

# Mandatory Psychiatric Care Act

## Unvoluntary treatment

## Compulsary treatment

REMCO DE WINTER MD PHD

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Fórum de Prevenção do Suicídio

[WWW.SUICIDALITEIT.NL](http://WWW.SUICIDALITEIT.NL)



**Rivierduinen**



**Parnassia Groep**



# Suicidal behaviour and involuntary 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

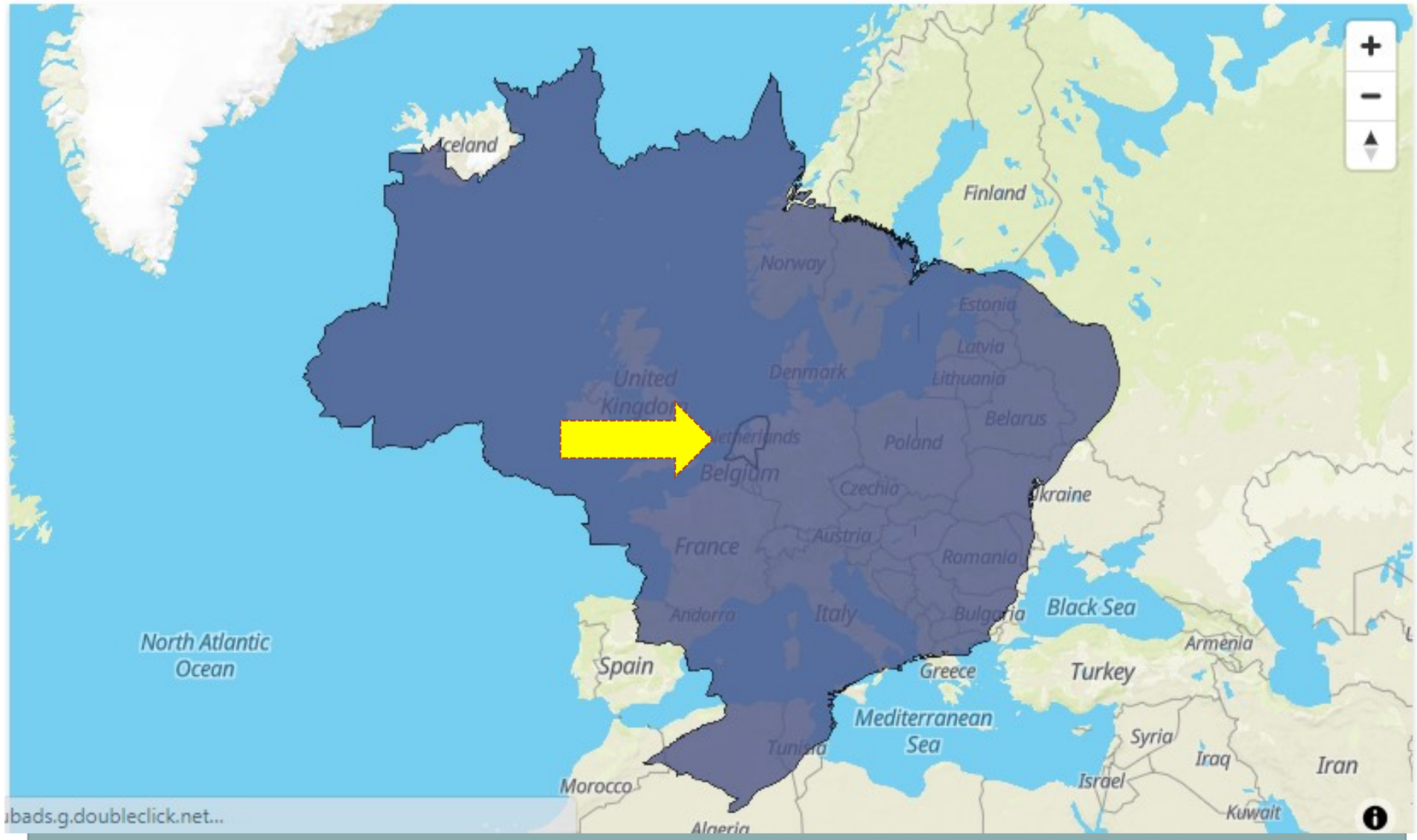
# Neth ands

- 17.2 million inhabitants
- Within top 15 richest countries (↓)
- Top 30 safest places
- 7<sup>th</sup> 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 forensische 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**

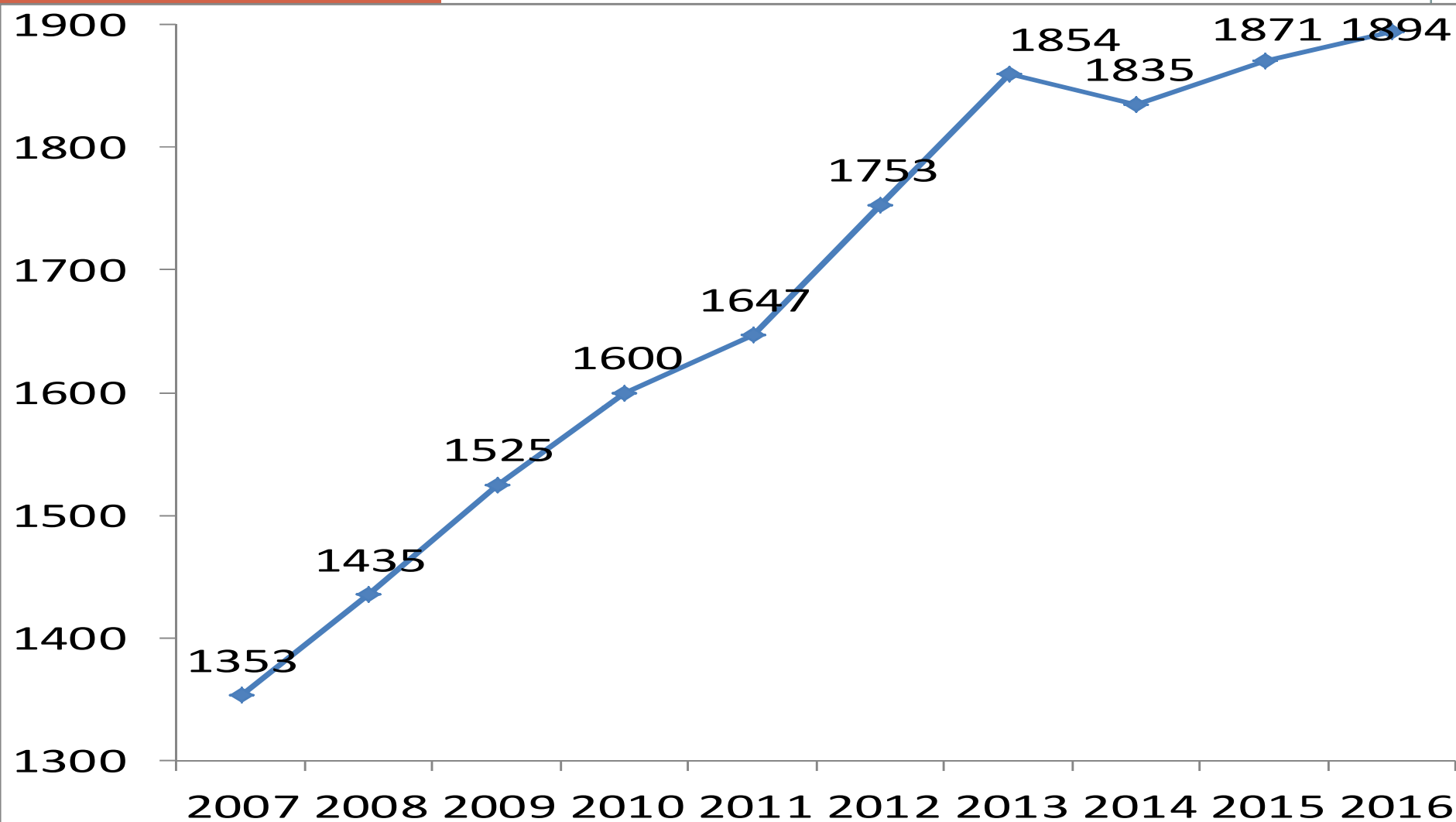


**9000 x acute**

**17000 X long-term**



# Suicide rate in the Netherlands





- 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!



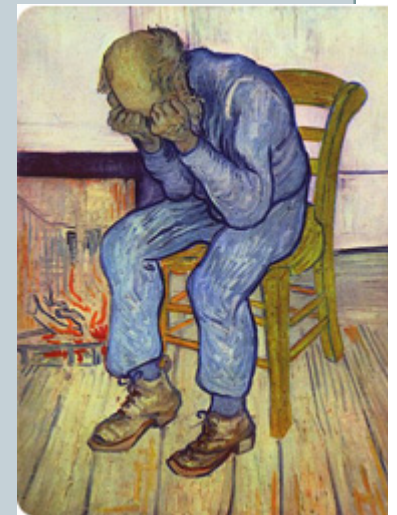
# Suicidal behaviour and closed admission



- 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!



# Acute ward, phase plan (de Winter et al 2011)



**Phase 5** (Red)

**Continuous**

**observation** ("evt" seclusion  
during night)

**Serious**

**suicidal**

**Phase 4** (Orange)

**Supervision** (differentiation)

**Phase 3** (yellow)

**No freedom outside**

**Phase 2** (Green)

**Freedom**

**Phase 1** (Blue)

**discharge**

**Non-suicidal**



# High risk? N =1284

(de Winter e.a 2012)



Fase 5 (very high risk)	3.5%
Fase 4 (high risk)	7.1%
Fase 3 (acceptable risk)	59.5%”
Fase 2 (acceptable risk)	28.0%
Fase 1 (acceptabel risk)	1.9%)

# 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

TJDSCHRIFT VOOR PSYCHIATRIE 58(2016)6, 434-445

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

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

Klinisch kenmerk	Totaal		Dwangmaatregel				Noodmedicatie			
	N	%	Ja	% Ja	$\chi^2$ -toets**		Ja	% Ja	$\chi^2$ -toets**	
Alle opnames	1283	100,0%	260	20,3%			182	14,2%		
<b>Opnamereden*</b>										
Psychotische decompensatie	472	36,8%	127	48,8%	$\chi^2 = 20,385$ ; df = 1; $p < 0,001$		94	51,6%	$\chi^2 = 20,404$ ; df = 1; $p < 0,001$	
Suïcidaliteit	370	28,8%	45	17,3%	$\chi^2 = 21,127$ ; df = 1; $p < 0,001$		23	12,6%	$\chi^2 = 27,003$ ; df = 1; $p < 0,001$	
Agressie	216	16,8%	78	35,8%	$\chi^2 = 40,681$ ; df = 1; $p < 0,001$		68	37,4%	$\chi^2 = 62,697$ ; df = 1; $p < 0,001$	

OPNAMEAFDELING



# 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 & 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

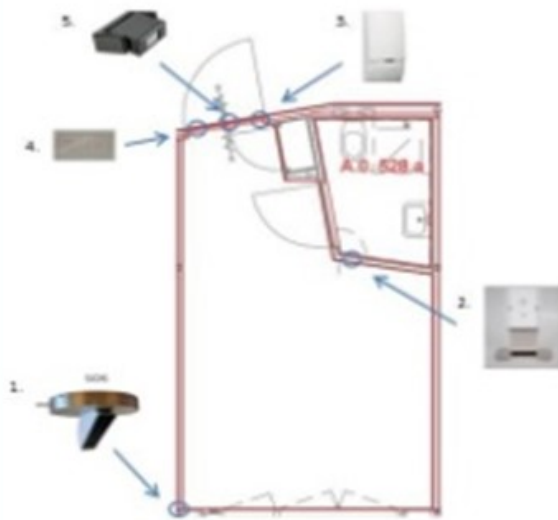


- finally
- Development of **Automation rooms!**



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Automati

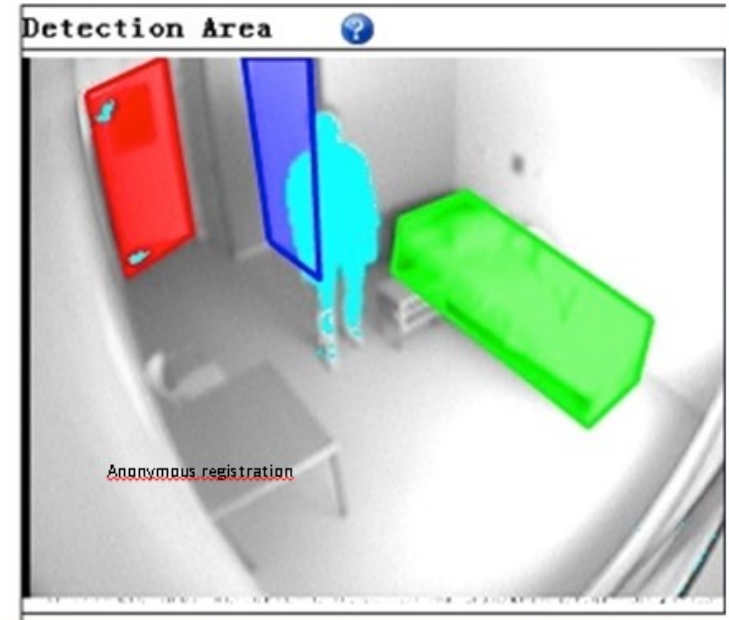
1. Smart sensor
2. Movement sensor
3. Movement sensor
4. Acoustic sensor
5. Door sensor
6. Smartglass



Smart sensor



Sensor



# 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 %** ↓

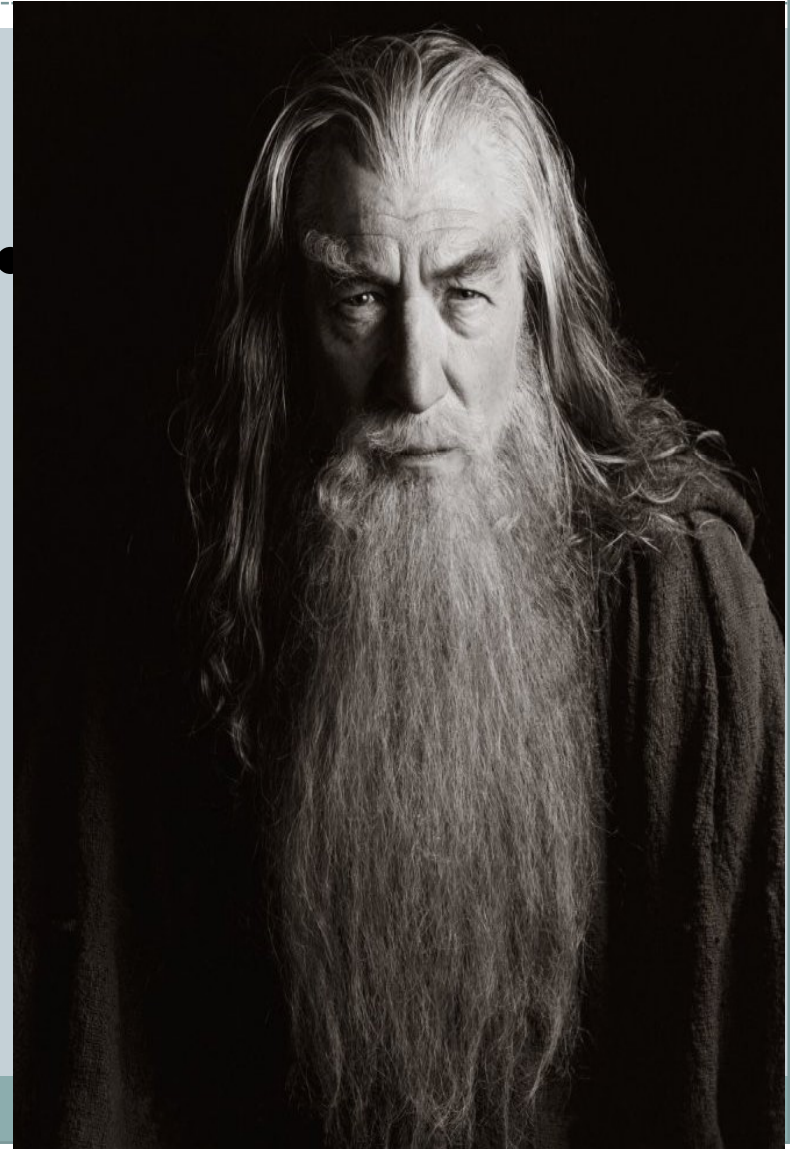
○ in using seclusion rooms for suicidal patients.

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

Time.....



● 9 years.....



# Discussion



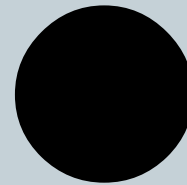
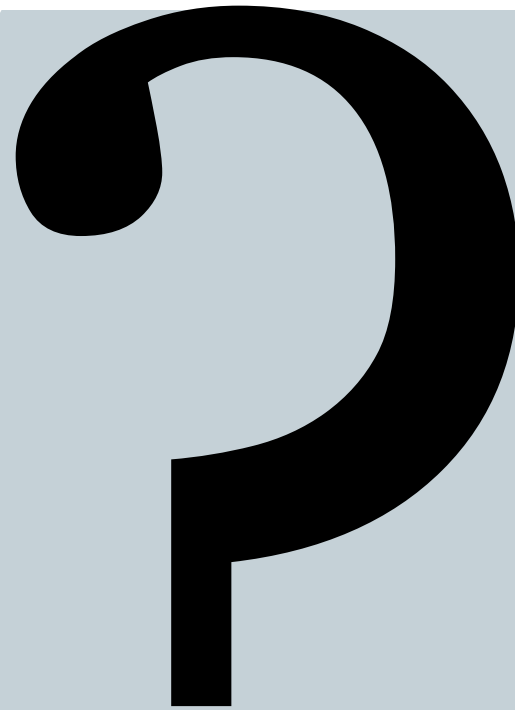


# Thank you audience.....



- !
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# Questions



?



- <https://youtu.be/o5HrZ6YnM1o>

