11.4. Involuntary committal in psychiatric hospitals (MH-4)

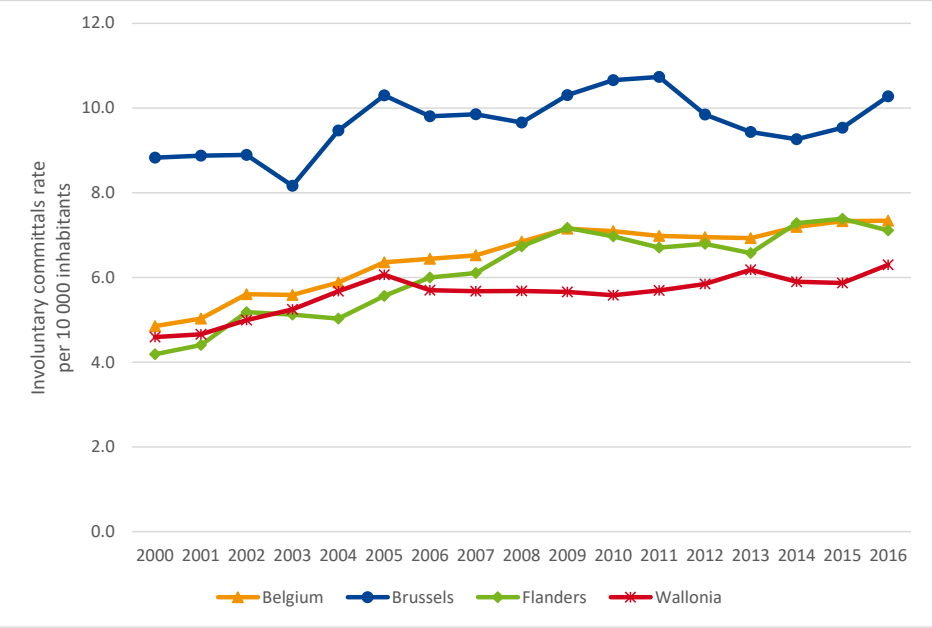
11.4.1. Documentation sheet

Description	Rate of involuntary committals in Psychiatric hospital or psychiatric services per capita
Calculation	Numerator: number of involuntary admissions per year Denominator: Midyear Belgian Population
Rationale	The need to minimize unnecessary involuntary admissions but provide appropriate treatment, supervision and protection for persons with serious mental illness is a key system goal. [1] An involuntary admission is indicative of a crisis episode but can also shed some insights into the availability and adequacy of inpatient resources and alternative forms of care for the group of more demanding patients. [2] In addition, this risk of involuntary admissions has been shown to be greater for ethnic minority groups. [2, 3] In order to better protect psychiatric patients, most European countries have reformed their mental protection laws and reviewed their criteria for involuntary commitment.[2] Despite these reforms, there are international and intra-regional differences in the use of involuntary admissions with rates increasing in some western European countries that cannot be explained by increased prevalence of severe mental disorders. [4] While some authors have expressed concern that an increased number of forensic beds signals re-institutionalization, this has not been accompanied by a consistent rise in forensic involuntary admissions. [4]
Primary data source	MPG
Indicator source	SPF – FOD Public Health
Technical definitions	**Numerator**: All involuntary admissions identified in MPG by variable “MA09 Type of admissions” by the following response categories (21” admission for observation”; 22 “internment”; 23” continuation forced stay”; 24 “probation”; 29 “other legal conditions”). **Denominator**: population For regional figures, calculations are based on patient’s residence.
International comparability	It is included in the International Mental Health Comparisons (adults and older adults services) from NHS Benchmarking Network The interpretation of this indicator in an international context requires investigation into the operation of legislation pertaining to such admissions in the countries under analysis. In Belgium a change in status from involuntary towards voluntary admission during the hospitalisation period is not taken into account whereas this was usually done by other countries. [5]
Dimension	Quality(appropriateness of mental healthcare)

11.4.2. Results

The rate of involuntary committals in psychiatric hospitals increased between 2000 and 2016: from 4.85 per 10 000 inhabitants in 2000 to 7.34 in 2016. It is higher for men (2016: 9.57/10 000) compared to women (2016: 5.18/10 000) and large differences can be observed between regions (in 2016): Flanders 7.11/10 000; Brussels 10.27/10 000; Wallonia: 6.30/10 000). Several initiatives are taken to deal with this increasing trend.

Figure 160 – Rate of Involuntary Committals per 10 000 inhabitants (2000-2014)



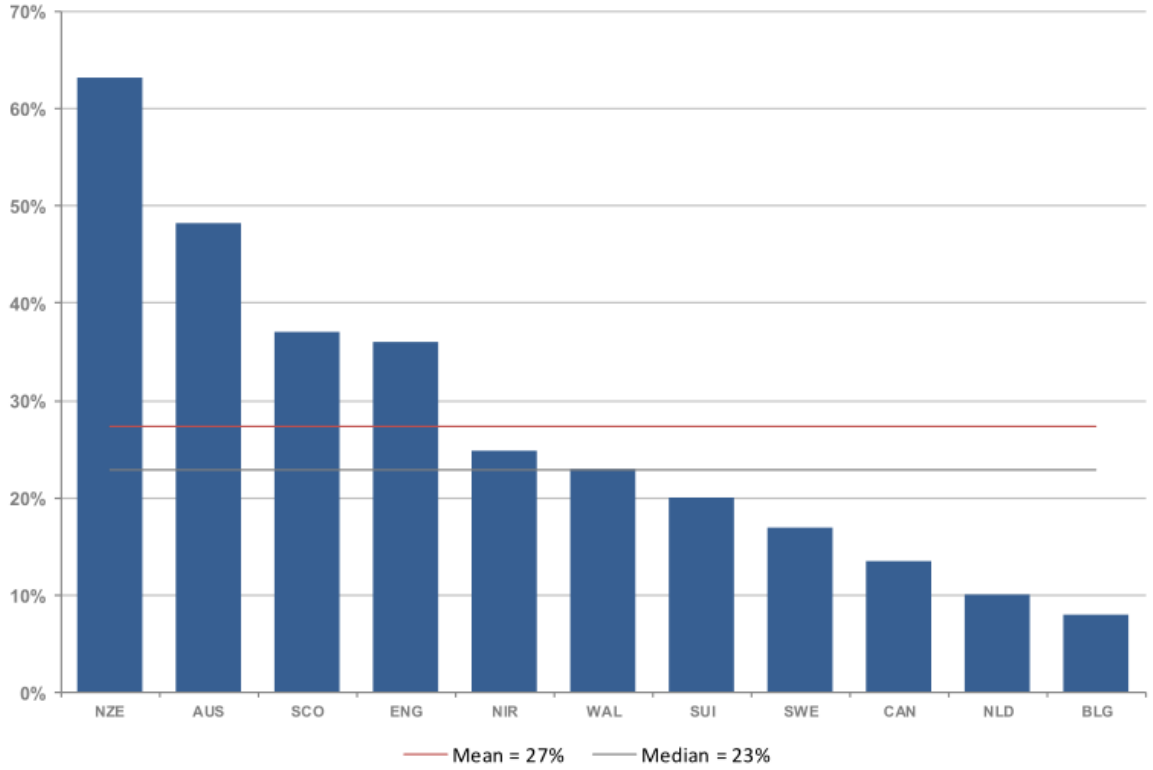
Source: SPF SPSCAE – FOD VVVL

The umbrella organization of Flemish (psychiatric) hospitals (Zorgnet Vlaanderen), for instance, installed a working group which made propositions for legal changes. They plea for a further investment in the development of ambulatory capacity crisis capacity to avoid involuntary committals (and only use them as a last resort).[kkk]

kkk http://www.zorgnetvlaanderen.be/Nieuws/Pages/Noodaanmodernkleedjevoorwetgedwongenopname.aspx

The proportion of admissions that were involuntary is lower in Belgium that in other countries (the Netherlands, Australia, New Zealand, Switzerland, Sweden, Canada (data for only 5 provinces out of 13) and UK, see Figure 161.

Figure 161 – Proportion of psychiatric admissions that were involuntary (international comparison)



Source: International Mental Health Comparisons, NHS Benchmarking Network
NZE: New Zealand, AUS: Australia, SCO: Scotland, ENG: England, NIR: Northern Ireland, WAL: Wales, SUI: Switzerland, SWE: Sweden, CAN: Canada NLD: the Netherlands, BLG: Belgium.

Key points

- **The involuntary committal rate in psychiatric hospitals rose from 4.9 / 10 000 pop. in 2000 to 7.3 / 10 000 pop. in 2016**
- **Large differences between regions exist with higher rates in Brussels (10.3 involuntary commitals per 10 000 inhabitants) compared to Flanders (7.1 / 10 000) and Wallonia (6.3 / 10 000).**

References

1. McEwan KL, Goldner E. Accountability and Performance Indicators for Mental Health Services and Supports. Ottawa (ON): Health Canada; 2001.
2. Lorant V, Depuydt C, Gillain B, Guillet A, Dubois V. Involuntary commitment in psychiatric care: what drives the decision? Soc Psychiatry Psychiatr Epidemiol. 2007;42(5):360-5.
3. Morgan C, Mallett R, Hutchinson G, Leff J. Negative pathways to psychiatric care and ethnicity: the bridge between social science and psychiatry. Soc Sci Med. 2004;58(4):739-52.
4. Priebe S, Badesconyi A, Fioritti A, Hansson L, Kilian R, Torres-Gonzales F, et al. Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. BMJ. 2005;330(7483):123-6.
5. Salize HJ, Dressing H. Epidemiology of involuntary placement of mentally ill people across the European Union. British Journal of Psychiatry. 2004;184:163-8.

11.5. Proportion of visits to the Emergency Rooms in general hospitals for mental health related problems (MH-5)

11.5.1. Documentation sheet

Description	Proportion of visits to the Emergency Rooms in general hospitals for mental health related problems
Calculation	Numerator: number of emergency room presentations with a mental health and/or social problem and/or suicide attempt
	Denominator: total emergency room presentations
Rationale	Although unforeseen and unavoidable emergencies do arise in mental health, mental health related emergency room use is used as an indicator of poor coordination of care and service failures. [1] The community treatment system to support services for people with mental health related problems is regarded as ineffective when utilisation rates of emergency departments of general hospitals are high. [2] Highly accessible outpatient care is considered to help people to enter treatment before reaching the crisis stage and minimise the need for emergency room visits. [1] In addition, it is assumed that effective liaison between emergency rooms and mental health crisis resources reduce the use of emergency rooms for mental health services/clients. High rates of mental health related emergency room visits are not only a concern for members of the mental health community. It is also a concern that overcrowding emergency department results in decreased quality of care and increased likelihood of medical error. [2] In the US, it has been illustrated that mental health related emergency room visits are on the rise for more than one decade[3]. This stresses the importance of the availability of expertise in the field of mental health in emergency rooms to manage these crises. Depending on the number of visits