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CONFERENCE ABSTRACT

The relationship between the services available to patients in primary care and at local psychiatric clinics and the use of coercion: recent findings from Northern Norway

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Introduction: Psychiatric patients may be subjected to coercion in many different forms, including involuntary admission to psychiatric hospital, involuntary outpatient treatment, and involuntary treatment with medications [1]. The use of coercion in the psychiatric services involves a range of ethical, clinical, and legal issues [2,3]. The Norwegian authorities have stated that it is a goal to reduce the use of coercion in the psychiatric services, as it is believed that this will improve the services and increase the quality of care [4].

Purpose and methods: We review and discuss findings from studies on coercion in North Norway, focusing on the relationship between the services available to patients in primary care and at local psychiatric clinics and the use of coercion.

Results and discussion: A lack of services at the municipal level might increase the use of coercion. For instance, approximately half of the involuntary admissions had been referred from doctors working at municipal out-of-hours clinics [5]. These doctors often felt pressured to commit patients to psychiatric hospital, as few other options were available at nights and week-ends [5-7]. The increased availability of other services at nights and week-ends could therefore possibly result in reduced levels of coercion. Having sufficient resources available at the secondary level might also reduce the amount of coercion patients are subjected to. For instance, an area that had beds available for emergencies at local psychiatric clinics had significantly fewer (95% CI for EXP(B)=1.133-2.206, p=0.005) involuntary admissions than a comparable area without such beds [8]. While much of the coercion of psychiatric patients takes place at the tertiary/hospital level, this study suggests that the availability of services at the primary and secondary levels might influence the level of coercion at the tertiary/hospital level.

Conclusion: The present study suggests that increasing the availabilty of voluntary psychiatric services at the primary and secondary levels might represent one way of achieving the goal of reducing coercion in the psychiatric services. This relationship should be examined further in future research involving the North Norwegian psychiatric health services.

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