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Compulsory admissions in southwest Greece 2010–2011: A descriptive report

M. Skokou,[1] P. Gouma,[2] P. Gourzis[1]

[1]Department of Psychiatry, General University Hospital of Patras, School of Medicine, University of Patras, Rio, Patra,
[2]Department of Child and Adolescent Psychiatry, General Children's Hospital "Agia Sophia",
National and Kapodistrian University of Athens, Athens, Greece

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Compulsory admissions represent a significant proportion of psychiatric hospitalizations. A wide variation seems to exist internationally regarding legal frameworks, administrative procedures, detention rates and clinical practice. The aim of the present study is to describe qualitative and quantitative features of compulsory admissions in a large administrative area in southwest Greece, in order to identify targets for future research and possible remediation. Involuntary assessments and admissions in the Department of Psychiatry of the University Hospital of Patras were retrospectively assessed, during a 12-month period, for demographic features and data regarding legal procedures. Diagnoses following compulsory first assessment and at discharge were recorded for the patients who were admitted in our department. During the period of observation, 218 compulsory assessments were made, corresponding to 190 patients and resulting in 183 compulsory admissions. Thirty five cases (16.1%) were assessed as not justifying hospitalization and corresponded mainly to the diagnoses of alcohol and/or substance abuse or dependence. Involuntary hospitalizations represented 44.9% of all psychiatric admissions in our department. Diagnosis at first assessment was most frequently psychosis (68.4%). Diagnoses at discharge were most often schizophrenia (52.8%) and bipolar disorder (21.3%). A history of multiple hospitalizations (>5) was observed in 17 (15.8%) patients, whereas 46 patients (42.6%) were hospitalized for the first time, and 13 (11.7%) exhibited their first psychotic episode. Of the 108 patients who were admitted in our department, 88 (81.5%) declared that they did not wish to attend the court hearing, 7 (6.5%) were not able to attend due to severe health condition, and only 13 (12.0%) actually presented in court. Concluding, current situation regarding legal procedures, involuntary admissions and mental health care in Greece is rather far from satisfying. Future directions should include the systematic recording of mental health care parameters, such as compulsory hospitalizations, as well as efforts to improve these parameters and the existing legal framework and procedures.

Key words: Compulsory, admissions, psychosis, law, Greece.

Background

Compulsory placements represent a significant proportion of psychiatric admissions, posing strains on the therapeutic relationship and restrictions on the patients' freedom.[1] The Law has to protect the civil rights of the patient and at the same time provide the context for the patients' optimal treatment.[2] A wide variation seems to exist regarding legal frameworks, administrative procedures, detention rates and clinical practice, across Europe and elsewhere, as well as a significant lack of data or comparability of statistics among countries.[3–5] Particularly in Greece, there is a paucity of data regarding compulsory admissions, for example rates or quotas, whereas clinical practice and implementation of the law presents remarkable diversity.[4] Currently, the rate of involuntary admissions is roughly estimated around 50/100,000 inhabitants per year, and quotas around 50% of hospital admissions, however collection of data is rather not systematic.[6]

Mental health legislation in Greece is mainly based on the law nr 2071/1992, according to which, there are two main criteria that have to be fulfilled in order to have a patient involuntary placed in hospital: Firstly, a mental disorder must be present, the patient must not be capable of making an admission or treatment decision, and the patient's health must be at risk of deterioration or its improvement excluded in case he/she is not admitted to hospital. Secondly, there must be a risk of harm against self or others, if treatment is not provided.[7] After Oviedo Convention in 1998 and according to the law nr 2619/98, the second condition has been rendered not necessary.[8] In the law nr 2071/92, it is stated that the inability or refusal of a person to conform to the ethical, social or political values that prevail in society, do not per se constitute a mental disorder. Also, the management of persons suffering from alcohol or substance abuse or dependence, is ruled by other special laws.[7]

The process through which a patient is brought for involuntary assessment and/or admission begins with the application to the Public Prosecutor. The application can be made by a first or second degree relative, or guardian, accompanied by the expert opinion of two psychiatrists. In extreme cases, the Public Prosecutor himself makes the application. If the patient refuses to be examined, the Public Prosecutor can order the involuntary assessment of the patient, by two psychiatrists. Psychiatric assessment must be documented, either on separate files or on one joint file. In case of disagreement between the two examiners, a third psychiatrist must examine the patient and respond to the Public Prosecutor accordingly. The period of observation and assessment must not exceed 48 hours, and if criteria are fulfilled, the patient is kept for compulsory inpatient treatment. Within 10 days, the Public Prosecutor is committed to send the case to Court.[7] The patient must be formally informed that he/she has the right to be present in Court, accompanied by a lawyer and a psychiatric counselor, and is also able to take legal action against the Court decision.[8] Involuntary hospitalization cannot last longer than six months. At the end of three months a report describing the patient's condition must be submitted to the Public Prosecutor by the director of the psychiatric department. In extreme cases where a hospitalization longer than six months is needed, the patient must be examined by a committee of three psychiatrists, one of whom is the psychiatrist in charge of the patient, and again submit their report to the Public Prosecutor.[7] It has to be noted that involuntary hospitalization is always accompanied by involuntary administration of treatment.

Strategies for reducing the rate of compulsory admissions have been implemented internationally with inconclusive results.[9,10] The presumably high quota of compulsory admissions in Greece,[11] as well as the scarcity of formal and systematic collection of data, call for more detailed research on qualitative and quantitative aspects of this issue, and at the same time, for exploring ways of reducing involuntary hospitalizations. The aim of the present study is to describe naturalistic aspects of compulsory admissions in a large administrative area in Greece, belonging to the 6th Health District of Peloponnese-Ionian Islands-Epirus & Western Greece, in order to identify targets for future research and possible remediation. This administrative area refers to a population of about 1,000,000 people, and includes the states of Achaia, Ilia, Etoloakarnania, Zakynthos, Kefalonia, Leukada, Itaka. Legal and administrative aspects of everyday practice regarding involuntary admissions in this area are also described.

Material and Methods

Compulsory assessment orders and compulsory admissions in the Department of Psychiatry of the University Hospital of Patras, during a one year period, from 1st July 2010 to 30th June 2011, were retrospectively assessed using hospital records. Parameters which were examined were total emergency assessments, demographic features and data regarding legal and administrative procedures. Diagnoses following compulsory first assessment and at discharge were recorded for the patients who were admitted in our department (111 admissions, 108 patients). The Microsoft Excel 2007 version was employed for the database and descriptive statistics. The study was approved by the Deontology and Ethics Committee of the University Hospital of Patras.

Results

During the period of observation, 2684 emergency assessments were made, 218 of which were compulsory assessments, corresponding to 190 patients, aged 14–89 years old (mean±SD: 44.37±14.89). The involuntary assessments resulted in 183 compulsory admissions in the University Hospital of Patras and other hospitals, whereas 35 cases (16.1%) were assessed as not justifying hospitalization. Commanding Public Prosecutor's offices and psychiatric hospitals where involuntary admissions finally took place are shown in figures 1 and 2.

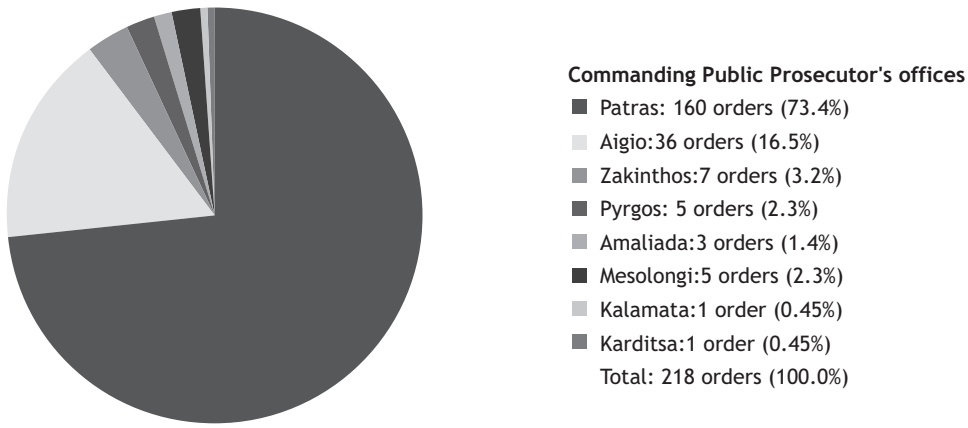

Figure 1. Commanding prosecutor's offices ordering involuntary assessments of patients by the Department of Psychiatry of the University Hospital of Patras, for the 12-month period of observation.

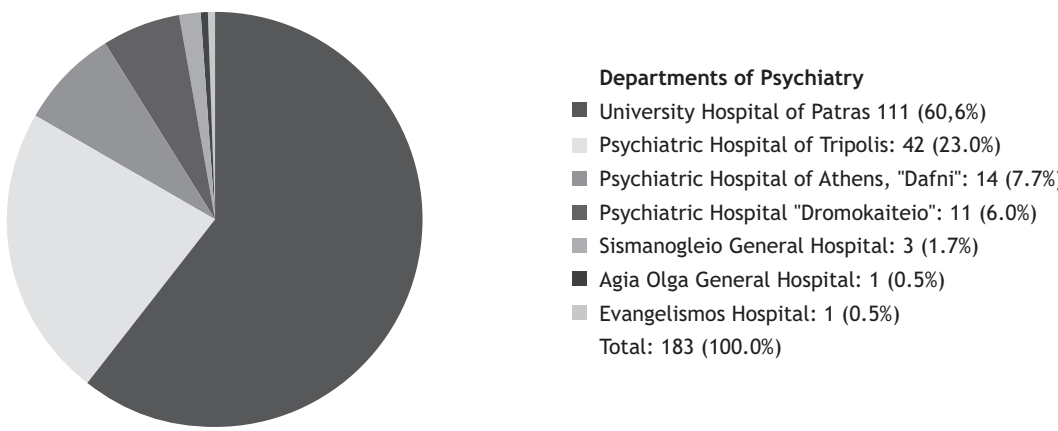

Figure 2. Psychiatric hospitals and departments where compulsory admissions took place, for the 12-month period of observation.

Voluntary admissions were 136, during the same period, in the Department of Psychiatry of the University Hospital of Patras. Demographic features are shown in table 1 (sex, ethnicity, place of residence).

A significant number of patients (19, 10% of patients) were involuntarily examined more than once in the one-year period: 14 patients twice, 3 patients thrice, one patient 4 times and another one 6 times.

Compulsory admissions represented 44.9% of all admissions in our psychiatric department. Patients were obliged to be hospitalized in other hospitals on days of extreme occupancy, which is 116–142% occupancy of beds in our department of 24 beds, corresponding to 4–10 additional beds, located in the corridor of the department (mean±sd: 129%±0.06% occupancy, on average 7 additional beds).

Patients who were compulsorily admitted were diagnosed most frequently with psychosis (68.4%), whereas those who were not admitted represented mostly addicted persons or diverse categories (tables 2 and 3). Diagnoses at discharge were most

Table 1. Demographic features of patients brought for compulsory assessment.

Demographic features	Patients (%) (n=190)
Sex	
Men	133 (70)
Women	57 (30)
Ethnicity	
Greek	181 (95.3)
Foreign	9 (4.7)
Place of residence (distance from Patras, km)	
Patras (0)	113 (59.5)
Achaia Prefecture (10–115)	52 (27.4)
Ilia Prefecture (49–161)	9 (4.7)
Etoloakarnania Prefecture (18–166)	5 (2.6)
Zakynthos (112)*	8 (4.2)
Athens (215)	2 (1.1)
Messinia Prefecture (149–260)	1 (0.5)

*Access to Zakynthos is provided by car (30 minutes) and boat (2 hours)

Table 2. Diagnoses of initial involuntary assessments of patients who were admitted compulsorily in psychiatric departments and hospitals.

Diagnosis	Number of assessments (%)
Psychotic relapse	70 (38.3)
Psychotic symptoms	55 (30.1)
Relapse of bipolar disorder	10 (5.5)
Manic symptoms with or without psychotic features	10 (5.5)
Cognitive impairment and psychotic symptoms	4 (2.2)
Borderline Personality disorder and psychotic symptoms	2 (1.1)
Antisocial personality disorder and psychotic symptoms	2 (1.1)
Mental retardation and psychosis	6 (3.3)
Mental retardation, behavioral disturbance and/or alcohol use	7 (3.8)
Delirium and behavioral disturbance	2 (1.1)
Depressive symptoms and reported substance use	1 (0.55)
Alcohol and/or substance use and behavioral disturbance	2 (1.1)
Alcohol use and depressive symptoms	3 (1.6)
Alcohol use and psychotic symptoms	2 (1.1)
Alcohol use and personality disorder	2 (1.1)
Psychotic and depressive symptoms	2 (1.1)
Depressive symptoms and suicidal ideation	2 (1.1)
Obsessive compulsive disorder and suicidal ideation	1 (0.55)
Total	183 (100)

Table 3. Diagnoses of initial involuntary assessments of patients who were not admitted to hospital.

Diagnosis	Number of assessments (%)
Substance and/or alcohol abuse	7 (20.0)
Substance and/or alcohol abuse and behavioral disturbance	3 (8.6)
Reported substance use	3 (8.6)
Reported substance use and behavioral disturbance	4 (11.4)
Reported substance use and delirium	1 (2.9)
Mental retardation and alcohol use	2 (5.7)
Mild mental retardation	1 (2.9)
Mental retardation, alcohol use and remitted psychosis	1 (2.9)
Mental retardation and delirium	2 (5.7)
Dementia	2 (5.7)
Depression and alcohol abuse, remitted	1 (2.9)
Psychosis in remission	1 (2.9)
Conjugal problems	2 (5.7)
Absence of active psychopathology	3 (8.6)
Absence of active major psychopathology, with social problems and general medical conditions	1 (2.9)
Total	35 (100)

often schizophrenia (52.8%), and bipolar disorder (21.3%) (table 4).

A history of multiple hospitalizations (>5) were observed in 17 (15.8%) patients, whereas 46 patients (42.6%) were hospitalized for the first time, and 13 (11.7%) of them exhibited their first psychotic episode. Status of first hospitalization was voluntary in 14 (13.0%) patients, and involuntary in the rest 94 (87.0%) of patients.

Duration of hospitalization (mean±SD) was 41.8±23.6 days. In 4 cases hospitalization exceeded 90 days (108, 113, 115 and 128 days, respectively), in which cases required documents regarding the patients' condition and need for further detainment were submitted to the Public Prosecutor's Office, accordingly. Nine orders were applied for by the Public Prosecutor after notification by the police, 5 orders were applied for after the testimonies of neighbors or social workers' reports, and the rest 96 (93.6%) were ordered following the petition of relatives.

Transfer of the patients to the hospital for the psychiatric assessments was made by the police, without ambulance. Transfer was immediate in 107 (49.1%) cases. In 56 (25.7%) cases the patients were transferred within 1–2 days, in 37 (17.0%) cases within 3–10 days, and in 18 (8.3%) within more than 10 days. In one case the patient reached hospital 53 days later than the Public Prosecutor's assessment order.

In all cases the documents of the psychiatric assessments were compiled in due time, that is within 48 hours, and in most cases (210, 96.3%) immediately. Although patients were orally informed by the psychiatric staff about the conditions of compulsory admission and their legal rights, the compilation of the relevant document was almost always neglected.

Of the 108 patients who were admitted in our department, the great majority (88, 81.5%) declared that they did not wish to attend the court hearing, 7 (6,5%) were not able to attend due to severe health condition, and only 13 (12.0%) declared that they wished to attend court. In the latter group, only one patient presented to court accompanied by a lawyer, and in two other cases, where the court in charge was located in another prefecture, the court hearing was deferred because the transfer of the patients by the police was not possible. Of note, hospitalization of patients away from their residence and the Prosecutor's Office that has ordered the admission, sometimes at a distance greater than 200 km, poses additional difficulties in keeping with the legal procedures and thus protecting the patients' civil rights.

Table 4. Diagnoses according to DSM-IV-TR criteria at discharge of patients who were compulsorily admitted.

Diagnosis	Admissions (%)	Patients (%)
Schizophrenia, paranoid type	49 (44.1)	49 (45.4)
Schizophrenia, undifferentiated type	7 (6.3)	7 (6.5)
Schizophrenia disorganized type	1 (0.9)	1 (0.9)
Psychotic disorder NOS	2 (1.8)	2 (1.9)
Psychotic disorder due to dementia	5 (4.5)	5 (4.6)
Psychotic disorder due to general medical condition	1 (0.9)	1 (0.9)
Brief psychotic disorder	1 (0.9)	1 (0.9)
Delusional disorder	1 (0.9)	1 (0.9)
Bipolar Disorder I, current episode manic or mixed with psychotic features	16 (14.4)	14 (13.0)
Bipolar Disorder I, current episode manic or mixed without psychotic features	5 (4.5)	5 (4.6)
Bipolar disorder I, current episode major depressive with or without psychotic features	2 (1.8)	2 (1.9)
Bipolar disorder II	1 (0.9)	1 (0.9)
Bipolar disorder NOS	1 (0.9)	1 (0.9)
Schizoaffective disorder	2 (1.8)	2 (1.9)
Major depressive disorder with or without psychotic features	4 (3.6)	4 (3.7)
Mental retardation and psychotic disorder NOS	3 (2.7)	3 (2.8)
Mental retardation and behavioral disturbance	5 (4.5)	4 (3.7)
Mood disorder due to alcohol and alcohol dependence	1 (0.9)	1 (0.9)
Personality disorder and alcohol dependence	3 (2.7)	3 (2.7)
Substance abuse and intoxication	1 (0.9)	1 (0.9)
Total	111 (100)	108 (100)

The courts' verdict was in all cases confirming of the psychiatric assessments, except for one case, where the judge decided that the admission was not justified, because the psychiatrists compiled a joint document instead of two separate ones; the patient was discharged immediately after. In 3 cases the day of court hearing was set in due time, within 10 days of admission, whereas for the rest of admissions (108, 97.3%) it was set later, and in many cases (34, 30.6%) after the patients' discharge.

During the period of observation, there were 24 inpatient psychiatric beds provided by the Department of Psychiatry of the University Hospital in Patras, Achaia, and none in Etoloakarnania, Messinia, Zakynthos- Kefalonia, and Ilia. As for residential care facilities and rehabilitation units, there were 2 supported housing wards in Patras, Achaia, one in Pyrgos, Ilia, one in Mesologgi, Etoloakarnania, and 2 boarding houses, 3 supervised apartments, as well as one day hospital in Patras, Achaia.

Discussion

The present study attempts to describe aspects of every day practice of compulsory care delivery in a large area of Greece, Achaia and neighboring prefectures in particular. At first glance, the data point to a rather high quota of involuntary hospitalizations, 44.9%, higher than the European average, ranging from 5.8% for Belgium, to 30% for Sweden.[3] It is possible that this quota is comparable with those of other regions in Greece;[1,12] however, psychiatric hospitals that accept compulsory admitted patients from other areas on days of extreme occupancy might yield even higher quotas. There are certain reasons that can be thought of as contributing to this high percentage of involuntary placements of beds. Previous work has tested the correlations of procedural features, sociodemographic characteristics and psychopathology with compulsory admission quotas, but the data are far from being exhaustive. In

countries where the inclusion of a legal representative of the patient is mandatory, involuntary admissions tend to be lower,[3] therefore the fact that such an inclusion is not obligatory in Greece could contribute to the local high percentage of involuntary placements. Moreover, as an administrative routine and everyday practice, the application of a first degree relative is often enough to commence the procedure of involuntary assessment, and indeed, in our sample, this was the prevailing mode, which is, in 93.6% of cases. This fact is also mirrored in the not at all trivial proportion of orders which were negatively assessed, that is, were documented as "hospitalization is not needed". A part of these cases were free from psychopathology. In certain instances, distressed relatives would use the legal process of compulsory psychiatric assessment to continue a family dispute. There are also other cases that correspond to the diagnoses of alcohol or substance abuse or dependence. These cases are not managed on a compulsory basis, and when there is not another diagnosis on axis I, they are advised to refer to mental health detoxification units. The relative scarcity of such units in Greece and in our area in particular, which leads to long waiting lists, often encourages these patients and their families to the legal process of compulsory assessment, with the hope of involuntary hospitalization, which, in the end, seems to be a major pathway to mental health care in our country.

The extreme shortage of beds and crowded corridors of psychiatric departments, and as a result the pressure on clinicians to manage more cooperative patients on an outpatient basis with the assistance of family members and caregivers, could presumably represent another contribution to the present situation. Severe economic crisis has been found to increase mental health care demands,[13] therefore contributing to the heavy load of mental health care services. Family bonds are rather strong in Greece, so that available relatives frequently agree to supervise a patient who has relapsed, in the sense of "making an effort to keep him outside the psychiatric hospital". If more beds were available, some of these patients would probably be hospitalized voluntarily. Stigmatization of patients with mental disorders is common in Greek society,[14] possibly causing delays in mental health care delivery. It can be hypothesized that, as valuable time passes, patients get worse, probably become uncooperative, leading to a compulsory assessment order at this stage of deterioration. A comparison with voluntary examined and/or admitted patients would be necessary to test these hypotheses. On the other hand, premature discharges and the absence of community treatment orders, which have been reported to support outpatient treatment and possibly reduce readmissions in a subgroup of frequently hospitalized patients,[15] could contribute to frequent relapses and the revolving-door phenomenon. Community care is based grossly on outpatient clinics of the general hospitals in the capital of each prefecture, while some patients are directed to day hospital or rehabilitation and residential care facilities, but co-ordination between community mental health care facilities and connection with inpatient clinics seems rather poor. This fact is especially true for patients who happen to be hospitalized away from their place of residence.

Concerning the implementation of legal procedures, a number of issues arise, which point to a disparity between the law and actual everyday practice. The vast majority of patients are not typically informed about their legal rights and do not attend court for a variety of reasons. In many cases court is scheduled on remarkably overdue dates, and often after patients' discharge. The hospitalization of patients hundreds of miles away from the responsible Public Prosecutor's office represents a further obstacle. In the one case where the judge decided that the involuntary placement of the patient was not justified, the decision was based on a superficial matter, namely the compilation of one instead of two separate psychiatric documents, and thus deprived the patient of necessary treatment. Although Mental Health Legislation in Greece is considered quite protective of the patients' civil rights theoretically,[8] in its everyday routine implementation it does not seem to meet patients' needs.

Regarding demographic characteristics and clinical diagnoses, those were in most cases schizophrenia, similarly with other European countries which have reported similar percentages of 30–50% of psychotic disorders in this group of patients,[3] and males prevailed. When thinking of first psychotic episodes, it is of concern that the first experience of a young psychotic patient regarding mental health care is often an involuntary admission. The involvement of the police and the compulsory nature of the contact almost always constitute a negative experience, which

has been found to correlate with poor engagement in treatment, greater dissatisfaction with services and future delays in help-seeking.[16] Notwithstanding legal admission per se has not been found to adversely influence treatment adherence and outcome,[17] perceived coercion has been shown to negatively interfere with the therapeutic relationship.[18] Although the present data is not sufficient to extract conclusions regarding help-seeking behavior of patients in their first psychotic episode, it is possible that a significant portion has the negative experience of a first contact with the police, which bring them involuntarily to hospital.

An important limitation of the present study is the absence of data regarding voluntary admissions. In future work, voluntary admissions should be included and correlations of status of hospitalization with demographic and clinical variables should be sought for.

Concluding, current state of affairs regarding legal procedures, health statistics recording and mental health care in southwest Greece and possibly at a national level has still a long way to run. The present situation is even more harassing in the context of severe economic crisis. Clinicians and researchers should not be discouraged from further efforts aiming at improving health care parameters as well as legal processes. Future directions should include the systematic recording of involuntary admissions at a national level, assessment of time series, which may in part reflect the impact of economic crisis and political or administrative routine changes in the field of mental health care, assessing level of coercive measures, correlations of sociodemographic and clinical variables with the compulsory status of inpatient care, and implementing possible ways of remediation.

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Ακούσιες νοσηλείες στη νοτιοδυτική Ελλάδα 2010-2011: Μια περιγραφική μελέτη

Μ. Σκώκου,[1] Π. Γκούμα,[2] Φ. Γουρζής[1]

[1]Πανεπιστημιακή Ψυχιατρική Κλινική ΠΓΝΠ, Ιατρική Σχολή, Πανεπιστήμιο Πατρών, Ρίο, Πάτρα,
[2]Παιδοψυχιατρική Κλινική Πανεπιστημίου Αθηνών, Νοσοκομείο Παίδων "Η Αγία Σοφία", Εθνικό και Καποδιστριακό Πανεπιστήμιο Αθηνών, Αθήνα

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Οι ακούσιες νοσηλείες αποτελούν σημαντικό ποσοστό των συνολικών ψυχιατρικών νοσηλειών. Φαίνεται ότι διεθνώς το νομικό πλαίσιο και οι σχετικές διαδικασίες, η συχνότητα των ακούσιων εισαγωγών και η καθημερινή κλινική πρακτική ποικίλλουν ευρέως. Σκοπός της παρούσας εργασίας είναι η περιγραφή ποιοτικών και ποσοτικών χαρακτηριστικών των ακούσιων νοσηλειών στη διοικητική περιφέρεια της νοτιοδυτικής Ελλάδας, ώστε να αναγνωρισθούν στόχοι για μελλοντική έρευνα και παρέμβαση. Εξετάστηκαν αναδρομικά οι ακούσιες εξετάσεις και νοσηλείες που έλαβαν χώρα στην Πανεπιστημιακή Ψυχιατρική Κλινική του Πανεπιστημιακού Γενικού Νοσοκομείου Πατρών (ΠΓΝΠ) κατά τη διάρκεια μιας 12μηνης περιόδου, σε σχέση με δημογραφικούς παράγοντες και με τις νομικές διαδικασίες που ακολουθήθηκαν. Καταγράφηκαν οι διαγνώσεις κατά την αρχική ακούσια εξέταση και κατά την έξοδο από το νοσοκομείο, για τους ασθενείς που νοσηλεύθηκαν στο ΠΓΝΠ. Κατά τη διάρκεια της περιόδου παρατήρησης, έλαβαν χώρα 218 ακούσιες εξετάσεις, που αντιστοιχούσαν σε 190 ασθενείς

και κατέληξαν σε 183 ακούσιες νοσηλείες. Για το 16,1% των συνολικά εξετασθέντων (35 περιπτώσεις) δεν πληρούνταν τα κριτήρια για την ακούσια νοσηλεία, ενέπιπταν δε κατά το μεγαλύτερο μέρος στις διαγνώσεις της κατάχρησης ή εξάρτησης από αλκοόλ ή/και ουσίες. Οι ακούσιες νοσηλείες αντιπροσώπευαν το 44,9% του συνόλου των νοσηλειών στην Πανεπιστημιακή Ψυχιατρική Κλινική του ΠΓΝΠ. Η διάγνωση κατά την πρώτη εξέταση ήταν πιο συχνά η ψύχωση (68,4%). Οι διαγνώσεις κατά την έξοδο ήταν συχνότερα η σχιζοφρένεια (52,8%) και η διπολική διαταραχή (21,3%). Ιστορικό πολλαπλών νοσηλειών (>5) παρατηρήθηκε σε 17 (15,8%) ασθενείς, ενώ 46 εξ αυτών (42,6%) νοσηλεύονταν για πρώτη φορά, και 13 (11,7%) εμφάνιζαν πρώτο ψυχωτικό επεισόδιο. Από τους 108 ασθενείς που εισήχθησαν στην Ψυχιατρική Κλινική του ΠΓΝΠ, 88 (81,5%) δήλωσαν ότι δεν επιθυμούσαν να παραστούν στη δικαστική διαδικασία, 7 (6,5%) δεν ήταν δυνατόν να παραστούν λόγω σοβαρών προβλημάτων υγείας, ενώ μόνο 13 (12,0%) τελικά παρέστησαν στη δικάσιμο. Συμπερασματικά, η παρούσα κατάσταση σε σχέση με την ψυχική υγεία, τις ακούσιες νοσηλείες και τις νομικές διαδικασίες στην Ελλάδα απέχει μάλλον από το να είναι ικανοποιητική. Μελλοντικές κατευθύνσεις θα πρέπει να περιλαμβάνουν τη συστηματική καταγραφή παραμέτρων ψυχικής υγείας, περιλαμβανομένων των ακούσιων νοσηλειών, καθώς και προσπάθειες βελτίωσης αυτών των παραμέτρων και των υφιστάμενων νομικών διαδικασιών.

Λέξεις ευρετηρίου: Ακούσιες, νοσηλείες, ψύχωση, νόμος, Ελλάδα.

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Corresponding author: P. Gourzis, Department of Psychiatry, General University Hospital of Patras, School of Medicine, University of Patras, University Campus, GR-265 04 Rio, Greece
Tel: (+30) 2613-603 245, Fax: (+30) 2610-994 534
e-mail: pgourzis@upatras.gr