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COERCIVE MEASURES IN PANDEMIC PSYCHIATRIC CARE — RETROSPECTIVE STUDY

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ABSTRACT — Coercion raises serious ethical and legal issues in psychiatric care. Coercive medical measures are applied in psychiatric institutions for protective purposes. Alcoholism is a social and medical problem because it especially affects the behavior of the individual. Alcohol consumption can catalyze exacerbations of mental illness and predispose to behaviors with an increased risk of violence.
Aim: The purpose of this study is to illustrate medical and legal issues related to coercive measures in emergency psychiatric care during the pandemic.
Methods: The study is retrospective, and the data were taken from the observation sheets of patients in the period between March 1, 2020–March 31, 2021, in acute section II in the Institute of Psychiatry "Socola" Iasi.
Results: Of those who required coercive measures during hospitalization, most were restraint for symptoms such as: self-aggression and aggression towards others. Mechanical restraint measures were also necessary in cases with hallucinatory-delusional symptoms, associated with self-aggression and aggression towards others. The share of hospitalized patients for alcohol abuse, who required coercive measures, was significantly higher during the pandemic.
Conclusion: Manifestations of violence among patients with major mental disorders are rare. Mechanical restraint was necessary especially in those who had self-aggression and aggression towards others, symptoms secondary to alcohol consumption. Alcohol consumption amplifies the psychological imbalance in the context of the COVID-19 pandemic.

KEYWORDS — coercion, psychiatric emergencies, pandemic.

INTRODUCTION

Psychiatry has faced many ethical and legal issues since its inception. The development of psychiatry was based on social ideological concepts that pursued ethical goals such as autonomy, independence, the removal of involuntary hospitalizations and compulsory treatment. Urgently, there are certain exceptions that interfere with the activity of obtaining valid informed consent: patients without disease awareness, unable to decide for themselves (Valcea et al., 2016). Containment, marginalization, stigma, involuntary hospitalization, and involuntary treatment are an important part of psychiatric care in psychiatric emergencies, but at the same time raise many ethical issues (Buda, 2008; Radulescu et al., 2020). Patients with mental disorders, in voluntary hospitalizations, but especially in non-voluntary hospitalizations, may be subjected to various coercive measures such as isolation, pressure and coercion (Olsen, 2003; Widdershoven & Berghmans, 2007). Patients with severe psychiatric disorders often end up in emergency situations where coercive treatment is warranted. These ethical justifications for coercive interventions in most European countries involve criteria such as self-aggression and aggression towards others. Although coercive measures are necessary, they should not become a routine (Janssens et al., 2004). The use of coercion in psychiatry must be accompanied by responsibility and care for the patient with mental disorders (Frueh et al., 2005; Tannsjo, 2004). Coercive practice is the most radical measure in controlling aggression in patients with mental disorders (Ciobotea et al., 2016; Olofsson & Norberg, 2001; Untu et al., 2015;). Coercive measures in psychiatric hospitals have been, are and will be topics with extensive ethical and legal debates in psychiatric care (Luca et al. 2020; Katsakou et al., 2010). The use of coercive measures is regulated in several laws, which differ internationally, depending on the socio-cultural and legal variety. The model of using coercive measures in psychiatric care differs in European countries, restraint and isolation being frequent interventions in psychiatry in patients with aggressive behavior. In the past, measures to abolish compulsory measures in the treatment of patients with mental disorders have been the subject of controversial discussions in several European countries (Brumă (Mancaș), 2020; Hodorogea, 2021; Rotilă, 2021; Strugar, 2018).

Also, in the US, the number of coercive measures that some researchers recalls were nine times more common than they are today. Over time, psychiatry has undergone many changes and the frequency of using coercive measures has decreased significantly (Steinert et al., 2007).

Coercion, a traumatic procedure for the patient, has a negative impact on the doctor-patient relationship. Some studies show that inexperienced psychiatrists have used coercive measures more frequently in patients with mental disorders than experienced psychiatrists. The misuse of these procedures has raised many critical debates. Coercive treatment should only be used in situations where in the absence of this procedure, the patient's health may be endangered. Some studies show that coercive policies have a negative impact on the patient with mental disorders, which will trigger stigmatization and self-stigmatization in significant percentages. However, other authors have shown negative effects of mandatory treatment measures on quality of life and stigma, although there is a decrease in hallucinatory-delusional symptoms. But if several coercive measures are associated, they generate negative effects on the patient with mental disorders, up to self-stigmatization. Coercive treatment such as injectable medication would be more justified than mechanical restraint or isolation. The current study shows many hospitalized patients with alcohol consumption who are associated with mechanical restraint and forced treatment.

METHODS

The study is retrospective, and the data were taken from observation sheets from emergency hospitalizations from March 1, 2020–March 31, 2021, in section 2 acute from the Institute of Psychiatry "Socola" Iasi. The study group included 71 observation sheets for patients admitted to the emergency room of the psychiatric hospital, according to the mental health law.

RESULTS

The gender distribution of patients with emergency mental hospitalizations, mechanically restrained, highlighted a higher share of male cases. The distribution of the group, depending on the environment of origin, highlighted the higher frequency of patients with mental disorders, coming from rural areas (Fig. 1).

On the case of patients who were mechanically restrained, 40 unmarried persons was identified, to which is added 11 — divorced persons and widows (in number of 7). Also, hostile, violent behavior is associated with young age and the onset of the disease, but also with the status of single/unmarried person (Fig. 2.).

In the studied group, 39 of the patients with mental disorders are uninsured, a very important aspect in the medical assistance, especially due to their difficulty in obtaining a compensated treatment at discharge. Patients in the diagnostic category (schizophrenia or other psychotic disorders) are psychiatric patients with a higher level of education (Fig. 3).

The large number of days of hospitalization is associated with mental disorders in the category of psychoses. Factors associated with a short duration of hospitalization are related to the state of marriage, patient occupation, secondary education, and who have not met the criteria for a diagnosis of dementia or schizophrenia (Fig. 4).

Multiple hospitalizations lead to isolation, hospitalism, then over time to institutionalization and labeling. The large number of hospitalizations is associated with mental disorders in the category of psychoses (schizophrenia, bipolar affective disorder, schizoaffective disorder, delusional disorder).

Among the coercive measures in psychiatry, mechanical restraint is the most traumatic measure but necessary especially in emergencies with aggressive potential. Studies show that among the less restrictive coercive forms with less emotional impact during hospitalization is mandatory injectable treatment. But when mechanical restraint is associated with forced treatment, self-stigmatization occurs, and the patient is doubly traumatized.

DISCUSSION

Psycho-social education interventions aim to reduce the coercion of the patient with mental disorders. Reducing coercive measures such as isolation, restraint, non-pharmacological methods, is a challenge in psychiatric care, and requires trained medical personnel. Forced treatment and mechanical restraint are often necessary measures in psychiatric care. Thus, autonomy is violated in the forms of self-aggression or aggression towards others, in hallucinatory-delusional symptoms in which the patient is not aware of his disease. Coercive measures are still widely used in psychiatric care. Issues regarding ethics in psychiatry remain an open topic, with the possibility of re-evaluating legal and ethical aspects and adapting them to modern times.

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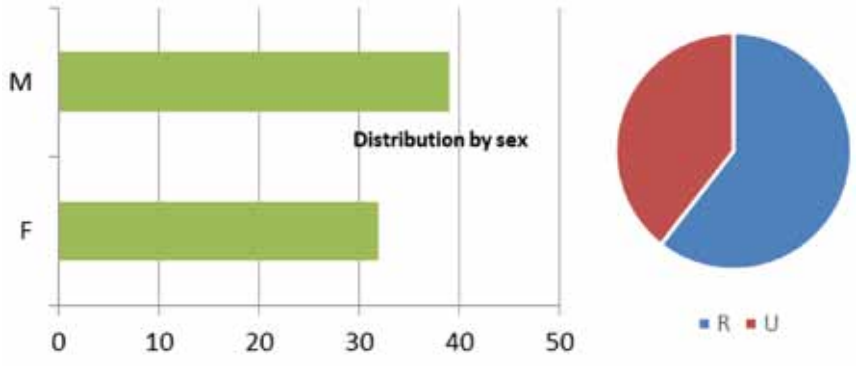

Fig.1. Distribution by sex and means of origin

Fig.2. Distribution by marital status and age ranges

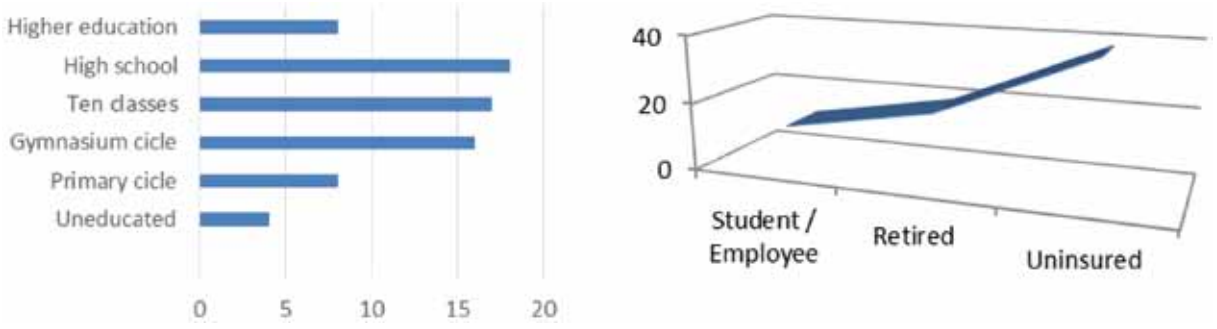

Fig.3. Distribution by schooling and form of insurance

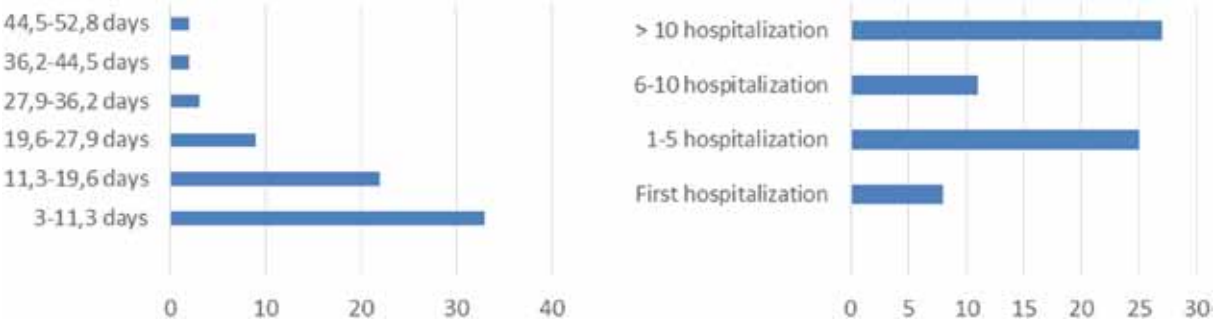

Fig.4. Distribution according to the number of hospitalization days and the number of hospitalizations

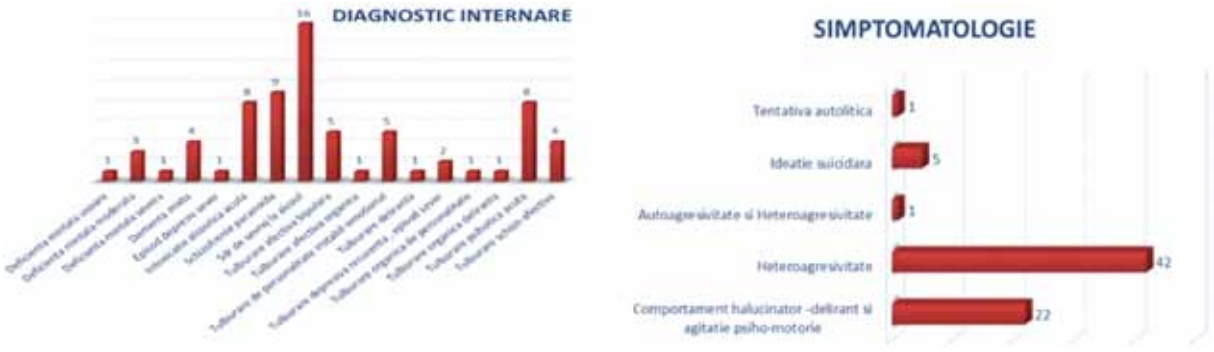

Fig.5. *Distribution by diagnosis and symptomatology*

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