UN CRPD: Perspectives for Psychiatric Care in Germany

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Requirement: social inclusion

I. Housing & living: Living & participating in the community
Inpatient treatment in the sector (neighborhood) in a general hospital with easy access for friends & relatives and close cooperation with outpatient services.
Poverty and mental health problems

Mental Health Burden (GHQ-28) shown by height of bars

Percent of the population on social aid (poverty index) color-coded: yellow < 20% dark red >40%
Requirement: social inclusion

II.
Working:
Access to normally paid jobs
Income inequality & mental health

Pickett & Wilkinson, BJP 2010
Jobless rates and mental health

- 60-80 percent of people (in the US) who live with mental illness are unemployed and, for people living with the most severe mental illnesses, unemployment rates can be as high as 90 percent. *(National Alliance of Mental Illness, 2010)*

- Unemployment has a negative effect on the mental health of men > women (age-adjusted odds ratio [OR] = 2.98; 95% CI = 2.30, 3.87) > OR = 1.51; 95% CI = 1.11, 2.06).

  ➢ Gender differences in effects were related to family responsibilities and social class *(Artazcoz et al (2004)*
Stress and unemployment during the COVID pandemic

Liu et al., Medicina (Kaunas), 2021
Requirement: social inclusion

III. Human rights in disease, illness and sickness
Article 14: Liberty and security of person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
   
   (a) **Enjoy the right to liberty and security of person**;
   
   (b) Are **not deprived of their liberty unlawfully or arbitrarily**, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to **guarantees in accordance with international human rights law** and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.
Coerced treatment against the will of the forensic patient is not allowed to protect other persons against criminal acts which the patient might commit after discharge, since future crimes could be prevented by detaining the patient in a psychiatric institution without treatment.

But the state is not obligated to leave forensic patients to the fate of permanent confinement because of the primacy of an illness-determined will, but coercion has to follow a rule of law.

→ Three state parliaments were urged to reformulate their civil commitment laws so, that compulsory treatments will be made possible under strict legal conditions, namely:

- the patient is not able to consent to the necessary treatment
- the physicians have tried to convince him
- the treatment is necessary to avert considerable health detriments
- the compulsory treatment is used as a last resort treatment
- its benefit-risk-balance is positive.
The concept of a mental malady: disease plus illness or sickness

Disease (ICD)

Sickness (ICF)

Illness
Treatment against the natural will of a patient only if:

1) Symptoms of a **disease**: dysfunction relevant for survival
   
   *plus 2) or 3)*

2) Subjective suffering or harm (**illness**)

3) Disability impairing basic social participation (**sickness**) 
   
   (cf. activities of daily living, not social conformity)
   
   *plus 4)*

4) No sustaining external cause

   *plus 5)*

4) **Lack of insight**

   (operationalized as in informed consent)

   (Bundesverfassungsgericht 2012; Müller et al., 2013)
Requirement: social inclusion

IV.
Treatment:
Respect for patients’ autonomy and preferences
PATIENTS: REBELLION

PERSONELL: CONTROL

[Diagram showing a cycle between 'PERSONELL: CONTROL' and 'PATIENTS: REBELLION']
Table 1

<table>
<thead>
<tr>
<th></th>
<th>Closed 91%</th>
<th>Open 75%</th>
<th>t/chi²</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients (n)</td>
<td>176</td>
<td>161</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (male)</td>
<td>111</td>
<td>97</td>
<td>1.6¹</td>
<td>n.s.¹</td>
</tr>
<tr>
<td>Age (years ± SD)</td>
<td>39.9 ± 15</td>
<td>40 ± 17</td>
<td>0.026²</td>
<td>n.s.²</td>
</tr>
<tr>
<td>Diagnoses</td>
<td></td>
<td>7.33¹</td>
<td></td>
<td>n.s.¹</td>
</tr>
<tr>
<td>Duration of stay (days ± SD)</td>
<td>18.8 ± 23</td>
<td>18.6 ± 21</td>
<td>-0.90²</td>
<td>n.s.²</td>
</tr>
<tr>
<td>Absconders (n = 57)</td>
<td>35</td>
<td>22</td>
<td>5.107¹</td>
<td>p = 0.029¹</td>
</tr>
<tr>
<td>Interval to readmission (days ± SD)</td>
<td>9 ± 9</td>
<td>26 ± 34</td>
<td>2.314²</td>
<td>p = 0.025²</td>
</tr>
<tr>
<td>Aggressive incidents (n = 36), 319 patients included</td>
<td>23</td>
<td>13</td>
<td>4.46¹</td>
<td>p = 0.050¹</td>
</tr>
<tr>
<td>Suicides (n)</td>
<td>2</td>
<td>0</td>
<td>2.2¹</td>
<td>n.s.¹</td>
</tr>
<tr>
<td>Instances of Coercive Medication (n = 25), 319 patients included</td>
<td>17</td>
<td>8</td>
<td>4.646¹</td>
<td>p = 0.037¹</td>
</tr>
</tbody>
</table>

¹ = Chi², Chi²-test.
² = t, t-test.

Lang et al., 2011 EJP
Reduced coercion due to home treatment
Schöttle et al., Psychother Psych Med 2014

50 patients (43,5 %) had experienced compulsatory admission at least once in their life,
in 34,8 % within the last 2 years before study inclusion.

Within the first 2 years in the study this number dropped to 7,8 %,
and 1 year later to 9,5 % (11) patients

(McNemar's Test, p < 0,001).
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Cooperations:
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