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COVID-19 IN INVOLUNTARY ADMISSION TO THE HOSPITAL OF PSYCHIATRY VALCEA, ROMANIA

Radu Popa-Nedelcu[1], Cristian Delcea[2*], Costel Siserman[2]

1. ***Department County Service of Forensic Medicine Vâlcea, Romania.***
2. ***Department of Forensic Medicine, "Iuliu Haţieganu" University of Medicine and Pharmacy, Cluj-Napoca, Romania.***

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ABSTRACT

The last period has been full of special situations. Among these, a particular case that caught our attention is that of a person who is involuntarily admitted to a psychiatric ward because of their pathology, is subsequently diagnosed positive with SARS-CoV-2, and is admitted, suffers a very unfavorable evolution that ends in death. It thus becomes a forensic necropsy case and is examined from this point of view as well. The duty to maintain the integrity, health, and care of the involuntarily committed person is not only the responsibility of health professionals, the judiciary, or the people in whose care they are placed. It is not just a matter that can be assigned as a job task to the staff, it is a duty that belongs to the state and the state system, as appreciated in other studies. Involuntary admission is only in psychiatric hospitals that have adequate conditions for specialist care under specific conditions.

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Introduction

In the Romanian Criminal Code, involuntary admission is a procedure provided for by Law 487/2002. This is called the Law on Mental Health and Protection of Mentally Disordered Persons [1] and sets out the legal criteria under which this criminal law security measure can be ordered. In principle, this law is intended to protect society from people who in a pathological state pose a danger to themselves or others. This is not only true for mental illnesses, but also for people with infectious or contagious diseases or people who use psychoactive substances.

As the law governing this diligence tells us, a person may be committed under the involuntary admission procedure only if a licensed psychiatrist determines that the person suffers from a mental disorder and finds that:

- because of this mental condition, there is an immediate threat of injury to oneself or others;
- Non-admission for a person suffering from a major mental disorder may result in a serious deterioration of his or her condition or hinder adequate treatment.

The request for involuntary admission of a person is made by:

- the family doctor or psychiatric specialist who is responsible for the person's care;
- the person's family;
- Local government officials in charge of social, medical, and public order issues;
- representatives of the police, gendarmerie, or fire brigade, and the public prosecutor;
- the civil court, whenever it considers that the state of mental health of a person in the course of a trial may require involuntary admission.

The proposal for involuntary admission, drawn up following the provisions, shall be examined by a committee specially constituted for this purpose, within 48 hours of receipt of the proposal, after examination of the person concerned, if possible. The commission consists of three members nominated by the hospital manager: two psychiatrists and one additional professional or civil society representative. The implementing regulations of this Law should specify the manner of appointment, the selection procedure, and the standards that civil society representatives must meet.

Corresponding Author: Cristian Delcea; Department of Forensic Medicine, "Iuliu Haţieganu" University of Medicine and Pharmacy, Cluj-Napoca, Romania. E-mail: cristian.delcea.cj@gmail.com.

The commission's decision will include:

- diagnosis;
- the solution adopted;
- the reasons for the solution;
- the signatures of all members of the committee.

The judgment is held in chambers as a matter of urgency.
The patient's participation and listening are mandatory, if the patient's health condition allows it. Otherwise, the judge may order the patient to be heard in the health facility.
If the patient does not have a designated defender, he or she will be represented ex officio.
The prosecutor's participation is mandatory.
In line with the legislation, the patient and their legal or customary agent may request a forensic psychiatric assessment or offer any other evidence.
The court shall decide whether to confirm or terminate the involuntary medical admission.
Involuntary admission is only in psychiatric hospitals that have adequate conditions for specialist care under specific conditions.

Case Study
A 45-year-old male was brought by Ambulance and Police, handcuffed, to the Emergency Unit of the Valcea County Emergency Hospital on 16.08.2021. A psycho-motor agitated patient is presented for influenced general mood, sweating, and verbal and motor aggression. He is hemodynamically and respiratory stable. ER diagnosis is established: Organic personality disorder. Transferred to the Psychiatric Ward for admission. The result of the rapid antigen test for the SARS-COV-2 virus, performed on 16.08.2021, is negative.
The reasons for admission mentioned in the medical documents are extreme psychomotor agitation. The patient was brought in handcuffed by the police; physical and verbal hetero-aggression towards the mother and bizarre behavior.
The anamnesis shows that the patient has a higher education, adequate housing conditions, strained family relations, and is an employee. He denies using any toxic substances and is not on medication prior to admission.
History of illness: A patient with no history of psychiatric illness presents to the emergency department brought by ambulance and accompanied by the police for the reasons mentioned above. He is admitted for investigations and treatment.
General clinical examination – objective examination in normal relations.
Psychiatric examination reveals inadequate attitude, circumstantiality, tangentiality, delusional ideas with religious content, ideas of influence, “glimmering” vision, not amenable to argument and evidence, uncritical. The diagnosis is established: Acute psychotic disorder with symptoms of schizophrenia, and the Commission recommends involuntary admission.
Psychological examination reveals the following: relatively easy communication, paranoid ideational content of influence and prejudice; interpretive, affective reversal, and vindictive behavior. Schizoid personality type.
The decision of the Involuntary Admission Commission no. 2/17.08.2021: the patient was diagnosed with psychomotor agitation and acute psychotic disorder. After examining the patient, the Commission adopts the following solution: Involuntary admission. The solution is motivated as follows: bizarre behavior, delusional ideation with religious content, and ideas of influence, without awareness of the illness.
"I won't accept to stay in hospital. I am clinically and mentally healthy. I have a driver's license. I am clinically and mentally healthy and have no psychiatric deficiencies. I don't accept to stay at the ward, I don't have mental and psychiatric problems. I don't need to stay in hospital. I was admitted against my will. I do not accept admission" - statements of the patient mentioned in the observation sheet on 17.08.2021.
The established treatment scheme was: Rispolept sol 1 ml 1-0-1; Diazepam 10 mg 1-0-1; Convulex 300 mg 1-1-1; Romparkin 2 mg 1-0-1.
In the evolution of the case, delusional ideation, soliloquy, and bizarre behavior were preserved. It was observed that the patient had moments when he was calm and cooperative, but thought disturbances persisted, sleep was most often medically induced, and awareness of the disease was absent. At other times, the patient was argumentative and exhibited ideo-verbal disorganization, but accepted treatment even though he did not feel he needed it. From a psychiatric point of view, the case was considered clinically stationary, and further treatment was decided.
Other statements made by the patient are recorded in the medical records:

- "Those of us who have the Mother of God over our heads don't have mental problems. I'm an Orthodox Christian gypsy."
- "I'm going to find out which judge committed me without my consent, because I don't have physical, mental, psychosomatic, and psychiatric problems, and I'm going to sue him."

The patient continued to be anxious, demanding, and requesting discharge on the grounds that he was "mentally healthy". Delusional paranoia ideation persists.
The course is now considered unfavorable and resistant to treatment, with serious ideo-verbal disorganization and sleep disturbances.
On 27.09.2021, 09:00 am, the patient's chart states: anxious patient, thought disorder, delusional-paranoid ideas. 1:45 pm patient complains of headache, afebrile, T =36.3^{0C}, positive rapid test. 17:00, T = 36.7^{0C}. It is recommended to perform a chest

X-ray that reveals bilateral alveolar microopacity. Symptomatic and specific treatment follows (Quamatel, Favipiravir, Remdesivir, Dexamethasone, oxygen therapy). However, the patient's condition is progressively deteriorating. Subsequently, an attempt was made to transfer the patient to the Anaesthesia and Intensive Care Unit, but there were no places available locally or in the country. Referred to ER for non-invasive ventilation on 06.10, where the patient's condition continues to worsen. A CT scan is performed which shows areas of bilateral "matte glass" densification, alveolar condensation, and critical level damage (80%). O_2 saturation had reached 80% even though he had 30 liters of supplemental oxygen from 2 sources. On 08.10.2021 at 12:14, the patient goes into cardiorespiratory arrest. Resuscitation maneuvers, external cardiac massage, and Adrenaline 1 ampoule every 3 minutes are instituted without therapeutic success. Diagnosis: Unresuscitable cardiorespiratory arrest. Asystole. Death 12:35.

Being a person dies during an involuntary medical admission, the death becomes a medico-legal case according to the Romanian legislation in force - Article 185 of the Code of Criminal Procedure [2]. The body of the aforementioned person was autopsied at the morgue of the Valcea County Forensic Medicine Service, and the findings were recorded in a forensic expert report that was submitted to the police according to the procedure.

The necropsy revealed significant changes due to SARS-CoV-2 infection (bronchopneumonia with diffuse alveolar lesions), but also pre-existing medical conditions (cardiac, hepatic, and renal). The intra Vitam findings related to the patient's state of health and supported by clinical and paraclinical examinations were confirmed during the forensic autopsy. We also discovered pathologies of which the patient was unaware, which were included in the pathogenetic chain of causation of death and which completed the diagnosis established during life. We concluded that the death was due to multiorgan failure resulting from bronchopneumonia COVID-19 following SARS-CoV-2 infection, severe fomite, in a person with associated pathologies (dilated cardiomyopathy, myocardiocoronary sclerosis, hepatic fibrosis, splenic-hepatomegaly, nephroangiosclerosis).

Conclusion

First of all, it should be noted that involuntary admission must be a protective measure for both the patient and the people around him [3].

This procedure may be applied to cases representing psychiatric emergencies (acute mental disorders or acute decompensation of chronic mental disorders) that present with manifest or potentially violent behavior or risk of such behavior implied by failure to immediately seek appropriate treatment.

Psychiatric emergencies, for the implementing rules, means psychopathological states in which the patient is in severe brain dysfunction, a critical situation in which he/she may cause serious self-injury, aggression against others, death, destruction of property, behavior unjustified by the characteristics of the present reality (confusional states) [4].

Simplified procedures and optimization of existing ones are needed to shorten response times and increase the efficiency of existing ones. Special situations such as the last pandemic bring to light even the smallest inaccuracies in the functioning of a system. As demonstrated in other models [5], implementing new schemes can reduce the occurrence of situations such as the one presented.

It is also essential to keep pace with the growing need for psychiatric care. The growing accessibility is evident, with a high and increasing number of people seeking and requiring psychological and psychiatric facilities [6].

The COVID-19 pandemic has an effect on mental health that cannot yet be quantified, but it can certainly trigger, exacerbate, or alter various serious psychiatric symptoms [7], a situation increasingly observed in psychiatric units and affecting society in various ways. For this reason, an approach is needed that also includes the possibility of providing infectious disease-specific care in psychiatric hospitals [8-21].

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Ethics statement: The study was conducted according to the guidelines of the Declaration of Helsinki and was approved by the dr Radu Popa Nedelcu Center, Nr. 1/15.12.2022.

Written informed consent was obtained from all subjects enrolled in the study.

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