Mandatory Psychiatric Care Act
Unvoluntary treatment
Compulsary treatment

10 september 2020
Fórum de Prevenção do Suicídio

WWW.SUICIDALITEIT.NL
Suicidal behaviour and unvoluntary treatment?
No Conflict of Interest
Mandatory Psychiatric Care Act

- Suspicion or determination psychiatric classification
- Relation with symptoms and danger needed
Danger

- Self (suicide) **later focus**
- Others
- Goods
- mental health of others
- social decline
European laws

- **Netherlands**
- **New Law 2020** very difficult & labour intens

- **Important players**
  - Medical director, Psychiatrist, public prosecutor, judge, lawyer, mayor, patient counselor

- **Maximum duration**
Netherlands

- 17.2 million inhabitants
- Within top 15 richest countries (↓)
- Top 30 safest places
- 7th place happiness population (↓) *(WHR)*
- High density psychiatrists (1:5600)
- Suicide rate 1:11.03 overall (2019)
  - Since 10 years >30% increase in suicides
Netherlands is about 205 times *smaller* than Brazil.

Brazil is approximately 8,515,770 sq km, while Netherlands is approximately 41,543 sq km, making Netherlands 0.49% the size of Brazil. Meanwhile, the population of Brazil is ~207.4 million people (190.3 million fewer people live in Netherlands). We have positioned the outline of Brazil near your home location of Leiderdorp, ZH, Netherlands.
3 laws

- **Law Mandatory Psychiatric Care**
  - Wet verplichte geestelijke gezondheidszorg
  - Mainly major diagnosis psychiatry

- **Law care and coercion**
  - Wet zorg en dwang
  - mainly neurocognitive problems mentally impaired

- **Forensic Care Act**
  - Wet forensiche zorg
  - psychiatry and justice worthy of criminal proceedings
Law Mandatory Psychiatric Care

- **Acute** Mandatory maximum 3 weeks after judge
- Crisisforce
  - Acute symptoms

- Long term **Mandatory** maximum 6 months after judge
  - care authorization
  - Chronical symptoms
Long term Mandatory maximum 6 months after judge

- Need 25 meters of paper
Mandatory Psychiatric Care

- **Needed**
- Lot of forms and
- Patients
  - May make an own plan
- Care plan
  - care-responsible care provider 8 pages format
- **medical statement**
  - independent psychiatrist
  - 7 pages format
9000 x acute
Law

Mandatory Psychiatric Care

- 8 different mandatory directions

- All are judged and defenced by lawyer(s) > involuntary
  - admission
  - Medication
  - somatic inspection
  - restriction freedom of movement
  - Isolation
  - Forced supervision
  - clothing or body searches,
Ultimum remedium

- All voluntary treatment is tried
- **Mandatory Psychiatric Care has to be**
  - proportional
  - subsidiarity
  - effective (treatment possible)

- All is administrated
Baseline law(s)

- Autonomy of a patient must be protected at all times!
When wrongful care

- Have to pay fines to patients

- Patient are assisted by
  - Independent patient counselor
  - lawyer

- &

- For all patient complaints committee
  - Templar, lawyer, secretary
  - Independent nurse, psychiatrist, physician
When wrong and

- In case of serious error resulting in deprivation of liberty for a patient.

**Imprisonment for the performer for a maximum of 3 years!**
But still Mandatory Psychiatric Care

9000 x acute
17000 X long-term
Focus on suicidal behaviour and involuntary admission
Suicidal behaviour

- Unvoluntary admission during suicidal behaviour is Ultimum remedium.
- Should never be done.
- But sometimes with your back to the wall.
Suicidal behaviour in society & MH

- Suicide......... too late for mental health
- 40% suicides treatment in mental health....(Huisman et al 2010)

Mental health:
- Experts diagnosis & treatment of serious suicidal behaviour!
- Very very very serious > admission...
  - Last resort
  - And then....?
Admission

- False sense of security?
- Iatrogenic?
- Last resort?

- Possible rapid treatment
- Observation
- Unburden support system
Risk taxation suicidal behaviour & closed wards

- Concentration of serious suicidal behaviour
- Increased risk suicide (>50-80 x)
- No specific guidelines, just general
- ? Open < > closed (Huber et al 2016)
Serious suicidal behaviour and acting

“study design”

- Acting of mental healthworker changes outcome......
- Randomised trial > serious lethal suicidal behaviour
  - Group 1 admission
  - Group 2 no admission

- Outcome suicide!
Suicidal behaviour and closed admission

- Suicidal behaviour 28.7% (368/1324) (Miedema ea 2016)

**Development Phase plan 2007**
- For every patient multidisciplinary risk taxation!
- Daily registration and taxation
- registration monitored on digiboard
- Clarity of taxation for all!
<table>
<thead>
<tr>
<th>Phase</th>
<th>Color</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Blue</td>
<td>discharge</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Green</td>
<td>Freedom</td>
</tr>
<tr>
<td>Phase 3</td>
<td>Yellow</td>
<td>No freedom outside</td>
</tr>
<tr>
<td>Phase 4</td>
<td>Orange</td>
<td>Supervision (differentation)</td>
</tr>
<tr>
<td>Phase 5</td>
<td>Red</td>
<td>Continuous observation (&quot;evt&quot; seclusion during night)</td>
</tr>
<tr>
<td>Phase</td>
<td>Risk Level</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Phase 5</td>
<td>Very High Risk</td>
<td>3.5%</td>
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<tr>
<td>Phase 4</td>
<td>High Risk</td>
<td>7.1%</td>
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<tr>
<td>Phase 3</td>
<td>Acceptable Risk</td>
<td>59.5%</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Acceptable Risk</td>
<td>28.0%</td>
</tr>
<tr>
<td>Phase 1</td>
<td>Acceptable Risk</td>
<td>1.9%</td>
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A study of the connection between coercive measures used in a closed acute psychiatric ward and the socio-demographic and clinical characteristics of the patients involved

N. MIEDEMA, M.C. HAZEWINKEL, D. VAN HOEKEN, A.S VAN AMERONGEN, R.F.P. DE WINTER

**TABLE 2** Klinische kenmerken in relatie tot dwangmaatregelen

<table>
<thead>
<tr>
<th>Klinisch kenmerk</th>
<th>Totaal</th>
<th>Dwangmaatregel</th>
<th>Noodmedicatie</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>Ja</td>
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<tr>
<td><strong>Alle opnames</strong></td>
<td>1283</td>
<td>100,0%</td>
<td>260</td>
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<tr>
<td><strong>Opnamereden</strong></td>
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<td>Psychotische decompensatie</td>
<td>472</td>
<td>36,8%</td>
<td>127</td>
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<tr>
<td>Suicidaliteit</td>
<td>370</td>
<td>28,8%</td>
<td>45</td>
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<tr>
<td>Agressie</td>
<td>216</td>
<td>16,8%</td>
<td>78</td>
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</table>
Alternatives

- Phase 5 permanent observation
  - For 52 patients 4 nurses (23.00 - 7.30)
  - During nights seclusion...........

- Seclusion and suicidal behaviour!

- Seclusion = detrimental (de Winter et al 2011)
Mission!

- No more use of seclusion rooms for suicidal patients!
Finding alternatives

- Since 2010, development of alternatives!

- Patients and staff prefer modern detection systems above separation (Hazewinkel et al. 2014).

- Searching for alternatives with detection?

- Learning detection systems/smart wrist application/smartphone application/rooming in etc.
Alternative for seclusion during nights

- finally

- Development of Automation rooms!
1. Smart sensor
2. Movement sensor
3. Movement sensor
4. Acoustic sensor
5. Door sensor
6. Smartglass
Acting after signal

- **Signal:**
  - 1. Sensor detection movement or otherwise in room.
  - 2. Signal notification on handsensor
  - 3. Watching Video fragment on pc
  - 4. Face to face contact patient
Light in the darkness
Decrease in seclusions

- **76.2 %**
  - in using seclusion rooms for suicidal patients.

- All seclusions < 4 % primary suicidal behaviour (was 17.3%!)
Time

9 years.....
Discussion
Thank you audience........

- !
- R.dewinter@parnassia.nl
- info@suicidaliteit.nl

Thanks:
• [https://youtu.be/05HrZ6YnM10](https://youtu.be/05HrZ6YnM10)