

Module: Mental Disorders and Psychopathology

Written Assignment

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In a period when views about mental diseases were not evolving by nature, laws in England and Wales established a precedent by acknowledging that some people with mental illnesses could become better and eventually heal (Forrester et al., 2008). This essay will examine the evolution over time and present state of mental health legislation and regulations. The analysis of legislative acts, from the early Lunacy Act of 1890 to the recent Mental Health Act amendments of 2022, is meant to shed light on the intricate interplay between societal perceptions, governmental responses, and psychiatric advancements in addressing mental illness. Additionally, this essay will explore the multifaceted nature of bipolar disorder, a prevalent and complex condition classified under the ICD-11, by scrutinising its diagnostic criteria, treatment modalities, and the pervasive stigma that surrounds it. By combining historical perspectives with contemporary research findings, the essay will analyse the transformations, effects, and outcomes of current mental health support provisions, underscoring both progress made and challenges that persist in promoting holistic care and societal inclusion for the affected people through mental disorders.

The normality of inhumane practices, such as mechanical restraint and punitive measures relegated to patients with psychological disorders, reflects past societal perceptions of mental illness as a moral failing or criminal behaviour (Hamilton, 1983). During a century, public awareness over the stigma and wrongful treatment of mentally ill patients led to several cornerstones' legislation, such as the Lunacy Act 1890, which aimed to prevent the admission and detention of sane patients, focusing specifically on lunatics and distinguishing them from the mentally deficient, who were later addressed in a separate Act in 1913 (Hamilton, 1983). The Mental Treatment Act 1930 laid the foundation for a more compassionate and effective mental health care system by promoting more humane and patient-centred approaches to treatment, changing terminology, and facilitating advances in psychological regimens and medications (Hamilton, 1983). After the Second World War, the beginnings of the National Health Service symbolised a new optimism and commitment to providing comprehensive healthcare services to all citizens, including those with mental health problems (Forrester et al., 2008). These feelings stemmed from the belief that the introduction of new non-invasive treatments would

revolutionise mental health care and lead to the complete eradication of mental illness by the year 2000 (Forrester et al., 2008).

The Mental Health Act 1959, hailed for its enlightened principles, abolished magistrates' judicial decisions on compulsory admission in favour of medical professionals, integrated mental hospitals with other healthcare facilities, granted patients the autonomy to choose informally and voluntarily their therapy (Hamilton, 1983; Bean, 1975), established adequate provisions for cases that require compelled treatment for the patients' or society's benefit, and improved communication and cooperation between various departments and agencies involved in treatment (Bean, 1975). In alignment with Bean (1975), critics advocate for the integration of formal legal rules into the mental health system to uphold patients' traditional legal rights, thereby challenging the equilibrium between therapeutic and legal considerations in mental health care. Bean (1975) sustains that the dispute exposes the complex relationship between individual autonomy and societal responsibilities, causing ethical and political concerns about physician's roles as agents of social control, as well as a possible conflict between medical interventions and patient autonomy.

Under the Mental Health Act 1983, Hamilton (1983) states that one significant alteration is the transition from 'mental subnormality' to 'mental impairment', aiming to modernise terminology and differentiate between conditions. However, concerns are raised regarding potential confusion and stigma, particularly as updated terminology also includes traits like psychopathic disorders, influence on patient medical care, and legal consequences (Hamilton, 1983). Further, changes in detention criteria remove age limits and prioritise treatment effectiveness, while prohibiting detention based solely on moral conduct (Hamilton, 1983). For example, Sections 2 and 3 (Mental Health Act, 1983) outline the clear requirements and duration of up to one month, respectively, up to six months, for compelled admission and confinement of persons with mental health issues deemed essential to the patient's wellness and safety for himself and others (Bhugra and Dazzan, 2000). Section 4 (Mental Health Act, 1983) revised urgent admittance processes to include the engagement of relatives or social workers, with expanded standards of eligibility (Hamilton, 1983). During the legislative process, debates centred on 'consent to treatment', balancing psychiatrists' treatment autonomy with patient consent and protection (Hamilton, 1983). The Act outlines procedures for treatments requiring permission or an additional standpoint, with certain urgent treatments exempt from

consent requirements (Hamilton, 1983). While acknowledging the importance of patient safety and striving for the least restrictive treatment settings, Eastman (2004) argues that it falls short in delineating clear principles, particularly concerning capacity evaluation and the concept of reciprocity in therapy decisions. Critics of the practical challenges denote that mental illnesses require both distinct legal considerations due to their unique impact on reasoning, ethical standards, accountability, and self-control, distinguishing them from physiological medical conditions, as well as adequate training of physicians to assess capacity in this regard (Eastman, 2004). By advocating for enhanced care rights for confined individuals, Eastman (2004) considers that reciprocity addresses the intricate balance between a person's rights and societal interests, going beyond the protections outlined in existing human rights conventions. Regarding mandatory admission under this law, Bhugra and Dazzan's (2000) study sheds light on the decision-making process of London psychiatrists, influenced by a diversity of aspects related to both the clinical characteristics of patient and his disease. Despite the weaknesses of the study, such as the small number of participants and potential disparity between hypothetical responses and actual clinical practice, the results validate the Act's recommended criteria, suggesting as the most important factors risky behaviour towards oneself or others, state of mind, and degree of illness, as well as doctors' seniority and gender, that may influence the prioritisation of these factors (Bhugra and Dazzan, 2000).

The amended Mental Health Act 2007 provides continuity in the relevance of skills and knowledge acquired under the previous legislation from 1983 (Jones and Williams, 2008). Referring to its amendments, Jones and Williams (2008) and Harvey (2010) identified some of the following: a broader description of 'mental disorder' as any condition or impairment of the mind; patients' admission in health facilities needs to be in accordance with their age and needs; expansion of eligible health professionals' role in renewals and discharge decisions, and availability of advocacy services upon request, ensuring accessibility and awareness of support resources throughout the treatment process. Furthermore, Glover-Thomas (2011) state that the Act represents a change towards understanding risk assessment and mitigation as vital parts of how decisions are made in the field of mental wellness services, pointing out the need for efficient methods for assessing and minimising dangers that impact mentally ill people. Glover-Thomas's (2011) empirical study

examined stakeholders' experiences after implementation of the 2007 Act to determine the effects of risk on public obligations proceedings. The findings identified several concerns and challenges regarding the implementation of the law (Glover-Thomas, 2011). Some of them refer to: a) decision-makers' dilemma in articulating a clear definition of risk relying only on their judgement based on specific criteria; b) the difficulties in balancing the different factors involved in psychological wellness risk evaluation and control, including static and dynamic risk factors, and the potential for certain risk factors to act as protective mechanisms; and c) the potential for the increased use of detention and involuntary treatment under the 2007 Act to result in less effective and more coercive mental well-being services delivery, particularly for marginalised and vulnerable groups (Glover-Thomas, 2011). In terms of ethics, Lepping (2007) initiates an ethical discussion on the balance between consequentialist and rights-oriented ideologies in the establishment of mental health regulations. The legislative move from mental health to a utilitarian or deterministic paradigm, prioritising public safety above individual liberty, could affect individual rights in the absence of compelling proof of improved public security (Lepping, 2007). As such, it emphasises the need for empirical support and ethical inspection in ensuring that any regulatory changes are consistent with society's benefits and ethical norms, cautioning against fast regulatory adoption in the absence of substantial data or consideration for ethics (Lepping, 2007).

In alignment with contemporary societal perceptions and advancements in mental health care, the British government has proposed significant reforms for the new Mental Health Act 2022, aiming to promote greater autonomy and choice for individuals receiving 'appropriate medical treatment', reduce unnecessary detention, enhance safeguards for patients, and ensure that regimen is provided in the least restrictive manner possible (Local Government Association, 2023). The inclusion of specific provisions, such as the introduction of Advance Choice documents, expanded access to support services, and reforms in aftercare planning, demonstrates a recognition of the diverse and evolving needs of individuals with psychiatric conditions (Local Government Association, 2023).

Scientifically defined by the ICD-11 (2024), Bipolar Disorder (BD) and its associated conditions represent recurrent conditions of mood marked by 'Maniac, Mixed or Hypomanic episodes or symptoms'. Classified based on its longitudinal

course (Grande et al., 2016), BD refer to Type I (6A60), Type II (6A61) and Cyclothymic (6A62) presenting both similarities and differences (ICD-11, 2024). Their main similarity is the episodic nature of illness, which translates to mood swings happening on a regular basis rather than continuously (ICD-11, 2024). Bipolar Type I, Bipolar Type II, and Cyclothymic illnesses have widely distinct signs, magnitudes, time limits, and influences on everyday functioning. Bipolar Type I and Type II typically involve manic, hypomanic, and depressed symptoms that persist for several days to one week, and can impair functioning (ICD-11, 2024). In contrast, Cyclothymic disorder presents hypomanic and depressive signs that do not exactly correspond with the requirements for manic or times for depression, persisting for at least two years and causing severe difficulties or limitations in various aspects of life (ICD-11, 2024). Examining the changes made to the diagnostic criteria for BD in the ICD-11 system, Angst, Ajdacic-Gross and Rössler (2020) welcome the variety of diagnoses related to hypomanic episodes, as an improvement over the earlier versions, such as the ICD-10 and DSM-5. This is because it results in a larger occurrence of bipolar II disorder, aligning more closely with clinical observations. Nevertheless, further studies are needed to ascertain if outpatient treatment should be considered as a criterion for hypomania (Angst, Ajdacic-Gross and Rössler, 2020). One notable limitation is the lack of pure mania as an autonomous and codifiable disorder in both the ICD-11 and DSM-5 medical handbooks, which underscores the need for further refinement and development in this area (Angst, Ajdacic-Gross and Rössler, 2020).

Ranked among the most prevalent long-term conditions, this mental disorder affects one percent of the worldwide population (Grande et al., 2016) and a sizeable portion of the United Kingdom, with approximately 1.3 million individuals diagnosed (Bipolar UK, 2024). Today's evidence-based research describes a variety of clinical disparities affecting bipolar females, despite historical perceptions of it being a mental condition with no gender variations (Menculini et al., 2022; Dell'Osso, Cafaro and Ketter, 2021). Despite Menculini et al.'s (2022) cross-sectional study focusing on the association between duration of untreated illness and treatment outcomes, and Dell'Osso, Cafaro and Ketter's (2021) literature review discussing a broader range of topics, including the impact of BD on women during pregnancy and postpartum, their standpoints share similarities. The scientists underline the following: a) the necessity of comprehending divergent manifestations in men and women, including variations

in symptom severity, treatment response, and socio-economic outcomes; b) the need to consider prophylactic medication during pregnancy emerges as pivotal in preserving mood stability and mitigating relapse risks; and c) prompt diagnosis and tailored therapeutic interventions are paramount to attenuate adverse sequelae such as relapses, suicide attempts, and rapid cycling (Menculini et al., 2022; Dell'Osso, Cafaro and Ketter, 2021).

Standard criteria for assessing and managing bipolar persons' illnesses, recommended by the National Institute for Health and Care Excellence (NICE) (2023), involve comprehensive psychiatric assessments, documenting detailed mood histories, evaluating social and personal functioning, assessing for potential comorbidities, and involving family members or carers for additional insight, collaborative care planning, and risk assessments. These criteria prioritise engagement, effective risk management, and care in environments promoting hope and optimism, aligning with Section 1.3 of the NICE (2023) guidelines on mental health service user experience. However, challenges related to correctly diagnosing BD, as noticed by Grande et al. (2016) and Humpston, Bebbington, and Marwaha (2021), include delays of 5 to 10 years from the onset of signs, misdiagnoses with other comorbid conditions with bipolarity, and discrepancies in prevalence rates due to the diversity of sources and methodologies used in clinical diagnostic assessments. Being typically diagnosed based on observing behaviour and patients' subjective reports, BD is often unrecognised due to its heterogeneous nature, and the lack of clear biomarkers for underlying pathophysiological mechanisms which complicates diagnosis and treatment (Phillips and Kupfer, 2013). The symptomatology's similarity with depressive episodes in the early stages of illness, especially in BD type II, makes it difficult to differentiate from unipolar depression (Phillips and Kupfer, 2013). The presence of mixed-mood episodes further complicates diagnosis, as these are increasingly recognised as more common than previously thought, challenging the traditional view of distinct mood states (Phillips and Kupfer, 2013). Previous studies suggest that, in conjunction with the manic or mixed emotional times, bipolar individuals can experience auditory verbal hallucinations, described as experiences of 'hearing voices', similar in cognitive mechanisms, but different in length, rate, and emotional effect than those in schizophrenia spectrum disorders (Jenkins et al., 2017; Smith et al., 2022). Examining cognitive function, Jenkins et al. (2017) identified the impairment of

working memory as an underlying factor responsible for the development of hallucinatory experiences across these psychiatric disorders. Smith et al. (2022) study's participants helped them understand the nuanced nature of these experiences in terms of variable frequency from constant to occasional, incongruence between mood and hallucinations' tone or content, and the unpleasant impact of direct addressing using 'you'. These findings underscore the importance of subjective understanding and consideration of all aspects, like the cognitive factor, and how the interpersonal dynamics of auditory verbal hallucinations influence individuals' relationships with the voices and their levels of engagement and compliance with treatment (Jenkins et al., 2017; Smith et al., 2022).

As mentioned in NICE's (2023) guideline sections 1.5 to 1.7, successful illness' management includes not only addressing immediate mood episodes but also employing strategies to prevent future occurrences through a combination of pharmacological, psychological interventions (Grande et al., 2016), as well as cognitive remediation therapies (Jenkins et al., 2017). Zhuo et al. (2020), moreover, recommend the use of transcranial direct current stimulation as a potential targeted intervention for modulating aberrant brain connectivity patterns associated with auditory or visual hallucinations in individuals with BD. His research on the non-invasive brain stimulation technique of applying a low electrical current to specific areas of the brain has shown promising results in reducing hallucinatory episodes (Zhou et al., 2020). On the other hand, bipolar patients present an interest in a person-centred approach known as self-binding directives (SBDs) or the Ulysses contract -a form of advance decision-making mechanism that involves a proactive strategy for the patient or family and doctors to outline tailored options for assessment and treatment (Hindley et al., 2019). From slightly different angles, Hindley et al. (2019) and Gergel et al. (2021) studied the attitudes and experiences of individuals with BD towards these tools for choice, and the results show contrasting views. While some individuals express a growing acceptance of SBDs (6,9%) because of their previous experience of coercive treatment (Hindley et al., 2019), others remain hesitant or outright reject the concept, being reluctant about potential loss of autonomy, apprehensions regarding clinical judgement in crisis situations, or doubts about the effectiveness of SBDs in ensuring appropriate treatment during episodes of illness (Gergel et al., 2021), judgements probably

justified by the younger age, and the absence of trust in mental health services (Hindley et al., 2019).

Despite the prevalence and severity of BD, Bipolar UK (2024) argues that many individuals do not receive adequate support and treatment. A huge portion of those diagnosed with BD receive no self-management advice, and anecdotal evidence suggests a lack of support and instances of abuse in hospital settings (Bipolar UK, 2024). A useful example of this aspect is Humpston, Bebbington, and Marwaha's (2021) survey, which revealed that a considerable portion of individuals potentially affected by BD are not receiving necessary psychiatric care, due to factors like lack of awareness, difficulty recognising their condition, or barriers hindering access to care. The correlation between suicidal ideation and the receipt of care suggests that individuals with BD may only receive appropriate mental wellness assistance once they reach a crisis point, underscoring the necessity for enhanced screening, resources, and early intervention strategies within the healthcare system (Humpston, Bebbington, and Marwaha, 2021). An international example is the cross-sectional study conducted by Cunningham et al. (2020), where they explore the gender disparities in New Zealand's mental health service. Their findings, compatible with those from Denmark and Austria, revealed that women (30%) primarily receive outpatient treatment and exhibit comorbid anxiety. Conversely, men were more inclined towards substance use disorders, criminal convictions during illness, and receiving inpatient treatment (Cunningham et al., 2020).

BD is a chronic condition associated with fluctuating emotions that can cause functional and cognitive challenges, affecting overall quality of life (Grande et al., 2016). It is the main source of impairment among young individuals and can incur substantial societal costs, particularly given its onset in early adulthood (Grande et al., 2016). By way of illustration, Simon et al.'s (2021) research on the British economic burden of BD revealed an average annual cost per patient amounting close to £15,000 in 2018-2019. The societal expenditure was ascribed to lost employment and unofficial medical services (68%), hospital charges (31%), personal spending (1%), and social services costs (0.5%) (Simon et al., 2021). Moreover, employment rates among people with BD are low, and disclosing the condition to employers can lead to regret or negative outcomes (Bipolar UK, 2024). Recent evidence-based reviews (Perich, Mitchell and Vilus, 2022; Latifian et al., 2023) shed a light on the multifaceted negative effects of social discrimination, prejudice, and

ignorance on individuals with bipolar disorder and their families. These individuals often face marginalisation and exclusion from societal institutions, leading to decreased self-esteem, heightened levels of stress, and challenges in accessing adequate healthcare and support services (Perich, Mitchell and Vilus, 2022; Latifian et al., 2023). Moreover, stigma surrounding BD can exacerbate symptoms of the condition, impede treatment-seeking behaviours, and contribute to social isolation and diminished quality of life (Perich, Mitchell and Vilus, 2022; Latifian et al., 2023). Relatives of individuals with BD also face stigma, which can compound the emotional burden and strain on caregiving relationships (Perich, Mitchell and Vilus, 2022; Latifian et al., 2023). The prevalent nature of discrimination underscores the urgent need for comprehensive anti-stigma interventions and public awareness campaigns to promote understanding, acceptance, and assistance for those suffering by BD (Perich, Mitchell and Vilus, 2022; Latifian et al., 2023).

In conclusion, this essay provided a chronology of mental health care, illustrating the nuanced path shaped by evolving social attitudes, governmental reactions, and advancements in psychiatric practice. This analysis revealed progress in mental health legislation towards more compassionate and patient-centred care. While considerable progress has been made in promoting holistic care and societal inclusion for those affected by mental disorders, challenges persist. These challenges include addressing gaps in access to care, combating stigma, and ensuring the implementation of evidence-based interventions. Moving forward, it is imperative to continue advocating for policies that prioritise mental health, increase awareness, and promote early intervention and support. By doing so, efforts can be made towards a future where individuals with mental health conditions receive the care, assistance, and acceptance they deserve, leading to improved outcomes and an enhanced quality of life for all.

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