How to facilitate & support self-determination of patients in psychiatric practice

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Mental health is more than the absence of mental disorders

Mental health has its own criteria:

Cf.: One concentration camp guard becomes depressed, the other not –
does not mean that the non-depressed guard is mentally healthy

-> Criteria for mental health:

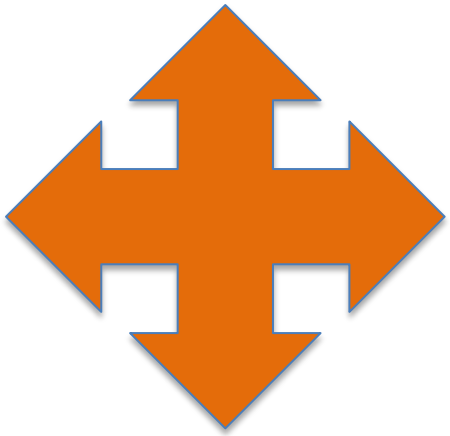
- Empowerment of the ability to flexibly adjust behavior
- Self-efficacy & coherence of individual narrative of life
- Empathy (also required for shared decision making)

(Heinz, 1994)

Self-determined social inclusion: promoted by person-centered approach

Shared Decision Making

Sense of Coherence



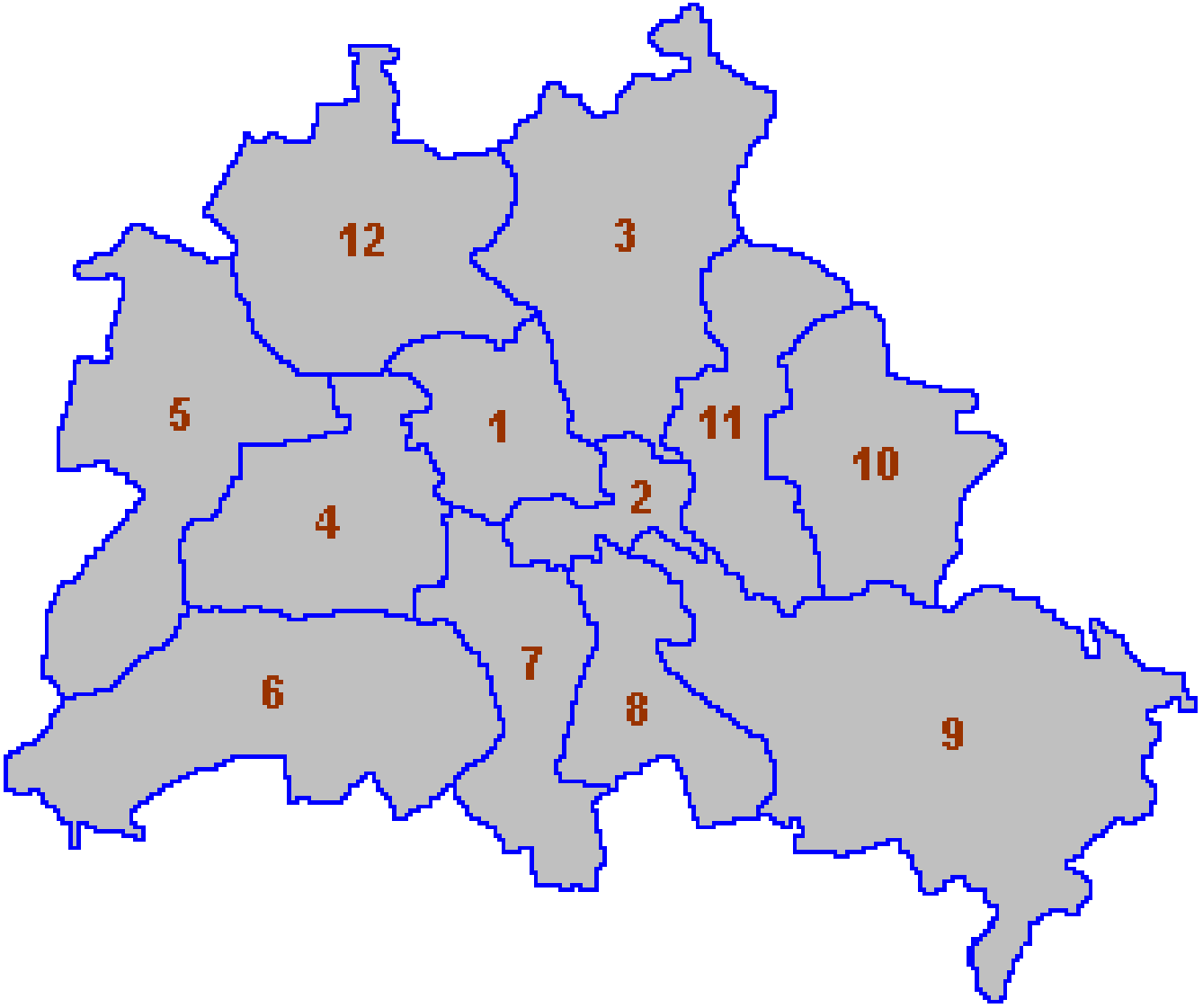
Empowerment

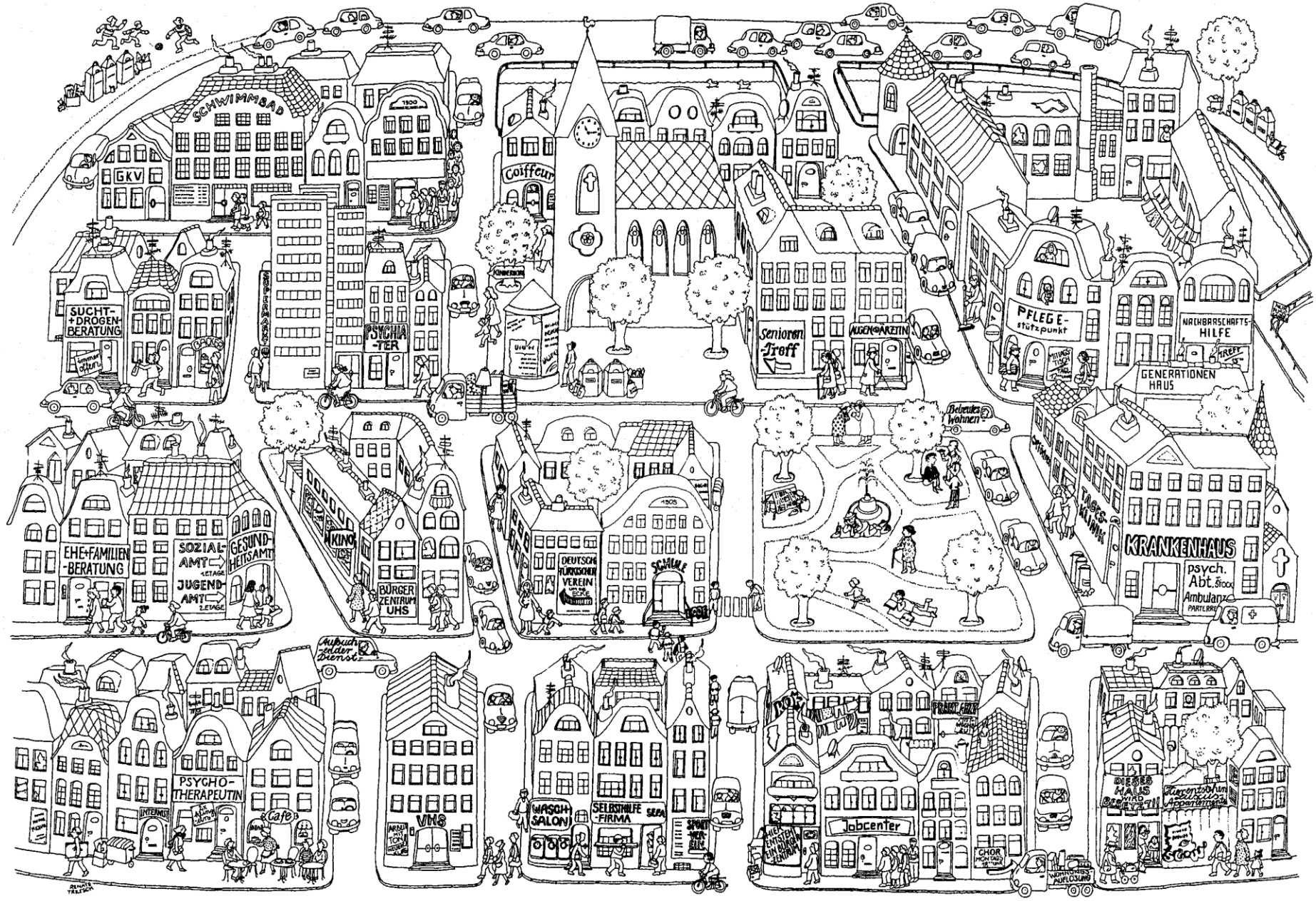
Resilience

Requirement: social inclusion

I.
Housing & living:
Living & participating in the community

Inpatient treatment in the sector (neighborhood)
in a general hospital with easy access for friends & relatives
and close cooperation with outpatient services




SCHWIMMBAD
GKV
Coiffeur
SUCHT-
+DROGEN-
BERATUNG
PSYCHIA-
TER
Senioren
-Treff
AUGEN-ÄRZTIN
PFLEGE-
stützpunkt
NACHBARSCHAFTS-
HILFE
GENERATIONEN
HAUS
Betreutes
Wohnen
EHE+FAMILIEN
-BERATUNG
SOZIAL-
AMT
JUGEND-
AMT
GESUND-
HEITSAMT
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UHS
DEUTSCH
TÜRKISCHER
VEREIN
SCHULE
KRANKENHAUS
psych.
Abt.
Ambulanz
PSYCHO-
THERAPEUTIN
Cafe
VHS
WASCH-
SALON
SELBSTHILFE
-FIRMA
Jobcenter

Requirement: social inclusion

II.
Working:
Access to normally paid jobs

Jobless rates and mental health

- 60-80 percent of people (in the US) who live with mental illness are unemployed and, for people living with the most severe mental illnesses, unemployment rates can be as high as 90 percent.
  (National Alliance of Mental Illness, 2010)

- Unemployment has a negative effect on the mental health of men > women
  (age-adjusted odds ratio [OR] = 2.98; 95% CI = 2.30, 3.87) > OR = 1.51; 95% CI = 1.11, 2.06).

➢ Gender differences in effects were related to family responsibilities and social class
  (Artazcoz et al (2004)

Requirement: social inclusion

IV.
Human rights in disease, illness and sickness

Convention on the Rights of Persons with Disabilities

Article 14: Liberty and security of person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

Committee on the Rights of Persons with Disabilities – Concluding observations on the initial report of Austria, Sept. 2013

"Liberty and security of the person (art. 14)

The Committee is deeply concerned that Austrian laws allow for a person to be confined against his or her will in a psychiatric institution where they have a psychosocial disability and it is forecast that they might endanger themselves or other persons.

The Committee is of the opinion that the legislation is in conflict with article 14 of the Convention because it allows a person to be deprived of their liberty on the basis of their actual or perceived disability.

The Committee urges the State Party to take all necessary legislative, administrative and judicial measures to ensure that no one is detained against their will in any kind of mental health facility. [...]

The Committee also urges the State party to ensure and that all mental health services are provided based on the free and informed consent of the person concerned. [...]"

Special Report on torture and other cruel, inhuman or degrading treatment or punishment by Juan E. Méndez (United Nations Special Rapporteur on Torture)

"The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions." (p. 14-15).

- General claim that every compulsory treatment of patients with mental disorders, except in life threatening situations, is torture.
- The report only focuses on "psychiatric treatment" and "psychiatric disorders" – suggesting that similar compulsory treatments of e.g. neurological disorders in neurology, intensive care wards, senior citizen homes/closed homes for chronic patients would not be ethically problematic.

Special Report on Torture and other cruel, inhuman or degrading treatment or punishment by Juan E. Méndez (United Nations Special Rapporteur on Torture)

Defining compulsory medical treatments performed with the aim of helping patients as "torture"

The canonical definition of torture ("Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment") contains four elements:

1. an act inflicting severe pain or suffering, whether physical or mental;
2. the element of intent;
3. the specific purpose;
4. the involvement of a State official, at least by acquiescence.

Méndez' new definition of torture leaves out the 2. and 3. element

→ Compulsory medical treatments performed with the aim of helping patients can be subsumed under the redefined term "torture"
except in life-threatening conditions

The concept of mental maladies: I. Symptoms of a disease

Boorse, 1976

- Disease: relevant dysfunction of an organ impairs survival or reproductive fitness
- Deviation from statistical norm

Critique:

- Biological reductionism pathologizes homosexuality -> medicine cares for individual, not assumed species requirement
- Are there universally relevant mental/psychic functions?

The concept of mental maladies: II. Suffering without external cause

Culver & Geert, 1982:

- Malady = suffering harm in the absence of an external sustaining cause
- Impairment of relevant functions (cf. broken arm)
- Increased risk to die (cf. undetected cancer)
- Loss of freedom (cf.OCD)
- Anhedonia (cf. Depression, schizoprenia)

Critique (Schramme 2000):

Mixes concepts from the individual life world
(suffering = illness)
with universally applicable normative categories
(social participation = sickness)

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The concept of mental maladies: III. Symptoms of a disease & harm

Wakefield, 1992:

- Dysfunction must be harmful for the individual
- Functions defined by their goal
- What are the relevant human goals?
- Evolutionary criteria for necessary human goals

Critique (Heinz 2013):

No distinction between harm as expression of illness or sickness

History of Social Darwinism shows abuse potential of ad hoc evolutionary explanations

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Psychopathological assessment of key diagnostic symptoms

- 1. Vigilance
- 2. Orientation: person/place/time
- 3. Understanding communication

  (incl. proverbs)

o.k.: no delirium/ acute brain organic syndrome

- 4. Concentration (100-7)
- 5. Short-term memory (3 concepts/10 m.)
- 6. Long-term memory

o.k.: no dementia/ chronic brain organic syndrome

- 7. Formal thought disorder (coherence, speed, inhibition)
- 8. Delusions (Delusional mood, delusional perceptions, systematic delusions)
- 9. Ego disorders (thought insertion, thought broadcasting, thought blockade)
- 10. Hallucinations (acustic, optical, commenting voices, voices arguing, commading voices)

o.k.: no schizophrenic psychosis

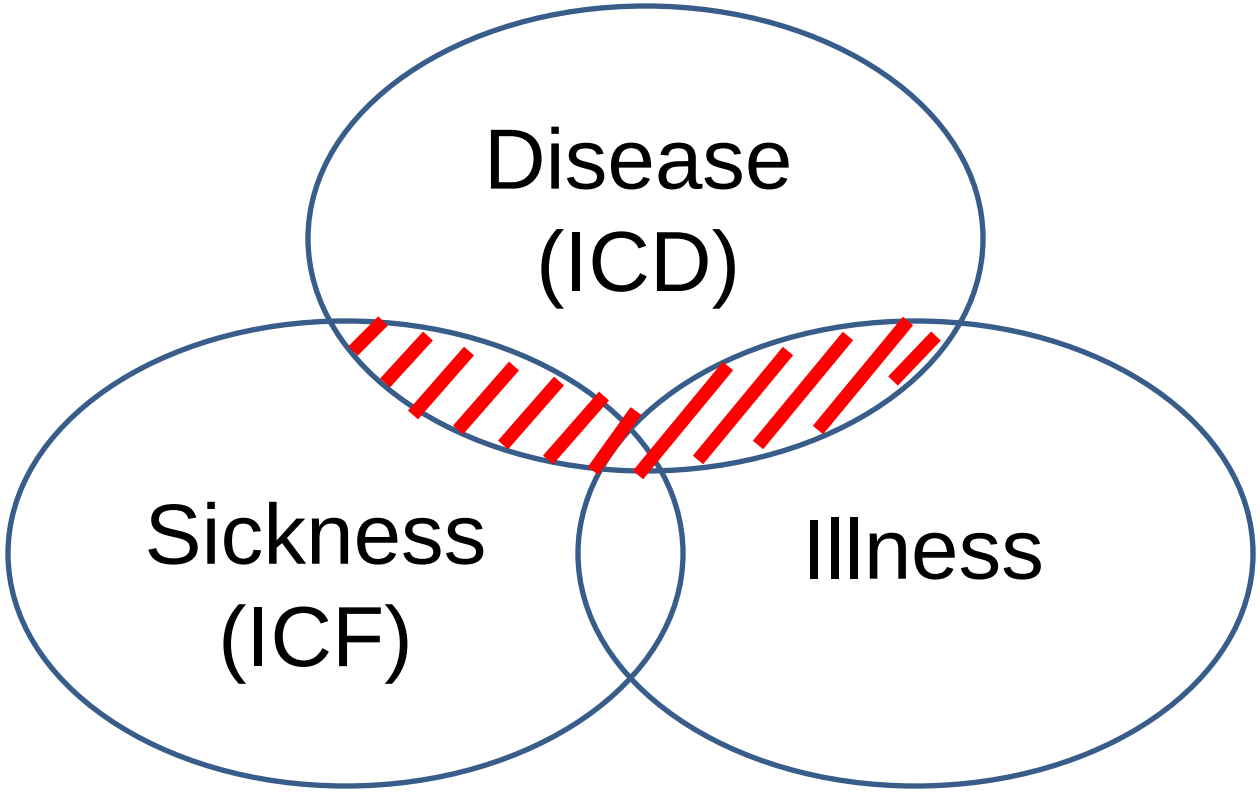
- 11. Obsessions and compulsions
- 12. Mood (elevated, depressed, anxious, affective resonance, early morning depr.)
- 13. Drive/motivation (reduction, inhibition)

o.k.: no OCD/ no affective disorder

Diagnostic scheme: Diseases *versus* variations of human suffering (disorders)

Exogenous psychoses (brain organic syndromes)	**Endogenous psychoses**	**Variations**
Acute **e.g. delirium**	**The group of schizophrenias**	**Neuroses** **(trauma & conflict-related causes)**
Chronic **e.g. dementia**	**Major affective psychoses** **(unipolar & bipolar depression)**	**Personality disorders (traits)**

The concept of a mental malady: disease plus illness or sickness



Concept of mental malady: disease, illness & sickness aspects

1) Objective symptoms of a **disease**:

   dysfunction or high risk to loose a function relevant for survival

plus 2) or 3)

2) **illness**: subjective suffering or harm
3) **sickness**: disability impairing basic social participation

   (cf. activities of daily living: eating, dressing etc. – not social conformity!)

plus 4)

4) No sustaining external cause

   (Culber & Geert 1982; Sartorius 2010; Heinz 2013)

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Federal Constitutional Court of Germany

Coerced treatment against the will of the forensic patient is not allowed to protect other persons against criminal acts which the patient might commit after discharge, since future crimes could be prevented by detaining the patient in a psychiatric institution without treatment.

But the state is not obligated to leave forensic patients to the fate of permanent confinement because of the primacy of an illness-determined will, but coercion has to follow a rule of law.

→ Three state parliaments were urged to reformulate their civil commitment laws so, that compulsory treatments will be made possible under strict legal conditions, namely:

- the patient is not able to consent to the necessary treatment
- the physicians have tried to convince him
- the treatment is necessary to avert considerable health detriments
- the compulsory treatment is used as a last resort treatment
- its benefit-risk-balance is positive.

Treatment against the natural will of a patient only if:

1) Symptoms of a **disease**:
   dysfunction relevant for survival

plus 2) or 3)

2) Subjektive suffering or harm (**illness**)
3) Disability impairing basic social participation (**sickness**)
   (cf. activities of daily living, not social conformity)

plus 4)

4) No sustaining extrnal cause

plus 5)

4) Lack of insight
(operationalized as in informed consent)
(Bundesverfassungsgericht 2012; Müller et al., 2013)

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Requirement: social inclusion

V.
Treatment:
Respect for patients‘ autonomy and preferences

International variations in patients committed to locked versus open wards

Legal status	Committed		Voluntary	
Door of ward	Locked	Open	Locked	Open
Austria	6.1	8.9	2.5	82.5
Hungary	12.5	24.5	7.6	60.3
Romania	2.7	1.8	2.6	92.9
Slovakia	4.2	2.2	53.7	39.9
Slovenia	5.9	4.1	19.8	70.2

	1996		1999		*P*
	N	%	*N*	%	(chi-square test)
Committed patients					
Austria	156	14.9	138	14.1	ns
Romania	36	6.3	39	8.0	ns
Slovakia	56	5.5	59	6.4	ns
Patients in locked wards					
Austria	126	12.1	90	9.0	0.02
Romania	123	21.6	40	8.2	0.001
Slovakia	378	38.2	535	57.9	0.001

Rittmannsberger et al 2004

Containment strategies for people with serious mental illness (Review)

Muralidharan S, Fenton M

AUTHORS' CONCLUSIONS

Implications for practice

In the absence of any controlled trials, no recommendations can be made about the benefits or harms of containment strategies. Continued use of these interventions is not based on information from randomised controlled trials and, given the marked variation in use across institutions, there is an argument that current practice should only be continued within the context of such trials.

Self-harm increased in locked wards

Containment					
Door locked <1 h	1.27 (0.98–1.64)	ns	1.22 (0.95–1.58)	ns	
Door locked 1–3 h	1.22 (1.00–1.48)	<0.05	1.19 (0.99–1.44)	ns	
Door locked >3 h	1.51 (1.17–1.94)	<0.01	1.48 (1.15–1.89)	<0.01	
Door locked full shift	1.24 (1.10–1.39)	<0.001	1.20 (1.07–1.35)	<0.01	
Prescription required as needed	1.10 (1.07–1.14)	<0.001	1.09 (1.05–1.13)	<0.001	x
Seclusion	1.03 (1.00–1.06)	<0.05			

Bowers et al. 2008

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Suicide rates on locked & open wards

More suicides occuring on locked versus open wards
(60% versus 40%)
[Koester und Engels]

Locking wards increases suicide risk
[Bochnik u. Gärtner-Huth 1989, Pohlmeier 1994, Venzlaff 1996]

Suicides decrease with open door policy
[Fujimori, Sakaguchi 1986]

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Absconing from locked wards

Up to 65% of all patients abscond from locked wards
[Dickens und Campell 2001]

50-80% abscond when first being allowed to leave the ward
[Dickens und Campell 2001, Bowers et al. 1998, Falkowski et al. 1996]

Up to 20% of all patients abscond in spite of locked doors and personell guarding the exits
[Bowers et al. 1998]

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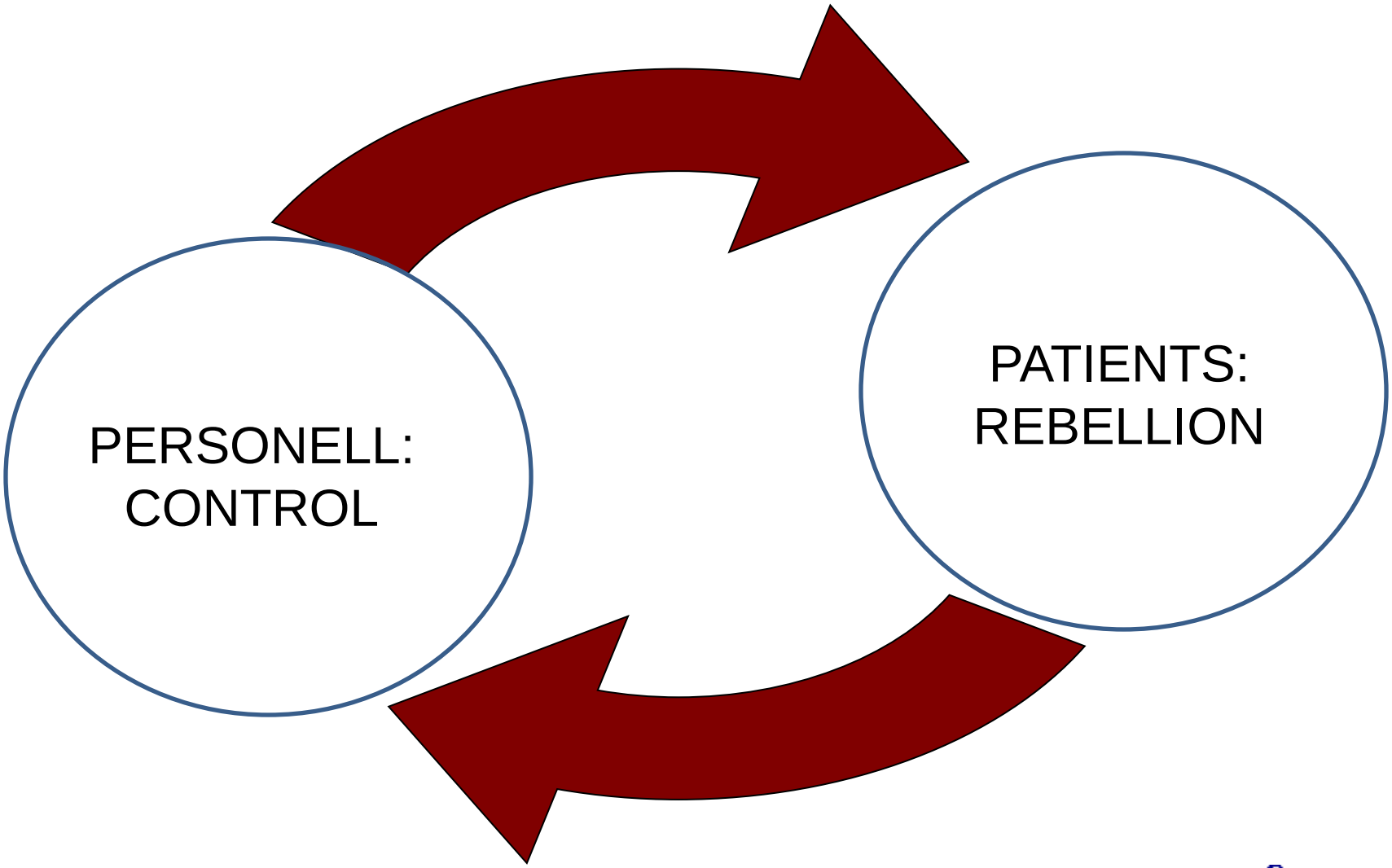
PERSONELL:
CONTROL
PATIENTS:
REBELLION

Table 1

	Closed 91%	Open 75%	t/chi[2]	Significance
Patients (n)	176	161		
Gender (male)	111	97	1.6[1]	n.s.[1]
Age (years ± SD)	39.9 ± 15	40 ± 17	0.026[2]	n.s.[2]
Diagnoses			7.33[1]	n.s.[1]
Duration of stay (days ± SD)	18.8 ± 23	18.6 ± 21	-0.90[2]	n.s.[2]
Absconders (n = 57)	35	22	5.107[1]	p = 0.029[1]
Interval to readmission (days ± SD)	9 ± 9	26 ± 34	2.314[2]	p = 0.025[2]
Aggressive incidents (n = 36), 319 patients included	23	13	4.46[1]	p = 0.050[1]
Suicides (n)	2	0	2.2[1]	n.s.[1]
Instances of Coercive Medication (n = 25), 319 patients included	17	8	4.646[1]	p = 0.037[1]

[1] = Chi[2],Chi[2]-test.

[2] = t, t-test.

Lang et al., 2011 EJP

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Requirement: social inclusion

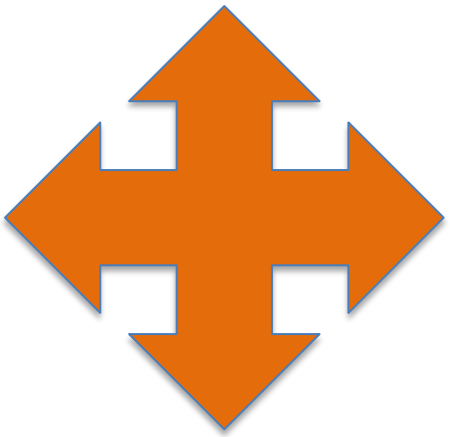
VI.
Self-organization of patients/clients & relatives

Shared Decision Making:

open treatment settings, aims, time and personell

Sense of Coherence:

meaningful narration of individual history, focus on autonomy



Empowerment:

meaningful participation in community, paid work

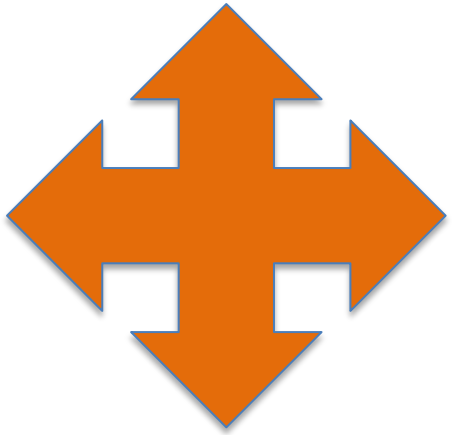
Resilience:

social inclusion and support from the community

Shared Decision Making

In medical settings: hospitals,policliniics,practices

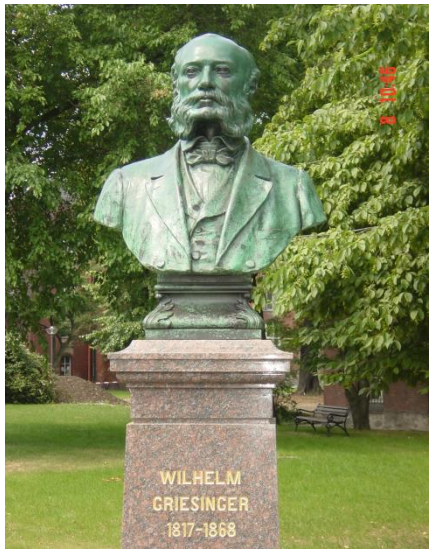
Sense of Coherence:
access to psycho- & sociotherapy



Empowerment:
participation in the community & workplace

Resilience:

organization of patients & relatives,
meeting points/cafés, visible presence in community



Müller S, Müller C, Mahler L, Montag C, Schouler-Ocak M, Sterzer P, Sutej I, Ströhle A, Voss M, Gallinat J, Walter H

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