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Involuntary psychiatric hospitalization of children and adolescents in Northern Greece: Retrospective epidemiological study and related ethical issues

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The aim of the present study was to investigate epidemiological data on involuntary hospitalization of underage patients in psychiatric settings and illustrate the related ethical issues. The medical records of 131 involuntary psychiatric admissions of children and adolescents ordered by public prosecutor between 2005 and 2014 were examined carefully. The examined variables involved the place of origin, the place of residence of minors after discharge, the length of stay in hospitals, the discharge diagnosis, the rate at which the minors were introduced to police and other authorities before their hospitalization, and the results of the neuropsychological assessment (WISC II). Data were analyzed by SPSS (Statistical Package for the Social Sciences). The mean age of the minors was 14.19 years (Male: Female ratio; 1.6:1). First, a high rate of incidences of compulsory admissions was found [5-year period (2005-2009):(2010-2014) ratio; 1:1.85] most likely due to organizational factors, which, however, could have been avoided in a more patient-oriented healthcare system. It is most likely that the criteria used for making decisions in favor of compulsory admissions were disproportionately (unduly) broad. In parallel, it was observed that, during 2010-2014, despite the increase in the rate of the prosecutor's orders, there was a decrease in the duration of coercive hospitalization of minors in psychiatric departments of hospitals in comparison to the period 2005-2009 [5-year period duration of hospitalization (2005-2009):(2010-2014) ratio; 2.33:1]. Furthermore, family was found likely to wield considerable influence on the decision-making for compulsory admissions. In addition, the effectiveness of a compulsory hospitalization of minors in a child and adolescent psychiatry department was found largely dependent on the type of the underlying mental health problem. In that respect, low rates of recidivism (7.6%)

indicated that the measure of involuntary hospitalization was necessary and effective. It was also observed that the short-term removal of the minor from the family environment was a potentially relieving strategy for both the child and the family apart from the need for therapeutic intervention. The paper concludes by highlighting the role of a multi-stakeholder decision-making process (which entails shared decision-making as an integral component of providing mental healthcare to minors) in facilitating a decision about involuntary psychiatric hospitalization that is proportional and respectful to patient autonomy.

Key words: Involuntary hospitalization, bioethics, child psychiatry, autonomy, decision-making, prosecutor's order.

Introduction

Compulsory admission is accepted as necessary or even mandatory in certain cases of considerable danger to oneself or others due to psychiatric illness, despite the fact that it entails legal restriction of patient's personal freedom and self-determination. Involuntary hospitalization is an integral part of mental healthcare provision, especially when the patients are children and adolescents.¹ However, the potential misuse of coercion in psychiatry may give rise to ethical concerns, given the truth of the assumptions that coercive measures may affect patients' personal interests profoundly,² and may be associated with negative outcomes due to possible adverse effects on the therapist-patient relationship.³ Moreover, it is argued that 'compulsory admission of people with mental disorder has far-reaching effects also in terms of health-care costs'.⁴

More precisely, it is a complicated process to answer the question of whether a minor is in need of involuntary psychiatric hospitalization and involves answers to questions regarding the patient's best interest and decision-making capacity. However, this is not always the case in practice. Importantly, Rotharmel showed that the children were either poorly informed or even not informed at all at the time of involuntary psychiatric admission.⁵

Patients who experienced involuntary admission may be thought of as being under formal coercion; at least to the extent that coercion is conceptualized as a negative experience rather than merely a perception.⁶ Mielau et al⁷ put it best in saying 'Subjective experience of coercive interventions played an important role for the justification of treatment against an individual's "natural will"'. Involuntary admission

is a coercive measure and hence special attention should be paid to the principle of proportionality.⁸

Most importantly, minors may be at considerably higher risk of being subject to involuntary psychiatric hospitalization as compared to adults.⁹ Already in 1979 the Supreme Court of Columbia held that involuntary psychiatric hospitalization of minors requires special procedures.¹⁰

The legal basis for coercive psychiatric admission in Greece is regulated by the law n. 2071/1992 (articles 95 and following). Despite the strict legislative control of use of involuntary psychiatric hospitalization laid down in this law, a high rate of involuntary psychiatric hospitalizations (of adults) has been noticed within the last decades in Greece. It is argued that the legislative control is applied in practice in a less strict way than the specified in the law.¹¹

Compulsory admission is accepted as necessary or even mandatory in certain cases where the criteria for involuntary psychiatric hospitalization (requirements laid down by the article 95 of the Law 2071/1992) are fulfilled. Moreover, it is to be mentioned that according to the article 28 of the Greek Code of Medical Ethics (law n. 3418/2005) the freedom of psychiatric patients can be restricted only to the minimum extent necessary whilst their autonomy should be respected to the greatest possible extent.

As is the case with jurisdictions of other countries, the Greek law (Code of Medical Ethics, namely, law n. 3418/2005, article 12) regards minors (younger than 18 years) as not being capable of giving valid consent to their medical treatment. Nevertheless, in the context of modern bioethics this position raises reasonable concerns when it comes to mature adolescents. Importantly, there are multiple interacting factors profoundly affecting the level of adolescent's

maturity.¹²⁻¹⁴ Furthermore, scholars argue that perfect understanding and appreciation of the information provided are not necessarily requirements for decision-making capacity.¹⁵

In the present study, the data from the Child Psychiatry Department in Thessaloniki –the largest city northern Greece– were studied over a decade (2005–2014). Quantitative and qualitative characteristics of the adolescents hospitalized in the clinic were studied and an attempt was made to identify the factors that prompted the prosecution order for the clinical assessment and admission of minors to the child psychiatry department. Moreover, the present study was aimed to examine whether the imposition of the therapeutic approach to involuntary hospitalization among children and adolescents is consistent with the principle of proportionality, the principle of non-harm and the principle of autonomy.

In this paper the term ‘minor’ bears the meaning of the term ‘child and adolescent.’

Material and method

Study design

A retrospective patient record study on the incidences of coercive hospitalization of children and adolescents in Northern Greece was designed. The patient records of 131 children and adolescents regarding admissions to the Department of Child and Adolescent Psychiatry of the general (tertiary level) hospital "Hippokratia" in Thessaloniki (prefecture of Central Macedonia) imposed by a prosecutor's order in the period between 2005 and 2014 were carefully reviewed. Occasional supplementary data were registered. Data were analyzed by SPSS (Statistical Package for the Social Sciences): Binomial test was utilized in order to examine the statistical significance of deviations from a theoretically expected distribution of observations into two categories; the chi-square (χ^2) test, in order to detect statistical associations between two or more categorical variables; the Mann–Whitney U test, in order to investigate whether two independent samples were selected from populations having the same distribution providing a detailed breakdown of ranks, calculations, and data; the T- test, in order to compare the means of two groups, which may be different in relation to a certain feature; as well as descriptive statistics: mean

value (average of a data set) and standard deviation (measure of the amount of dispersion of a set of values). Then, the authors discussed the results placing considerable emphasis on the ethical implications of the findings of data analysis.

Research sample

The research study sample contained the medical records of 131 children and adolescents who were involuntarily admitted to hospitals by order issued by public prosecutor between 2005 and 2014. The mean age of the minors was 14.19 years (range=2-18; SD=3.15). Eighty out of a total of 131 minors were boys (61.06%) with a mean age of 14.03 (SD=3.27), whereas 51 were girls (38.93%) with a mean age of 14.4 years (SD=2.98).

The examined variables involved the place of origin, the place of residence of minors after discharge, the length of stay in hospitals, the discharge diagnosis, the rate at which the minors were introduced to police and other authorities before their hospitalization, and the results of the neuropsychological assessment (WISC II).

Ethical considerations

The ethical principles of anonymity, voluntary participation and confidentiality were considered. Anonymity and confidentiality have been maintained throughout the study. The data were stored in a strictly confidential fashion. The study and research procedure was approved by ethics committee affiliated to Aristotle University of Thessaloniki, Faculty of Health Sciences, Department of Medicine (No:2.138 27/2/2019).

Results

Place of origin

68.5% of the participants came from Thessaloniki, while the remaining 31.5% originated from other regions of Greece. The Binomial test indicated that this difference was statistically significant (exact $p < 0.001$) (test value 0.5) (table 1).

Place of residence after discharge

After discharge from hospital, 69.7% of the involuntarily hospitalized children returned back to their homes after having completed their treatment, as

Table 1. Place of origin (residence prior to admission).

City	Cardinal number (N)	Percentage (%)
Thessaloniki	89	68.5
Kozani	7	5.4
Kilkis	4	3.1
Xanthi	3	2.3
Karditsa	3	2.3
Ioannina	3	2.3
Larisa	3	2.3
Volos	3	2.3
Kavala	3	2.3
Imathia	2	1.6
Serres	2	1.6
Kastoria	2	1.6
Chalkidiki	1	0.8
Thasos	1	0.8
Alexandroupolis	1	0.8
Drama	1	0.8
Kerkyra	1	0.8
Athens	1	0.8
Total	131	100.0

opposed to 31.3% of the hospitalized minors who followed a different path (transfer to institution 26.9%; escape 1.7%; unknown 0.8%; transference for continuation of hospitalization to other hospital department 0.8%). The Binomial test showed that this difference was statistically significant (exact $p < 0.001$) (test value 0.5) (table 2). All discharged minors returning back home continued to live at the same place as previously.

Table 2. Place of residence after discharge.

	Cardinal number (N)	Percentage (%)
Parental home	83	69.7
Unknown	1	0.8
Institution	32	26.9
Escape	1.5	1.7
Transference	0.8	0.8
Total	119	100.0

Distribution per year and diagnosis

Given the number of participants and the uneven distribution per year, the examined decade was split into two groups of five years to investigate whether there had been a significant increase in the rate of prosecutions from the five-year period 2005–2009 to the five-year period 2010–2014. In particular, during the five-year period between 2005 and 2009, 46 public prosecutor's orders were recorded (35.1%), while in the five-year period from 2010 to 2014, 85 public prosecutor's orders were issued (64.9%). This increase was statistically significant (exact $p < 0.01$) (test value 0.5) (table 3).

In terms of diagnosis, initially there were 22 individual diagnoses, which were then grouped into diagnostic umbrella categories. The χ^2 test showed that there was a statistically significant differentiation between the categories regarding the diagnoses ($\chi^2(7)=170.374$; exact $p=0.001$). Table 4 indicates that the predominant diagnosis was the category "Behavioral Disorder; Disruptive and Impulsive Behavior" (table 4).

Regarding the diagnostic procedure, it was observed that psychiatric diagnoses associated with neurodevelopmental disorders (schizophrenia, pervasive developmental disorder, intellectual disability) involved 36.3% of all involuntary psychiatric hospitalizations of minors by order of the public prosecutor during the period 2005–2014.

Table 3. Prosecution orders per year.

Year	Prosecution orders	
	Cardinal number (N)	Percentage (%)
2005	2	4.26
2006	1	2.13
2007	1	2.13
2008	6	12.77
2009	5	10.64
2010	6	12.77
2011	7	14.89
2012	6	12.77
2013	9	19.15
2014	4	8.51

Table 4. Diagnostic categories.

Diagnosis	Cardinal number (N)	Percentage (%)
Behavioral disorder, impulsive behavior	64	48.9
Pervasive Developmental Disorder	21	21
No diagnosis	19	14.5
Intellectual Disability	14	10.7
Schizophrenia	6	4.6
Drug or alcohol abuse	4	3.1
Personality disorder	3	2.3
Total	131	100.0

Among all the minors who were examined in the study in the period between 2005 and 2014, the rate of involuntary admissions ranged from 0 to 3, while the average length of stay in hospital was 14 days. The application of the Mann-Whitney test showed that there was a significant difference in the length of hospital stay between the two five-year periods (2005–2009 compared with 2010–2014) ($U=1035$, exact $p<0.01$). With regard to average values, it was observed that despite the increase in the rate of the prosecutor's orders, there was noticed a decrease in the length of stay of minors in psychiatric departments of hospitals in the second five-year period (2005–2009: mean=22.68, SD=30.87; 2010–2014: mean=9.73, SD=10.69). In short, the length of hospital stay was significantly shorter during the five-year period 2010–2014 (mean = 9.73 days) as compared to the five-year period 2005–2009 (mean=22.68 days) (table 5).

Table 5. Duration of hospital stay per year (in days)

Year	Length of hospitalization (days)	
	Mean	SD
2005	17.33	6.03
2006	15.80	6.97
2007	9.5	8.25
2008	23.0	15.41
2009	31.17	45.43
2010	8.43	4.12
2011	12.11	12.48
2012	9.29	8.07
2013	4.17	2.17
2014	11.74	14.47

Juvenile delinquency

The interest of the authorities was engaged in the cases of 47 (35.9%) out of a total of 131 minors who constituted the research study sample. The authorities intervened for reasons such as running away from home, hetero-destructiveness against other individuals (including parents, classmates), and juvenile delinquency (involving thefts, substance abuse, foreign property damage). The χ^2 test showed that the rate of minors who had concerned the authorities again in the past remained the same during the two five-year periods ($\chi^2(1)=0.33$; exact $p=0.58$). Furthermore, contact with the police authorities did not appear to vary according to age (contact with the authorities: mean (age) = 14.43, SD=2.34; no contact with the authorities: mean (age)=14.05, SD=3.54, $U=1852$, exact $p=0.56$) or the sex of the examined children ($\chi^2(1)=0.24$; exact $p=0.71$).

Intellectual ability

Also, with regard to the 44 children who were examined through the WISC test during the decade 2005–2014, the mean value of intelligence index was 70, with a maximum of 113 and a minimum of 30. The Intelligence Index was not differentiated in relation to the minor's gender ($t(42)= 0.02$; $p=0.98$), or the minors' place of residence after hospitalization ($F(1)=1.56$; $p=0.59$). However, it was observed that there had been a significant difference between the two five-year periods ($t(42)= 2.34$; $p<0.05$), with a reduced intelligence index in the second period (2005–2009: mean=80.15, SD=24.42, 2010–2014: mean=61.68, SD=26.95).

Recidivism and hetero-destructive behavior

The rate of re-hospitalizations was 7.6% (10 individuals), among which 70% (7 individuals) had occupied the authorities' interest resulting in a public prosecutor's order for involuntary re-hospitalization being issued. Given that in 48.9% of total admissions were diagnosed a conduct disorder/impulsive behavior, expressions of antisocial behavior were reasonably expected-including theft, inter-family conflicts, hetero-destructive conduct against objects, or verbal and physical aggression towards others.

Discussion

According to the authors' data, in the decade 2005-2014 qualitative differences have been observed in the status/frequency of involuntary admissions and characteristics of minors.

A reliable explanation seems to be that with the passage of time it has been increasingly realized that long stay in psychiatric hospital may exacerbate the perceived stigma and hence, profoundly affect negatively the already vulnerable mental health/well-being of hospitalized minors. The implementation of Psychiatric Reform in Greece with the "Psychargos" program seems to have contributed greatly to the above-mentioned reduction in length of hospital stay as well as the reduction of the rate of incidence of compulsory admissions.¹⁶ The "Psychargos" program provided for delivering effective and timely psychiatric care and organization of mental health services and facilities designed to re-integrate institutionalized patients with mental disorders back into the community¹⁶ and facilitated a much more patient-oriented perspective in the context of psychiatric healthcare. The high rate of incidences of compulsory admissions prior to the implementation of the "Psychargos" program most likely was due to organizational factors, which, however, could have been avoided in a more patient-oriented healthcare system.¹⁷

The cases of delinquent minors who were already familiar with the authorities prior to the hospitalization exhibited no significant differentiation either between the two examined five-year periods or in association with the qualitative characteristics of the examined minors.

Considering the low rates of recidivism (7.6%) it is reasonable to suppose that the coercive measure of involuntary hospitalization had a positive outcome and hence it might be thought of as being effective. Furthermore, the reduced in length minors' stay in a children/adolescents psychiatric department during the second period (2010-2014) might also be thought of as being beneficial to both child and family. The short-term removal of a minor from the family environment may lessen or even relieve both child and family of the burden of receiving and providing psychiatric treatment, respectively.

In case of a hard-to-resolve conflict between two or more fundamental bioethical principles (autonomy, beneficence, nonmaleficence, justice) the principle of mutuality devised by DeMarco establishes a moral obligation to investigate all the possible alternatives to ameliorate, eliminate or circumvent the conflict so that all the conflicting principles will remain inviolate as much as possible, at the same time.¹⁸ Besides, provided that according to the authors' data and findings the percentage of minors who were discharged without having received a formal diagnosis was not insignificant, and given the truth of the consideration that within the last decades in Greece the legislative control of involuntary psychiatric hospitalizations of adults has been applied in practice in a less strict way than the specified in the law,¹¹ it was reasonable to suppose that the criteria used for making decisions in favor of compulsory admissions were disproportionately (unduly) broad and in all likelihood involuntary psychiatric hospitalizations have been used as preventive means (in a paternalistic perspective). The percentage of minors who were discharged without having received a formal diagnosis (14.5%) was also significant, which may be either due to children who were admitted to with the intention of a subsequent placement into an institution due to inadequate family environments or associates with children/adolescents who experienced no severe psychopathology, but the prosecutors' orders had been triggered by the individuals' acts of impulsivity and dysfunction in their environments (home, institution). Therefore, it was reasonable to suppose that involuntary psychiatric hospitalizations have in all likelihood been used as preventive means.

Importantly, in the reviewed medical records the authors found no value arguments used in the decision for coercive care. This finding is in consistency with the findings of a study conducted by Pelto-Piri et al.¹⁹ It is most likely that family wields considerable influence on the decision making for compulsory admissions. As Greek family changes over time the (traditionally strong) intimate bonds between its members tend to become increasingly weaker. This is partly due to the economic crisis occurred in Greece over the last years. In the authors' opinion, this may partly explain the rise in the public prosecutor's orders during the second examined five-year period (2010-2014), provided the significant role of family in juvenile delinquency.²⁰⁻²² The year 2010 was roughly corresponding to the initial stage (warning phase) of the Greek economic crisis. Among 48.9% of the reviewed patient records, the diagnostic entities of conduct disorder or impulsive behavior were prevalent. These are diagnoses that according to the ICD-10 (International Statistical Classification of Diseases and Related Health Problems 10th Revision), their manifestation often may additionally involve family factors; a fact that therefore reflects the importance of an adequate family environment in ensuring the child's smooth psycho-emotional development.²³

Interestingly, the data that have been outlined earlier indicated that psychiatric diagnoses associated with neurodevelopmental disorders among minors were more manageable and the use of involuntary hospitalization was easier for the family to decide, compared to behavioral disorders associated with psychosocial factors.²⁴ Behavioral problems such as conduct disorder and externalizing or antisocial behavior can be associated with adverse family environments and negative stimuli passed to the juveniles acting out in delinquent behaviors. Parents' behavior management practices, parental stress, and family environment are highly pertinent to children's conduct problems.^{25,26} Therefore, many parents may also try to avoid resorting to coercive psychiatric care in a feeling of parental incompetency and failure and/or in fear of social stigma and/or in denial of acknowledging their participation in any way. Furthermore, it has been observed that choosing a coping strategy is influenced by

how a person appraises the degree of potentiality of problem-solving in assessing a threatening situation. Caregiving burden may be characterized by an imbalance of perceived demands and resources leading to an experienced overload.²⁷

Furthermore, the authors found that the effectiveness of a compulsory hospitalization of minors in a child and adolescent psychiatry department largely depends on the type of the underlying mental health problem. In this perspective, low rates of recidivism indicated that the measure of involuntary hospitalization as implemented was necessary and effective. It was also observed that the short-term removal of the minor from the family environment was a potentially relieving strategy for both the child and the family apart from the need for therapeutic intervention.

At any rate, involuntary psychiatric admissions of minors should be associated with symptoms severity. It should be highlighted that the association between involuntary psychiatric admissions of minors and variables such as aspects of the adolescent living conditions or even gender identity may be a serious ethical and legal problem.²⁸ Kaltiala-Heino stresses the risk of unnecessarily subjecting girls to involuntary psychiatric hospitalization. Indeed, female gender is considered one of the risk factors for involuntary psychiatric admissions of minors.²⁹ Notwithstanding, Mears et al. found that involuntary admissions occurred more frequently among boys.³⁰ Ulla et al found that a greater proportion of girls than boys were subjected to coercive measures in adolescent psychiatric inpatient treatment.³¹ Female gender, advanced age, out-of-home placement and suicidal acts prior to admission are cited in the literature as risk factors for involuntary psychiatric hospitalization of minors.⁸ As anticipated above, the authors found that involuntary admissions occurred more frequently among boys.

As is the case with the laws of other European countries³² the Greek law leaves room for a gap between public policymakers' intention and practice in the context of involuntary psychiatric hospitalization of minors. As a consequence, considerable variation may be seen in the use of the measure. As the decision making for involuntary psychiatric hospitalization of minors is a complicated and multid-

mensional process, the authors highlight the need for a multi-stakeholder process for making decisions about involuntary psychiatric hospitalization of minors. This process should involve shared decision making process, despite the fact that the communication in such cases may be too complicated to handle.

Shared decision making (SDM) is a key component of patient-centered health care good medical practice. It "is increasingly being suggested as an integral part of provision of mental health provision".^{33,34} Note, however, that research has shown a perception-reality gap despite the fact that many clinicians feel they already use shared decision-making.³⁵

At any rate, the minor's decision-making capacity should be taken seriously into account, especially when it comes to adolescents mature enough to make their own decisions. This is in consistency not only with patient autonomy but also with the principle of beneficence given the truth of the assumption that involvement of adolescents in treatment decision making process may have positive effects on their self-esteem and self-confidence.³⁶ In that regard, American courts developed the "the mature minor doctrine".¹⁰ Note, however, that it is not always an easy task to fully engage minors in a surrogate decision making about their psychiatric treatment.³⁷

When the surrogate is a parent, their parenting capacity plays a crucial role in a decision on the involuntary psychiatric hospitalization of the child. Involuntary admission of adolescents is said to be associated with distinctive conflicts between these adolescents and their parents.³⁸ The findings of Golubchik et al. highlight the crucial role of the parents (namely, the crucial role of their parenting capacity in terms of their ability "to cope and to contain the child") in the process of such a decision making.³⁹

A major limitation of the study is that it is not based on a representative nationwide dataset although it is based on a sufficiently large dataset that was representative of the Northern Greece (It is one of the two centers in Northern Greece - representing 50% of the cases). Another limitation of the study was related to the co-operation of the family during follow-up. Across all studied medical

records of patients there was missing data concerning the family and adolescent co-operation after discharge, which might have a significant effect on the conclusions that could be drawn from the data. Furthermore, the retrospective nature of the study and the structure of the data allowed the authors draw limited conclusions.

At any rate, it might be thought of as being strength of this study the fact that in the currently available academic literature there is a limited number of comparable studies involving investigations about involuntary psychiatric admissions focusing on minor patients. As regards the Geek context, little is known about the epidemiology of involuntary psychiatric hospitalization focusing on children and adolescents.

The results of this study might be evaluated in eventual compulsive hospitalization plans which, however, in a patient-oriented healthcare system should be well-designed and based on clinical evidence that balances risks and expected outcomes with patient preferences, values and human rights. This is important from a public health policy perspective, given the truth of the assumption that "rates of involuntary admission and treatment reflect characteristics of national mental health care".⁸

Conclusion

The main points raised in the authors' data analysis and findings are the following: The authors found a high rate of incidences of compulsory admissions most likely due to organizational factors, which, however, could have been avoided in a more patient-oriented healthcare system. It is most likely that the criteria used for making decisions in favor of compulsory admissions were disproportionately (unduly) broad and in all likelihood have been used as preventive means (in a paternalistic perspective). Furthermore, the authors found that the effectiveness of a compulsory hospitalization of minors in a child and adolescent psychiatry department largely depends on the type of the underlying mental health problem. In that respect, low rates of recidivism indicated that the measure of involuntary hospitalization was necessary and effective. It was also observed that the short-term removal of the minor from the family environment

was a potentially relieving strategy for both the child and the family apart from the need for therapeutic intervention.

The paper concludes by highlighting the role of a multi-stakeholder decision making (involving shared

decision making process as an integral component of provision of psychiatric healthcare to minors) in facilitating a decision about involuntary psychiatric hospitalization that is proportional and respectful to patient autonomy.

Ακούσια ψυχιατρική νοσηλεία παιδιών και εφήβων στη Βόρεια Ελλάδα: Αναδρομική επιδημιολογική μελέτη και συναφή ηθικά ζητήματα

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Σκοπός της παρούσας μελέτης ήταν η διερεύνηση των επιδημιολογικών δεδομένων όσον αφορά στην ακούσια ψυχιατρική νοσηλεία ανηλίκων ασθενών καθώς και η παρουσίαση των σχετικών βιοηθικών και δεοντολογικών ζητημάτων που αναδύονται γύρω από αυτή. Εξετάστηκαν προσεκτικά τα ιατρικά αρχεία 131 ακούσιων ψυχιατρικών νοσηλείων παιδιών και εφήβων που εισήχθησαν κατόπιν εισαγγελικής παραγγελίας προς εξέταση κατά το χρονικό διάστημα 2005-2014. Οι εξεταζόμενες μεταβλητές αφορούσαν στον τόπο καταγωγής, τον τόπο διαμονής των ανηλίκων μετά το εξιτήριο, τη διάρκεια ενδονοσοκομειακής παραμονής, τη διάγνωση εξόδου, το ποσοστό παρουσίας των ανηλίκων σε αστυνομικές και άλλες αρχές πριν από τη νοσηλεία τους και τα αποτελέσματα της νευροψυχολογικής αξιολόγησης (WISC II). Τα δεδομένα αναλύθηκαν μέσω του SPSS (Στατιστικό Πακέτο για τις Κοινωνικές Επιστήμες). Η μέση ηλικία των ανηλίκων ήταν 14,19 έτη (με αναλογία αρρένων: θηλέων 1,6:1). Αρχικά, πιθανότατα λόγω παραγόντων που αφορούσαν στην οργάνωση, διαπιστώθηκε υψηλό ποσοστό επίπτωσης στις ακούσιες εισαγωγές [πενταετείς περίοδοι (2005-2009):(2010-2014) με αναλογία 1:1,85], οι οποίες, ωστόσο, θα μπορούσαν να είχαν αποφευχθεί σε ένα σύστημα υγειονομικής περίθαλψης με μεγαλύτερη εξατομίκευση προς τον ασθενή. Είναι πολύ πιθανό ότι τα κριτήρια που χρησιμοποιήθηκαν για τη λήψη αποφάσεων υπέρ της ακούσιας εισαγωγής να ήταν δυσαναλόγως γενικευτικά. Παράλληλα, παρατηρήθηκε ότι κατά την περίοδο 2010-2014, παρά την αύξηση του ποσοστού των εισαγγελικών παραγγελιών προς εξέταση, σημειώθηκε μείωση της διάρκειας της ακούσιας νοσηλείας των ανηλίκων στα ψυχιατρικά τμήματα των νοσοκομείων σε σύγκριση με την περίοδο 2005-2009 [διάρκεια νοσηλείας ανά πενταετία (2005-2009):(2010-2014) αναλογία; 2,33:1]. Επιπλέον, η οικογένεια βρέθηκε να ασκεί πιθανόν σημαντική επιρροή στη λήψη αποφάσεων για την ακούσια νοσηλεία. Επίσης, η αποτελεσματικότητα της υποχρεωτικής ψυχιατρικής νοσηλείας ανηλίκων διαπιστώθηκε πως εξαρτάται σε μεγάλο βαθμό από το είδος της υποκείμενης ψυχικής διαταραχής. Από αυτή τη σκοπιά, τα χαμηλά ποσοστά υποτροπής (7,6%) έδειξαν ότι το μέτρο της ακούσιας νοσηλείας ήταν απαραίτητο και αποτελεσματικό. Παρατηρήθηκε επίσης ότι, πέρα από την

ανάγκη για θεραπευτική παρέμβαση, η βραχυπρόθεσμη απομάκρυνση του ανηλίκου από το οικογενειακό πλαίσιο ήταν μια ενδεχομένως ανακουφιστική στρατηγική τόσο για το παιδί όσο και για την οικογένεια. Το άρθρο τονίζει τον ρόλο των πολλαπλών φορέων στη λήψη αποφάσεων (γεγονός συνεπάγεται τη διαδικασία κοινής λήψης αποφάσεων ως αναπόσπαστο στοιχείο της παροχής ψυχιατρικής υγειονομικής περίθαλψης σε ανηλίκους) για τη διευκόλυνση της λήψης απόφασης για την ακούσια εισαγωγή στην παιδοψυχιατρική κλινική σύμφωνα με την αρχή της αναλογικότητας και με σεβασμό στην αυτονομία του κάθε ασθενούς.

Λέξεις ευρετηρίου: Ακούσια νοσηλεία, βιοηθική, ψυχιατρική παιδών, αυτονομία, λήψη αποφάσεων, εισαγγελική παραγγελία.

References

1. Hein IM, De Vries MC, Troost PW, Meynen G, Van Goudoever JB, Lindauer RJ. Informed consent instead of assent is appropriate in children from the age of twelve: Policy implications of new findings on children's competence to consent to clinical research. *BMC Med Ethics* 2015, 16:76, doi: 10.1186/s12910-015-0067-z
2. Katsakou C, Priebe S. Outcomes of involuntary hospital admission - a review. *Acta Psychiatr Scand* 2006, 114:232–241, doi: 10.1111/j.1600-0447.2006.00823.x
3. Bonsack C, Borgeat F. Perceived coercion and need for hospitalization related to psychiatric admission. *Int J Law Psychiatry* 2007, 28:342–347, doi:10.1016/j.ijlp.2005.03.008
4. Lay B, Salize HJ, Dressing H, Rüsich N, Schönenberger T, Bühlmann M et al. Preventing compulsory admission to psychiatric inpatient care through psycho-education and crisis focused monitoring. *BMC Psychiatry* 2012, 12:136, doi:10.1186/1471-244X-12-136
5. Rothärmel S. *Patientenaufklärung, Informationsbedürfnis und Informationspraxis in der Kinder-und Jugendpsychiatrie und Psychotherapie*. Vandenhoeck & Ruprecht, Göttingen, 2006
6. Nytingnes O, Ruud T, Norvoll R, Rugkåsa J, Hanssen-Bauer K. A cross-sectional study of experienced coercion in adolescent mental health inpatients. *BMC Health Serv Res* 2018, 18:389, doi:10.1186/s12913-018-3208-5
7. Mielau J, Altunbay J, Gallinat J, Heinz A, Bempohl F, Lehmann A et al. Subjective experience of coercion in psychiatric care: a study comparing the attitudes of patients and healthy volunteers towards coercive methods and their justification. *Eur Arch Psychiatry Clin Neurosci* 2016, 266:337–347, doi:10.1007/s00406-015-0598-9
8. Jendreyshak J, Illes F, Hoffmann K, Holtmann M, Haas CR, Burchard F et al. Voluntary versus involuntary hospital admission in child and adolescent psychiatry: a German sample. *Eur Child Adolesc Psychiatry* 2014, 23:151–161, doi:10.1007/s00787-013-0440-8
9. Turunen S, Välimäki M, Kaltiala-Heino R. Psychiatrists' view of compulsory psychiatric care of minors. *Int J Law Psychiatry* 2010, 33:35–42, doi:10.1016/j.ijlp.2009.10.007
10. Huntington C, Scott ES. Children's Health in a Legal Framework. *Future Child* 2015, 25:177–197, doi:10.1353/foc.2015.0008
11. Psaroulis D, Voultsos P. *Medical Law and Elements of Bioethics*. University Studio Press, Thessaloniki, 2010
12. Anand AK, Kunwar N, Kumar A. Impact of different factors on Social Maturity of Adolescents of Coed-School. *Int Res J Social Sci* 2014, 3:35–37, ISSN 2319–3565
13. Calkins SD. Biopsychosocial Models and the Study of Family Processes and Child Adjustment. *J Marriage Fam* 2011, 73:817–821, doi:10.1111/j.1741-3737.2011.00847.x
14. Steinberg L, Cauffman E. Maturity of judgment in adolescence: Psychosocial factors in adolescents decision making. *Law Hum Behav* 1996, 20:249–272, doi: 10.1007/BF01499023
15. Hermann H, Trachsel M, Elger BS, Biller-Andorno N. Emotion and Value in the Evaluation of Medical Decision-Making Capacity: A Narrative Review of Arguments. *Front Psychol* 2016, 7:765, doi:10.3389/fpsyg.2016.00765
16. Psychargo III. Psychargo Program Review Plan 2011–2020. Greek Ministry of Health and Social Solidarity (Cited 11 March 2020) Available from [https://www.psychargos.gov.gr/Documents2/%CE%9D%CE%95%CE%91/%CE%A8%CE%A5%CE%A7%CE%91%CE%A1%CE%93%CE%A9%CE%A3%20%CE%93%20\(2011–2020\).pdf](https://www.psychargos.gov.gr/Documents2/%CE%9D%CE%95%CE%91/%CE%A8%CE%A5%CE%A7%CE%91%CE%A1%CE%93%CE%A9%CE%A3%20%CE%93%20(2011–2020).pdf)
17. Sjöstrand M, Sandman L, Karlsson P, Helgesson G, Eriksson S, Juth N. Ethical deliberations about involuntary treatment: interviews with Swedish psychiatrists. *BMC Med Ethics* 2015, 16:37, doi:10.1186/s12910-015-0029-5
18. DeMarco JP. Principlism and moral dilemmas: a new principle. *J Med Ethics* 2005, 31:101–105, doi:10.1136/jme.2004.007856
19. Peltó-Piri V, Kjellin L, Lindvall C, Engström I. Justifications for coercive care in child and adolescent psychiatry, a content analysis of medical documentation in Sweden. *BMC Health Serv Res* 2016, 16:66, doi:10.1186/s12913-016-1310-0
20. Savignac J. Families, youth and delinquency: the state of knowledge and family based juvenile delinquency programs. National Crime Prevention Centre, Public Safety Canada, Ottawa, Ontario Canada, 2009
21. Black JM, Hoefft F. Utilizing biopsychosocial and strengths-based approaches within the field of child health: what we know and where we can grow. *New Dir Child Adolesc Dev* 2015, 147:13–20, doi:10.1002/cad.20089
22. Agnafors S, Svedin CG, Orelund L, Bladh M, Comasco E, Sydsjö G. A Biopsychosocial Approach to Risk and Resilience on Behavior in Children Followed from Birth to Age 12. *Child Psychiatry Hum Dev* 2017, 48:584–596, doi:10.1007/s10578-016-0684-x

23. Stephanis K, Soldatos K, Mavreas B (Rendition in English). *ICD-10, Classification of Mental Disorders and Behavioral Disorders, Clinical Descriptions and Guidelines for Diagnosis*. BETA Medical Publications, Athens, 1992
24. Fite PJ, Greening L, Stoppelbein L. Relation between parenting stress and psychopathic traits among children. *Behav Sci Law* 2008, 26:239–248, doi:10.1002/bsl.803
25. Blader JC. Which family factors predict children's externalizing behaviors following discharge from psychiatric inpatient treatment? *J Child Psychol Psychiatry* 2006, 47:1133–1142, doi:10.1111/j.1469-7610.2006.01651.x
26. Jaffee SR, Hanscombe KB, Haworth CM, Davis OS, Plomin R. Chaotic homes and children's disruptive behavior: a longitudinal cross-lagged twin study. *Psychol Sci* 2012, 23:643–650, doi:10.1177/0956797611431693
27. Carona C, Silva N, Crespo C, Canavarró MC. Caregiving burden and parent-child quality of life outcomes in neurodevelopmental conditions: the mediating role of behavioral disengagement. *J Clin Psychol Med Settings* 2014, 21:320–328, doi:10.1007/s10880-014-9412-5
28. Kaltiala-Heino R. Involuntary commitment and detainment in adolescent psychiatric inpatient care. *Soc Psychiatry Psychiatr Epidemiol* 2010, 45:785–793, doi:10.1007/s00127-009-0116-3
29. Ellilä HT, Sourander A, Välimäki M, Warne T, Kaivosoja M. The involuntary treatment of adolescent psychiatric inpatients—a nation-wide survey from Finland. *J Adolesc* 2008, 31:407–419, doi:10.1016/j.adolescence.2007.08.003
30. Mears A, White R, O'Herlihy A, Worrall A, Banerjee S, Jaffa T et al. Characteristics of the Detained and Informal Child and Adolescent Psychiatric In-Patient Populations. *Child Adolesc Ment Health* 2003, 8:131–134, doi: 10.1111/1475-3588.00059
31. Ulla S, Maritta V, Riittakerttu KH. The use of coercive measures in adolescent psychiatric inpatient treatment: a nation-wide register study. *Soc Psychiatry Psychiatr Epidemiol* 2012, 47:1401–1408, doi:10.1007/s00127-011-0456-7
32. Førde R, Norvoll R, Hem MH, Pedersen R. Next of kin's experiences of involvement during involuntary hospitalization and coercion. *BMC Med Ethics* 2016, 17:76, doi:10.1186/s12910-016-0159-4
33. Hayes D, Edbrooke-Childs J, Town R, Wolpert M, Midgley N. Barriers and facilitators to shared decision making in child and youth mental health: clinician perspectives using the Theoretical Domains Framework. *Eur Child Adolesc Psychiatry* 2019, 28:655–666, doi:10.1007/s00787-018-1230-0
34. Holder AR. From chattel to consentor: adolescents and informed consent: 2009 Grover Powers Lecture. *Yale J Biol Med* 2010, 83:35–41, PMID: 20351980
35. Stiggelbout AM, Van der Weijden T, De Wit MP, Frosch D, Ligaré F, Montori VM et al. Shared decision making: really putting patients at the centre of healthcare. *BMJ* 2012, 344:e256, doi:10.1136/bmj.e256
36. O'Brien MS, Crickard EL, Rapp CA, Holmes CL, McDonald TP. Critical issues for psychiatric medication shared decision making with youth and families. *Fam Soc* 2011, 92:310–316, doi:10.1606/1044-3894.4135
37. Mandarelli G, Sabatello U, Lapponi E, Pace G, Ferrara M, Ferracuti S. Treatment Decision-Making Capacity in Children and Adolescents Hospitalized for an Acute Mental Disorder: The Role of Cognitive Functioning and Psychiatric Symptoms. *J Child Adolesc Psychopharmacol* 2017, 27:462–465, doi:10.1089/cap.2016.0092
38. Felkins B, Guthrie M, Walch J. Voluntary or involuntary status of 50 adolescent inpatients. *Hosp Community Psychiatry* 1991, 42:1062–1063, doi:10.1176/ps.42.10.1062
39. Golubchik P, Server J, Finzi-Dottan R, Kosov I, Weizman A. The factors influencing decision making on children's psychiatric hospitalization: a retrospective chart review. *Community Ment Health J* 2013, 49:73–78, doi:10.1007/s10597-012-9487-0

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