

Compulsory psychiatric treatment and its alternatives - the facts

1. What is compulsory psychiatric treatment?

While there are different definitions of forced or compulsory psychiatric treatment under different national legislations, this term is generally used when someone is subjected to medical treatment against his or her own will. In this regard psychiatry represents a clear exception because other medical fields usually do not allow for forced treatment.¹ Types of treatments forced on people vary, and are not only taking place in hospitals - some can be forced to take psychotropic drugs in other institutions, including in their own home as well. Coercive treatment most often entails the administration of psychiatric drugs, but sometimes physical measures are also applied. The latter refer to restraint, seclusion, caged or net-beds and electroshock. In most European countries, compulsory psychiatric treatment is legally permitted. The rules on the application of such treatment vary country by country. Such measures are either ordered by court or on the basis of medical professionals' or general practitioners' assessments. In some countries, more than one opinion is required, in others only one is enough. The duration of the treatment varies, and so does the possibility of revision.

When trying to understand what compulsory psychiatric treatment means, we have to consider the differences in the perspectives of medical professionals and patients. While for the doctors, nurses or members of the judiciary involuntary treatment represents a form of medical treatment, people subjected to coercive treatment experience it as a serious limitation of their personal freedom. Many feel threatened by the decisions taken over their lives without their consent. Some people who have experienced compulsory treatment doubt its overall purpose:

"And the truth is, you can't heal me without my cooperation, you cannot.

There's no such thing as forced healing.'²

In most legal systems in Europe, the basis of compulsory treatment is the presumption that the person concerned poses a serious risk towards him or herself or towards others. In other cases, people are compelled to undergo treatment because they have already done something which qualify them as 'dangerous' to others or to themselves – this can be something as small as getting in an argument and using graphic language, or as big as attempting suicide. Such behaviors can be connected to people's distress, or even to purely cultural patterns.

¹ Forced treatment can be used also for certain infectious diseases.

² Carol J Patterson in 'Personal Stories' available at: http://www.mindfreedom.org/personal-stories/personal-stories/atct_topic_view?b_start:int=20&-C=

2. What is informed consent to psychiatric treatment?

The consent to treatment should be free and informed which means that the decision should be taken by people once they have received all the necessary information. Such information includes the perceived medical condition they are facing, the treatment options, the detailed treatment plan including its length, information about the possible side effects and risks as well as comprehensive information about patients' rights. Consent is often given without full information and under pressure and threats making it impossible to talk in terms of choice.

Many people with psychiatric diagnoses are deprived of legal capacity and live under guardianship which means they are unable to decide even about the basic issues of their lives, including whether they want or do not want to undergo treatment. Hence many times it is their legal guardians who decide for them to be treated or admitted into a psychiatric facility. Human rights organisations and advocacy groups of users and survivors of psychiatry have long fought against this measure: the consent of a legal guardian should not be substituted for the consent of the person concerned.

It is important to note that admission into a hospital does not necessarily mean that the person will undergo 'treatment' there, even if relatives and friends believe that this is the case. Patients often spend weeks in a hospital without other therapies than medication. Physical restraint is also used all too often. Compulsory treatment is not aimed at improving health, but is aimed at preventing damage resulting from behaviours that are believed to cause such damage – suicide or endangering the life of others. This concept relies on the belief that psychiatric treatment may effectively influence such behaviours and that people may be "cured". As one person said:

"Nothing was done, many people let me down and a real treatment didn't exist. I have the impression that compulsory admission means that it is all over, no treatment, not really."³

3. But isn't it dangerous to leave people with severe mental health problems living among us?

No, there is simply no evidence to support this. This question arises regularly whenever the media claims to discover mental health problems as the main factor behind famous crime cases. Yet, the empirical evidence we have points to exactly the contrary - studies show that people with mental health problems are much more likely to become the victims of crime rather than the perpetrators.

The image of the 'disturbed criminal' is projected by the media through powerful images, movies and headlines. At the same time, only in a very small fraction of murders or other felonies do we find proof that the perpetrators had a history of mental health problems.

When hearing of vicious crimes, we often ask ourselves 'how can someone possibly do that?'. The reality is that what leads a person to commit a horrific crime is rarely a medical

³ Quoted by Russo and Rose (2013): "But what if nobody's going to sit down and have a real conversation with you?" Service user/survivor perspectives on human rights. In. JOURNAL OF PUBLIC MENTAL HEALTH, Vol. 12.

condition, but the result of many factors combined, including the background of the person and decisions taken by that person.

4. Isn't compulsory treatment the safest way to help a person in crisis or even save their life?

Though in theory compulsory treatment is put in place to protect patients' lives and treat their 'illnesses,' reality shows that involuntary treatment does not result in recovery – in fact, experience shows that it is the cause of many irreversible problems. First of all, being involuntarily treated is a traumatic life experience which usually makes people feel overpowered by external forces, hence it contributes to an even greater distress.

Furthermore, depending on the type of involuntary treatment applied, there can be serious side effects: anti-psychotic medication has proven to contribute to irreversible health damage⁴ including motor coordination problems (tardive dyskinesia or dystonia), hormonal changes, or changes in brain tissue and these drugs also increase the risk of early death or dementia. Other medical interventions are also used, such as electroconvulsive therapy (also known as 'electroshock therapy'), despite the evidence of its irreversible damaging effects such as memory loss.

Many other medical treatments are accepted, despite their often severe side effects, for the sake of saving a person's life, for example in the case of chemotherapy treatment against malignant tumors. However, when it comes to one's mental health, informed consent is not required from patients who are compelled to undergo treatment that in itself imposes a significant risk to one's health. Proponents of compulsory treatment claim that this difference is due to the lack of ability to make a sane decision during psychosis, and thus during psychotic episodes, professionals need to decide "over the patients' lives".

Opponents of involuntary treatment argue against the above statement. They claim that 'sane decisions' as we know them are a myth and that in most life situations people make their decisions based on subjectively selected arguments. Such gaps between professional and individual assessments of one's situation are quite common. In physical illnesses such as cancer, many patients decide to take part in a treatment despite medical opinion proving it is not evidence-based or refuse treatment despite medical opinion – and all these decisions are based on purely personal beliefs and fears, or even religious grounds. Such patients' capacity to make decisions over their own future is not questioned, despite the fact that fear of death or fear of pain might also alter one's perception and judgment.

⁴ Results of studies may vary depending on many factors, including the scope of study, the methodology etc. Studies financed by pharmaceutical companies tend to have different results from government-sponsored or independent (including mental health user-controlled) studies. For an overview of efficacy studies on anti-psychotic drugs, see the annotated compilation of Robert Whitaker: <http://robertwhitaker.org/robertwhitaker.org/Outcomes%20in%20the%20era%20of%20atypical%20antipsychotics.html>

5. Drugs help a lot, don't they?

Since involuntary treatment of mental health patients very often includes forced medication, it's worth explaining how it correlates with recovery from mental health problems.

There is a wide variety of modern medication available that aims to treat depression, anxiety, insomnia, bipolar disorder, schizophrenia etc. As always with any type of drug, it is not the existence of these drugs that is controversial, but their use to help people in mental distress.

Although anti-psychotic medication should not be the only type of treatment available for people, in most mental health systems professionals have no time and resources for psychotherapeutic methods, thus medication often remains the only treatment offered. Studies⁵, human rights recommendations⁶ and personal testimonies⁷ all suggest that medication does not treat mental health problems if it is not accompanied by other methods such as individual or group therapy, or alternative therapies. Studies⁸ have also shown that neuroleptic drugs may significantly affect brain tissue and life expectancy.

Although we have very little data available from official statistics on the death of psychiatric patients, we have evidence that shows that there is correlation between the use of psychotropic medication and suicide. For example, in Sweden in 2007, in a rare case when such statistics were revealed, a study showed that an overwhelming majority of people who committed suicide had received large doses of anti-psychotic medication and/or antidepressants within a year before their death.

6. If there are no psychiatric hospitals, where will all the 'mentally ill' go?

Alternatives to traditional psychiatric hospitals have proven to effectively help people with mental health problems *without* using involuntary admission or any type of involuntary treatment. These examples show that even acute mental health problems such as early psychosis can be addressed without confinement. We will provide an indicative list of such methods at the end of this paper.

Governments, regional/local authorities and NGOs need to develop services that offer support. In the meantime, they must dismantle psychiatric units that involuntarily treat people, and also ensure that the legal basis for any type of compulsory treatment is abolished. Instead, a wide variety of strong community-based services should be developed, including alternatives to medical services.

⁵ E.g. the 'TADS' study, see at: <http://www.nimh.nih.gov/health/trials/practical/tads/index.shtml>.

⁶ See the reports and observations of the European Committee for the Prevention and Inhumane and Degrading Treatment or Punishment (<http://www.cpt.coe.int/en/>) or the reports of the Committee Against Torture (<http://www.ohchr.org/EN/HRBodies/CAT/Pages/CATIndex.aspx>)

⁷ See personal testimonies at: <http://www.mindfreedom.org/personal-stories>.

⁸ See Navari and Dazzan (2009): Do antipsychotic drugs affect brain structure? A systematic and critical review of MRI findings at http://www.researchgate.net/publication/24250405_Do_antipsychotic_drugs_affect_brain_structure_A_systematic_and_critical_review_of_MRI_findings

- The Soteria Model has been successfully working⁹ since the 1970s around the world. The concept is based on the ‘recovery approach’¹⁰ and services are run by mostly non-medical personnel. Users of Soteria services – usually diagnosed with schizophrenia – remain in control over their decisions and develop a meaning of their subjective experiences. The model hardly uses any psychiatric drugs and uses no involuntary measures.
- The Open Dialogue approach originated in Finland and is helping people who experience psychosis. It is one of the most successful models in the world, where over 80% of patients return to work. On-going research shows¹¹ that 75% of them have no remaining sign of residual psychosis. The model is based on the immediate and wide involvement of the patients’ families and friends, right after the first signs of psychosis – the Open Dialogue¹² does not use compulsory treatment. As a result, since the launch of the model, in some districts the number of new long-stay schizophrenic patients fell to zero¹³.

Though progressive models are not yet widespread in Europe, the fact that we have very few alternatives to the compulsory treatment of people with mental health problems does not excuse us from prolonging the present situation.

7. What can be done while there are not enough community services or other alternatives?

New alternatives are not easy or fast to develop but this should not be an excuse for continuing the arbitrary violations of the rights of people with mental health problems and the limitations of their personal freedom.

People who experience psychosis may need acute intervention, but the way it is done now can be changed swiftly. For example, health systems should encourage patients to draw up an agreement or statement that appoints a person who can temporarily support their decisions, and the limits of those decisions, should they experience difficult times or become unable to communicate. These statements should be regarded as legal documents and should be accepted by medical personnel and judiciary. Such ‘Advance Directive’ forms or living wills, particularly regarding medication, are not at all unknown – they are already used by people with terminal diseases who want to decide on the extent of their care should they become unconscious.

Patients who are already under involuntary treatment should be supported by other means of care, should they request medical or social help. With a limited number of acute beds in

⁹ <http://schizophreniabulletin.oxfordjournals.org/content/34/1/181.full>

¹⁰ http://en.wikipedia.org/wiki/Recovery_approach

¹¹ Seikkula et al., Five-year experience of first-episode non affective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, March 2006; 16(2):214–228 (<http://www.iarecovery.org/documents/open-dialogue-finland-outcomes.pdf>)

¹² A short video introduction to Open Dialogue <http://www.youtube.com/watch?v=aBjlvnRFja4>

¹³ <http://www.tandfonline.com/doi/full/10.1080/17522439.2011.601750#.Up2-X8RDvTo>

hospitals, the main field of professional and financial support should be services delivered in the community.

8. But mental health problems are illnesses, so they should be cured in a hospital...

People who experience mental distress may be treated by the health sector, but many argue that the nature of mental health problems is not medical but psychological and social. In fact, developments in the recent decades deeply transformed the way we see mental health problems nowadays – social and environmental factors and life events seem to be decisive in the development of mental distress.

Also, the validity and the function of the diagnostic categories have been critically debated by the professionals¹⁴, social scientists¹⁵ and, by users and survivors of psychiatry for a long time. Many claim that psychiatric diagnoses do not foster recovery or help in finding the right treatment. Yet, diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) issued by the American Psychiatric Association, or the International Classification of Diseases (ICD) by the World Health Organisation, are extremely powerful instruments that shape the life and fate of millions of patients worldwide.

The core of the problem is that whereas medical diagnoses, such as that of kidney stones or pneumonia, offer a key for our illness and give a proper indication on what treatment we may need, psychiatric labels simply don't. Furthermore, there are no objective tests for establishing psychiatric diagnoses, which makes them highly subjective and thus a matter of opinion for the person who examines the patient. For example, what is considered to be a mental illness by a practitioner in Manchester, UK, might not be deemed so by another one in Helsinki, Finland, or Mumbai, India. As the famous reform psychiatrist Thomas Szasz MD wrote in 1973, *"If you talk to God, you are praying; If God talks to you, you have schizophrenia. If the dead talk to you, you are a spiritualist; If you talk to the dead, you are schizophrenic."*

Moreover, diagnostic labels are highly influential in redefining one's identity, imposing a powerful stigma over one's life, and they also carry frightening legal consequences. Often, upon diagnosis, judiciary processes are launched to withdraw a person's legal capacity for the rest of their life.

Diagnostic labels are not at all necessary prerequisites to service provision. There are already established support services that work outside of the labeling system, with very good results in recovery.

¹⁴ <http://www.psychiatrictimes.com/dsm-5-0/british-psychological-society-condemns-dsm-5>

¹⁵ For example: Moncrieff (2010): Psychiatric diagnosis as a political device.

<http://www.psychiatry.freeuk.com/Jodiagnosis.pdf>

9. Who will support the families of people with mental health problems?

Families' needs are often different from the needs of the family member experiencing mental health problems. Difficult situations of severe mental distress often result in actions taken by the family, such as launching a compulsory hospitalization process and/or taking away the legal capacity of family members. Yet, these ways of trying to solve the problem are often nothing more than desperate stemming from a lack of appropriate support.

Support should be offered to families via a system in ways to help that are tailored to their needs. Family groups, family associations, clinical services, 24/7 help-lines, which respect human rights such as the right to freedom, privacy, personal integrity, and the right to live independently and be included in the community are good examples of appropriate means of support. Such support services can also include so-called 'runaway-houses,' where one can find peace and space outside of the medical system, away from family and friends. Short-term respite services for either the person or the family can also be established and they can represent substantial help in difficult times.

Useful reading

- Books:
 - *Robert Whitaker: Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill.* – In this widely-read book, Whitaker examines the historical aspects of psychiatric care, including the use of antipsychotic medication.
 - *Judi Chamberlin: On Our Own.* – A powerful and enlightening account from a former mental health service user that shaped the way we think about forced psychiatric treatment today.
- Websites:
 - www.madinamerica.com: independent and regularly-updated website on news about psychiatry and the experience of mental health service users
 - www.mindfreedom.org/personal-stories: Personal stories of ex-users of psychiatry “about their experiences of survival, resistance, recovery and self-determination in the mental health system”.
- Other:
 - UN Convention on the Rights of Persons with Disabilities (CRPD): the most important human rights treaty to date, with clear implications on compulsory medical treatment: www.un.org/disabilities
 - The “Rosenhan Experiment”: Dr. Rosenhan and his team admitted themselves to psychiatric hospitals across the United States. The study explores issues dealing with diagnostic labels, hospital admissions and depersonalisation in psychiatric hospitals: <http://www.bonkersinstitute.org/rosenhan.html>

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- Mapping Exclusion: Mental Health Europe's video addresses institutional hospital care where people are compelled to live together: <http://www.youtube.com/watch?v=zN5kzVbY9xw>