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ARE PSYCHIATRIC HOSPITALS AND PSYCHOPHARMACOLOGY THE ULTIMATE REMEDIES FOR SOCIAL PROBLEMS? A NARRATIVE APPROACH TO AID SOCIO-PSYCHOPHARMACOLOGICAL ASSESSMENT AND TREATMENT

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Psychotic Disorders, Personality Disorders, Narrative Analysis, Psychiatric Hospitals, Mindfulness, Psychopharmacology.

Abstract

Objective: To evaluate how mindful psychopharmacological treatment can be assisted by a narrative analysis of patients with mental illness at admission into psychiatric wards.

Population and method: A narrative and discourse analysis of patients' narratives innotesat admission into an adult psychiatric ward was used to generate a theoretical and practical model to aid socio-psychopharmacological assessment and treatment. The ward is a mixed-gender unit with seventeen beds for the general adult population presenting with psychiatric illness, including psychosis, personality disorders, mood disorders, adjustment disordersand substance misuse. The admission rate is about 250 patients per year.

Results: The narratives collected from patients with psychiatric illness revealed that different socio-demographic, ethnographic and economic reasons influenced, distorted or intensifiedpsychiatric diagnoses at admission into a psychiatric ward and the subsequent psychopharmacological treatment.

Conclusion: Mindful psychopharmacology is a comprehensive process that we defineas the socio-psychopharmacological assessment and treatment plan (SPPATP) model. This model is inclusive of a detailed analysis of the social, economic, ethical, personal and geographic factors that influence, modify or justify psychiatric diagnoses. Thus, this model suggests that a modern psychopharmacological approach utilise patients' narratives to develop alow-risk treatment plan that is mindful of patients' cultural milieu

Introduction

Inrecent years, psychiatry in theUnited Kingdom has witnessed an upsurge of admissions into psychiatric hospitals, which has created a rapid saturation of the available beds. Furthermore, a concern has arisen that psychiatric hospitals, like other health facilities, are gradually becoming places for "social admissions". This means that people who do not suffer from enduring mental illness are now seeking psychiatric hospitals as places for socialisation, especially when they are homeless, are facing minor life crises or are looking for companionship in timesof social isolation. In addition, mental health conditions requiring negligiblecommunity interventionsare instead relying on psychopharmacological treatment when community support is missing. This scenario has created a global need for a novel approach to psychopharmacological treatment. Therefore, the authors of this article propose thesocio-psychopharmacological assessment and treatment plan (SPPATP) model. This model comprises ananalysis and an awareness of the importance of using patient narratives of their social and cultural milieu to direct decisions about the most appropriate psychopharmacological treatments for their presenting psychiatric conditions. More traditional assessment and treatments are based on a purely diagnostic methodologyfocused only on mentalhealth symptoms. Thistacticrisks discouraging results becausethe social, economic, geographic and environmental factors of patients' presentationsare not included inthe equation for the psychopharmacologicaltreatment plan. What, instead, this

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paperaims to show is that modern mental health conditions can be caused or reinforced by social difficulties and impasses. Therefore, psychiatristsshould progressively aim to find substantial and non-threatening solutions that integrate psychopharmacological treatment with mindful psychosocial assessment. This theory-basedpaper also supports the idea that a widearray of social problems that have psychiatric pathologies as their outcomes can be more beneficially supportedbymindful psychopharmacology when the psychosocial determinants of psychiatric admissions are taken into account. The SPPATPmodel addresses the impasse created by the traditional dyadic psychiatric diagnosis–psychopharmacological treatment model in mentalhealth assessment. Instead, the authors of this paper propose an alternative approachto the socio-psychopharmacological treatment decision-making process that is inclusive of 1) the socio-psychopharmacological diagnosis of the psychiatric problem at admission, 2) a risk assessment of the impact that the psychopharmacological treatment will have on after-discharge care, 3) a mindful diagnosis of the possible psychopharmacological motives behind admission-seeking patients and 4) mindfulness of the psychopharmacological impact upon patients' life. Therefore, both major psychosocial theories and analyses of patients' narratives at admission into a psychiatric ward helped to create the SPPATP model, which is a novel practice in psychopharmacology.

Population and methods

Narratives help to explain how peoplemake sensein a participative practice. [1] Narratives also aid in retrieving, appraisingand integrating pertinent concepts of one's own environment to clarify one'sknowledge and engagement. [2]Furthermore, narratives represent a hermeneutic approach to research, this being a scientific interpretation procedure to understanding the meaning of human events, stories and other significant events in peoples' life. [3] This inductive and qualitative method aidsin creating models of observed phenomena. [4]In this research, grounded theorywasapplied to the narrative analysis, because it uses a processcalled "constant comparative methods" whereby the researcher finds similarities betweenpieces of narratives, called "incidents", during coding. [5]For this research, the authors analysed250patients' narratives in patients' notes at admission during the year 2016. The ward where this research took place is a general adult, mixed-gender ward withseventeen beds in a major psychiatric hospital in Colchester, Essex, United Kingdom. This is an acute unit offering inpatient services to the local population. The catchment area includes approximately 1,443,151 people as from data of the Census of 2015.Major diagnoses at admission were psychoses, including drug-induced psychoses, schizoaffective disorder, personality disorders (mostly borderline), mood and bipolar affective disorders and adjustment disorders. Access to the ward is open to a population from socio-economically deprived areas, with a high rate of unemployment, domestic violence, child abuse, social isolation, use of illicit substances and police records for criminality. The statistics from UK CrimeStats of Essex Police [6] indicate that the most prevalent crimes are antisocial behaviours (48,031 cases in 2016) and violent crimes (32,787 cases in 2016). This population accesses psychiatric hospitals for different reasons. Moreover, both the disclosed and hidden agendas that these patients bring to mentalhealth assessmentsshould informdecisions abouttheir psychopharmacological treatment.

Results

The analysed narratives generated three major strategies for the SPPATP model, which are discussed in the following paragraphs,socio-behavioural-psychopharmacological assessment and treatment (SBPPAT), socio-historic-psychopharmacological assessment and treatment (SHPPAT) and socio-economic-psychopharmacological assessment and treatment (SEPPAT).

Socio-behavioural-psychopharmacological assessment and treatment (SBPPAT)

NARRATIVE 1. A thirty-seven-year-old male with a dual diagnosis of substance misuse and brief psychotic episodes. 'I have been on the road for years. I use benzos because I can't sleep at night. When I have no money to buy Valium on the Internet, I become worried and I try to go to A&E (the accident and emergency department)to be admitted into hospital. I hope to get sufficient sleep tablets to go on for another week. I also try to get plentyof clonazepam at discharge for my girlfriend, who is also a drug addict. Most of the time, I mix substances, use legal highs and cannabis, as domy friends. Having benzos and antidepressants helps with my sleep and gives me a buzz. My community workers do not give me what I need. This is why I seek admission into psychiatric hospitals when I need'.

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The socio-behavioural-psychopharmacological assessment (SBPPA) model is supported by the authors' theory of socio-behavioural change. The core of this theory is that variations in a culture'ssocial typology determine variations in the vulnerable population that accessespsychiatric hospitals. More specifically, according to this model, diagnoses duringadmission intopsychiatric hospitals willreflect a global change in thepopulation's vulnerability to specific riskybehaviours, such as mental and behavioural disorders connected to theuse and misuse of substances.Consequently, in their psychopharmacological treatment decisions, psychiatrists need to be mindful of the post-discharge psychopharmacological risks posed by patients (e.g. selling psychotropic medication with street value) and the support available from the environment and community after discharge (e.g. the risk of patients' sharing benzodiazepines with friends or creating cocktails of their prescribed medications for unorthodox use). Furthermore, a mindfulpsychopharmacological solution should be non-life threatening for discharged patients. This also entails that psychiatrists be aware that patients with mental illnesscan use prescribed medication for non-therapeuticgoals, such as addictive behaviours. Other pivotal points in this model of psychopharmacological therapy for socio-behavioural problems are that this approach should be rapid, economical and used to resolve a crisis,such as psychotic episodes triggered by short-term drug misuse or intoxication that might benefit from antipsychotic medication. The SPPATPmodel can thus be seen asa safer approach to treatment. Furthermore, mindful psychopharmacology includes an awareness of the hidden agendas of patients with mental illness. For instance, these patients might askpsychiatristsfor medicationsthey are not initially offered, such as painkillers or sleep tablets. In fact, the process of agreeing on medication between psychiatrists and new patients can daunting and challenging, especially when admission-seeking/medication-seeking patients come into psychiatric hospitals with some detailed expectations about what psychotropic drugs should be provided to them. This behaviour is likely to be due to limited follow-up from primary care providers, prior addictions or simply biased expectations about what specific medications can do. Peer culture and peer pressure also have big impactson the information patients bring from their social environments. Consequently, during moments of decision-making about psychopharmacological treatment, psychiatrists need to consider how prescribed medications will be totally in the hands of their patients once they are discharged. For instance, powerful psychotropic drugs have street value and can be sold for money, can be used to overdose or can simply remain unused due to poor compliance or lack of patient response. These after-care risks alsorequire an ethical-psychopharmacological treatment decision thatis wise, decisive and complete when the patient is still in hospital. Therefore, psychiatrists have the duty to prescribe medication that not only reduces symptoms but also does not come with undue risk of overdoseif accidentally or voluntarily consumedby patients who want toend their own life.In this case,the narrative also describes what might be done with medication, as emerging from the storyprovided by a forty-five-year-old male patient, 'I sell pregabalin, as it has a high value on the street. Other times, I crush it and I don't swallow it because I can get a buzz. I always tell my doctor that I am anxious and that I need more pregabalin'.

Socio-historic-psychopharmacological assessment and treatment (SHPPAT)

NARRATIVE 2. A twenty-three-year-old woman with borderline personality disorder and suicidal ideation. 'I have been abused all my life. I have been sleeping rough since the age of 15, after I left home, because my father used to abuse me physically. I use medications to forget, to reduce all this pain and flashbacks I have in myself. I overdosed many times with my antidepressants when I felt very low and I wanted to die. I feel they gave me the strength to do so, and I realise that they made me more impulsive. I often mix my antidepressants and paracetamol to go to A&E(the accident and emergency department)for overdose. Then, I started to store lithium when I convinced my doctor that I was bipolar. I read that lithium is more effective and lethal in overdoses. The doctor thought that my highs and lows were signs of bipolar disorder, but I know that I am borderline. I keep self-harming and I constantly store oral tablets. I have a script from my GP(general practitioner or family doctor), and I always claim to be depressed or bipolar and that I need more medication. So, the doc keeps increasing my antidepressants or gives me what I need'.

This assessment is a supporting example ofthe authors' theory of historical-ethical change, whichis that a social downfall increasesmental illnesses, starting inadolescence but also found during adulthood. Consequently, patients who access psychiatric hospitals arefrequentlyadolescents, victims of derailed families, family abuse and problematic upbringingthat might havetaken place years ago and that donot necessarilyreflect thesocio-economic conditions of a definite geographic area. More specifically, psychiatric hospitals are witnessing an increase ofadolescents with antisocialpersonality disorder (primarily in males)andborderline personality disorder (primarily

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in females).These symptomsmay also becomorbid with post-traumatic stress disorder and attention deficit disorders. On the other hand, adolescent males are more inclined to be emotionally unstable and impulsive, with symptoms comorbid with antisocial personality disorders. These presentations can be attributed to a disrupted family upbringing of a vulnerablegroup of adolescents living into a problematic milieu. Therefore, as in the above case, the psychopharmacological treatment decision should include two parts. Initially, the socio-pharmacological diagnosis of the psychiatric problem should consider previous suicidal attempts by overdose with prescribed medications. Such repeated episodes suggest that a limit should be placed on the prescription of oral medications, mainly antidepressants, becausethe authors' experiences are when all patients with personality disorders are placed on antidepressants, specifically SSRIs (Selective Serotonin Reuptake Inhibitors), it often triggers increased impulsivity and suicidal ideation. The second psychopharmacological assessment entails a risk assessment of the pharmacological treatment afterdischarge. Here, the treatment decision should focus on what is mostappropriate, particularly in people who tend to disengage from services, interrupt prescribed medication and relapse during major life events. In these cases, mainly in patients with borderline personality disorder, histories of overdoses of prescribed medication—such as antidepressants, lithium and paracetamol—are common inclusions inpatient narratives in psychiatric hospitals and during A&Eassessments. Moreover, apsychiatric history may reveal violent family relations, inclusive of sexual and physical abuse. These abusesare likely to trigger long-term borderline personality disorders,particularly in the young female population. A riskyoutcome of the psychopharmacological treatment of adolescents with personality disorders is that they are inclined to impulsive acts, therebyoverdosing on prescribed psychotropic medication during major life crises. Hence, in this case, a mindfulpsychopharmacological solution would take into account the risk of overdose (which is likely to belethal in those treated with lithium), increased impulsivity and deliberate self-harm (especially when antidepressants are of the SSRI group and are notbuffered by major mood stabilisers) and brief psychotic episodes after life crises. Consequently, mindful psychopharmacology, in line with the SPPDT, should include the use of long-acting injections (LAI). In this case, the authors' clinical experienceand the international literature support the use of zucopenthixoldecanoate (Clopixol), which reduces the risk of self-harm. [7]Likewise, mindful psychopharmacology should prompt healthcare professionalsto be aware of patients' unofficial use of prescribed medications, such asusing cocktails of psychotropic medications for self-harm or overdoses and selling medications with street value, especially painkillers. Therefore, the socio-historic psychopharmacological assessment(SHPPAT)requires awareness of these elements while providing adequatetreatment to patients inside psychiatric hospitals and in the community after discharge. Finally, female patients with borderline personality disorder tend to create circumstancesthat trigger the desired reactions of mental health staff, who are unaware of these games. Staffare thus inclined to increase psychotropic medications, to administer it intramuscularly or to swap to more powerful mood stabilisers such as lithium. Emotional reactions from staff are triggered by the fact that the behaviour of patients with borderline personality disorders seems not to respond to the psychopharmacological regimen typically used in psychiatric hospitals. The ability to manipulate healthcare staffhas also been named "borderline maladaptive behaviour", because it is very common in female patients with borderline personality disorder; it is a game played by these patients to get the medications they want.[8]Unfortunately, the risk of erroneous psychopharmacological treatment triggered by these behavioural games is high, whichgenerates a vicious circle of increased dosage with little or no improvement. This presentation can be explained by exploring the narratives that accompany this behaviour, such asthe story provided by a nineteen-year-old girl with borderline personality disorder inpatient into the authors'psychiatric ward, 'I get into crisis after working hours. I want more attention but there isn't any. Therefore, I ask for more medication and I start to act madly. As a result,staff gives me clonazepam'.

Socio-economic-psychopharmacological assessment and treatment (SEPPAT)

NARRATIVE 3. A Fifty-five-year-old male with diagnosis of chronic low mood at admission. 'I go to hospital because I have nowhere else to live. I am homeless with a lot of mental problems. I can't sleep, and I feel alone. Being a patient in a psychiatric hospital is the best option I have. I have been evicted from my home. I have no friends. Burglars entered into my property and stole all of what was left in my flat. I don't know where my family lives. So, I decided to live where I could. I believe I have some mental problem. Therefore, psychiatric hospitals keep me out of filthy conditions. It does not matter what doctors give me. I know that nothing will help. The important thing is that I have a roof and a warm meal. I just need some sleep and to feel relaxed. I made up a story

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that I read in a book of psychology, so doctors at admission will not question my symptoms as long as they sound real'.

This narrative supports the authors' theory of socio-economic change. According to this theory, changes in economic and social welfare determine the prevalence of some social pathologies that lead to admission into psychiatric hospitals. This case shows how people who are socially vulnerable, who live in poverty, or who have had poor schooling, seek protection into psychiatric hospitals. Consequently, psychiatric hospitals see an increase of the social pathologies at admission. Therefore, there is an increase of people with antisocial personality disorders who are living alone, are unemployed or are in continual conflict with the law and with others. Moreover, as a result of changing social norms in the United Kingdom, psychiatric hospitals are now becoming shelters for people who do not necessarily have an enduring mental illness. However, these people mightclaim to have severe mental illnessand exaggerate their symptoms of discomfort (such as "hearing voices")to accelerate their admission and gain beds, thereby usingpsychiatric hospitals for socialising andshelter. Economically, this has a huge impact on the National Health Servicebecause, according to lawsin the United Kingdom, patients with mental illness cannot be discharged when they claim to be homeless or provide evidence of not having enough financial assets to support independent living. In some cases, due to challenging behaviours leading to Police investigations, a chaotic lifestyle, drug use and other public threats, patients may remain in hospital even aftertheir presentation has stabilised, because they claim they will relapse once back in their communities.Other times, patients with antisocial personality might intensify their symptoms, and play 'the madness role', with the mere intention to avoid charges from the Police. In any case, psychiatristsface great difficultiesin discharging socially vulnerable patients because there has been a progressive reduction in the social organisations that can provide continualcare and support to patients at high risk of relapse. In the United Kingdom, due to the progressive reduction in community support, the usual pathway to admission into psychiatric hospitals is via A&E departments.[9] In fact, people seeking social admissions into psychiatric hospitals prefer this pathway as the easiest, especially during weekends and after working hours. During these moments, junior psychiatristscover psychiatric duties and may have limited knowledge of patients' psychiatric historiesor intentions. Mostly, this is due to poor information sharingor sparse electronic records as a result of patients frequently changing their family doctors and relative catchment areas. Furthermore, admission-seeking patients know that when they declare suicidal thoughts they are granted automatic admission into psychiatric hospitals. Moreover,claims of low mood and suicidal ideationcan beheld tenaciously and complemented by detailed descriptions until admission is finally granted. Consequently, for the socially vulnerable population,A&E departments and psychiatric hospitals in United Kingdom have become the only available option for solving problems, not limited to psychiatric ones, that may include family conflicts, homelessness, social derailment, poverty, drug addiction orisolation. Accordingly,psychiatric hospitals have become the places where socially vulnerable peoplehope to have their problems solved. Finally, these patients aim to remain in hospital for as long as possible, perhaps forever. This is evidenced by the following narrative collected from a forty-three-year old male patientwho was homeless for years, mostlyliving into council's acommodations,'Having medication or not does not change my life as long as I can count on a roof and warm meal in a psychiatric ward'.

Conclusion

This paper provides an alternative model of psychopharmacological assessment and intervention for the adult and adolescent population. As previously described, a narrative approach that includes social, personal, culturaland psychiatric history components will provide useful and vital elements in deciding the best course of psychopharmacological treatmentfor modernpsychiatric patients. This approach divergesdramaticallyfrom the traditional one thatfocuses only on the importance of psychiatric symptoms as indictors of diagnosis and psychopharmacological treatment. Instead, as thisresearch shows, there have been social and global changes in the causes of psychiatric disorders. A new population of patients with psychosocial problems is resorting to psychopharmacology to solve them. Consequently, patients' requests towardpsychiatrists arealso changing. The authors of this paper encourage thesocio-psychopharmacological approach ofmindfulpsychopharmacology, whichutilises patients' narratives to direct psychopharmacological treatment. In fact, psychiatrists should be mindful that the social problem is often the primary problem and that psychotropic medications targeted solely to mental illness may not address patient needs in a holistic way. Therefore, a new way to interpretsocio-psychopharmacological interventions are due to global societal transformationsgenerated by socio-economic, historic and ethical forces; these forces have altered and somewhat transformed the meanings attributed to mental

health and wellbeing. Instead,in the modern era,challenging socio-economic conditions have led more people to use psychiatry, psychopharmacology and psychiatric hospitals as solutions to their existential and quotidian problems. As a consequence, the clinical skills for future psychiatrists should include how to interpret social changes as pathogenic elements. Additionally, modern healthcare professionals will have to listen attentively to the explicit and implicit meanings of patients' words and behavioursas well as both their disclosed and hidden agendas, especially for thosedesperately seeking admission into psychiatric hospitals or refusing to be discharged.As described in this paper, a biased psychopharmacology only uses literal psychiatric symptoms to guide treatment plans. Instead, the authors advocate for a mindful psychopharmacology that takes into account patients' narratives along with presenting psychiatric symptoms, becausesocial, demographic, cultural, educational, ethical and geographic factors are generating new psychiatric pathologies. These pathologies will still need psychopharmacological solutions andsafe, integrated treatment plans. In such cases, a narrative approach shouldbe integrated intothe treatment plan. More explicitly, as described by Foucault, discourses can exercise incredible influence on people concerning how specific content can be discussed and what counts as understanding in certain settings. [10] As a consequence, a psychopharmacological treatment plan should be accompanied by the sharing of knowledge between patients and psychiatrists. More specifically, common ground is needed to communicate unspoken needs and not fuel reciprocal resistance and misunderstanding. Furthermore, an integrated assessment of patients' hidden motives often suggestsalternative routes to psychopharmacological treatment that would be unavailable by adopting more orthodox diagnostic procedures and treatments. This field is open to creativity and understanding.This modern approach to psychopharmacology should overcome recent weaknesses of the current mental healthcare in the United Kingdom and other countries that adopt the same paradigm. In fact, although the classic psychopharmacological planhas its own assets and strengths, it does not reinforce continuity of care and follow-up with patients after their discharge from psychiatric hospitals. Furthermore, the reduction of integrated care and communication between the healthcare professionals in the communityand psychiatric hospitals is progressively leading to frequent changes of medications once patients return to their communities. These patients, especially those with personality disorders, also put increasing demands on their family doctors to increase their medications. In this case, the risk remains high that patients may be impulsive and take high doses, sellmedication with street value or otherwise not comply with the prescription. Perhaps more mindful psychopharmacology, combined withthe utilisation of discourse analysis from the social sciences inassessments and treatment plans,will fill the gaps in current psychopharmacological practice.

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Conflict of interest

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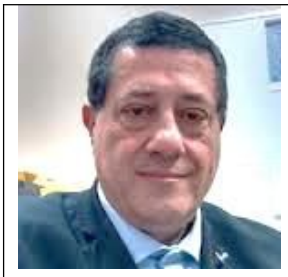

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