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Psychiatric emergency-treatment: help against one's will or action of professional violence?

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Abstract. Treatment with toxic psychiatric drugs and electroshocks, bearing risks of irreversible brain damage, are dangerous interventions into bodily integrity. This is especially true in neuroleptics, the atypical ones included those that can cause disease and death. In general, psychiatric treatment does not deal with the causal problems that lead to commitment. Often human and civil rights are violated in psychiatry. Funding for user-run or user-controlled alternatives are necessary. The Berlin refuge, besides other alternative institutions, shows that psychic crisis, which usually lead to commitment and forced treatment, can be managed without psychoactive drugs and means of coercion. Psychiatrists asked what they would want for themselves if in a psychic crisis were afraid to be treated as their patients are. "Participation of the users" and "innovative approaches" should be the keywords of reforms, new approaches should be based on the needs and interests of clients and users. Information, prevention and activities focusing on the major threats to health should have high priority, human beings in psychosocial emergency should have choices. The withholding of choices in particular turns psychiatric emergency wards into dictatorial institutions, undignified in a society understanding itself as free and democratic.

Keywords: alternatives, forced treatment, human rights' violation, refuge, treatment-damages, user-participation.

Emergency treatment and the European network of (ex-)users and survivors of psychiatry

In general psychiatric emergency treatment equates with the suppression of disturbing and uncomfortable ways to live and feel by means of psychotropic substances or electroshocks without informed consent. Based on their position of power, guaranteeing the status quo, there is a tendency by helpers/professionals to interpret emergency treatment as help against one's will. Many persons treated, however, conceive this treatment as the withholding of human support and as professional violation of human rights, especially the right to freedom from bodily insult.

A wide range of perspectives to enhance the situation of the (ex-)users and survivors of psychiatry have been highlighted by the European Network of (ex-)Users and Survivors of Psychiatry, with the term "user" referring to people who have mainly experienced psychiatric diagnosis and treatment as helpful in their specific situation. The term "survivor", in turn, refers to those who have mainly experienced psychiatric diagnosis and treatment as posing a danger to their health and life. These definitions are often misunderstood: to "survive psychiatry" does not mean that psychiatrists are being accused of trying to intentionally maltreat or kill people; but it does mean that diagnoses such as "schizophrenia" and "psychosis", which very often have a depressing and stigmatizing effect, lead to resignation and chronic hospitalization. Therefore, these must be prevented as must the side effects of drugs such as neuroleptic malignant syndrome, tardive dyskinesia, febrile hyperthermia, pneumonia, asphyxia and other dystonic or epileptic attacks, which can pose a danger to health and sometimes cause death. The unifying element in the European Network is dissatisfaction with the psychiatric system. This does not deny problems that have to do with psychosocial stress or with mental ill-health and mental disorders; nor does it deny that some of the persons treated are fully satisfied with their treatment.

Dangerous treatment forms

Many actual forms of professional action even if they happen within the framework of health promotion might even – unintentionally – enhance marginalisation processes, as the report of "Promotion of mental health on the European agenda" states [1]. According to thousands of reports, psychiatric treatment, especially electroshock and psychiatric drugs such as neuroleptics and antidepressants, can cause a deterioration in mental health. Neuroleptic drugs can lead to apathy, a state of absolute emotional deadness, depression, suicidal states, confusion, delirium and intellectual disturbances. Antidepressants and lithium can lead to apathy, depression, suicidal states, loss of creativity and lack of concentration. Antiepileptics (administered as psychotropic drugs, e.g., carbamazepin) can lead to apathy, paradoxical agitation, lack of creativity and epileptic attacks. Psychostimulants (administered to children in order to subdue them) can lead to apathy, depression, paradoxical agitation and memory problems. Tranquilizers can lead to lethargy, suicidal states, paradoxical agitation, sensory problems and memory gaps [2].

Even if many individuals feel that they cannot continue to exist in their present condition without taking psychiatric drugs, the treatment may still cause a deterioration in their mental health by, among other things, lowering their emotional resilience, impairing the conditions for psychosocial development and life skills, reducing their capacity to deal with the social world and to recruit the support that could be provided by other people, and diminishing their capacity to participate in the common effort to improve the environment and other conditions of life. Drug-caused receptor changes cause other mental health problems, making the life of many patients even worse and preventing them from having equal opportunities in life. The treatment may, thus, result in increased risk of marginalisation, disability and death. Indeed, as a result of suicide and other causes of death, the mortality of psychiatric patients is markedly higher than

that of the population in general.

Neuroleptics, antidepressants, lithium, antiepileptics (administered as psychotropic drugs), psychostimulants (administered to children in order to subdue them) and tranquilizers can have severe, permanent and even lethal effects. The psychologist David Hill from the British organization MIND has estimated that, by 1992, 190,000 people were known to have died from the neuroleptic malignant syndrome, a so-called side effect of neuroleptics – without taking into account the huge number of unrecorded cases [3]. Another example is the above average incidence of breast cancer among female psychiatric patients: the rate is 3.5 times higher than among patients in medical hospitals, and 9.5 times higher than in the average population [3,4]. This obviously has to do with increased production of the hormone prolactin, another so-called side effect of psychiatric drugs. This effect you can see in all kind of psychiatric drugs, and in the modern atypical neuroleptics too. These drugs are suspected of producing chronic psychosis and blood diseases in a higher rate than the conventional neuroleptics. The risk of clozapine, an older atypical neuroleptic, to cause agranulocytosis, leading to a death rate of 50%, is well-known. Remoxipride, a modern atypical neuroleptic, was introduced on the German market in 1991 and known as "the rose without thorns", meaning a neuroleptic without side effects; 3 years later it had to be withdrawn from the market again due to fatal blood disorders [3]. Since 1978 it has been mandatory in the USA to make information available on the fact that rats which receive neuroleptics in maintenance treatment and in comparable dosages may start to develop neoplasm in breast glands that may result in tumors. All the literature shows that especially neuroleptics and even so-called low-potent neuroleptics, can produce irreversible and life-threatening damage after only a short period of application and are principally dosage-independent, so that sometimes one so-called mini-dose can lead to a life-threatening bodily disease (e.g., asphyxia as a result of aspiration). This emphasizes the necessity of receiving informed consent when administering psychiatric drugs. It is the perspective of the European Network to implement or strengthen users', ex-users' and survivors' rights to self-determination at all levels of the psychiatric system.

A controlled survey on quality of care

A quality-of-care-survey, made in 1995 by the German Bundesverband Psychiatrie-Erfahrener e.V. (German association of human beings who have experienced psychiatry) shows the catastrophic situation for people treated in emergency psychiatry. Over 100 members of the organization had participated in the survey, which was suggested by the psychiatric magazine "Sozialpsychiatrische Informationen". The results:

> Mainly "no" was answered to the question asked, whether they dealt with special problems, which led to admission +98 to the madhouse. Only in about 10% of the cases had they obviously dealt with the causal problems. The question of whether human dignity was respected without limits, showed similarly shameful results. We can assume in only 10% of the cases that this is correct, many people came of their own will, but the psychiatrists put them in the closed ward and forced them to take psychiatric drugs. Some (10%) of the ill people were tied to the bed and were given injections in a dosage that was too high. "They laid me in a cell without a bed on the bare floor and locked me in over night." The term "cell" instead of "patient's room" often appears. Complaints were also made about authoritarian and indifferent staff, arrogance instead of the ability to empathize, fixation, tranquillization, isolation, beating, which indicate in almost all cases humiliating treatments. According to the answers the patients' wish was ignored in 90% of the people questioned. In not one case was the answer "yes" given to the question, whether or not psychiatrists gave complete information to the persons they treated about the risks and side effects of treatments. Only seven of the 100 people questioned could have had sufficient time to reflect on the treatment forms offered and speak with people they trusted about them. Only 10% of ill people could decide freely, that is, without any fear of the consequences of rejection [5].

These results differ from published results of surveys made by psychiatrists themselves, this is mainly due to three reasons. The questions were formulated by people who experienced psychiatric treatment themselves. The answers were given outside the psychiatric sphere of influence, so the people answering did not have to be afraid of being punished at some time. (Ex-)Users and survivors of psychiatry participated in the analysis.

Funding and appropriate help

Funding is necessary to create effective social and emotional support controlled by (ex-)users, users and survivors of psychiatry themselves and by people they trust. Therefore, the European Network favors refuges, crisis centers and communication centers combined with self-help, without registration and without compulsory methods [20]; supportive institutions to which people do not have to be removed forcebly by the police but where they can go with trust instead of fear, even when they are emotionally extremely stressed or confused.

Without underestimating the responsibilities and potentials of health and social care institutions and of working life, we urgently need to enhance the situation of the so-called mental patients in emergency situations. "Participation of the users" and "innovative approaches" should be the keywords. New models of support in emotional crises, without the risk of causing a deterioration in mental health or increased marginalisation as a result of professional actions, are needed. These approaches should be based on the needs and interests of clients and users to a greater degree than they are at present. Information, prevention and activities focusing

on the major threats to health should also have high priority.

There is a basic need to put the discussion of alternatives to current psychiatric institutions on the political agenda. We need a public and open discussion about innovative approaches to the development of better concepts, about methods of evaluation and sets of indicators relating to mental health and its promotion, and about the development of better methods for enhancing the visibility of the best national and European models of promotive work.

Example Berlin runaway house

One example of an appropriate and user-controlled institution is the Berlin refuge. The refuge is an institution for people who have decided that they want to live without psychiatric diagnoses and without psychoactive drugs. Here they can regain their strength, talk about their experiences and develop plans for the future without psychiatric views of illness blocking access to their feelings and their personal and social difficulties. People who are addicted to alcohol or drugs or who are in forensic care cannot be admitted. In the team 10 social workers, survivors of psychiatry and psychologists and four short-time employed people work around the clock. Half of the staff members are survivors of psychiatry.

The dream of the refuge could come true because of a donation of one million DM from a relative. With this donation, the Association for Protection against Psychiatric Violence, which is a charity, was able to get an old villa in the northern part of Berlin. With contributions from charitable lotteries, sympathetic associations and of individuals and sponsors, the building was transformed into the refuge "Villa Stoeckle". It was named after Tina Stoeckle who had cofounded the project in its first stages and who died in 1992.

The Berlin refuge was opened on 1 January 1996. The internationally highly regarded model project offers protection to homeless people who want to escape from the violence of psychiatry and the effects of revolving-door psychiatry. The refuge is the first officially run institution in Germany of its kind. The Association for Protection against Psychiatric Violence (the supporting foundation behind the house) has fought for 10 years to establish its antipsychiatric project; its continuation is acutely endangered by capricious administrative acts.

Three years work experience in the refuge has shown that psychic crises can be managed without psychoactive drugs and without means of coercion. However, such crises have put the hard test to the tolerance of co-inhabitants and staff which reached its limit at the employment of force against others. When contact with certain inhabitants stopped short or mutual agreements became impossible, it was difficult. For those reasons some people have left the project. In other cases inhabitants had to leave because of alcohol- or drug-abuse. Those who had to go for the above reasons often returned to living in the street or to psychiatry because of lack of alternatives. Regularly the inhabitants who had previously been treated with psychoactive drugs against their will, were not sufficiently informed, and their problems not considered [7].

Psychiatrists would want alternatives for themselves

Psychiatric workers know of the suffering (ex-)users and survivors of psychiatry experience in madhouses. This was shown at the Congress Stationaere Alternativen (Inpatient alternatives), held by the Swiss psychiatry foundation Pro Mente Sana 1992 in Nottwil, Switzerland. In the working group Asylum for (ex-)users and survivors of psychiatry, male and female psychiatrists, social workers and nurses presented their practices vividly and realistically. They described many depressing reasons to run away in case they themselves should experience psychiatric practice on their own bodies; in detail they told of:

1) force: forced commitment; forced treatment; intimidation during the stay and the consent to treatment;
2) lack of rights: incapacitation; no information about the risks and damage of the treatment; only "yes" is accepted as legally valid, but not "no"; treatment occurring in spite of current legal action; dependence on psychiatric workers; lack of freedom to decide (being forced to give reasons for everything); lack of the right to look fully at their own treatment records; the choice of madhouse and key worker;
3) treatment: neuroleptics as main treatment, treatment setting: danger of the admission ward; imposed day structure; destructive time spent; hours of handicraft work getting on your nerves; therapeutic work of expression under neuroleptic armor-plating; forced communication; forced to share sleeping quarters; permanent control; reduced privacy, and
4) diagnostics: being reduced to a diagnosis [8].

Improving quality assurance in the psychiatric and psychosocial field

In addition to supporting the development of alternatives in human and social rights and the exchange of relative information, the European Network is making proposals to introduce or improve quality assurance in the psychiatric and psychosocial field. In April 1997 the European Network was asked by the World Health Organization to comment on the planned Declaration on Quality Assurance in Mental Health Care. To promote the human rights of people in the psychiatric system the European Network suggested, among other things, that:

1) (ex-)users, and survivors of psychiatry should be invited to hearings before legislation is enacted;
2) (ex-)users and survivors of psychiatry should be invited to be ombudsmen and women at a national level;
3) there should be a body including (ex-)users and survivors of psychiatry at a national level to monitor the human rights of people who have, or who are said to have, mental disorders, and to record new treatment measures and the decisions of ethical commissions in research fields;
4) (ex-)users and survivors of psychiatry should be involved in the education and examination of health and psychiatric professionals in a paid capacity;

5) irreversible treatments such as psychiatric drugs, electro- and insulin shock for mental disorders should never be carried out on an involuntary patient or without informed consent. Psychiatrists who treat patients without informed consent should lose their medical license;
6) clinical trials and experimental treatments should never be carried out on an involuntary patient without informed consent, institutions carrying out any such measures should be obliged to prove that any damage arising was not caused by these measures [9].

As for improving the current situation in psychiatric emergency wards: good will could be sufficient. Here are some minimal demands, made to WHO and WPA by the European Network of (ex-)Users and Survivors of Psychiatry: There should be phoneboxes for inmates/patients in each psychiatric ward. There should be easily visible coin-operated telephones at the entrance halls of each psychiatric institution. In each psychiatric ward there should be a notice that is easily visible, saying when inmates/patients can get writing paper, envelopes and stamps if wanted. There should be noticeboards in every ward, on which local, regional and national organizations of (ex-)users and survivors of psychiatry can put up uncensored information. For each inmate/patient there should be the possibility of taking a daily walk in the open air for at least one hour. On each ward there should be a kitchen where inmates/patients can prepare food and drinks around the clock. In the medium and long term, however, the situation will change only if:

1) you get rid of the scientifically outdated conception of man, unilaterally dominated by natural science and medicine that reduces the human being with psychosocial difficulties to a mistake of his metabolism that can be manipulated psychopharmacologically and electrotechnically;
2) organizations of (ex-)users and survivors of psychiatry can participate in a meaningful way in decision-making structures and can have control functions, e.g., in law-making processes, in the editorial staff of specialist magazines, in the education and training (including the boards of examiners) of psychiatrists, physicians, psychologists, nurses, social workers, occupational therapists at a well-paid level, in congresses and in bodies that register new treatment measures and in ethical commissions in research fields;
3) the legal position of the (ex-)users and survivors of psychiatry is strengthened, for example, if the institutions and persons carrying out psychiatric emergency measures are obliged to prove that possible damage is not due to these measures, if declarations of consent in advance (psychiatric consent, treatment agreements) are acknowledged legally;
4) the psychosocial system meets the needs and demands of the ex-users and survivors of psychiatry, giving a free choice for everyone whether he or she prefers to visit a psychiatric hospital or a psychosocial institution outside the psychiatric system, e.g., a nonpsychiatric refuge or an institution like Soteria, California).

The right to drug-free care has to be respected both in- and outside psychiatry. Low-risk naturopathic psychotropic drugs, specialized nutrition (healthy food, vitamins, minerals, proteins) have to be available and offered [9].

Forced treatment: Psychiatry's basic evil

The basic legal problem in psychiatry is forced treatment. Who can count the people who give the madhouse a wide berth even in a situation when they know that they need help? Who can count the people who killed themselves due to fear of being committed and treated by force? Who can count the people who had traumatic experiences with forced treatment? Of course physicians have the duty to forcefully treat a person who cannot express his or her natural will rationally and is in deadly danger, but whoever died from a syndrome characterized by a lack of haloperidol? If people who do not work inside a psychiatric institution do not know about the dangers and risks caused by the administration of psychiatric drugs and electroshocks, they may not understand that fundamental violation of the inviolable dignity which should be guaranteed by human rights' declarations and national constitutions.

As in medicine in general, treatment without informed consent in emergency psychiatry has to be banned; only in a concrete and provable acute life-threatening situation, in accordance with the proven impossibility to express the natural will, can a life-saving treatment without consent be justified. Generally speaking, the absence of psychiatric drugs like haloperidol can neither be seen as causing a life-threatening illness nor can the application of psychiatric drugs be definitely considered as a life-saving measure. So emergency psychiatry treatment without informed consent has to have consequences based on punitive and civil law. Patients who think it is good for them to be treated by force in a state of emergency may make declarations of consent in advance to allow forcible treatment in their cases.

That forced application is not necessary, but dangerous and antitherapeutic, is shown by a lot of experiences as well as by the refuge in Berlin. There is a lot of literature about the issue and these experiences [10–20]. Another example, where results are possible if there is good will and willingness on the part of psychiatrists to work without force and to communicate with the relatives and friends of their patients and especially with patients themselves, this is the "open dialogue" principle, practised in a certain area in the northern part of Finland (covering a population of 90,000 inhabitants). The "open dialogue" is the fundamental treatment principle: within 24 h the staff member who receives a patient has to arrange the first session with the patient, a relative and a group of professionals. In many cases, the first session more or less solves the problems. The session can take place in the patients home, at the hospital or somewhere else. The idea is to make the many voices speak and not to talk about the patient without his or her participation. The language of the professionals has to cope with the language of the user (how willing this person may be to use psychiatry). In 1997,

out of 64 first-time diagnosed "schizophrenics", only 16 were given neuroleptics. This positive Finnish experience with open dialogue as the fundamental principle of psychiatry should be highlighted and introduced elsewhere in psychiatry, as well as in emergency psychiatry.

There are psychiatrists who support our demands as there are psychiatric patients who understandably consider treatment by force as helpful, especially given the lack and withholding of treatment alternatives. The impossibility of solving this conflict gives evidence of the following: a positive reform of the situation in emergency wards is only possible under the following conditions; with the enhancement of the legal status of the (ex-)users and survivors of psychiatry; with a psychosocially-oriented education for psychosocial workers, integrating the treasure of knowledge of the people who have experienced psychiatric treatment and coping with different psychiatric problems; by means of the integration of the (ex-)users and survivors of psychiatry into all decision-making structures and their inclusion in treatment teams (and not at the bottom of the hierarchy); by financing nonpsychiatric forms of support for human beings in psychosocial emergency in order to create possibilities for having and making choices. Particularly, the withholding of choices turns psychiatric emergency wards into dictatorial institutions, undignified in a changing society understanding itself as free and democratic.

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