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Editorial

Unchaining people with mental disorders: medication is not the solution†

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Summary

Chaining of people with mental disorders, and their incarceration and abuse in prisons or mental hospitals, is an affront to psychiatry and humanity. Although mental healthcare always needs attention to cultural and social contexts, this must never be at the cost of allowing human rights violations to go unchallenged. A rights-based approach must enforce well-established international human rights conventions, and scale-up comprehensive community services around the needs and preferences of people affected by mental disorders.

Declaration of interest

None.

The study from Ghana described by Ofori-Atta and colleagues[1] in this issue of the *Journal* is remarkable for the fact that it represents a rare example of a randomised controlled trial conducted by mental health professionals within a prayer camp run by a faith-healer whose founding mission was to 'set free those held captive by Satan through its ministry of fasting and prayer'.

Ethical issues raised by conducting a trial that involves patients who are chained

Chaining is a 'long-standing custom' in which residents who are 'agitated, or considered at high risk for harming self or others, or leaving without informing staff' are shackled using 'a chain of approximately two feet in length which was fastened around one leg and anchored to the concrete floor'. On average, trial participants spent 12 out of the previous 14 days chained at the time of recruitment. Among the many notable features of this study are the ethical concerns, for example how such a large proportion of individuals with severe mental disorders who were chained could give 'informed' consent, or why the treating psychiatrists (who had similar levels of contact with participants in both trial arms) did not prescribe medication to participants in the control arm despite comparable levels of symptom severity in the two arms. These, and other, ethical issues are in part addressed in another editorial.[2] The reality is that the practice of chaining exists in many countries[3–5] and the global community of mental health practitioners, policymakers and civil society must find ways of partnering with communities, lay healers and religious providers to address this outrage.

The effects of antipsychotic medication on chaining

Indeed, an aspiration of the study must have been to influence a change in the practice of chaining through treatment with antipsychotic medication leading to reduced symptom levels. In this context, the most remarkable finding is that the prescription of antipsychotic medication did not reduce the number of days people were chained, even though there were modest improvements in psychosis symptoms. In essence, what this study has shown is that antipsychotic medication reduced symptom severity in patients with severe mental disorders, about 90% of whom were affected by a psychosis, confirming that patients with this condition respond to these medications even when they are chained in a prayer camp. However, this symptomatic improvement had no effect at all on the experience of being chained, demolishing the justification that chaining was used for control of behavioural symptoms of mental illness. Although we cannot be sure why people remained in chains despite clinical improvement, we can certainly speculate that this was in response to the stigma and fear that mental illnesses and related behaviours evoked in the care-takers. Even if unintended, the impression is of incarceration and punishment rather than care and concern. There is evidence from other countries that chaining occurs alongside beatings and incarceration and other forms of restraint.[6]

Why would healers and families subject persons with mental disorders to such conditions? We think that the relative absence of any other modality of care, combined with a poor understanding of mental illness and the effectiveness of biomedical interventions, significant stigma and absolute faith in religious authority, are likely factors.[6] Although religious and spiritual rituals and networks can support coping, seeking help from religious camps may reflect the absence of alternative systems of care so people rely on culturally (predominantly religious in this instance) and socially accessible sources of perceived help. This is not always to the benefit to patients as is shown in this paper.

The implications are clear: symptom control through the solitary use of medications is not a means to reduce chaining. Indeed, this study reaffirms the need for a comprehensive, biopsychosocial and humane approach to the management of psychoses. In particular, addressing the social barriers that perpetuate inhumane practices and prevent the inclusion of affected individuals in their communities requires much work especially in the areas of the world where health literacy and resources are very limited. In this respect, the authors' assertion that 'psychiatric care' did not reduce chaining is incorrect unless one assumes that psychiatry is defined only by the use of medication regardless of the social, cultural and personal contexts in which people live their lives. What might be the strategies of effective intervention in such settings?

Strategies to stop chaining

Foremost, we must acknowledge that just as enforcement of any law has a deterrent effect, so should we fiercely apply the prevalent laws on human rights and mental health, best exemplified by the United

† See pp. 9–10 and 34–41, this issue.

Nations Convention for the Rights of Persons with Disability, which has been ratified by nearly a hundred countries. While a carrot and stick approach of engagement with those who are at the front line of such abuses (such as the healers, health workers and prison guards in the institutions where such abuses are perpetrated) is essential, we must never allow cultural relativism to creep into arguments that justify these practices, even as an interim arrangement. Patients hold multiple explanatory models of their illnesses and are able to accommodate multiple models of care. Religious coping and social support can be helpful, but should not be permitted at the expense of basic human rights or to eschew all that we know about good mental healthcare.

Legislative action must be accompanied by a concerted effort to provide community-based psychosocial services, with a focus on social integration enabling people to enjoy the same rights as their fellow citizens, including the right to supported decision-making on matters related to their mental healthcare. There are good examples of such multimodal interventions to address chaining.[6,7] In July this year, the Mental Health Authority of Ghana (the same country in which the study took place) released 16 people held in shackles at the Nyakumasi Prayer Camp, a spiritual healing centre and those who were actively symptomatic were offered hospital care; in large measure, this was the result of strident advocacy by a coalition of non-governmental organisations.[8] In Indonesia, pasung (physical restraints such as chains) were widely used to deal with mental disorders; at one point, over 18 000 people were reported by the Ministry of Health to be in pasung. A national campaign focused on raising mental health awareness of the general population and intersectoral collaboration to provide community-oriented quality mental health services since 2012 has been associated with over 80% of 4200 individuals identified in pasung being freed.[9,10] Task-sharing of front-line delivery of a range of psychosocial strategies has been demonstrated to be an effective and affordable approach to implementing community based mental healthcare in these countries.[11,12]

Disturbing practices in high-income countries

Chaining in the form that is practiced in some traditional healing settings in low- and middle-income countries is not the only way in which the fundamental, universal, human right of freedom is violated for people with severe mental disorders. The fact remains that other, seemingly less disturbing, forms of denial of the right to freedom continue to be used in biomedical psychiatric facilities around the world, including well-resourced high-income countries, typically in the form of 'seclusion and restraints'.[13,14] Injustices are noted where the levels of compulsory treatment are rising in high-income countries where there are ethnic and social inequalities in the use of legislation to forcibly treat patients.[15,16] Indeed, the Prime Minister in the UK recently criticised the injustices brought about by the Mental Health Act in England and Wales, an Act that has influenced so many cultures of care and legislation around the world. The use of restraints and seclusion, and then the deliberate and coercive use of high-potency antipsychotic medication, jabbed into the body of a struggling patient held down by burly attendants, is perhaps the most common form of the sanitised version of chaining that has found its way into modern psychiatric practices. In the richest countries of the world, incarceration in prisons is yet another form, exemplified by the USA, which spends more money on healthcare than any other country but still enjoys the notorious reputation that, in as many as 44 out of its 50 states, more patients with severe mental disorders languish in prisons than in hospital (http://www.treatmentadvocacycenter.org/).

We should not be complacent. The operationalisation of rights-based legislation is long overdue, in particular through investments in community interventions driven by the needs and preferences of people with mental disorders, rather than those of their caregivers. An example of a service option that emphasises empowerment with information, recreational and skills-building opportunities for social integration is the Clubhouse, essentially a community run by people with mental health problems, in partnership with professional staff. Originating in the USA (the legendary Fountain House, opened in 1948 in New York, being the first example), there are now over 300 in over 30 countries, most of which receive significant funding from local governments. Engagement with the Clubhouse has been reported to lead to increased chances of employment and reduced frequency and duration of admission to hospital.[17]

Conclusions

Chaining of people with mental disorders is an affront to humanity, and is nothing less than a euphemism for the incarceration and selective punishment and exclusion of people with mental disorders. If the similar violations of human rights of people with HIV/AIDS are now a distant memory, this was in large measure because of the vigorous and unrelenting advocacy by a partnership of civil society advocates with the physicians and academics who devoted themselves to the care of people living with HIV/AIDS. The result has been dramatic: what was once a feared disease that was guaranteed to kill those affected has now become a chronic condition with a slew of human rights instruments guaranteeing free care and rights to live a life without discrimination. None of this has come cheaply: development assistance for health (the money the rich world doles out, mostly to low-income countries) amounts to over US$140 per disability-adjusted life-year of the burden of HIV/AIDS, in comparison with a paltry amount of a less than $1 per DALY for mental and substance-use disorders.[18] It is time for the psychiatric profession to stand up to this outrage and ensure that no one with a mental disorder is chained, literally or symbolically, ever again, for only when we stand united with our patients will the world take notice of our common cause.

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