

## Forced admission and forced treatment in psychiatry causes more harm than good

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Forced treatment in psychiatry as we currently know it cannot be defended, neither on ethical, legal or scientific grounds. Ethically, the patients' values and preferences are not being respected, although the fundamental human right to equal recognition before the law applies to everyone, also to people with mental disorders.<sup>1,2</sup> This is clear from the United Nations Convention on the Rights of Persons with Disabilities,<sup>2</sup> which virtually all countries have ratified. However, we ignore the convention and continue to discriminate against people with mental problems.

Please consider this. Doctors cannot give patients insulin without their permission, not even if the lack of insulin might kill them, and they cannot give adult Jehovah's witnesses blood transfusions without their permission, even if the lack of blood might kill them. The only drugs that can be given without permission are also some of the most dangerous ones. Psychiatric drugs are the third major killer after heart disease and cancer, with an estimated 539,000 deaths in the United States and European Union combined.<sup>1,3</sup> Only soldiers at war and psychiatric patients are forced to run risks against their will that might kill or cripple them. But there is an important, ethically relevant difference: soldiers have chosen to become soldiers; psychiatric patients have not chosen to become psychiatric patients.

In many countries, a person considered insane, or in a similar condition, can be admitted to a psychiatric ward on an involuntary basis if the prospect of cure or substantial and significant improvement of the condition would otherwise be significantly impaired. After having studied the science carefully over many years, I have come to doubt that this is ever the case.<sup>1</sup>

Forced treatment most commonly involves the use of antipsychotics, but they are very poor drugs. The placebo controlled trials are seriously flawed because they have not been adequately blinded.<sup>1</sup> Antipsychotics have many and conspicuous side effects, so most doctors and patients can guess whether an active drug or a placebo is given, which exaggerates the measured effect markedly.<sup>1</sup> Furthermore, almost all patients in these trials were already in treatment with an antipsychotic drug before they were randomised after a short wash-out period. This cold turkey design means that abstinence symptoms - which may include psychosis - are being inflicted on patients who get placebo. Even helped by these formidable biases in the trials, the outcome is poor. The minimal improvement on the Clinical Global Impressions Ratings corresponds to about 15 points on the Positive and Negative Syndrome Scale,<sup>4</sup> but what was obtained in recent placebo controlled trials in submissions to the FDA for newer antipsychotics was only 6 points,<sup>5</sup> although it is easy for scores to improve quite a bit if people are knocked down by a tranquilliser and express their abnormal ideas less frequently. Thus, the FDA has approved newer antipsychotic drugs whose effect is far below what is clinically relevant. Old drugs are similarly ineffective.<sup>1</sup>

Whereas the benefits of antipsychotics are doubtful, the harms are certain, and the cold turkey design is lethal. One in every 145 patients who entered the trials for risperidone, olanzapine, quetiapine and sertindole died, but none of these deaths were mentioned in the scientific literature.<sup>6</sup> Therefore, if we want to find out how lethal these drugs are, we should look at trials in dementia, as such patients are not so likely to have received antipsychotics before randomisation. Randomised trials in dementia shows that for every 100 patients treated for a few weeks, one is killed by an antipsychotic, compared to those treated with placebo.<sup>7</sup> It could even be worse than this because deaths are seriously underreported in published trials. For example, a review found that only 19 of 50 deaths and 1 of 9 suicides on olanzapine described in trial summaries on websites also appeared in journal articles.<sup>8</sup>

There is no evidence that mechanical restraint in belts or seclusion has any benefits, but these treatments can also be lethal. Violence breeds violence and when psychotic patients become violent, it is very often because of the inhumane treatment they receive. It may also be because they get abstinence

symptoms when they drop a few doses of an antipsychotic because they are very unpleasant to take, which can include akathisia - an extreme form of restlessness that predisposes to both suicide and homicide.<sup>1</sup>

Electroshock is also forced on people although it doesn't seem to work for schizophrenia and although the effect on depression is temporary, which often results in a series of shocks.<sup>1</sup> About half of the patients get memory loss<sup>1</sup> and the more treatments they get, the more severe is the memory loss.<sup>9</sup> Some psychiatrists claim that electroshock can be lifesaving but this has never been documented whereas we know that electroshock may kill people: about 1 in 1000 patients die.<sup>10</sup>

Another reason for using force is if patients present an obvious and substantial danger to themselves or others, in which case they can be involuntarily admitted. However, this is not necessary. The National Italian Mental Health Law specifies that a reason for involuntary treatment cannot be that the patient is dangerous. This is a matter for the police, as it also is in Iceland, and patients in Italy can decide that they want treatment elsewhere.<sup>1</sup>

Forced treatment does more harm than good and it kills many people, not only because of the direct harms of the drugs but also because of suicide. A register study of 2,429 suicides showed that the closer the contact with psychiatric staff – which often involves forced treatment – the worse the outcome.<sup>11</sup> Compared to people who had not received any psychiatric treatment in the preceding year, the adjusted rate ratio for suicide was 44 (95% confidence interval 36 to 54) for people who had been admitted to a psychiatric hospital. These patients would be expected to be at greater risk of suicide than other patients (confounding by indication), but most of the potential biases in the study favoured the null hypothesis of there being no relationship. An accompanying editorial noted that some of the people who commit suicide during or after an admission to hospital do so because of conditions inherent in that hospitalisation.<sup>12</sup>

I fully admit that some patients are very difficult to treat optimally without using force. But it seems that, with adequate leadership and training of staff in de-escalation techniques, it is possible to practice psychiatry without using force.<sup>1,13,14</sup> In Iceland, belts have not been used since 1932, and there are psychiatrists all over the world who have dealt with deeply disturbed patients for their entire career without ever having used antipsychotics, ECT or force.<sup>1</sup>

I believe we have to abolish laws of forced admission and treatment, in accordance with the United Nations Convention on the Rights of Persons with Disabilities.<sup>2</sup> Abandoning using force will be harmful to some patients but it will benefit vastly many more. We will need to work out how we may best deal with those patients who would have benefited from forced treatment in a future where force is no longer allowed.

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