

Coercive Measures and Stigmatization in the Psychiatric Medical Care

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Abstract: *The involuntary commitment of psychiatric patients has been done for almost a decade under the Law 487/2002, the law of mental health and protection for people with psychiatric disorders. Frequent involuntary psychiatric hospitalizations have led to stigma attitudes and discriminatory acts towards patients with mental disorders. The coercive medical measures are applied in the psychiatric institutions of the mental health protection agencies. Coercion gives rise to serious ethical debates in the psychiatric assistance. The individual who was hospitalized in a psychiatric hospital anticipates social rejection becoming defensive, withdraws socially, experiences a complex internal conflict.*

The goal for this study is to illustrate aspects linked to coercive measures, mechanical restraint at involuntary admission of patients with mental illnesses in the psychiatric medical assistance.

Material and method: This study is a retrospective one, and the data was taken from the charts with involuntary admissions during the period of October 2002 to July 2012. The studied lot was comprised of 202 patients admitted involuntarily in a psychiatric hospital according to the Law 487/2002, the law of mental health and protection for people with psychiatric disorders.

Results: Of the 25.7% patients admitted involuntarily, that required coercive measures during admission, 58% were contained for symptoms like self-harm. The mechanical contention measures were especially necessary in the acute cases with symptoms as self-harm and/or harm of others, but also in situations with hallucinatory-delirium symptoms. The ratio of male sex subjects was significantly higher in the subject lot that needed coercive measures during hospitalization, of those admitted involuntarily (86.5% vs. 72%) ($p = 0.036$).

Conclusions: Involuntary admission and mandatory treatment remains in psychiatry a medical, legal and ethical problem. The required measures can lead mainly to clinical benefits, implying a paternal attitude from the psychiatry specialists by defying the patients' autonomy. Treatment compliance is directly proportional to the overall level of functioning and inversely proportional to the level of self-stigmatization.

Keywords: coercion; involuntary admission; stigma.

How to cite: Nechita, P., Luca, L., Voinea, A.-I., Moraru, C., & Dobri, M.-L. (2020). Coercive Measures and Stigmatization in the Psychiatric Medical Care. *BRAIN. Broad Research in Artificial Intelligence and Neuroscience*, 11(3), 137-145.
<https://doi.org/10.18662/brain/11.3Sup1/129>

Introduction

Liberty, from a philosophical point of view, represents the opposite of coercion. Some philosophers consider moral liberty to be the most authentic form of expressing liberty.

Psychiatry, since its beginning, has been confronted with numerous ethical and judicial aspects. In this field, there are 2 types of admission: one with consent (voluntary) and an involuntary one. In the past, patients with mental disorders were considered by society to be a threat and by this consideration they were treated differently from other patients. The psychiatric development was well grounded on social ideological concepts that followed ethical wishes like autonomy, independence, passing aside involuntary admissions and compulsory treatments. Nowadays, a patient with mental illnesses has the same right as any other patient, including the right to intimacy in one's relationship with the psychiatrist. Psychiatry raised much more ethical and judicial controversies than any other medical domain. In other medical specialties, a patient cannot be treated without one's free and informed consent. With that in mind, a psychiatrist is capable to treat a patient who is not capable of expressing his/hers consent. In emergency situations, there are some exceptions that interfere with the activity of obtaining a valid informed consent: patients without the disease consciousness, incapable to decide for themselves (Marian et al., 2012).

The patient with mental disorders can present, aside from his/her illness, also a degree of social danger, an aspect that compels sometimes a particular attitude from the qualified institutions concerning him/her: involuntary admission. The measure of involuntary admission is one of the highest controversial problems in the area of psychiatric medical assistance, being the subject of permanent debates among patients and mental health professionals. Restraint, isolation, stigmatization, involuntary admission and involuntary treatment are an important part in psychiatric medical assistance in emergency psychiatric situations, but in the same time, it raises many ethical dilemmas (Buda, 2018, Ciubara et al., 2015).

Patients with mental disorders, in voluntary admissions, but specially in involuntary ones, can be submitted to different coercive measures like isolation, pressure and constraint (Olsen 2003; Widdershoven & Berghmans, 2007). Patients with severe mental illnesses arrive often in emergency situations, in which coercive treatment is justified. These ethical justifications of coercive interventions in the majority of European countries, implies criteria as self-harm and hetero-aggression. Although coercive measures are

necessary, these should not become routine. Using coercion in psychiatry must be accompanied by responsibility and care regarding the mentally ill patient (Frueh et al., 2005; Janssens et al., 2004, Tannsjö, 2004). Coercive practice is the most radical measure when controlling aggression in mentally ill patients (Hiday, 1992; Monahan et al., 2005; Norberg, 2001; Olofsson & Haglund et al., 2003). Coercive measures in psychiatric hospitals were, are and will be subjects of ample ethical and judicial debates in the psychiatric medical assistance (Craciun et al., 2012; Ghebaur et al., 2008; Katsakou et al., 2010; Nicholson et al., 1996). Usage of coercive measures is regulated by a series of laws that differ at an international level, according to the social, cultural and judicial variety, and the involuntary admission represents one of the most controversial measures in the psychiatric medical care (Ciubara et al., 2015; Ghebaur et al., 2008).

The patient with mental disorders is part of the vulnerable population that beneficiaries of special medical measures but also of special legal measures with a goal of protecting the patient, but also society (Marian et al., 2012, Ciubara et al., 2016). The psychiatrist must actively collaborate with the judicial system to aid ethical ideals. Although present legal procedures make a psychiatrists' activity even harder concerning the involuntary procedure for admission/treatment, not all of these difficulties are of ethical nature (Bloch & Chodoff, 2000, Bolos et al., 2012; Marian et al., 2012).

The pattern of use of the coercive measures in the psychiatric assistance differs in the European countries, contention and isolation being frequent interventions in psychiatry in the case of patients with aggressive behavior (Legea 487/2002; Stoica et al., 2007). The criteria of injuriousness for involuntary admission lead to numerous ethical dilemmas for the psychiatrist. The coercion measure of forced hospitalization, sometimes due to the anticipation of the mentally ill patient's injuriousness also raises a series of ethical dilemmas (Untu et al., 2015, Valcea et al., 2016). The autonomy principle is sometimes trespassed in favor of the benefit principle, especially when people with mental illnesses are at risk of self-harm or aggression to those around them (Stoica et al., 2007; Kallert et al., 2011). In Romania, the criteria for involuntary admission include symptoms such as self-harm, hetero-aggression, and also hallucinatory-delirium symptoms.

The psychiatric research must respect the dignity and human rights, minimizing the risks and maximizing the benefits, this being realized with the bioethics committee's agreement. Patients with mental illnesses are a vulnerable group, that is why there are necessary supplementary measures to protect their rights (Rebeleanu et al., 2013; Vicol & Necula, 2013). The

EUNOMIA study highlights the lowered levels of social functioning of the patients with mental disorders, patients considered to be vulnerable, admitted especially by the form of involuntary admission (Kallert, 2011).

Psychiatric emergencies by involuntary admission are procedures that imply multiple ethical discussions (Fiorillo et al., 2011). Studies have shown that the frequency of involuntary admissions in terms of the legal, social and cultural variability is from 3% to 30% (Portugal vs. Sweden) (Salize & Dressing, 2004). Likewise, the increase in the number of medical-legal institutions give rise implicitly to the frequency of involuntary admissions (Priebe et al., 2005, Priebe et al., 2008). The EUNOMIA study highlighted the improvement of symptomatology in involuntary admissions (Kallert et al., 2008; Katsakou & Priebe, 2006), the patient's perception regarding the coercion measure being of high importance to study (Kallert, 2008). The legal regulation variability regarding involuntary admissions, coercive measures and human rights influences the domain of psychiatric clinical practice, with major differences between the European countries (Kallert et al., 2005; Kallert et al., 2007). In the past, the measures for total abolition of mandatory measures in the mentally ill patient therapy have suffered numerous changes and the frequency of coercive measures usage was reduced significantly (Steinert et al., 2007).

Material and method

A quantitative study was carried out that had as an objective finding the coercive measures in patients committed by form of involuntary admission, during a period of 10 years inside a psychiatric hospital, by Law 487/2002, the law of mental health and protection for people with psychiatric disorders. The study follows the way that mechanical contention was justified during admission, having in mind the consequences on oneself, referring to the trespassing the right to self-determination. The performed study is retrospect, carried on during the period of October 2002-july 2012, the data being obtained from the charts of a lot of 202 patients involuntary admitted in the "Socola" Institute of Psychiatry Iași.

Results

From the studied cases, of the total number of involuntary admissions carried out during 2002-2012, a number of 25.7% of committed cases was highlighted, that needed coercive measures during admission. Most cases that needed coercive measures were registered in the year 2007,

representing 13.5% from the total lot with mechanical restraint during the hospitalization period.

The involuntary admitted subject lot that needed mechanical restraint during admission, presented a downward annual distribution ($y=8.05-0.21x$). The ratio of subjects involuntary admitted that needed mechanical restraint for symptoms as self-harm was of 58% of cases, meanwhile symptoms like hetero-aggression was reason for mechanical restraint in 43.3% of mentally ill patients. The frequency distributions did not present significant differences from a statistical point of view ($p=0.147$).

Police involvement, with or without an ambulance, in the hospital transportation of subjects that needed coercive measures, was a ratio of 71%, a higher ratio compared to that of subjects that did not need coercive measures (57%), but this does not have significant differences statistically ($p=0.178$). From a statistical point of view no significant differences were highlighted concerning middle age in the subject lot that needed coercive measures ($p=0.915$), the mean age being that of approximately 40 years. The distribution of subjects with/without coercive measures had no significant differences linked to the background origin ($p=0.153$), 61.5% of subjects that needed coercive measures and 73.3% of those that did not need these measures are from urban background.

The mean number of admission days in patients that needed coercive measures during hospitalization was slightly higher (37.54 vs 33.23 days), without registration any differences from a statistical point of view ($p = 0.310$).

From the patient lot, 60% of subjects who needed coercive measures had no job, and from the rest of patients, 20% were employed and 20% were retired, though the frequency distributions did not differ significantly in comparison with the subjects that did not need coercive measures during admission ($p=0.536$).

Conclusions

Many times involuntary admission, respectively compulsory treatment and mechanical restraint, are measures necessary in the psychiatric medical assistance. This way, autonomy is breached by forms of self-harm or hetero-aggression, in the psychotic symptomatology in which the patient does not have his/her disease consciousness. Coercive measures are still utilized at a large scale in psychiatric care. Problems regarding ethics in psychiatry remain an open subject, permanently having the possibility to reevaluate legal and ethical aspects and their adaptation to modern times.

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