden</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>17</td>
<td>.004</td>
</tr>
<tr>
<td>Total</td>
<td>122</td>
<td>8</td>
<td>522</td>
<td>36</td>
<td></td>
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</tbody>
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<sup>a</sup> For the difference (Pearson chi square) in the pattern of applied coercive measures compared with other countries investigated.
“The question therefore arises whether complete (or almost complete) eradication of mechanical restraint might not be a realistic goal in the longer Term”. (Standard 44. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment)
How to cope without mechanical restraints

- Control & restraint techniques
- “Violence management teams”
Holds vs mechanical fixation

- Holds: 5-20 minutes
- Mechanical fixation: 4.17 hours
  (Masood 2016, Stewart 2009)

- The David Bennett Inquiry – UK 2003
Rapid tranquillisation
A study from Switzerland

Medication use (mainly injections) does not increase when mechanical restraints are used less

Correlation between types of coercion

- Coercive measures fluctuate together, attitudes of staff/society matter (Baker 2006)
- Number of incidents similar in 4 countries but types of coercion differ (Lepping 2016)
Dr. Helgi Tómasson
Shackles from another age
Major incidents involving coercive measures in Icelandic MH

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>32A</td>
<td>2.5</td>
<td>1.0</td>
<td>-60%</td>
</tr>
<tr>
<td>32C</td>
<td>3.0</td>
<td>2.9</td>
<td>-3%</td>
</tr>
<tr>
<td>33A</td>
<td>1.9</td>
<td>1.0</td>
<td>-48%</td>
</tr>
<tr>
<td>33C</td>
<td>2.2</td>
<td>0.3</td>
<td>-88%</td>
</tr>
<tr>
<td>31E</td>
<td>1.2</td>
<td>1.7</td>
<td>45%</td>
</tr>
<tr>
<td>Other</td>
<td>1.2</td>
<td>0.2</td>
<td>-83%</td>
</tr>
<tr>
<td>Total</td>
<td>12.0</td>
<td>7.1</td>
<td>-41%</td>
</tr>
</tbody>
</table>
PICU led to a reduction in incidents

Number of incident reports in the mental health division of Landspitali

<table>
<thead>
<tr>
<th>Incident type</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>234</td>
<td>226</td>
<td>99</td>
</tr>
<tr>
<td>Accidents / Mishaps</td>
<td>60</td>
<td>25</td>
<td>43</td>
</tr>
<tr>
<td>Property damage</td>
<td>19</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Needlestick mishap</td>
<td>2</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Unspecified</td>
<td>10</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>325</strong></td>
<td><strong>282</strong></td>
<td><strong>172</strong></td>
</tr>
</tbody>
</table>

Changes in staff satisfaction 6 months after changes

- Increase in satisfaction: 71%
- Decrease in satisfaction: 19%
- No change: 10%
Seven key strategies to reduce coercion

- Policy change / leadership
  - Local – general – political
- External review / debrief
- Data use
  - Feedback fostering learning and competition between units
- Training
  - Skill development (de-escalation/crisis management skills – in vivo training)
  - Attitudinal change (debunking myths – targeting key decision makers)
- Consumer / family involvement
- Increase in staff ratio / crisis response teams
- Program elements / changes
  - (early intervention – least restrictive crisis management approach – modifying environment – more activities)

3 recommendations for change

- Be bold – abolish mechanical restraints
- Comprehensive mental health outreach
- Seek user participation – negotiate - and trust!
DONT'T BE AFRAID OF CHANGE.