# The impact of legislation on coercion in psychiatric services in Finland

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* Prevention of coercion & violence, ps.pharmacology, genetics, schizophrenia. ”Epidemiological studies of severe violence & MMD ” 2007. Effects of S/R prevention with 6CS 2007-2017.
* 2008-2009 : RCT of the safety & efficacy of S/R Prevention.
* 2010-2016 NIHW task force & editorial board > ” Reducton of coercion and increase of safety in psyciatric care”
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* - No conflicts of interest.

# 1. Legislation of containment in Finland

**Mental Health Act** (1992) **revision 1997** : ”involuntary care” .

- ”Significant decrease of involuntary care was associated with the improved access to outpatient care and huge decrease of hospital beds since the end of the 1980'ies .” *
- **MHA revision (2001)** determined 10 coercive measures for psychiatric hospitals. 2009 and 2014 minor revisions.
- European Human rights Council: ”MHA does not assure the human rights of a person in involuntary treatment. ”(438/2014 )
- CPT : several recommendations of involuntary psychiatric care
- A new law of restrictions for all health care sectors is delayed by ongoing huge reformation of social and health )

# What changed with Mental Health Act revisions ?

* The intention of the law: ”Restriction of the fundamental rights must always be based on law.”

* 10 legal restrictions (+ staying in the hospital by night)
* The restrictions, not the decrease of them, must be ordered and postulated !
* In traditional prison & psych. hospital culture fundamental rights (free movement out, communication, own money, etc. ) were routinely lost when admitted, and had to be ”earned”
* The intention was to limit the indications of S/R. However, the final law was often misunderstood to legitimize the old practices.
* Reporting of long S/R to AVI

# 10 restrictions allowed during involuntary psychiatric hospital care
# MHA 11/2001; details in supplementary slides

* Seclusion
* Mechanical restraint (binding)
* Physical restraint
* Restriction of freedom to move (in the hospital area)
* Involuntary care of psychiatric illness
* Restriction of communication
* Confiscation of person
* Inspection of a person (blood- and urine tests)
* Confiscation of property and post (not reading)
* Involuntary treatment of a physical disease (includes medicins)

# Responsibilities MHA 1-3§ (11.12.2009/1066)

* Municipalities organize mental health work, i.e social and health care services & prevention, for their inhabitants
* Social 6 Health Ministry (STM): general planning, quidance and suprevision
* Local administrative offices (AVI):local planning, quidance & supervision, particularly of restiriction of the basic rights in 4§ (containment measures)
* S/R use is allowed only in public psychiatric hospitals.
* Containment and care of forensic psychiatric patients is also defined in MHA

# Inspection of hospitals (33§) 11.12.2009/1066

* **Inspections** : The National Supervisory Authority (VALVIRA)and the Regional Supervisory office (AVI) may inspect the psychiatric hospitals if there is reason, without informing the unit before it. (33a§).
* **Correction** : Eventual inadequacies in mental health services must be corrected . The institute or function may be closed if patient safety necessitates it. (33b§) .
* **Remarks**: A municipality, association of municipalities , state hospitals or state officers may be remarked for future, or required improvement . (33c§)

# Criteria of Involuntary psychiatric care (8§, 23.10.1992/954)

1. Mental illness / adolescent´s severe mental disorder
2. Such a need of psychiatric care that without involuntary admission the mental illness would get considerably worse, or the person's or other persons' health or safety would be seriously threatened, and
3. Alternative mental health services are unsuitable or in insufficient

- Under-aged (<18y) may not be treated with adult patients

## **Seclusion:** A person may be ”involuntarily secluded from other patients” in three conditions:

1. He/she is likely* to **injure him/herself or others** (behaviour or a threat)
2. His/her behavior severely **complicates the treatment of others**, severely risks her safety, or he/she is likely* to remarkably destroy **property**
3. It is nesessary for **other very weighty reasons**

# Mechanical restraint (22e)

- ”If a patient is likely to injure her/himself or others, he/she can be tied with a belt or other comparable way, if other acts are insufficient”

# … Physical restraint, manual holding (22e§)

* ”In these situations staff may use nesessary containment measures (SIC!) for holding the patient to seclude her/him. The doctor must be immediately informed .”
* ”A patient may be physically restrained even in other situations if it is necessary for care.” (SIC!)

# 2. The impact of the law after revisions: fewer S/R episodes, same practices

- ”A 15-year national follow-up : Legislation was not enough to reduce the use of seclusion and restraint” 1990 vs. 2004
- Register study by Keski-Valkama A, Sailas E, Eronen M, Lönnqvist J, Kaltiala-Heino R (Soc. Psych . Psych Epid. 2007) 1990,1991,1994,1998 vs. **2004**
- Results: Number of individuals exposed to S/R decreased . Same risk of being secluded or restrained, same duration of R, longer duration of S. Huge local differences.
- Conclusion : ”Legislative changes solely cannot reduce S/R or change the prevailing treatment cultures. S/R should be vigilantly monitored and ethical questions should be under continuous scrutiny.”

# Interventions to prevent S/R in Finland 2011-2016

* 2008-2009 first controlled study of the efficacy and safety of a coercion prevention methodology in Niuvanniemi Hospital:
* ”It is possible to significantly decrease the use of S/R without increase of violence, with the 6 Core Strategies (6CS).
* 2011-2013 the psychiatric hospitals' representatives met regularly in NIHW task force for S/R reduction in Finland.
* Discussions, sharing of ideas, local interventions. Editorial group: ”Coercion reduction and increase of safety in care
* 2011 and 2016 Niuva organized a national training by KA Huckshorn and J. Lebell, the authors of the Six Core strategies.”
* Active hospitals and e.g. Helsinki district, decreased S/R . Some hospitals did not participate and /or increased S/R.

# 2. . Did the 2001 legislation decrease S/R ? (2003 vs. 2013)

* Total exposure of the Finnish population to involuntary care and restrictions has decreased after the new legislation, peak rate was 2006-2007 .
* Some districts have decreased, some have increased S/R.
* The association between S/R decrease and the legislation is unclear as the law did not ban any previous practices or limit the indications.
* Many efforts to reduce S/R in Finland have unintentionally used the Core Strategies for reduction of S/R

# Restrictive interventions during 2014 in psychiatric hospitals in Finland

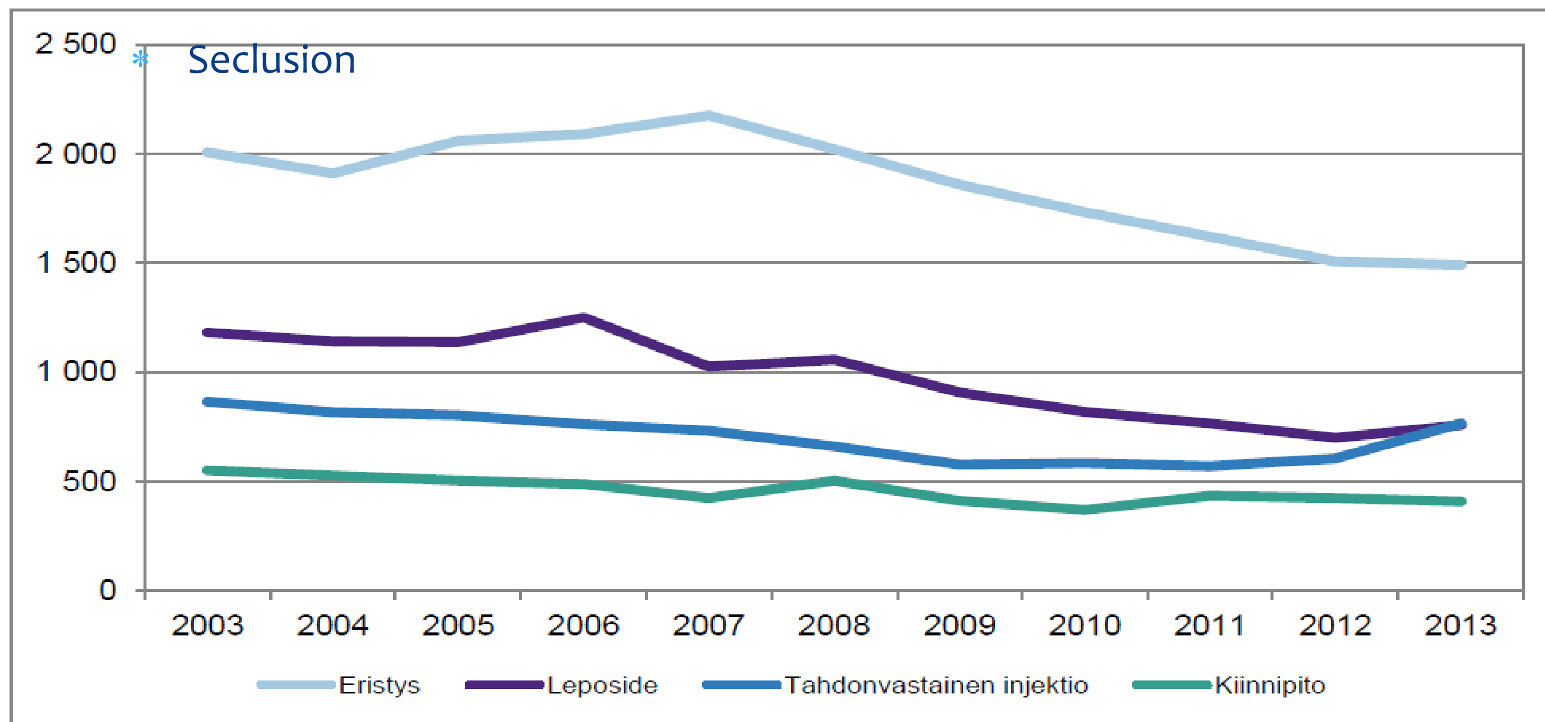
Statistics of National Institute of Health and Welfare

Out of 5,5 million inhabitants , 23 665 individuals experienced psychiatric hospital care , (503 / 100 000)

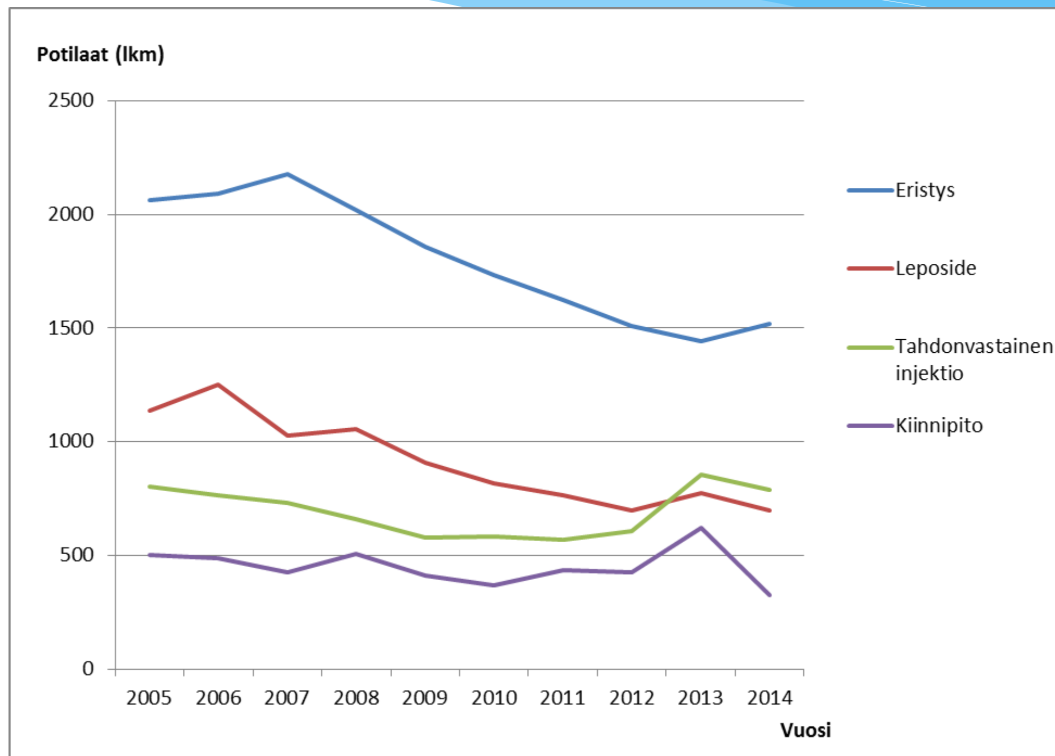
* 32% (7 534 persons) involuntarily; (27% reduction to 2006),
* 31% (2 329) of them experienced restrictions
* 46% (1520) were secluded (7% reducton to 2006)
* 21% in mechanical restraint
* 24% (787 ) experienced involuntary injection
* 10% (326) were physically restrainted

# Inhabitants (N) exposed to containment measures in psychiatric hospitals in Finland **2003-20013**
# Seclusion, mechanical restraint , forced injections, and physical restraint

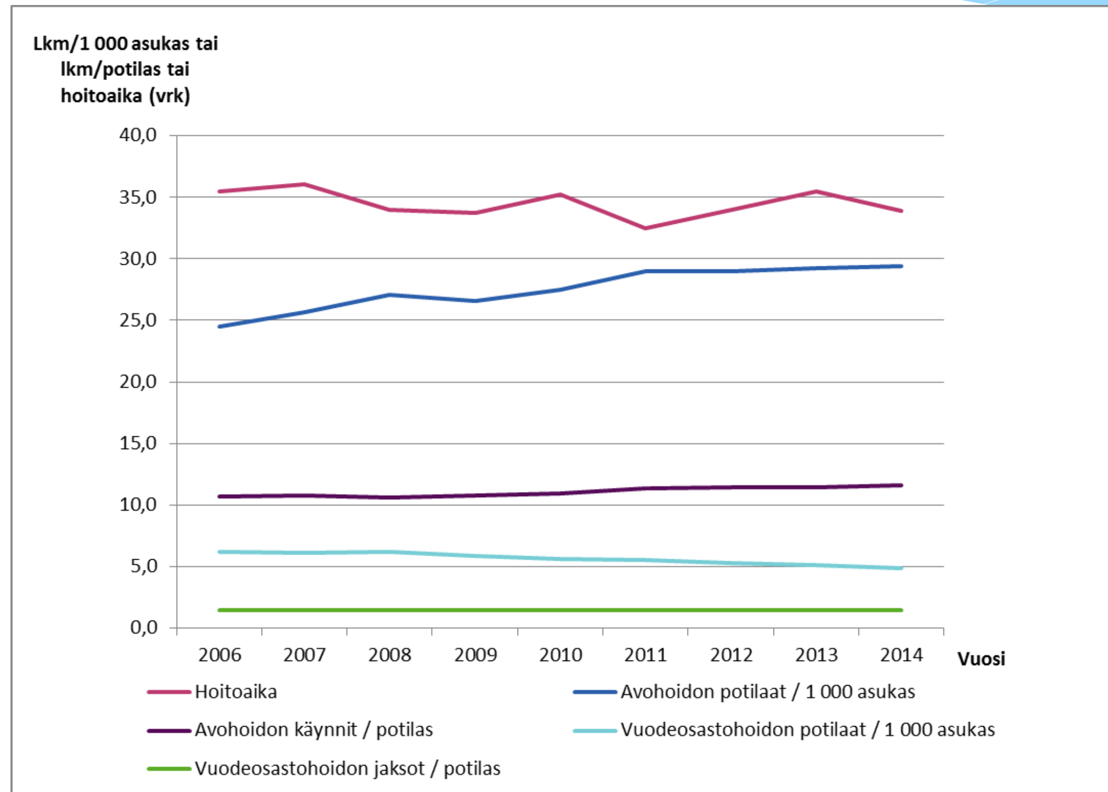
**Kuvio 6. Psykiatrisessa erikoissairaanhoidossa pakkotoimien kohteena olleet potilaat 2003–2013**



Number of individual patients exposed to coercive interventions in psychiatric hospitals Finland **2005 -2014**. (National task force to reduce S/R 2011-2013) seclusion (blue line), mechanical restraint, involuntary injection, physical restraint.



# Psychiatric hospital care in Finland 2006-2014 (number per 1000 inhabitants) . Length of a hospital stay in days (red line) , Users of open services (blue), out patient visits /user, Users of hospital care , Number of hospital stays

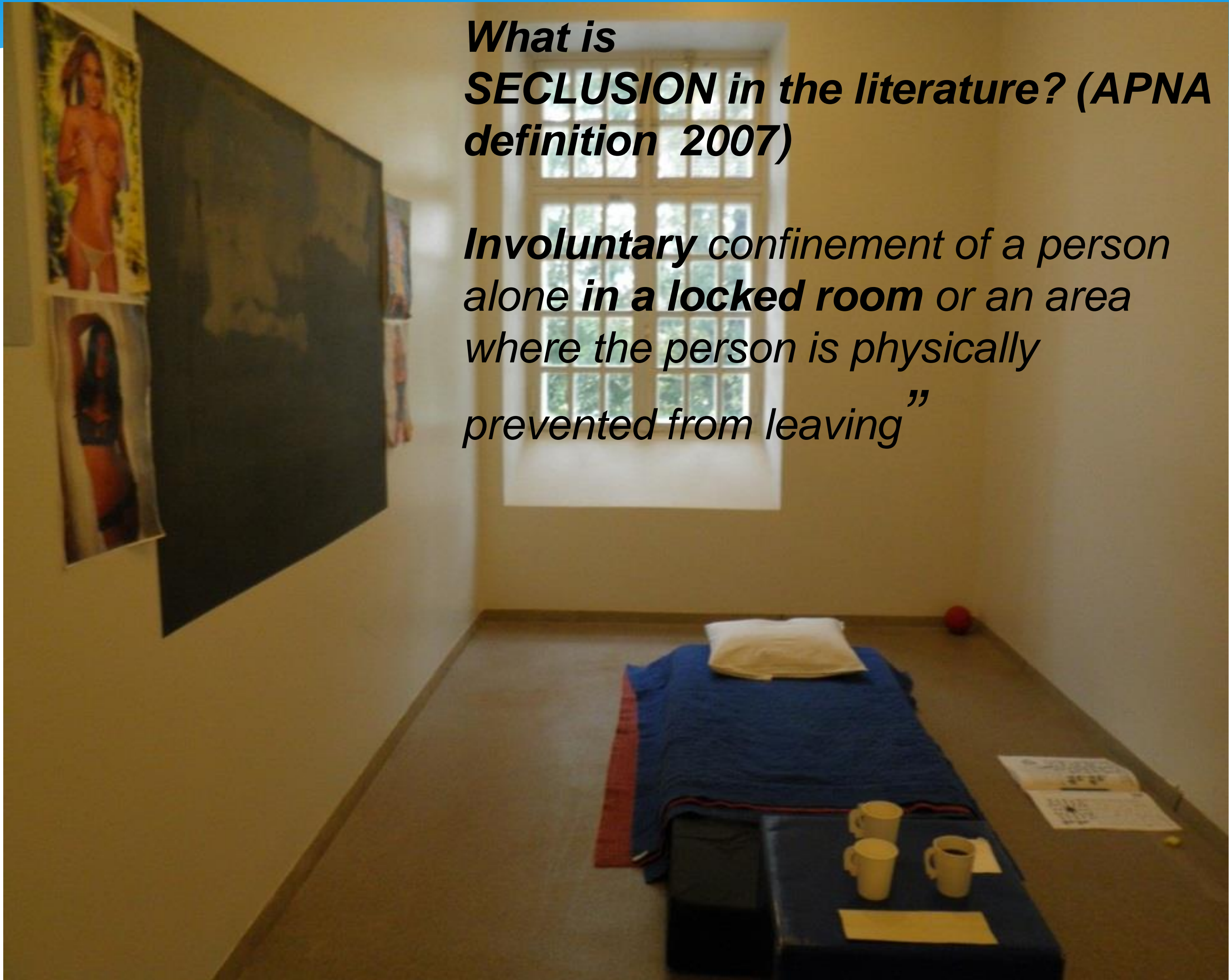


# Did the practices change?

* Huge local differences: some decreased S/R, some increased
* S/R may have been replaced by physical restraint on the ground – (no data of the proportion of prone restraint, the most dangerous restriction )
* Awareness increased.  S/R reduction with single interventions in local projects. One 6CS  study among adolescens (effective, PhD Anja Hottinen)
* Effective prevention of S/R depends on professionals, patients, and devoted hospital leaders.
* Used restrictions are choosen on the basis of traditions, rather than service user's preferences (Traumas, sexual abuse, triggers)
* ”What is good for  one person may be bad for another”:

# Problems of current legislation

* Encouraged old practices (67% not associated with violence),  does not ban S/R used for punishment or staff convenience of,  or call S/R ”last choise”
* Constitution and human rights
* No proper definitions for S and R – imposible to compare
* Does not limit or even record physical  restraining of a person on on other surfaces,  or pushing him on the ground by several persons (restraint deaths, triggering of patient-to-staff violence) e.g.



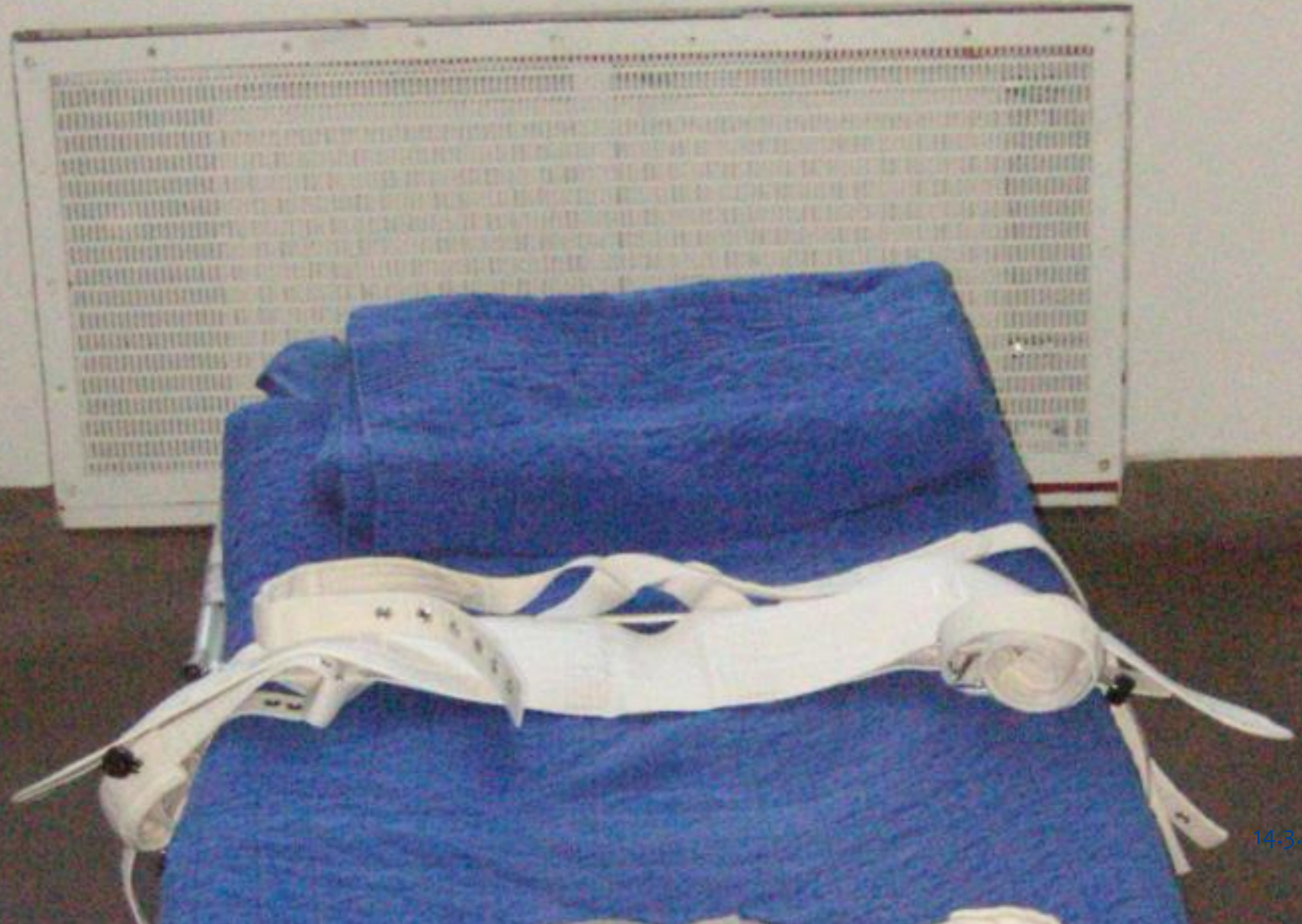
## *What is SECLUSION in the literature? (APNA definition 2007)*

***Involuntary*** *confinement of a person alone* ***in a locked room*** *or an area where the person is physically prevented from leaving"*

**A definition of RESTRAINT in the literature (APNA 2007)**

“Any manual method, or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body or head freely”

- Physical, mechanical, chemical,elctronical etc...



# Needed

* Expressed aim to reduce coercion in psychiatric care
* Service users' full inclusion
* Non-discriminating attitude and lanquage
* Recommendations of systematic prevention of S/R & violence by improving the culture of care with 6CS
* Detailed definitions of S/R and variables
* On-line monitoring and supervision system of all restrictions
* Incidence and duration of S/R (per patient days) , to enable benchmarking and positive competition

# What France could do to reduce S/R?

* 1. Provide the missison of psychiatric care
* 2. Define all legal restrictions and when, where and how they can be used . State that "Restriction of fundamental rights should always be based on law"
* 3. Organize on-line monitoring, reporting and feedback system for each hospital.*
* --Include number and total duration of all restrictions, particularly of prone restraint (and total number of patient days). Consider bonus salary limits.