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AN OBSERVATIONAL STUDY INTO OUTPATIENT INVOLUNTARY TREATMENT IN THE NETHERLANDS

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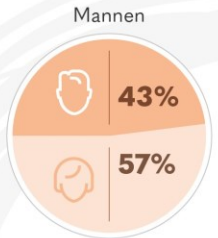
21022 patiënten zijn in 2020 door GGNet behandeld

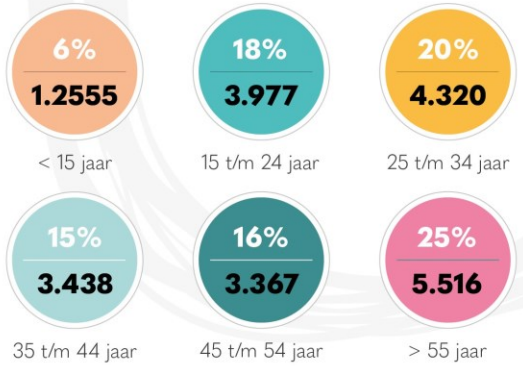
Verhouding man-vrouw



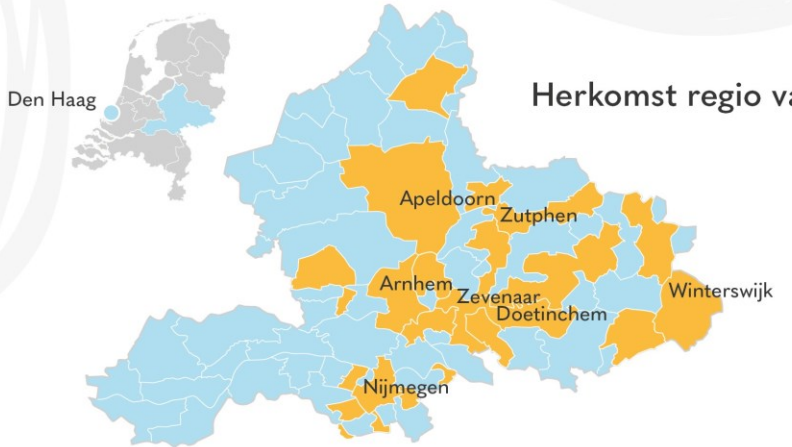
Meest voorkomende hoofddiagnoses

19%	Depressieve stoornissen
18	Angststoornissen
10	Persoonlijkheidsstoornissen
8	Schizofrenie en andere psychotische stoornissen

Leeftijd



Herkomst regio van de patiënt



Apeldoorn	25%
Winterswijk	20%
Zevenaar	17%
Doetinchem	13%
Zutphen	13%
Buiten werkgebied	5%
Arnhem	3%
Den Haag	2%
Nijmegen	2%

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COMPULSORY CARE ACT (WVGGZ) 1

- Replaced the Special Admissions Act (BOPZ) january 2020
- Where the Compulsory Care Act enables enforced treatment and admission, the Special Admissions Act only enabled involuntary admissions
- Due to the BOPZ procedures seclusion use was estimated to be the highest within Europe (Lepping et a, 2016; Verlinde et al, 2017).
- Social participation, preservation of as much personal autonomy as possible, and focus on treatment with as little coercion as possible are the basic principles of the new legislation

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COMPULSARY CARE ACT (WVGGZ) 2

- The new law provides for two measures: short-term crisis intervention and long-term care authorisation (CTO)
- The conditions for compulsory outpatient treatment are authorized by a judge in a community treatment order (CTO)
- Outpatient involuntary treatment may include enforced medication, supervisory measures, and admission as the ultimate remedy

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EXPECTATIONS

- An important motivation for the new law was the assumption that a CTO will lead to fewer admission days and fewer inpatient coercive measures such as seclusion or enforced medication in patients who are involuntarily admitted
- Reasoning as follows: Early enforced outpatient treatment if applied in time should lead to prevention of crisis thus prevention of inpatient interventions
- Fringe conditions are good. Nationwide availability of 24/7 ambulatory care via FACT teams during the day and crisis intervention teams in the evening and at night working within the same casefile avoiding errors in information transfer

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CRISIS INTERVENTION BEFORE AND AFTER CHANGE OF LAW (IBS VS. CM)

	Before	After
Inpatient treatment Duration Mediane duur IBS of CM	100% 17.8 21.0	100% 18.2 21.0

Still 100 % inpatient execution of crisis measures and no use of the possibility to involuntary treat patients at home

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Total hours any seclusion
60.000
50.000
40.000
30.000
20.000
10.000
0
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

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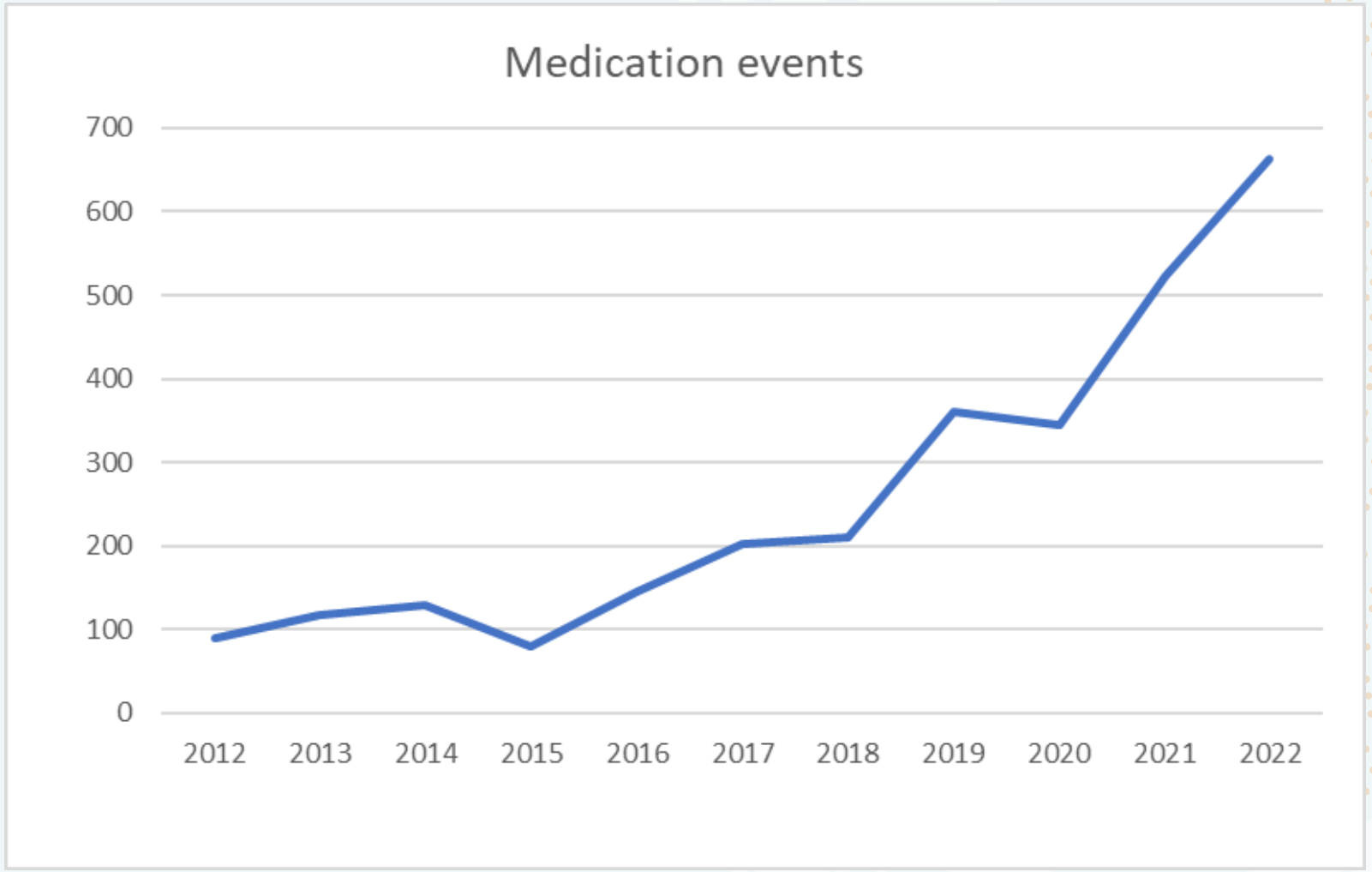
Medication events
700
600
500
400
300
200
100
0
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

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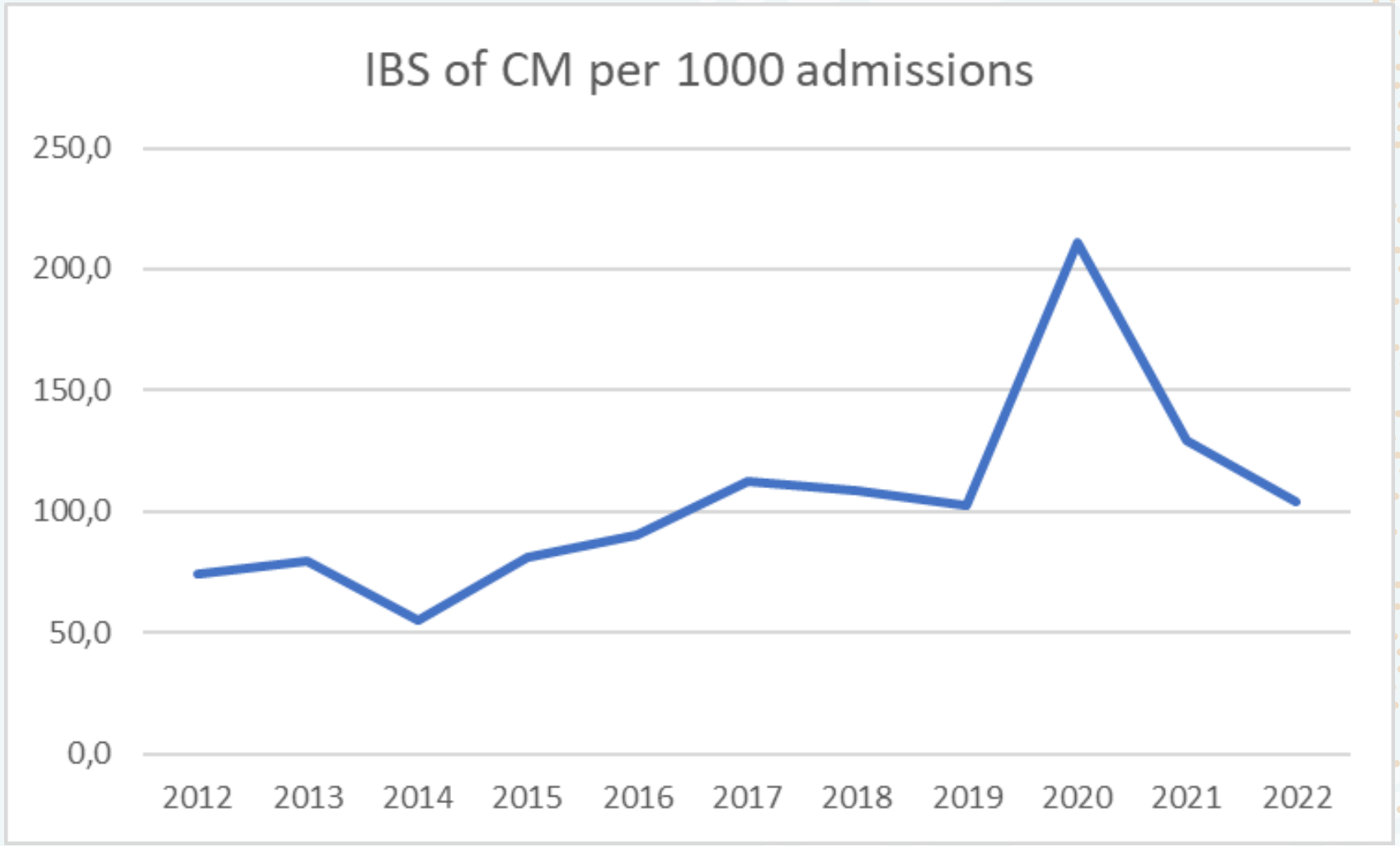
IBS of CM per 1000 admissions
250,0
200,0
150,0
100,0
50,0
0,0
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

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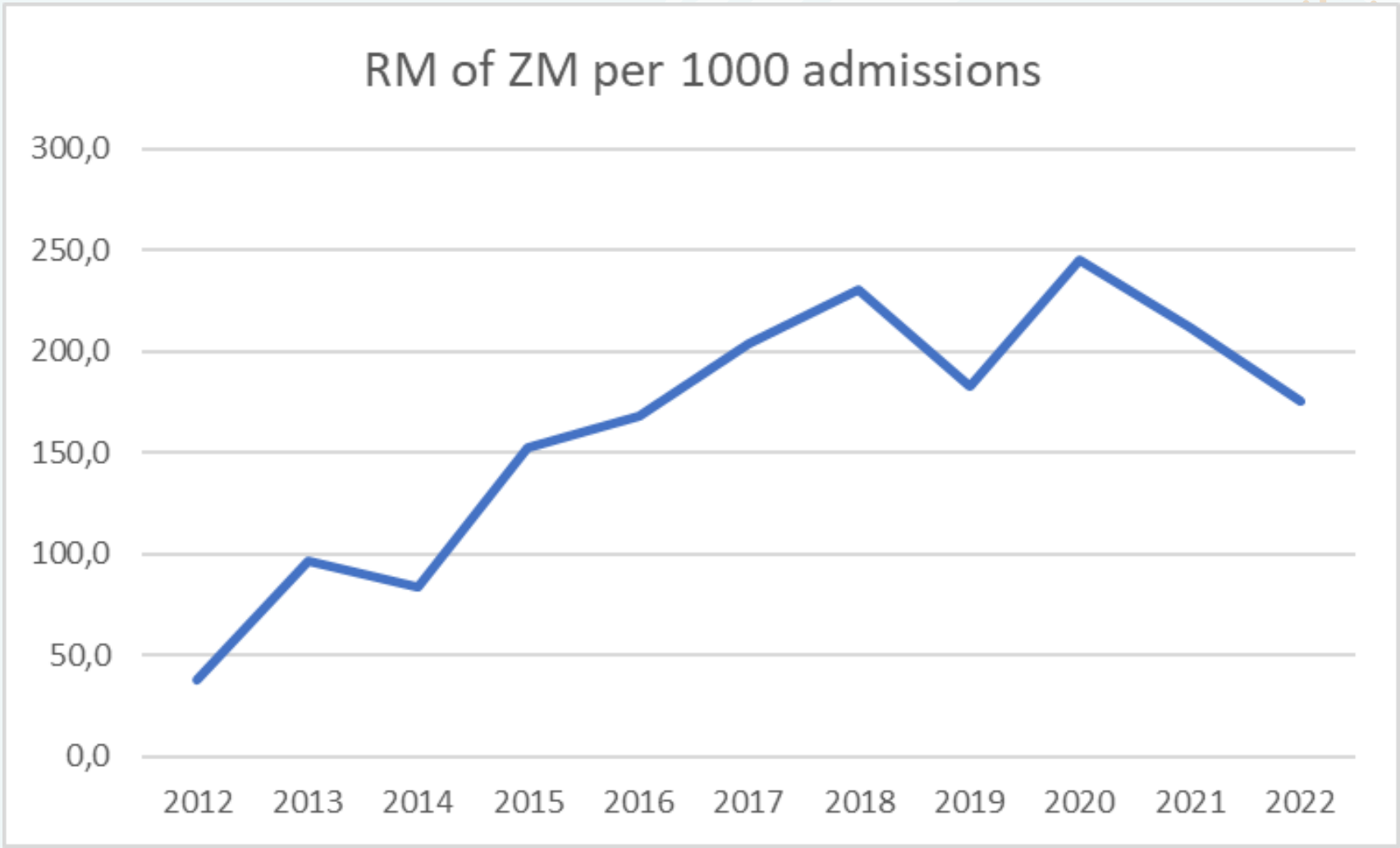
RM of ZM per 1000 admissions
300,0
250,0
200,0
150,0
100,0
50,0
0,0
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

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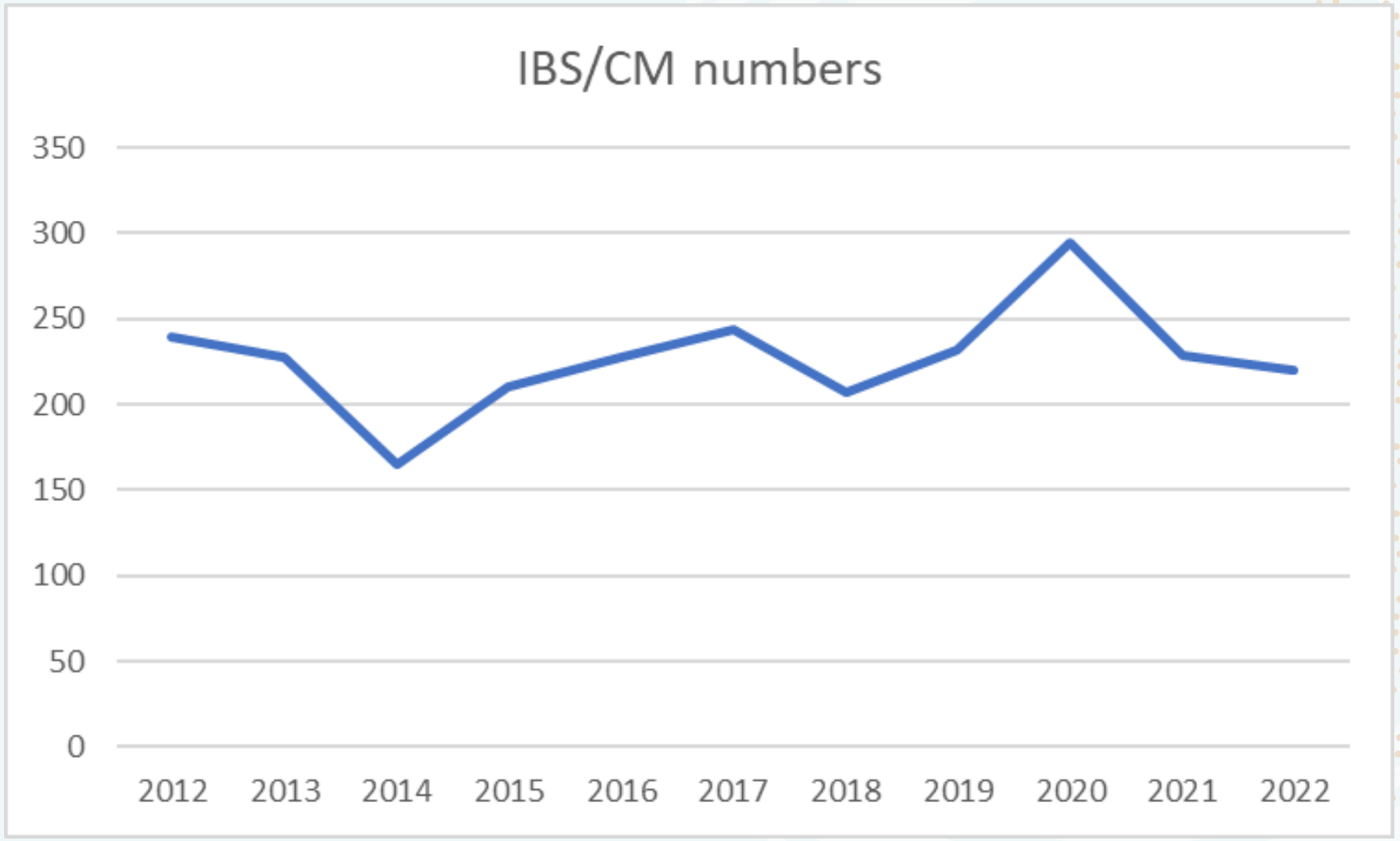
IBS/CM numbers
350
300
250
200
150
100
50
0
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

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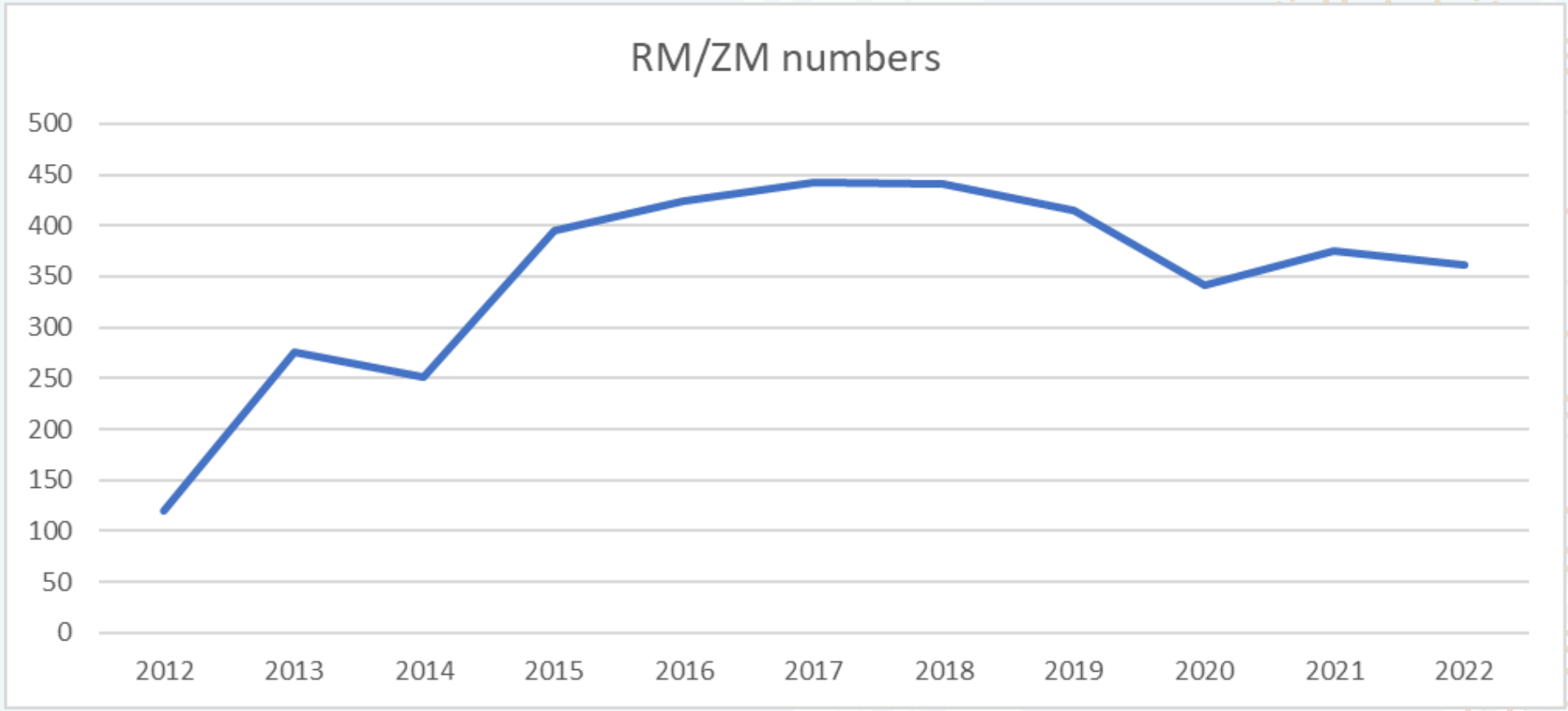
RM/ZM numbers
500
450
400
350
300
250
200
150
100
50
0
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

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NUMBER OF MEASURES

	2016-2017	2021-2022
IBS / CM	491	449
RM/ZM	1382	879
chi square = 21.6132 the p-value<0.00001		

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DURATION MEASURE IN DAYS

	2016-2017	2021-2022
IBS / CM	8399	9327
RM/ZM	171200	131309
chi square = 595.1127 the p-value<0.00001		

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SUBGROUP ANALYSIS ACUTE ADMISSION GROUP

	before_after	N	Mean	P	ES
Numdays_involun_adm	before (2016 -2017)	340	**74,37**	0.002	0.256
	after (2021-2022)	264	**58,47**		
Numdays_involuntary_outpatient	before (2016 -2017)	339	**45,17**	<0.001	-0.418
	after (2021-2022)	262	**77,04**		

Acutely admitted patients have shorter admissions and recieved longer outpatient involuntary care

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TRENDS 1

- As expected
  - Less seclusion
  - More medication events in total and from 2021 on in outpatient settings too
  - No inflation of number of measures (after all anyone may report cases to public prosecution)

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TRENDS 2

- As feared
  - Crisis measures still leading to 100 % admissions
  - Registration errors of involuntary treatment due to lack of experience in outpatient teams
  - Ethical debate coercion versus compulsion

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QUESTIONS

1. Are there positive or negative experiences with outpatient involuntary care in other countries?

2. What factors could make outpatient compulsory treatment successful?

3. Qualitative research shows that CTO is popular with professionals. Would it be useful to include qualitative aspects, e.g. interviews with professionals in the study?