

Formal Psychiatric Treatment: advantages and disadvantages

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Abstract

This paper discusses the merits and undesirable effects of compulsory detention on psychiatric patients and the dilemmas of the mental health staff. It also points out the added risk and the iatrogenic stress psycho geriatric patients in particular may be subjected in instances of mental health act assessments. There is a scarcity of research specifically concerned with the identification of the ill effects of compulsory detention and detection of a subset of highly vulnerable patients who are likely to respond negatively to compulsory care. The author does acknowledge the advantages of mental health acts. The objective is to enhance the awareness among mental health professionals for the need to upgrade the quality of research on the effects of involuntary admission and find more sophisticated alternatives.

Keywords: Key words: Mental health acts; suicides; PTSD, merits; demerits.

Introduction

The closure of asylums in the last century has resulted in an increased number of compulsory hospital admissions for psychiatric patients. Psycho-geriatric patients are highly vulnerable in this respect. Although the traditional buildings instituted for the care of the mentally afflicted have gone, misconceptions about provision and anecdotes about incarceration continue to haunt the community. Recent legislative changes have further extended the occurrence of involuntary hospital admission.¹ Compulsory community care is under constant review. Concurrently the validity of the concept of mental illness, psychiatric classification and diagnostic dilemmas all continue to be debated. Confinement has regained respectability in the discourses of present-day British mental health system because of violent offences committed by psychiatric patients and the public media portraying them as a reflection of failure of community care.

Table 1, Advantages of Mental Health Acts

1. Mental health acts secure the safety of vulnerable people
2. Helps to regain control on their lives
3. Compulsory treatment helps to prevent further deterioration of mental health
4. Aimed to provide effective care and treatments
5. Ensure better after care
6. Protects the safety of other people
7. Prevents suicides
8. Provides opportunities for assessments and diagnosis
9. Can be therapeutic by unburdening personal responsibilities to an institution.

Numerical quantitative studies imply that generally involuntarily admitted patients show clinical improvement and

retrospectively view their compulsory admission rather positively.² It is an unquestionable fact that Mental Health Acts prevent suicides and homicides (table 1). Mental Health Acts have some unsatisfactory outcomes particularly on a subset of patients including senior citizens admitted formally. It is important to identify such patients and take additional precautions in their management as they run the risk of leaving hospital feeling inferior and inadequate. Patients' specific characteristics, thought processes and past treatment experiences, colour their attitude towards coerced treatment and determine the gains and shortcomings of compulsory care.

Disadvantages

The Mental Health Acts are open to social abuse and elderly patients can be more defenceless in this respect. Specifically they may be: invoked to control behaviour; misused for material gain and implicated in subtle expressions of revenge. They are sometimes invoked to hasten divorce proceedings and to secure the custody of children by a specific parent. They are also used to control the behaviour of children by their parents. Mental Health Acts designed to control psychiatric patients are being enacted and enforced in some underdeveloped countries that lack an efficient tribunal system to monitor their effects.

A patient who has been detained is at risk of repeat detention and someone who has been inappropriately assessed becomes increasingly vulnerable to control on psychiatric grounds. The experience of being detained involuntarily has a reductive effect on behaviour after discharge – it may induce anxiety or post-psychiatric depression. The awareness of being deemed to require compulsory detention generates such negative attitudes as self-denigration, fear and unhealthy repression of anger. It may also impede self-direction and the normal sense of internal control and may encourage the view that in a world perceived as

being divided into camps of mutually exclusive 'normal' and 'abnormal' people, the patient is in the latter category. Compulsory detention may lead to suicide because the patient loses their sense of integration within their own society. Furthermore, the fear and anxiety associated with involuntary admission delays the recovery process. There are other frequently occurring barriers to recovery for those affected such as, loss of capabilities, whether real or imagined, ineffectual medication due to poor elicitation of symptoms because of patient's lack of cooperation and negative drug side effects.

Depressed patients have a higher suicide risk than the population at large and one of the reasons for detention is suicidality. Some of the subjective symptoms of depression can be ameliorated by denying them, while compulsory detention may reinforce depressive symptoms. Detention gives carers a false sense of security and this may lead them to relax their vigilance towards the patient. The Mental Health Acts increase the stigma associated with psychiatric illness and with the exuberant expression of emotions. Patients who are under section or are frightened of being placed under section may deliberately mask their symptoms in an attempt to have the section lifted or to avoid sectioning.

Trans-cultural studies

Trans-cultural studies show that members of migrated cultures, particularly the elderly, are more at risk of inappropriate sectioning than the rest of the population because of the lack of knowledge on part of professionals about the patient's culture. For instance, the debate of over diagnosis of schizophrenia among Afro-Caribbean patients is still unsettled. A study conducted in South London has concluded that Black Africans and Black Afro-Caribbean patients with psychosis in that area are more likely than White patients to be detained under the Mental Health Act 1983.³ Great Britain has become a multicultural society and a significant percentage of professionals working in psychiatric units have been trained overseas, in a wide range of countries. This creates further risk of inappropriate diagnosis. There needs to be more emphasis on the significance of trans-cultural psychiatry in the United Kingdom. In particular, psychiatrists should be aware that psychiatry is a medicine of language and culture as well as of the mind.

Medical Dilemmas

Countries in which Mental Health Acts are widely enforced have not achieved any reduction in suicide rates through their implementation. Sectioning is perceived by many patients affected as a psychological guillotine – a form of psychiatric terrorism. The medical profession is invested by the Acts with undue power over society. This is of particular concern because training in psychiatry does not include the study of free will and allied philosophical issues and also because there is no clear definition or description of mind and consciousness. In

psychiatry there is a lack of clinical indicators and psychophysiological parameters so the criteria for diagnosis are imprecise, with a concomitant risk of the Acts being erroneously implemented. It has been postulated that once a person has been classified as having deviant behaviour, that categorisation has a potent effect on the subsequent actions of the person concerned and those interacting with them.

Is it not justifiable to argue that even if a few mentally ill patients are underdiagnosed and not subjected to psychiatric admission, someone whom we would regard as normal should not be detained in a psychiatric hospital against their will? Such a view is analogous to the judicial view regarding capital punishment where even if ninety-nine murderers escape capital punishment because there is no death penalty, one innocent person should not be sentenced to death. Mental Health Acts may be a necessary evil but they present a dilemma for mental health professionals: the morality of helping patients and protecting the society from the consequences of their illness against the immorality of restricting their freedom. Clinicians become torn between the ideals of curing mental illness and defending the sanity of patients.

Patients' Perception

A small survey conducted by the author revealed that no sectioned patient in the group studied sent a thank-you card after discharge to the ward in which they were confined. However, many voluntary patients expressed appreciation in that way. This is an indicator of the attitude of sectioned patients towards the Mental Health Acts. One reason must be that a record of being sectioned limits their freedom to travel and also affects their employment opportunities adversely. A patient has commented that it is easier for an ex-convict to gain employment than it is for a once-sectioned psychiatric patient.

There is anecdotal evidence illustrating the panic that may be generated with the word 'section' in psychiatric patients. A recovering elderly hypomanic patient explained that he misconstrued the word on hearing it when he was ill, taking it in relation to sectioning in Obstetrics and General Surgery. He remembered that as he resisted entering a taxi while being persuaded to agree to admission, the driver said that he was going to be sectioned if he refused hospital admission. The patient misunderstood this and interpreted it as he was going to be cut into pieces and tried to jump out of the vehicle.

Post-traumatic stress disorder

Any loss of intrinsic importance to an individual constitutes bereavement. Denial, anger and depression experienced in compulsory detention are comparable to bereavement.⁴ In the case of a detained patient, the loss of self-identity and of social functioning causes a grief reaction. It has been hypothesised that there are high levels of Post-traumatic Stress Disorder (PTSD) symptoms in detained patients.⁵ Very few repeat detainees become habituated to the implementation of the

Mental Health Acts. The vast majority become increasingly frustrated and develop a pessimistic outlook towards their mental health. There is a high incidence of suicide among patients who have multiple detentions.

Post-hospitalisation Stress Disorder is much more common than generally recognised. Formal admission may lead to fear, anger, frustration, depression or loss of self-esteem, depending upon the individual's psychological response.⁶ Involuntary admission may result in pervasive distress in any patient – this kind of hospital admission may be perceived as threatening and even as a catastrophe. Detained psychotic patients are less aware of their environment because of the preoccupation with their symptoms. Non-psychotic patients, when detained for instance because of a risk of suicide, are fully aware of their immediate environment and the chaos they have caused to themselves. They have a high risk of PTSD.

Preventive detention

Fear of liability may lead to compulsory hospitalisation solely to prevent violence on the part of patients who otherwise do not require in-patient care.⁶ Psychiatrists are not trained to police society and may lack sufficient knowledge and experience to participate in the social control responsibilities that are part of the remit of the criminal justice system - they are sometimes involved in that function. Psychiatry has to be safe and secure in the hands of individual psychiatrists and psychiatrists have to be protected when practising psychiatry. Mentally ill patients are sometimes mistakenly processed through the criminal justice system rather than the mental health system. When that happens, compulsory detention may be perceived as a form of criminalisation of mental illness. Unless there is scrupulous monitoring, mandatory treatment impinges on civil liberties. Preventive detention is legally ambiguous and clinically impractical.

Assessment

Amongst the government's fundamental powers and responsibilities are, protecting people from injury by another and caring for less able people, whether physically or mentally incapacitated. These functions encompass the welfare and safety of both the individual concerned and the public.

A decision about compulsory detention is made on the basis of three considerations: loss of emotional control; psychotic disorder and impulsivity with serious thoughts, threats or plans to kill oneself or others. Any perceived risk must be imminent and provocative. The clinician is legally required to determine the least restrictive environment to which a patient may be safely assigned for continued care. To fulfil these requirements while implementing the Mental Health Acts, a psychiatrist needs the skills of a physician, lawyer, judge, detective, social worker and philosopher. The decision-making process is influenced by multiple factors such as: the clinician's propensity to detain patients; the record of past untoward incidents

involving the patient; attitude towards risk taking and availability of hospital beds and alternative safe treatment facilities. It is regrettable that in section 5(2) assessments, often it is a junior doctor, the least experienced person in the team, who is called upon to conduct the evaluation.⁴ A multitude of interviews with mental health staff, a social worker and solicitor will have to be endured by the patient - these are regarded as ordeals by most of them.

Non-detainable patients

Since the introduction of the Mental Capacity Act 2005, the number of assessments that are followed by a decision against compulsory detention is increasing. Patients who are assessed for formal admission but not found to be detainable may develop new risks subsequently as a result of the assessment procedure itself. Before assessment, mental health professionals may place themselves in covert locations around the patient's house and neighbours may watch eagerly behind their curtains. Thereby the patient's social image is damaged. After meticulous assessment, it may be a relief for the patient that they are not detained and that euphoria may continue for a short while but all too often damage has been done. The patient who is tormented by psycho-social stressors may find the assessment experience intensifies the injury. The decision about whether it is appropriate to assess someone is therefore an area in which more clarification and some management guidelines are much needed. In situations such as these, untoward incidents have been periodically reported. That may mean that the professionals involved and perhaps also family members who initiated the assessment, blame themselves and endure severe guilt feelings or blame each other. Furthermore, psychiatrists are not mind readers. It is possible that a patient will cleverly deny any suicidal intent during assessment, intending to fulfil a suicidal urge afterwards and that may falsely appear to be a reaction to the assessment. An interview for assessment may be the factor that takes them beyond their limit. Because of all these circumstances, the patient may need intensive home care and counselling after an assessment that does not lead to hospital care. In addition to treating mental illness, it is the duty of the psychiatrist to defend the sanity of patients. The difficulty of defining normalcy is notorious: it is easier to detect psychiatric symptoms than to describe normal behaviour.

Tribunals

Mental health tribunals are demanding and may be humiliating and intimidating. They are highly stressful for the patient and clinician and they involve the breach of patient confidentiality. Tribunals are often emotionally charged scenes for the patient and psychiatrist, they may result in traumatising. The largely professional make-up of a tribunal is often perceived as intimidating by patients, who tend to be suspicious of collusion between professionals and above all of their reluctance to challenge the decision of a psychiatrist.⁷ Psychiatrists who are aware of legal profession's ignorance on psychiatric issues

dominate the tribunal scene by flamboyant linguistic expressions, while lawyers question the objectivity of psychiatry and the expertise of psychiatrists in legal matters. Tribunals are concerned with the legality of detention and not with the appropriateness of treatment. However, one study has shown that patients who appear before tribunals find it easy to accept they require compulsory admission.⁸ Psycho-geriatric patients find it extremely distressing to attend tribunals. Hospital managers' review hearings are often arranged and carried out promptly. Managerial hearings involve local people too which may make them less intimidating for detained patients.

Involuntary treatment

Although mental health staff usually have the best of intentions, when mandatory treatment is applied to patients it may prove traumatic and counter-therapeutic. The experience of undergoing forced treatment adds to the patient's perception of stigma and discrimination. Involuntary psychiatric drug treatment is bound to be less effective than voluntary treatment. An outcome may be misdiagnosis, long-lasting and disabling side effects. Forced treatment potentially violates a person's right to respect private life under Article 8 of the European Convention on Human Rights. Article 8 is violated only if patients can prove the treatment given is more harmful than the claimed therapeutic benefits, yet the clinician can administer the treatment if he thinks it is therapeutically necessary. Compulsory treatment makes patients feel infantilised, especially because forced psychiatric treatment often involves coercion, emotional intimidation, bullying and threats.

Community Treatment Order (CTO) is being constantly evaluated in terms of its merits and demerits. The results have been inconclusive and warrant more systematic studies. It was Section 41 of the Mental Health Act that inspired the introduction of CTO - the main purpose being to protect the community from the aggressive behaviour of some of the psychiatric patients as in the case of the successful Section 41. There are indications that CTO has fulfilled such a goal. It was also targeted to enhance compliance and concordance with the mental health services and to prevent suicides but studies indicate that those goals were not achieved.^{9,10} The Oxford Community Treatment Order Evaluation Trial (OCTET) substantiates a lack of any evident advantage in dropping relapse.

The "knee jerk" reaction from part of community service has apparently resulted in spontaneous readmissions of patients under CTO. It has also contributed to prolonged detention of patients awaiting community placement under CTO. This is because detained patients must stay on section 3 or 37 to allow the Mental Health Act to be converted to CTO upon discharge. Obviously, such a scenario curtails liberty. Patients always feel bitter about the "hanging feelings" of continued detention. Coercion runs the risk of weakening therapeutic alliance. It may be true that if fewer conditions are imposed, CTO could serve

as a "memory knot" for patients with limited insight. Despite all the controversies surrounding the benefits of CTO, its use is increasing worldwide.¹¹

Assertive Human Rights

All human beings have individual rights and mental health professionals in particular must be mindful of those rights. Table 2 presents the list of assertive human rights, as modified from Gael Lindenfield (2001).¹²

Table 2, Assertive Human Rights

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| <ol style="list-style-type: none"> 1. The right to ask for what we want (realising that the other person has the right to say "No"). 2. The right to have an opinion, feelings and emotions and to express them appropriately. 3. The right to make statements which have no logical basis and which we do not have to justify (e.g. intuitive ideas and comments). 4. The right to make our own decisions and to cope with the consequences. 5. The right to choose whether or not to get involved in the problems of someone else. 6. The right to know about something and not to understand. 7. The right to be successful. 8. The right to make mistakes. 9. The right to change your mind. 10. The right to privacy. 11. The right to be alone and independent. 12. The right to change ourselves and be assertive people. 13. The right to be neutral. 14. The right to be empathetic and apathetic. |
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Discussion

Community care is more innovative than compulsory detention in hospital. For majority of patients, the best way forward is having high quality home treatment facilities as it is least restrictive and using compulsory detention should be the last resort. In some cases, forced psychiatric admission is indicative of failure in the supply of quality home treatment. One thing that sometimes leads to in-patient admission is lack of confidence in the service available. The perception of home treatment may be at fault here - it needs to be understood as more than merely staying outside hospital. Forensic patients and treatment resistant psychotic disorders lacking insight may be a different state of affairs. CTOs have serious impact on the autonomy and privacy interests of individuals and should not be applied to compensate for under-resourced community services.

Caring and supportive relationships between mental health staff and patients during involuntary in-patient care have considerable bearing on the outcome of compulsory detention.

A recent study has revealed that among patients who have been detained involuntarily, perceptions of self are related to the relationships with mental health professionals during their inpatient stay.¹³ Perceived coercion at admission predicts poor engagement with mental health staff in community follows up. When professionals demonstrate their genuineness and encourage patient participation in the treatment options, coercive treatment would be perceived as less of an infringement to the autonomy of patients and their sense of self-value.¹⁴ If patients maintain both positive and negative views about detention, interventions should be designed to enhance positive experiences by focussing on respect and autonomy. Patients admit only compulsory detention gave them an opportunity to receive medication in a time of crisis and report it did not necessarily prevent thoughts relating to self-harm. It simply reduced the opportunities for impulsive acts.

'Rooming-in' is worth debating as an alternative to compulsory detention. This is the voluntary participation of so-called confidants, who may be chosen family members or trusted friends. They provide a 24-hour vigil for the patient in a safe hospital environment. An Australian study has suggested this system is highly valued by nursing staff, patients and their families.¹⁵ It is an initiative that needs further testing and evaluation. The resolution of angry feelings towards the mental health professionals has a significant bearing on their future compliance. The post-detention period tests the attention given to patients by mental health professionals. Here the staff members have to take the initial steps required to repair damaged relationships which may have developed in particular with angry patients. Detained patients should be offered counselling in post-discharge follow-ups and should be given satisfactory explanation of the circumstances for formal admission. Detained patients should be given the support to enable them to: rewrite their life story; reconstruct a sense of self; achieve healing of the assault of their illness and the treatment procedures inflicted on their personality. Specific interventions should be designed and evaluated in order to deal with any unresolved PTSD symptoms relating to formal psychiatric admission.

Competing Interests

None declared

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