Voluntary or involuntary acute psychiatric hospitalization in Norway: A 24 h follow up study

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1. Introduction

Involuntary hospitalization (IH) is a controversial issue in psychiatry due to the ethical complexity of admitting a person for treatment against his/her will. The Madrid Declaration on Ethical Standards for Psychiatry Practice from August 25th 1996 states in article 4 (World Health Organization, 2005): “...No treatment should be provided against the patient’s will, unless withholding treatment would endanger the life of the patient and/or the life of others. Treatment must always be in the best interest of the patient.” International law bodies like the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment focus on how IH is performed in countries, the patient’s right to information about use of coercion, and how national supervisory bodies function with inspections practice (Ministry of Justice and Public Security, 2000).

1.1. Background

The autonomy of the psychiatric patient is a complicated construct. In situations where the patient might lack insight about the illness and is believed by health care professionals to suffer from psychosis, major depression or to be in a manic state, the balancing of patient autonomy with the right and need for treatment may be challenging. Patients with psychosis often lack insight – a capacity to gain an accurate and deep understanding of someone or something including awareness of a mental disorder and understanding social consequences of the disorder, the need for treatment and awareness of specific signs and symptoms of the disorder (McCormack, Tierney, Brennan, Lawlor, & Clarke, 2014). A study on the “patient’s perspective”, and “family burden of coercion” showed that IH often is associated with a feeling of being excluded from participation in the treatment (Kallert, 2008).
Due to differences in mental health legislation both across Europe and in the rest of the world, levels of IH are difficult to compare (Kallert & Torres-Gonzales, 2006). EU-countries have been recorded varying rates from 3.2% in Portugal, to 21.6% in Finland. France has reported IH rates of 10.5–12.5% (1988–1999), UK 11.7–13.5% (1976–1999) and German reports range from 3.9 to 44.8% in 1978 and 17.7% in 2000 (Riecher-Rossler, 1993).

On a general level patients' may experience unaccountability or incompetence to give consent for hospitalization as a consequence of young age, or disturbance of consciousness caused by a serious medical condition. In some cases necessary treatment may conflict with religious beliefs, for example refusal to receive blood or blood products, or refusal to break off an ongoing hunger strike (Norwegian Ministry of Health and Care Services, 1999; Yate, Milling, & McFadzean, 2000).

In these circumstances physicians have to make choices for the patients based on best practice and the need to save lives. Under the Norwegian Act of Health Personnel, necessary health care shall be given, even if the patient is incapable of granting his consent thereto, and even if the patient objects to such treatment (Ministry of Health and Care Services, 1999a).

In Norway, family members are commonly the ones making contact with the primary health care system if they believe a person to be in need of psychiatric hospitalization. The family doctor/the general practitioner (GP) is often the first port of call, or alternatively, the local afterhours emergency clinic might perform an evaluation of the patients' mental health status. The physician then determines whether or not there is a need for hospitalization as IH or VH.

1.2. Norwegian law

The Norwegian Mental Health Care Act follows the principles of the World Health Organization's checklist which states that IH and involuntary treatment may only be given when 1) there is evidence of a mental health disorder of specified severity 2) a serious likelihood exists that the person might do harm to him/herself or others, 3) substantial likelihood exists that serious deterioration might occur in the patient's condition if treatment is not given and 4) admission is for therapeutic purposes (World Health Organization, 2005).

1.2.1. The Norwegian Mental Health Care Act process

In order to be admitted to an acute psychiatric unit in Norway the patient must be evaluated by a physician (in most cases a GP) outside the hospital (Ministry of Health and Care Services, 1999b). The referring physician decides, based on the Mental Health Care Act, if a patient should be referred as voluntary hospitalization (VH) (§ 2–1), involuntary observation (IH) up to 10 days (§ 3–2) or involuntary hospitalization (IH) with unlimited duration (§3–3). To fulfill the IH observation criteria, the physician must suspect that the patient is suffering from a serious mental disorder. IH patients may be referred through a court decision, and adolescents can enter the hospital under the law of child protection or the law of social services. While the vast majority of IH is by referral from a physician, VH should always be considered first if the present condition of the patient does not clearly preclude this.

When the patients are admitted to the psychiatric acute emergency unit at a psychiatric hospital, they are immediately met by a physician or a resident physician for a first evaluation. The IH patient is re-evaluated by a psychiatrist or a psychologist with special authorization within 24 h. This is commonly done in the morning following the admission. This re-evaluation assesses whether the patient is in further need of IH. If IH is not indicated the patient can be treated as VH or discharged. Follow as indicated is performed by their GP and/or outpatient clinic or local municipality services. The 24 h observation period is intended to allow for more accurate decisions to be made regarding the need for IH. Given that patients are admitted, additional information regarding their condition and behavior may then be gathered from their GP, relatives, and other relevant sources like district psychiatric centers or municipality mental health teams. The observation of patients by health care staff at the acute psychiatric emergency unit is also valuable in this decision process. Competent psychiatric staff, a quieter environment, reduction of stress, contacts with relatives and detoxification of drugs combines to allow for a more thorough re-evaluation. Especially in cases of substance abuse, the acute crisis might be over within this 24 h period. There is no claim that the Voluntary Hospitalized (VH) patients have to be re-evaluated within 24 h by a specialist since there is no process of changing their legal status of admission.

1.2.2. Conversion from VH to IH

Conversion from a VH to IH was not legal in Norway during 2005–2006. Under this act, if a VH patient required IH due to worsening of his/her condition he or she was required to return to the GP/or the local afterhours emergency clinic for a new “first” evaluation. In severe cases the GP could be called to the hospital, but this was rarely done in practice. A new Parliament revision took place June 30th 2006 and legalized January 1st 2007 (Mental Health Act § 3–4). From that time on it has been legal to convert a seriously ill patient from VH to IH on order of a specialist, if there was an imminent serious danger to the patient or others, but even so a second physician has to assess the patient.

1.2.3. Patients’ rights

The patient is entitled to be informed about their opportunity to contest IH. Referring physicians (GPs or a physician at the local afterhours emergency clinic), the resident receiving the patient and the psychiatric specialist reviewing their cases are all obliged to inform the patient of his/her legal rights. If the patient does contest an IH, he/she are also entitled to free legal services by an independent lawyer. The patient may direct the complaint to the Supervisory Commission (The Norwegian Social Affairs Committe, 1998–99), which in many ways is similar to the lowest court level in the Norwegian legal system. It consists of four members chaired by a lawyer qualified to serve as a magistrate. The remaining members are a physician not affiliated with the hospital, a former patient or next of kin to a patient, and a person from a community related profession, such as a social worker or psychiatric nurse. The Supervisory Commission is autonomous in its activity, and may overrule the psychiatric specialist decision for IH.

According to the Norwegian Mental Health Care Act, referrals for IH can only be made to psychiatric inpatient units in hospital departments or community mental health centers (District Psychiatric Centers) certified for this (Ministry of Health and Care Services, 1999b, 2012). Independent psychiatric forensic hospitals do not exist in Norway. The referring physician is required to have seen the patient in person within 10 days prior to hospitalization (Fig. 1). Other Nordic countries like Finland (Turunen, Valimaki, & Kaltiala-Heino, n.d.) and Denmark have similar laws (Jepsen, Lomborg, & Engberg, 2010).

1.3. Review of earlier studies

We have identified one national report and four studies from Norway describing the IH to VH conversion process. One study was based on large samples while three were minor projects. However, we identified no international studies.

The national report represented 54% of the admissions from Norwegian psychiatric hospitals in 2001 (N = 10,553) and 78% in 2006 (N = 15,721). A respective 40% and 39% of admitted patients were referred for IH, and 88% and 75% stayed involuntary after specialist re-evaluation (IH → IH) (Bremnes, Hatling, & Bjørngaard, 2008). Due to incomplete data from several sites in 2001 and improved admissions data recording in 2006, the number of included admission rose of nearly 50%. Hospital wards treating patients aged 15 and over (acute psychiatric emergency units, high security units and long term units) were included. The report found that patients with a diagnosis of schizophrenia had higher risk of IH than other diagnostic groups, and patients age 50–59 had a higher odds ratio than all other age groups for IH.
The Bergen University Hospital study (2005–2008) from one acute psychiatric emergency unit in southwestern Norway (N = 5317) found that 54.5% of patients were referred for IH. The overall rate of IH → VH was 26.4% (Fuglseth et al., 2016; Johansen, Mellesdal, Jorgensen, & Hunskaar, 2012). They found that local afterhours emergency clinic were more likely to refer the patients for IH, and that this group also had a higher proportion of IH → VH. Patients converted 16.9% reported illegal substance use, while this rate of IH varied from 53.1% to 54.1%. They reported an IH → VH rate of 44.9% (Tørrisen, 2007). Limitations of this study were its fairly low number of patients referred to a single hospital, and a majority (63%) was referred from a local out-of-office-hours casualty clinic.

A second small population study was from a local afterhours emergency clinic in northern Norway referring patients to a local acute psychiatric emergency unit (Deraas, Hansen, Giaever, & Olstad, 2006). They found that of 100 patients admitted, 59 were referred for IH. They reported an IH → VH rate of 15.3%. This study included patients referred both for IH observation and IH of unlimited duration. They described the diagnostic agreement between the referring physician and the specialist to be fairly good. The majority of the admissions (75%) happened during weekends, holidays or overnight, and 43% reported substance abuse. The clinic was staffed by local GP’s working nights/weekends/holidays. However, this study included a relatively low number of patients referred to a single hospital.

The third small population study from southeastern Norway, looking at 181 patients referred only for IH observation, found an IH → VH rate of 54.1% (Gjelstad, Lovdahl, Ruud, & Friis, 2003). However, the sample did not include those referred for IH of unlimited duration.

Overall we found that IH → VH conversion rates varied from 11.4% in the national report to 26.4% in the large hospital study. In the three smaller population studies the IH → VH rate varied much more widely from 15.3% to 54.1%.

1.4. Aims of the study

1. To identify the frequency patients on involuntary hospitalization were converted to voluntary hospitalization within 24 h observation across 20 acute psychiatric emergency units in Norway.
2. To study which factors predicted that a patient would stay on involuntary hospitalization or be converted to voluntary status after the 24 h observation period.

2. Materials and methods

2.1. Design

A prospective observational study of a cohort of patients consecutively admitted to acute psychiatric emergency units in Norway.

2.2. Subjects

A total of 3506 hospitalizations were registered. Due to incomplete data regarding involuntary hospitalization (IH) and missing data regarding their <24 h re-evaluation, a final data set for analyses was 3338. The units mainly received patients aged 18 or above. However, 29 patients aged 15–17 were included because certain hospitals lacked acute adolescent units. These patients were instead admitted to adult acute psychiatric emergency units. Of all patients referred for admission, 1468 patients were referred for IH and 1870 patients were referred for VH. Age was the only exclusion criterion.

2.3. Methods

Twenty acute psychiatric units geographically spread all over Norway gathered by the invitation of the Norwegian Directorate of Health to participate in an acute psychiatric network organization to do more research on acute psychiatry in Norway. Data was collected from all consecutive hospitalizations at these twenty acute psychiatric units for three months during the fall 2005 and early 2006 (Ruud, Grøve, & Hatling, 2006). The participating health trusts represented 75% of all Norwegian acute psychiatric wards located all over the
country. The VH and IH patients arrived to the acute units transported by hospital ambulance, followed by the police, relatives or came by themselves after they all had been evaluated by a physician/GP outside the hospital. Some patients may have been admitted to the acute psychiatric units before. The psychiatric specialist would use all psychiatric journal information available and use this as a base for evaluation. Data were collected by psychiatric health care professionals including psychiatric nurses, nurses and nurse assistants, psychiatrists and clinical psychologists. Staff were trained to use the Global Assessment of Functioning scale (GAF) (American Psychiatric Association, 1987; Wing et al., 1998; Wing, Curtis, & Bevor, 1999) and Health of the Nation Outcome Scales (HoNOS) through sessions involving discussions and the scoring of vignettes (Wing et al., 1998, 1999). Every site had a local project coordinator. Data was collected, anonymized and transferred to a central database for analysis.

2.4. Instruments and materials

General sociodemographic data was collected by an acute admission registration form purposely developed for this study (Ruud et al., 2006) which included: age, gender, ethnicity, having children < 18 years of age, child care status, housing status, source of income, nature of psychiatric problems, educational level and services received prior to admission. Also recorded were the admission date and time of day, acute admission status (whether or not the patient could wait another day to be assessed), referral agency and status (voluntary or involuntary), being escorted to the hospital by police, patient’s desire for admission and any previous contact with mental health agencies.

We used the Global Assessment of Functioning Scale (GAF) axis IV in DSM-IV, with symptoms (GAF-S) and functional level (GAF-F) scored separately (American Psychiatric Association, 1987; Goldman, Skodol, & Lave, 1992).

The Health of the Nation Outcome Scales (HoNOS) was used to assess the severity of psychiatric problems. The HoNOS consist of 12 items measuring behavior, cognitive impairment, symptoms and social functioning (Wing et al., 1998; Wing, Curtis, & Bevor, 1999) and Health of the Nation Outcome Scales (HoNOS) through sessions involving discussions and the scoring of vignettes (Wing et al., 1998, 1999). Every site had a local project coordinator. Data was collected, anonymized and transferred to a central database for analysis.

2.5. Ethical considerations

The study was approved by the Regional Ethical Committee in Eastern Norway (no. 04049), and by the Norwegian Social Science Data Service and The Norwegian Data Inspectorate under the Norwegian Ministry of Labor and Government Administration, NSD (no. 11074).

2.6. Statistical analyses

Analyses were made using SPSS 21.0 (SPSS, n.d.), and the GLIMMIX module of SAS Academic version 3.3 used for the generalized linear mixed modeling (Schabenberger, n.d.). For descriptive statistics, frequencies, means and standard deviations (SD) were calculated as appropriate. As the binary variable of conversion from involuntary to voluntary admission was the outcome variable for all analyses, generalized linear mixed modeling with the SAS GLIMMIX procedure was used for all inferential statistics, using random intercepts for the site to correct for different base-rates at the different sites, and fixed effects for all variables, with logit link-function. All effects are presented as odds-ratios (OR) with corresponding 95% confidence intervals. First of all, individual analyses were performed for each variable, but with random intercepts in order to estimate the unadjusted effects. Secondly, all variables showing unadjusted significant effects on conversion from involuntary to voluntary admission were entered simultaneously, in order to estimate adjusted multivariate effects. Initially 25 variables were used: admission time of day, who referred the patient, prior knowledge of the patient, escorted by the police to the hospital, patient requesting admission, age, gender, marital status, living alone, GAF symptom and functioning, HoNOS scores (9 items), use of drug or alcohol, living accommodation, income source, educational level and appearance of drug use.

Out of the 20 sites investigated, there were 11 sites with 11 or more converted cases, and 9 sites had fewer than 11 converted cases and were excluded from the analyses as they precluded good model fit.

3. Results

Overall, 43.9% (1468 cases) of the 3338 patients were referred for IH (Hustoft et al., 2013) (Table 1). After the 24 h re-evaluation period, 78.2% of those referred for IH remained on IH (1148 cases), whereas 21.8% (320 cases) were converted to VH. In addition we found that a very small proportion of 12 VH patients (0.6%) who were converted to IH. The mean age for patients referred for IH was 40.4 years, and 53.9% of IH were men.

3.1. The IH → VH rate

Out of the IH group 63.1% were referred for IH observation, while 34.9% were referred for IH with unlimited duration of stay (Table 1).

Table 1

<table>
<thead>
<tr>
<th>IH</th>
<th>Involuntary hospitalized at admission</th>
<th>Involuntary hospitalized within 24 h re-evaluation</th>
<th>Voluntary hospitalized within 24 h re-evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IH observation ≤ 10 days</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>IH with unlimited duration</td>
<td>512</td>
<td>34.9</td>
<td>470</td>
</tr>
<tr>
<td>IH Court decision</td>
<td>13</td>
<td>0.9</td>
<td>6</td>
</tr>
<tr>
<td>IH Law of child protection or Law of social services</td>
<td>16</td>
<td>1.1</td>
<td>3</td>
</tr>
<tr>
<td>Sum</td>
<td>1468</td>
<td>100.0</td>
<td>1148</td>
</tr>
</tbody>
</table>

§ 3–2: involuntary observation ≤ 10 days.
§ 3–3: involuntary hospitalized with unlimited duration.

* Excluded were 10 voluntary cases § 2–1 (VH) who were converted to IH observation § 3–2 and 2 cases (§2–1) who were converted to IH unlimited duration § 3–3 (VH → IH).

b 12 patients referred Law of child protection or Law of social services were converted to § 3–3.
Very few patients were referred on other IH paragraphs: 0.9% had an IH court decision, and 1.1% was under the Law of child protection/Law of social services. After reevaluation, 27.8% of the referred IH observation patients and 10.5% of patients referred on IH of unlimited duration were converted to VH (IH → VH) (Table 2). Of those patients converted IH → VH, 80.6% (258 cases) were referred for involuntary observation (§ 3–2), 16.9% (54 cases) unlimited duration (§3–3) and 2.5% (8 cases) on court decisions or laws of child protection or social services.

A univariate analysis found no significant differences between the groups IH → IH and IH → VH in age, gender, ethnicity, marital status, college or university educational level, living situation, whether or not the patient was referred from other psychiatric health care institutions, whether or not the patient was transported by the police or used drugs (Table 2). However, the IH → VH group had significantly more patients referred from local afterhours emergency clinics, more often wanted admission, higher HoNOS scores on self-harm not caused by accident and reduced mood level, and a higher score on alcohol use. The IH → IH group was more likely to be admitted during the evening and night shift, and scored significantly higher on the HoNOS scale for aggression, hallucinations and delusions, while having poorer scores on The GAF scale for both symptoms and functioning.

### 3.2. Predictors of IH → VH conversion

The multivariate analysis showed an increased odds-ratio (OR) for IH → VH if the patient wanted admission (0.522), had fewer symptoms (i.e. higher GAF symptoms scores at time of admission (1.022 per level of GAF-S)), lower HoNOS scores for hallucinations and delusions (0.614), and more use of alcohol (Drake Scale scores) (1.182) (Table 3).

### 4. Discussion

**4.1. The IH → VH rate**

We found that 21.8% of the patients who came on involuntary hospitalization (IH) were converted to voluntary hospitalization VH (IH → VH) (Fig. 2). This finding is similar to what was reported in the national report of 2006 with a rate of 25% and the Bergen University Hospital study (2005–2008) with a rate of 26.4% (Bremnes et al., 2008;...
Johansen et al., 2012). Our study had 43.9% IH referred patients, while the others had respectively 39% and 54.5% on a hospital level. Our study is closer in design to the national report. Our study also represents 75% of all acute psychiatric emergency units in Norway, and could therefore be representative in comparison.

4.2. Predictors of IH → VH conversion

We found the following factors to predict conversion of IH → VH: the patient wanted admission, fewer symptoms (higher GAF-S), lower scores for hallucinations and delusions, and more frequent self-reported use of alcohol. These are similar results as in the Bergen study concerning alcohol use and symptoms level (Fuglseth et al., 2016).

The finding that less severe symptoms predicted conversion from IH to VH carries face validity, as does the finding regarding use of alcohol. It is possible that GP’s in some cases use IH in order to get unstable patients into the hospital. However, our study does not explore this aspect in detail. The fact that many IH → VH patients were simply more intoxicated by alcohol at admission seems likely. Blood alcohol levels are generally reduced by 0.12–0.18 thousandth per hour in most people, with 0.15 thousandth per hours as a mean value across men and women (Health, N. D. o., 2005). Many of these patients probably “sobered up” during the night they stayed in hospital.

We find it puzzling that as many as 26.5% of the IH → VH patients stated that they actually wanted hospitalization. However, even if they wanted admission, very low GAF scores, lack of insight and ability to consent, might all leave patients in need of IH based both on the evaluation by the referring physician and the re-evaluating specialist. It is not so puzzling that 41.9% of the IH → VH population wanted admission since this population had lower score on HoNOS aggression-, hallucination and delusion score, higher GAF functioning and symptom score, and higher score on alcohol use (Table 2). However, it is difficult to interpret these findings because we did not study the extent to which extent patients wanted hospitalization when they were evaluated at the GP/out of office hour casualty clinic before they entered the hospital.

A review article shows that some VH is related to high scores on perceived coercion measures, and report that they are admitted against their free will (Hayer, 2008). Paradoxically some of these studies even report the opposite; IH patients might have a subjective opinion that they are VH, even if they legally are IH. In a Norwegian study 10% of the VH patients answered that they thought they were hospitalized against their own will (i.e. IH), and 40% of the legally IH patients answered that they had wanted to be hospitalized, and experienced the admission as VH (Iversen, Hoyer, Sexton, & Gronli, 2002). A study from Ireland showed that a significant proportion (22%) of VH patients may experience the same level of perceived coercion as IH patients (O’Donoghue et al., 2014). They found lower GAF-F scores in the IH group (score level 32.8) as compared to the VH group (score level 47.1). This is the same trends as in our study (IH score 33.4 and VH score 39.2).

Our data showed that the proportion of patients referred for IH observation § 3–2, 27.8% were converted to VH. This was more than twice the incidence as for those referred for IH of unlimited duration § 3–3 and converted with only 10.5%, (Table 1). IH observation § 3–2 represented 80.6% (258 patients) of all IH → VH patients (Fig. 2). It makes sense that a larger part of IH observation § 3–2 should be converted given that the criteria for IH observation in itself represent an uncertainty about the presence of a major psychiatric illness, and also that the symptoms found by the GP, during a potentially short assessment period, may be unclear. Given that a re-evaluation by specialist has to be performed within 24 h, this appears to work in securing patients’ right no coercion for a longer period than necessary. The Norwegian Mental Health Care Act has a basic criterion that initially voluntary mental health care has to be attempted. It is obviously pointless to attempt voluntary mental health care due to the patients symptom status at admission (Ministry of Health and Care Services, 1999b).

Clinically, patients with elevated blood alcohol levels often present with suicidal thoughts expressed to their spouse or other family members. They may have presented plans or even attempted suicide with intoxication of drugs in combination with alcohol when initially assessed by their GP or a local afterhours emergency clinic. However, during their stay at the acute psychiatric emergency unit, blood alcohol levels subside, and patients may present themselves as less suicidal when they have been examined by a specialist and they together have found a way out of the crisis situation. In some cases suicidal thoughts may have disappeared. This leaves them able to decide that they either want VH or wish to receive appropriate outpatient treatment.

It is a paradox that on the one hand it is important from human rights, ethical and legal standpoint to minimize the number of patients who have their autonomy reduced. On the other hand it is also important that patients in actual need of treatment will receive IH if they lack insight when IH is required. For example, adequate treatment for First Episode Psychosis (FEP) is very expensive, and in some countries, a low rate of IH might express unwillingness to spend resources on this vulnerable group of patients.

The Norwegian government (Ministry of Health and Care Services) set a goal in 2013 for the Norwegian psychiatric health trusts to reduce IH by 5% within a year (N. Ministry of Health and Care Services, 2013). However, this goal seems to be a politically rather than an empirically
based decision, as we do not know what the optimal level is for IH. Too much or too little use of IH might both harm patients whom might not receive or demand the treatment they need.

In a review of the legislation of coercive mental health care across 12 countries in Europe, substantial differences were found from the time the patients were admitted until the institutions informed the authorities (mostly courts) responsible for the IH evaluation (Kallert & Torres-Gonzales, 2006). In certain countries, e.g., Germany, the legal situation varies across the nation because each federal state within has its own Mental Health Act. Other countries like Bulgaria are younger democratic countries concerning the development of new laws and more centralized in structure meaning the law is equal in different parts/states of the country.

4.3. The IH decision process in Europe

In European countries the range of potential starting points for an IH process ranges from being any person (Spain), parents or relatives/guardian (Czech Republic, Greece, Slovak Republic) to physician or psychiatrist or administrative authority (Bulgaria, England, Germany, Israel, Italy, Lithuania, Poland, Sweden). Some countries also allow several sources to initiate an IH referral. While in Norway it is the GP/physician outside the hospital who is the generator of IH admission.

The time used to decide whether patients should remain on IH is very different in other European countries. In Germany the hospital must immediately inform the court and the administrative authority by at 10:00 AM the next morning at the latest. In the Czech Republic, within 24 h, IH patients are required to be reported to a court which then decides on involuntary placement within seven days. In Italy the judicial authority must be informed within 48 h, while in the Lithuanian the IH patient must be brought to court within 48 h. In Spain in emergency situations the head of the psychiatric facility shall inform the court as soon as possible so that the IH can be legally ratified. Such ratification must take place within a maximum of 72 h from the time the court was notified. However, there is a second time period for the courts or authorities hearing ranging from two to ten days.

Then, if IH is still required, the legal process may last for another week to six months. Norway, Sweden and Poland use a physician outside the hospital for assessment and a psychiatrist inside the hospital for re-evaluation. Italy uses at least 2 psychiatrists while Lithuania requires 2 psychiatrists as the referring source outside the hospital in addition to a specialist inside the hospital to re-evaluate within 24 to 48 h. We argue that the Norwegian system of re-evaluating the patient within 24 h represents a solid process which ensures that those patients not in need of IH are converted as soon as possible to VH. The process aims to ensure that the legal criteria of the Mental Health Care Act are fulfilled and the patient actually is in need of IH. It gives the psychiatric specialist more time to gather additional information about the patients’ pre-admission health status. The health personnel in the acute psychiatric emergency unit are able to make additional clinical observations during this period.

5. Conclusions

In our study, 21.8% of the IH patients were converted to VH within 24 h because they did not fulfill the medical-legal criteria for being kept on IH. Factors predicting IH → VH conversion were that they said that they wanted admission, less severe symptoms loads, fewer hallucination and delusions, and more abuse of alcohol at intake.

Involuntary hospitalization should only be used when it is in the best interest of the patient. The process of specialist re-evaluation of referred IH patients within a 24 h period is a reasonable process in the paradox of honoring the patient’s autonomy and ensuring that the patient gets appropriate treatment.

6. Limitations

One limitation of this study was that catchment areas differ in population density across Norway. In addition, each patient may have been admitted multiple times and might have differed in status (IH or VH) each time. Ratings were done by multiple people, because patients were included for admission continuously around the clock across 20 units all over Norway. Some raters failed to answer to all questions as data was not always available at the point of ward admission, and the patient was in such a labile state that the necessary information was not collectable.

Conflict of interest

None.

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