

The United Nation's Convention on the Rights of Persons with Disabilities

Human rights in psychiatry

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Summary

The United Nation's Convention on the Rights of Persons with Disabilities as well as rulings of the highest constitutional court in Germany (Bundesverfassungsgericht) have emphasised and defined human rights in psychiatry and directed therapeutic efforts towards social inclusion. We describe key aspects of the convention and some court rulings and discuss how to best put them into practice. We suggest that treatment should be centred around personal, not institutional needs. Such a person-centred approach has to be directed at the real world of subjects with mental disorders, promote paid job placement, provide flexible home treatment teams and open the doors of acute wards to reinforce the orientation of therapeutic activities towards users and to reduce aggressive interactions as well as absconding. Empirical evidence for this person-centred approach and the required resources is provided and discussed in light of current modifications and models of financing of in- and outpatient treatment.

Key words: UN Convention; mental disorders; human rights; disability; open psychiatry

Introduction

The Convention on the Rights of Persons with Disabilities [1] plays a major role in securing and promoting human rights of patients with mental disorders, because every chronic disorder constitutes a disability and therefore persons with chronic mental disorders are protected by this convention. Key articles of this Convention state, for example, that “every person with disabilities has the right to respect for his or her physical and mental integrity on an equal basis with others” (Article 17). Furthermore, the convention demands that persons with disabilities “enjoy the right of liberty and security of person” and “are not deprived of their liberty unlawfully or arbitrarily”. Therefore it ensures 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” (Article 14). These statements have sparked considerable debate on how to best secure the human rights of subjects with mental disorders, particularly if the mental disorder impairs insight and may constitute a severe threat to the health and life of the patient, e.g., in case of a delirium tremens induced by acute alcohol withdrawal. Indeed, the “Special report

on torture and other cruel, inhuman or degrading treatment or punishment” published by Juan E. Méndez [2] suggested that compulsory medical treatment performed with the aim of helping a mentally disordered person can be subsumed under the term “torture” if it is not carried out exclusively in “life-threatening situations”. In the ensuing discussion, among others the American Psychiatric Association (APA) and the World Psychiatric Association (WPA) voiced concerns that severe health risk may be encountered even if acute survival of the person is not threatened [3]. Méndez responded in a letter and stated that a threat to the health of another person or the afflicted patient him- or herself can be a valid reason for coercive treatment, which is then justified not by the “existence of a disability” alone but also by the specific threat to the well-being of the individual or other persons [4].

In Germany, the highest court, the Federal Constitutional Court, ruled in 2011 (2 BvR 882/09, 23.03.2011) that coerced treatment against a forensic patient's will is not allowed with the intention to protect other persons from criminal acts, which the patient might commit after discharge. According to the Court, detaining a patient in the psychiatric institution without treatment can as well prevent future crimes. However, the Court also argued that the state is not obliged to leave forensic patients in permanent confinement if they are legally incompetent. Compulsory treatment can be justified, if it is aimed at restoring the patient's capacity to consent, and if several requisites are fulfilled: the physicians must have tried to convince the patient and explained different treatment options, the treatment has to be necessary to avert considerable health detriments, the benefit-risk-balance has to be positive and the compulsory treatment is used only as a last resort. However, all these rules and regulations, as controversial as they may be in detail, emphasise one common point: coercive treatment applied in psychiatry is, if allowed at all, to be restricted to a very limited number of cases, in which it is aimed at the benefit exclusively of the mentally ill patient; it is not justified by institutional settings or economic interests of the institution, health care industry or society in general. So what does that mean in clinical practice?

Based on a main lecture at the annual meeting of the Swiss Society of Psychiatry and Psychotherapy.

An end to permanently locked wards?

If compulsory treatment is limited to situations in which the health of the patient is severely threatened and the treatment is aimed at restoring the patient's capability for autonomous decision making, then institutions have to be reorganised in order to minimise compulsion. This means that traditions or economic necessities, such as demands to minimise costs for personnel, cannot justify replacing personal interactions with compulsory treatment. We and others have argued that one way to reduce coercive treatment is to open previously locked doors even on wards for acute patients, who are admitted against their current will to a psychiatric hospital [5–8]. Indeed, the question whether patients admitted on their own will or via some legal procedure against their current will are placed on open or locked wards varies considerably from country to country. It appears to depend more on institutional traditions than on a careful examination of the situation of each individual [9]. Opening the doors of previously locked wards, far from increasing absconding and suicide rates, helps to reduce violent interactions as well as the occurrence of coercive medication and absconding [6], most likely because it forces the therapeutic personnel to interact intensely with all patients and to negotiate treatment settings in a way that makes it attractive for all patients to stay in the treatment setting.

Such a person-centred approach can be facilitated by further alterations of treatment settings in the interest of the patient, including the open discussion of treatment goals and plans with the patient, instead of discussing them behind closed doors and informing the patient only about decisions made in the treatment team without constantly involving this person in the discussion [10]. Furthermore, free access to means of communication (telephone, internet), accessibility of commodities like a kitchen on the ward, gardens that are directly accessible from the ward, animals that are kept on the ward and that are available for interactions with the patients (e.g., dogs trained for therapy) can further improve such person-centred treatment settings [11–16]. Continuity of therapeutic interactions with the patient, for example by obliging the regional department of psychiatry to treat patients from a certain sector of the city, can further help to establish personal trust and continuity of interactions between patients and therapeutic personnel. To further focus on the individual needs of patients, barriers between different parts of the health care treatment system need to be reduced,

for example by flexibly dosing days with inpatient treatment, day care and outpatient treatment in integrated health care settings.

Home treatment instead of inpatient treatment?

A further reduction in coercive treatment appears to be possible if patients are not necessarily admitted to a ward when a danger to themselves or others is caused by the mental disorder. Indeed, first data, e.g., from home treatment teams in Hamburg, suggest that coercive treatment is substantially reduced when patients are treated in their real world (Lebenswelt) instead of being admitted to a hospital [17]. Several factors seem to play a role here: patients not being forcefully removed from their homes towards inpatient treatment facilities can feel more respected and safe in their environment; to be able to treat therapists as guests in their own homes can empower patients and gives them more control about their life situations; furthermore, the absence of (often violent) interactions with the police or other state officials when being removed from one's home can prevent traumatisation by such interactions. This does not mean that there cannot be situations in which inpatient treatment is preferable to outpatient treatment, but it suggests that treatment should be modified to be flexible enough to cater for various personal needs of individual subjects with mental disorders.

Economic limitations vs human rights?

Replacing inpatient treatment to some degree by mobile teams that offer home treatment is not necessarily more expensive than established hospital structures. Several studies have indicated that such mobile teams can work at least as economically efficiently [18]. Once patients are to be admitted to inpatient treatment, however, quality of personnel as defined by the number of subjects interacting with a patient, and their training are key factors in reducing coercive treatment and improving healthcare facilities: doors to previously close wards can only be opened if there are enough nurses or other qualified therapists to interact with suicidal patients or patients who are violent due to disease-associated misconceptions of social interactions. On acute wards, it is of key importance that during night shifts, there is no therapist left completely alone to interact with anxious or threatening patients. Indeed, double shifts on acute wards for nurses are standard at night

time but currently not guaranteed by any law regulating the quality of inpatient treatment in Germany. Moreover, current legal requirements (Psychiatrie-Personalverordnung, [19]) which demand a certain number and education of therapeutic personnel on acute wards that treat patients against their will if admitted to such treatment settings, will expire in Germany within the next four years. It is currently absolutely unclear whether they will be replaced by new legal regulations. If such rules and regulations expire without legally binding replacement, hospital administrations may feel tempted to reduce personnel in order to increase financial resources generated by departments of psychiatry, which are often urgently needed to improve the building structure of the hospital, however, at the expense of financing the required therapeutic personnel. Unlike in somatic medicine, in psychiatry patients can be admitted against their will and have no chance to freely choose the treatment setting if not satisfied with the therapeutic interaction. Therefore, in the light of the Convention of the Rights of Persons with Disabilities [1], legally binding regulations defining treatment quality and number of personnel in departments of psychiatry are urgently needed to de-escalate tensions, to provide sufficient time for interactions with patients, to find adequate solutions for conflicting interests and to avoid coercive medication or other forms of coercive treatment except in those cases where the health of the patient is directly and severely threatened.

Social inclusion instead of reduction of symptoms as the overall treatment aim

In accordance with the Convention on the Rights of Persons with Disabilities [1], the overarching treatment aim of any psychiatric intervention is the social inclusion of all subjects with mental disorders. Individual well-being and social participation are thus key treatment aims and in many cases can be achieved while tolerating considerable psychopathological symptoms, which could only be treated at the expense of more or less severe side effects. Among such side effects, neuroleptic-induced anhedonia or avolition, brain volume reductions following long-term treatment or weight gain and obesity can play a role [20, 21]. In drug addiction, treatment aims also have to be articulated in accordance with the overall aims of harm reduction, personal well-being and social inclusion. Therefore, methadone or other opiate substitution is a standard therapy now in Switzerland and Germany, and therapeutic interven-

tions to reduce alcohol intake in subjects who do not decide to aim at full abstinence have been established and are gaining momentum [22]. Again, discussions about human rights helped to shift the focus of treatment aims and emphasise that it is the subject suffering from the mental disorders, not the therapists or not even the relatives of this person, who has to decide which treatment is best to promote the aims of the individual.

Personal freedom in a new liberal world?

This being said, there is a risk that some discussions about legal status and requirements neglect that mental disorders can severely impair the insight of a patient into his or her condition. One example has already been named, the appearance of an acute delirium tremens in alcohol withdrawal. It would be deeply inhuman to not treat a patient in a delirium, even if his or her acutely uttered will rejects treatment, because the state of a delirium can be detrimental to the health of the individual, who can even die in this situation. Likewise, reduction of health care facilities, as it has occurred in some industrialised countries in the last decades, can reduce inpatient treatment facilities to a degree that subjects with mental disorders suffer from homelessness or imprisonment and lack of the ability to receive adequate therapeutic interventions [23]. It would be cynical to suggest that this is the price to be paid to promote personal autonomy and that society is no longer obliged to provide adequate health care for all subjects with mental disorders. Instead, the Convention on the Rights of Persons with Disabilities [1] clearly demands that all necessary efforts have to be undertaken to socially include subjects with disabilities and to provide adequate medical treatment, including psychiatric therapies. Aiming at social inclusion requires adequate resources for shared decision making on the basis of fully informed consent. It demands serious efforts to promote empowerment of patients to fully participate in their community and to find paid jobs [24]. Furthermore, it requires resources to help persons with mental disorders to achieve a sense of coherence by interacting with other patients, relatives, friends and therapeutic personnel [25]. Articulating a meaningful narration of their individual history and personal experience can increase resilience among persons with mental disorders by promoting social inclusion and increasing support from the community [26]. Ultimately, promoting social inclusion and reducing stigma of mental disorders helps to increase liberty

of all persons living in a given society, because it reduces normative pressures and increases the human right to choose individual aims and to live according to them in a free society.

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