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Commentary

Involuntary hospitalisation: old and new

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Abstract

Current western involuntary hospitalisation legislation is based on legal philosophy and the freedom of the individual. Legislation based on medical philosophy, which focused on the need for care has been deposed. Formerly, doctors had greater authority, but with this came the difficulty of balancing the opposing agendas from various quarters. This role has been adopted by Mental Health Tribunals. Eventually, doctors accepted the new system, which in some ways made their lives easier. They continue to be concerned that the emphasis on freedom leaves some non-dangerous disorganized patients without care.

Keywords

Mental health legislation; involuntary hospitalisation; psychiatric intensive care

INTRODUCTION

The essence of medical philosophy and duty is the care of the sick. The essence of legal philosophy and duty is the protection of the innocent and the freedom of choice. Involuntary hospitalisation and treatment bring these disparate philosophies to a compulsory, uneasy meeting. The dominant philosophy has changed over time and differs between cultures.

The medical philosophy of care for the sick favours admission to hospital and treatment. The legal philosophy of protection of the innocent favours release from constraints, which naturally includes those "services".

In the case of the physically ill person who is conscious and has no mental illness there is no disagreement; the decision to accept or refuse hospitalisation and treatment is almost always a matter for the individual, irrespective of the consequences for the individual. An exception is where the individual has a highly contagious disease, such as tuberculosis in the past and potentially viral diseases in the future, where free movement represents a significant risk to the general public.

The mentally ill person, because of the mental illness, may not have the capacity to make the decision to refuse admission and treatment for the mental illness. In western cultures, the presence of mental illness alone, even with total lack of "insight" (the individual lacking knowledge that he/she has a mental illness) is not now sufficient justification for the imposition of involuntary hospitalisation and treatment.

Dangerousness is the accepted standard. Dangerousness in the absence of mental illness does not justify compulsory medical intervention. Dangerousness in the presence of mental illness,

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which compromises mental functions justifies involuntary hospitalisation and treatment. In the UK, this is made legal by the Mental Health Act 1983 (MHA) for the "safety of the patient or for the protection of others". Unfortunately, dangerousness is difficult, some say impossible, to predict (Litwack and Schlesinger, 1999). If dangerousness is inaccurately assessed, individuals may be improperly deprived of their right of free choice.

In many western cultures, but not all, another criterion which justifies involuntary hospitalisation and treatment is grave mental illness such that the individual is disabled and incapable of self-care. In the UK, this is made legal by the MHA: for the "health and safety of the patient". The definition of grave mental illness and disability varies, but includes a threat to the individual's life through an inability to provide the basic needs for food, clothing and shelter.

In most western countries, in the first half of the 20th century, with respect to involuntary hospitalisation and treatment, the medical philosophy and goal of providing care to the sick, was the dominant consideration. Following an application made by lay people, such as relatives or police, regarding a particular individual, doctors made decisions about the need for care, and these decisions were rarely vigorously challenged. In most jurisdictions, Mental Health Tribunals did not routinely review all cases of involuntary hospitalisation, but only those in which the committed individual lodged an appeal. As committed individuals were usually mentally disabled, appeals were relatively rare.

In the second half of the 20th century, the situation changed and the legal philosophy and goal of protecting the freedom of the individual became the dominant consideration. The current situation in all western jurisdictions is consistent with the 1991 United Nations "The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care". Doctors still make decisions about the need for care, following applications from relevant lay people, but these decisions can, following appeal, be reviewed within 28 days by a statutory Mental Health Tribunal. Other legal safeguards include extensive mandatory reporting by the health authorities to an external body in every case of involuntary admission, and the requirement for additional assessments by senior doctors to hold any individual in hospital beyond the first 72 h.

Currently, in many parts of the western world, a distinction has been drawn between hospitalisation and treatment. This paper focuses on involuntary admission. It is important to note, however, that authorisation to involuntarily detain does not always provide authorisation to involuntarily treat, and if an admitted patient refuses treatment, it may be necessary to pursue a separate process based on the same facts.

In the Islamic world commitment laws have the need for care and treatment of the mentally ill as the guiding principle (Chaleby, 2001). Accordingly, the matter of dangerousness and the associated debates do no arise, and involuntary admission and treatment are not separate matters.

DOCTORS IN THE REAL "OLD" WORLD

When the medical philosophy, focusing on care, was the dominant influence in involuntary hospitalisation, doctors had greater influence. But with influence came responsibilities, which were onerous. The doctor was identified as the responsible figure by various agents who had different priorities. The detained patient would often maintain that hospitalisation was unnecessary and plead with the doctor for release. The family would often complain to the doctor that their loved one was sick and in need of treatment. Sometimes, of course, the family were of the opposite view and would pressure for release. The police would often inform the doctor that that the individual was dangerous but because he/she had done nothing illegal (yet) there was nothing they could do, they would state that if released the individual was likely to do "something", and that the doctor was responsible for making sure (by extending the admission) that something terrible did not happen.

DOCTORS IN THE REAL "NEW" WORLD

Then the legal philosophy, focusing on freedom, became the dominant influence in involuntary hospitalisation. During the introduction phase,

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some doctors perceived the Mental Health Tribunals as yet another agency that was stressing them with additional requirements. In addition to the patient, the family and possibly the police, doctors interpreted appearances before the tribunal as another direction in which they had to defend their decisions.

The solution to the new situation was, however, simple. Doctors accepted that the system had changed from a medical to a legal orientation and passed over the responsibility for the decision to detain or release to Mental Health Tribunals. This released doctors from the stress of being the ultimate decision maker and they could refer complaining patients, families and the police to Tribunal decisions.

ISSUES ARISING FROM THE "NEW" SYSTEM

The new system has been described as a solution to a problem which did not exist. Mental health professionals in developed countries did not believe that there had been significant abuse of patients rights, and they were critical of the time consuming, expensive reporting procedures (including frequent appearances by professionals before Tribunals), and the large and expensive bureaucracies which support Tribunals. "Old timers" are able to point out that the majority of the patients who lived for years in asylums were not involuntarily detained, but remained by choice. In fact, with the arrival of deinstuitionalisation, some had to be strongly encouraged to leave.

The new system places public protection ahead of care of the patient, the primary medical concern. Naturally, this does not sit comfortably with doctors, but it has generally been accepted that this is the will of the people, and is unlikely to change. This is not the will of all the people, however, as the families of refusing mentally ill individuals frequently protest that mental health services do not retain their member in hospital long enough. Some correctly identify this as a function of the legislation rather than the fault of mental health professionals.

The abiding concern in many jurisdictions is that the requirement to demonstrate dangerousness allows mentally ill, but not clearly dangerous people, to go without care. A disorganised life-style and self neglect form a theoretical basis for involuntary hospitalisation and treatment, but this is problematic and the back alleys and parks of most cities house mentally ill individuals who in earlier times would have received more suitable housing and care.

In many jurisdictions there is a related concern arising from the separation of hospitalisation and treatment. This means that to care for refusing patients in accordance with medical philosophy, it is necessary to present the same material to two different authorities. This represents a waste of time and money and delays the provision of care.

References

Chaleby, K. (2001) Forensic Psychiatry in Islamic Jurisprudence. The International Institute of Islamic Thought, Richmond, Surry, UK.

Litwack, T. and Schlesinger, L. (1999) Dangerousness risk assessments: research, legal, and clinical considerations. In: Hess A Weiner I (eds). The Handbook of Forensic Psychology (2nd edition). John Wiley and Sons, New York, pp 171–217.

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