

Role of family and carers in compulsory mental health treatment

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Introduction

The civil commitment of the mentally ill person is a legal process that is primarily concerned with confinement and treatment of people who are disabled by a mental disorder. Although the purpose and objective of confinement under the mental health legislation may be remedial and therapeutic, legislation also appears to have been derived as a result of concern for protection of the community.

Treatment of a mental disorder under compulsion, as a legislated process that allows treatment to be given against the person's expressed wishes (or without informed consent), is somewhat unique among health disciplines. Medical practitioners working in branches of medicine other than Mental Health, at times, have to make treatment decisions on behalf of the patients who lack the 'capacity' (the English term) or 'competence' (its North American variant). However, it is quite peculiar that for treatment of patients with a mental disorder against their expressed wishes and without their consent, capacity and competence are not the criteria for treatment decisions. Instead, additional legal provisions in the form of presence of a mental disorder and presence of serious or significant risk have been deemed necessary and appropriate (Arya, 2012).

It is not unusual for family members and carers to be an integral part of decision-making process of civil commitment. Often they raise the alarm about the possibility that their family member may have a mental disorder for which assessment, including compulsory treatment, is required. The threshold at which family members and carers call for help and civil commitment is also a moving line as often the perceived risk and resources family members have determine whether they can continue to support the unwell family member without civil commitment. This can be a source of role conflict, confusion and misunderstanding.

The patient, the family, the community and the psychiatrist

Patients and their families can sometimes have different needs. Whereas the patient may value autonomy and independence despite experiencing a mental disorder, family members concerned about safety and welfare of the patient (or of others) may require mental health professionals to intervene using the Mental Health Act to manage, and if possible prevent, any adverse outcomes for the

patient (or others). Families often feel morally responsible to provide optimal care and support to the patient, which a person with mental disorder may not appreciate (as a result of their mental disorder) or wish to accept (irrespective of whether or not the person is suffering from a severe or incapacitating mental disorder).

Families are often expected to, and do, initiate assessment of the person under the Mental Health Act. Therefore, they can be perceived by some patients to be not acting in their (patient's) best interests. It is not unusual for some patients to feel that the families are abandoning them by initiating compulsory treatment or that their families would prefer to 'get rid of them' so that they do not have to carry on bearing burden of responsibility towards the patient.

Even in situation where families do not initiate assessment under compulsion, involvement of, and consultation with, the family is a significant part of any mental health assessment. The clinical practice standards and service standards that guide practice of mental health clinicians do require mental health clinicians to consider information and opinion of families when undertaking assessment and formulating treatment plans. Families are not only a source of useful clinical information; they are able to provide a longer term perspective on the patient's illness. A comprehensive assessment also allows determination of resources available to manage the patient's mental disorder. Ability of the families and carers to support the patient is often a determinant of what treatment can be provided to the patient and in what setting (e.g. inpatient or community). At times, whether compulsory treatment is required or not is contingent on whether families feel able to, or willing to, provide support, care and assistance to the person with a mental disorder. This can suggest to the patient that their families and caring services may be colluding and determining their fate without their involvement or participation.

In most jurisdictions, the psychiatrist is described as 'the clinician in charge of the treatment of the patient'. Clearly,

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the psychiatrist's primary concern is the patient, and he or she is guided by his or her patient's best interest. However, this has to be balanced with the expectation of the society that psychiatrists will take responsibility, even manage and control the behaviour of patients with severe mental disorder and if necessary disempower them (by use of compulsion) from making decisions that may pose a serious risks to them, or to others.

Involuntary commitment can be reassuring for the family as it ensures that their family member will receive the care he/she needs. Anecdotally, family members often express relief that by virtue of involuntary treatment provisions, responsibility for the welfare of the consumer with a mental illness is shared with mental health professionals. Removing complete responsibility from family members has also been attributed as a benefit of involuntary commitment of the consumer, as the mental health services are then able to take the responsibility away from the family (Adams & Hafner, 1991). However, patients can construe such a decision to initiate compulsory treatment in consultation with their families as a practice that is not necessarily for their benefit, but something that is for the benefit of others. On the contrary, a decision not to initiate compulsory treatment can be construed by the families (and the wider community) as failure to provide adequate care and treatment when that has been requested. Many psychiatrists feel that these often conflicting responsibilities and expectations interfere in their ability to develop rapport, form a trusting relationship and empower patients to take responsibility for their own treatment and supporting families and carers to provide best possible care to the patient, all of which are instrumental in facilitating recovery.

Should psychiatrists' decisions be influenced by families/carers?

Even though information provided by the family assists with the process of assessment and assists the psychiatrist to make assessment decisions with regard to compulsory treatment, this does not mean that views and expectations of the families and carers always prevail. Psychiatrists have to consider not only the information provided by families but also the objective evidence of mental disorder and attempt to engage the patient as an active participant in this process.

In relation to both the involvement as well as influence of family members in decisions with regard to compulsory treatment, there are several ethical questions from the perspective of the psychiatrist and clinical practice of psychiatry. These include the following:

Is it appropriate for a psychiatrist to be influenced by needs and perspectives of a family member in determining whether use of compulsion is appropriate as compulsory treatment does have significant impact on autonomy and freedom of the person?

If the psychiatrist chooses to give more importance to the patient's autonomy and not use compulsory treatment provisions, would it be possible for him or her to justify his or her decision if the patient did deteriorate and made some inappropriate financial, other material or social decisions that have an adverse impact on the family and even the wider community?

If the patient's mental state does deteriorate, would the family (and the community) have a grievance against the psychiatrist? Therefore, should the psychiatrist be defensive in his or her practice, override autonomy considerations and use the legal provisions available within the Mental Health Act, as that is the strategy that on balance will minimise the potential of risk for him/her and risk of harm to the patient?

It is also important to consider whether compulsory treatment is sometimes dressed up as a medical decision to gain social control of a behaviour that is seen to be slightly deviant by the family members, carers and the community in general.

For people experiencing severe mental disorders, it can be argued that because of impairment of their mental faculties these people are unable to make decisions with regard to accepting treatment that is in their best interest. These patients have an inability to make autonomous decisions, and therefore, it can be argued that concerns and opinions of the family members and carers should be given greater consideration in making treatment decisions. In such a situation, family members and carers are able to inform about the patient's needs, desires and expectations and what the patient would prefer to be done to him/her if he/she was able to give consent.

However, not all patients receiving compulsory treatment are unable or incapable of making treatment decisions that are in their best interest. Many people who wish to, and are able to, retain autonomous decision-making capacity may perceive their family members who make application under compulsory treatment legislation to be acting in their own interests over the patient's best interests. These concerns include suggestions that families/carers prefer compulsory treatment of the patient as it can potentially relieve them from the burden of providing care to the patient, require the patient to adopt a lifestyle that is compatible with their own likes and dislikes and in some way gain more control over the patient.

In addition to conflict with regard to their role in relation to patients with mental disorder, family members can also experience an internal conflict with regard to making an application for compulsory treatment of the person who they care for. The interplay can be between respecting the patient's autonomy and acting in the patient's best interest. While on the one hand, they may wish to support and provide as much care to the patient as they can, on the other hand, their concerns about risks and consequences

(material or other) that the mentally disordered patient may present to themselves or to the families and the wider community compel them to request compulsory treatment, which they know may result in incarceration and deprivation of their liberty. By participating in the process that overrules the patient's autonomous decision-making, they can be perceived by the patients to be not acting in their (the patients') interests.

Most psychiatrists are able to justify and rationalise application of compulsory treatment provisions within the Mental Health Act as a beneficent and non-maleficent act, that is, in the best interests of the patient and one that would enable the patient to receive appropriate care and treatment and return to his or her autonomous self in due course. However, the need to mandate compulsory treatment under the Mental Health Act can present with a potential role conflict for psychiatrists. Many experience this dilemma in carrying out their legislated responsibility that requires them to overrule their patient's wishes as well as their own clinical orientation to facilitate recovery, empower patients to make decisions and enable them to be more autonomous. This can place psychiatrists in a double bind – being simultaneously accountable to the patient as well as to the social and legislated requirements, with varying objectives and focal points.

Conclusions

The civil commitment of the mentally ill is a legal process that is concerned with confinement and treatment of people who are affected by a mental disorder. Even though the primary purpose and objective of confinement under the mental health legislation may be remedial and therapeutic, legislation in most jurisdictions also appears to have been

derived as a result of concern for protection of the community. A decision about compulsory treatment is informed by a number of considerations. These include input of the family as reliable informants as well as suppliers of resources to provide support, care and treatment to the patient. Families and carers involved in supporting the consumer are also able to provide longitudinal objective evidence of the patient's mental well-being at the point of assessment that is critically important.

The process of compulsory mental health treatment presents many complexities for families and caregivers. While the family's or caregiver's request for assessment under compulsory treatment is to protect the patient from perceived risks (to themselves or to others) and to prevent negative consequences of mental disorder, compulsory assessment and treatment does result in limiting the liberty of the patient. Family members concerned about the deteriorating mental state of the unwell member of the family are often the one who request assessment. This process tends to put them in conflict with the patient who may not necessarily perceive the need for assessment and treatment and, in many instances, is opposed to it. In an effort to act in the patient's best interests, at times, family members find themselves in direct contradiction to the desires of the patient. Many patients accuse them of colluding with psychiatrists and mental health services to get them admitted under compulsory treatment.

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