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The Detention of Voluntary and Involuntary Patients in Mental Health Facilities: The Ethical Considerations.

Preamble

It has been estimated that one in four people will experience some form of mental ill-health in their lifetime.¹ This can range from feelings of anxiety, to depression, to more severe mental health problems, such as psychosis. Most people can be treated in the community by their GP or other mental health professional. However, some people will require more intensive treatment, including admission to a psychiatric hospital. Many people will consent to hospitalisation, while others may not wish to be admitted and may be detained involuntarily. A third group of people may appear to be satisfied with their treatment plan and although deemed “voluntary” may, in reality, lack the decision-making capacity to provide explicit consent.

The detention of people with mental illness is provided for under the *Mental Health Act 2001* (MHA). As part of the current Programme for Government, the Department of Health is conducting a review of the MHA. An area of particular interest to this review relates to the way in which involuntary and voluntary patients are admitted, detained and treated. Also pertinent is the Government’s commitment to ratify the UN *Convention on the Rights of Persons with Disabilities* (CRPD) which provides for a rights-based approach to disability. While the MHA has been regarded as a positive step in providing some level of protection for involuntary patients, it does not extend those rights to the vast majority of people with mental illness who are detained in Irish mental health facilities i.e. those categorised as voluntary patients. Indeed, the open-ended definition of voluntary patient within the MHA is a matter of concern. The definition makes no reference to voluntariness or consent and encompasses all patients who have not been involuntarily detained under the Act irrespective of whether they possess decision-making capacity or not. The inclusion of patients lacking decision-making capacity as voluntary is inappropriate because it ignores the fact that such patients may not be able to exercise their free will.

Dealing with such issues involves consideration of numerous and potentially conflicting ethical principles such as autonomy, best interests, proportionality and the duty of care

¹ World Health Organisation, *The World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva (2001).

owed to individuals with mental disorders as well as the wider community. Indeed, the weight to be attached to each of these principles may vary depending on the capacity of the patient. In addition, since the enactment of the MHA, the Government policy *A Vision for Change* has been developed. This policy advocates the principle of partnership which recognises the need to redress the traditional power imbalance between people experiencing mental ill-health and the mental health professionals who have responsibility for their care and treatment. It also advocates the principle of recovery which aims to promote personal autonomy and enhance social inclusion.

In order to address these and other issues, the Minister for Health appointed an expert steering group to oversee the review of the MHA². Since its inception, this group has conducted a public consultation and a number of meetings with stakeholders. In addition the Steering Group submitted its interim report, which identified key areas of the Act which might be revised. This review is now nearing the end of its second stage. As part of this second-stage review, the National Advisory Committee on Bioethics received a request to examine the ethical issues pertaining to the detention of voluntary and involuntary patients in mental health facilities. In particular, the Committee was asked to consider three key ethical questions: **the basis on which somebody might be detained under the MHA; the ethical and legal differences between involuntary and voluntary detention; and the ethical permissibility of providing treatment to detained individuals who have refused it.**

In order to address these questions the following opinion document will focus on the involuntary and voluntary detention of people with acute forms of mental illness. It will also consider the current legal situation in Ireland with respect to the detention and treatment of patients who possess decision-making capacity and those who do not in addition to the key ethical issues associated with such practices. It will focus on ethical principles such as dignity, autonomy, beneficence, proportionality as well as personal rights versus the common good.

This opinion document is cognisant of the *Assisted Decision-Making (Capacity) Bill 2013*, which aims to support the individual rights of autonomy, dignity and bodily integrity in its guiding principles. The enactment of mental capacity legislation is regarded as essential in order to facilitate the ratification of the CRPD which declares that States must recognise that

² Steering Group on the Review of the Mental Health Act 2001

“persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life” (Article 12(2)).

Finally, it is important to acknowledge that terms such as “mental illness” and “mental ill-health” cover a vast spectrum of people as well as the disorders/diseases that affect them and that it is beyond the scope of this document to consider each cohort in great detail. However, the aim of the document is to examine the general ethical issues that are raised by the care and treatment of people suffering from various forms of mental illness within the context of the three key questions posed.

Background

Until the mid-twentieth century, mental health legislation in a number of countries reflected a mostly institutional approach to psychiatric treatment and detention. Consequently, many individuals suffering from mental ill health and intellectual disability were confined to large, Victorian style asylums for all or part of their lives.³ The *Criminal Lunatics (Ireland) Act* of 1838 gave the power to detain ‘dangerous lunatics’ to justices of the peace without the need for medical certification, which may have led to increased asylum admissions. However, the enactment of the *Mental Treatment Act* of 1945 restored control over diagnosis and admission to medical practitioners which led to a stabilisation in admission figures (at c. 20,000 per annum) between 1949 and 1959, with more patients being classified as voluntary rather than involuntary^{4,5,6}. From the 1960s onwards numerous governments began to revise their legislation on mental health treatment and it became much more human-rights oriented. For instance, new legal mechanisms for the involuntary detention and treatment of people suffering from mental disorders were established and a stricter set of criteria for detention was introduced. Increasingly, it was accepted across Europe that the primary reason for detaining someone for treatment purposes should be that they

³ Walsh D, Daly A, *Mental Illness in Ireland 1750-2002. Reflections on the Rise and Fall of Institutional Care*. Health Research Board (2004). Available at:

http://www.hrb.ie/uploads/tx_hrbpublications/Mental_Illness_in_Ireland.pdf

⁴ D Brennan ‘A Theoretical Exploration of Institution-based Mental Health Care in Ireland. In: Pauline M Prior (Ed). *Asylums, Mental Health Care and the Irish 1800-2010*. Dublin, Irish Academic Press 2012

⁵ Department of Health, *Report of the Inspector of Mental Hospitals for the Year 1949*, Dublin.

Available at:

<http://www.lenus.ie/hse/bitstream/10147/251937/1/ReportOfTheInspectorOfMentalHospitalsForTheYear1949.pdf>.

⁶ Department of Health, *Report of the Inspector of Mental Hospitals for the Year 1959*, Dublin.

Available at:

<http://lenus.ie/hse/bitstream/10147/249838/1/ReportOfTheInspectorOfMentalHospitalsForTheYear1959.pdf>.

constituted a significant threat either to themselves or to others⁷ and that the key focus, where possible, should be on facilitating recovery and active partnership between health care providers and patients.⁸ The patient rights movement and the growing focus on de-institutionalisation also led to significant changes in practice. For instance, mental health units in or attached to general hospitals as well as modern psychiatric hospitals, to a large extent, replaced the old asylum system. In addition, a more holistic, multi-disciplinary approach to dealing with physiological, psychological and social impacts on mental health was implemented and increased attention was given to providing patient-centred care in the community.

Despite this shift in attitude, however, it remains the case that people diagnosed with having a mental disorder are one of the few patient groups who can be involuntarily detained in hospital and treated against their will⁹ (people with notifiable infectious disease can be detained against their will but, where they have decision-making capacity, may not be treated without their consent) and this fact raises a number of ethical issues. For instance, concerns have been raised regarding the appropriateness of depriving someone of his/her liberty in order to provide treatment and the effect such deprivation has on personal autonomy and human dignity as well as on therapeutic relationships.

The Basis for Detention

Detention is usually justified because it is considered to be in the person's best interests. For instance, people with mental ill-health may be diagnosed as lacking sufficient capacity to care for themselves or to defend their own interests. Indeed one of the main reasons for psychiatric hospitalisation and detention under the MHA is to prevent suicide. Therefore, detention has come to be regarded as a measure for protecting patients from harm. Another goal may be to increase patients' ability to evaluate their own condition and restore their ability to make autonomous choices. However, while the rationale for detention may be to provide treatment and security for people suffering from mental ill-health, the practice inevitably impinges on their right to liberty.

⁷ Välimäki M, Taipale J, Kaltiala-Heino R, Deprivation of Liberty in Psychiatric Treatment: A Finnish Perspective, *Nursing Ethics* (2001), 8(6): 522-532.

⁸ Government of Ireland, *A Vision for Change: Report of the Expert Group on Mental Health Policy* (2006).

⁹ Zinkler M, Priebe S, Detention of Mentally Ill in Europe – A Review, *Acta Psychiatrica Scandinavica* (2002) 106: 3-8.

The Right to Liberty

Liberty has been defined as the right to pursue one's own ends without external interference.¹⁰ In mental health care, personal liberty might be restricted using a number of methods including involuntary admission and detention, seclusion and restraint, restrictions on leaving certain areas such as wards, compulsory medication, tube feeding and the confiscation of personal property. While the laws in different jurisdictions vary, it is generally acknowledged that detention for medical purposes should be subject to strict conditions, including the presence of a severe mental disorder that hinders or even prevents an individual from making his/her own treatment decisions and/or the likelihood that the person may harm himself/herself or others. According to the World Medical Association (WMA), involuntary hospitalisation should be the exception and it should be utilised only when it is medically necessary and for the shortest time feasible.¹¹ The WHO's framework *Mental Health, Human Rights and Legislation*, states that the deprivation of patients' liberty in mental health facilities should be the exception and occur only in very specific circumstances.¹²

Indeed, the right to liberty is widely regarded as one of the most important human rights and it is protected by international human rights instruments such as the *International Covenant on Civil and Political Rights* (1966) and the *European Convention on Human Rights* (1950). According to both of these instruments no one should lose the right to liberty without proper consideration of the alternatives or without sufficient legal safeguards. Article 9 of the *International Covenant on Civil and Political Rights* states that: "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law." In this respect, the UN Human Rights Committee stated in its 2014 *Concluding Observations on Ireland's 4th Periodic Report on the International Covenant on Civil and Political Rights* that, "The State party should promote psychiatric care aimed at preserving the dignity of patients, both adults and minors."¹³

¹⁰ Olsen DP, Influence and Coercion: Relational and Rights-Based Ethical Approaches to Forced Psychiatric Treatment, *Journal of Psychiatric and Mental Health Nursing* (2003), 10(6): 705-712.

¹¹ World Medical Association, *WMA Statement on Ethical Issues Concerning Patients with Mental Illness* (1995, 2006).

¹² World Health Organisation, *Mental Health, Human Rights and Legislation* (2005).

¹³ United Nations Human Rights Committee, *Concluding Observations on Ireland's 4th Periodic Report on the International Covenant on Civil and Political Rights*, July 2014. Available at: http://www.ihrc.ie/download/pdf/un_hrc_concluding_observations_on_ireland_and_iccpr_24_july_2014.pdf.

Nevertheless, in the area of mental health care, there are circumstances in which the curtailment of these basic rights is permitted and certain situations in which people can be treated against their will or without their consent. For instance, Article 5(1) of the *European Convention on Human Rights* (ECHR) discusses the right to liberty and security and states that:

“everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:...

(e) the lawful detention...of persons of unsound mind...”

In Ireland, the Constitution states that “no citizen shall be deprived of his personal liberty save in accordance with law” (40.4.1).¹⁴ Under the MHA, a person can be detained for treatment in an approved mental health centre against his/her will only if s/he is diagnosed with having a mental disorder. Section 3 of the MHA defines a mental disorder as a mental illness, severe dementia or significant intellectual disability where because of the condition there is significant likelihood of harm to the person or to others. Detention is permitted if the person is so impaired that failure to admit him/her would be likely to lead to a serious deterioration in his/her condition or would prevent the administration of appropriate treatment; and if detention and treatment would be likely to benefit or alleviate the condition to a material extent. There has been some criticism of this definition of mental disorder. In particular, the Department of Health’s Steering Group on the Review of the MHA has stated that significant intellectual disability should not be used as a criterion for involuntary detention unless the person concerned has a co-morbid mental illness of such a severity that it meets the threshold for mental disorder.¹⁵ The MHA defines significant intellectual disability as “a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person”.

¹⁴ *Bunreacht na hÉireann Constitution of Ireland* (1937) as Amended.

¹⁵ Department of Health, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001*, April 2012. Available at: http://www.dohc.ie/publications/pdf/int_report_sg_reviewMHA_latest.pdf?direct=1

Nonetheless, the detention of patients diagnosed with mental disorders raises some concern regarding the perceived paternalism involved in decisions made to deprive individuals of their liberty and the impact of detention on patient autonomy.

Personal Autonomy versus Best Interests

The principle of autonomy refers to a person's ability to make decisions or take actions based on his/her own convictions and free from coercive external influences. In general, an individual's right to autonomy is upheld provided the decisions of the individual do not result in the harming of others. This view of autonomy is encapsulated in John Stuart Mill's "liberty principle", which states that:

"the only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his body and mind, the individual is sovereign".¹⁶

Personal autonomy might be curtailed if the person is deemed e.g. to lack capacity or to be disturbed, distressed or aggressive and perceived to pose a threat to his/her own safety or the safety of others. In such cases, it has been argued that the individuals concerned should be detained because the mental disorder from which they are suffering has already deprived them of their autonomy. In essence, this argument suggests that there is a moral obligation on the state to treat in order to restore liberty and autonomy.¹⁷ This argument represents an application of the concept of *parens patriae* (father of the people) in that the State is expected to intervene in the manner of a parent to protect the vulnerable. The aim being that the intervention would reduce or even negate the need for future detention and decrease the level of perceived risk. This concept has a basis in the principle of best interests which has traditionally lain at the heart of medicine as well as the therapeutic relationship and which has long been used as the legal standard for regulating the treatment of patients who are deemed to lack capacity. According to Beauchamp and Childress, the best interests principle "protects another's well-being by assessing risks and benefits of various treatments and alternatives to treatment, by considering pain and suffering, and by evaluating

¹⁶ Mill JS (1863). *On Liberty*. 2nd ed. Ticknor and Fields, Boston.

¹⁷ Cleary M, Hunt GE, Walter G, Robertson M, Locked Inpatient Units in Modern Health Care: Values and Practice Issues, *Journal of Medical Ethics* (2009), 35: 644-646.

restoration or loss of functioning.”¹⁸ To illustrate this argument, evidence has shown that the risk of suicide is high in the weeks and months following discharge from psychiatric hospital.^{19,20} A recent report detailing the number of suicides by people with mental illness has found that, in the last number of years, there have been more suicides under home treatment than under in-patient care and that a substantial number of these deaths occur in patients who live alone or have refused treatment. The report also found that suicides by in-patients have fallen steadily.²¹ There has also been a suggestion that during the post-discharge period, while the risk of self-harm may decline slowly, the protective influence of in-patient care is withdrawn too abruptly and that this rapid decrease in care may lead to a heightened risk of suicide.²² Consequently, it has been argued that detention in hospital is in many patients’ best interests because it is effective in preventing suicide, that aftercare in the community is often deficient and that periods of in-patient care should be increased. In contrast, however, another recent study concluded that high quality, intensive aftercare in the community (including crisis resolution) following discharge from hospital may be protective and reduce the incidence of post-discharge suicide – if implemented and sustained consistently.²³ Nevertheless, it has been argued that curtailing the liberty of large numbers of patients in order to protect the smaller number who might abscond or be vulnerable to suicide or misadventure could be considered a disproportionate response.²⁴ In fact, there has been a move internationally away from this best interests approach in favour of autonomy with increasing recognition that all adults, including those with a disability, have a right to self-determination.²⁵ From the individual patient’s perspective, detention might not be perceived to be in their best interest or as a way of restoring autonomy but be

¹⁸ Beauchamp TL, Chidress JF, *Principle of Biomedical Ethics* (5th ed.), Oxford University Press (2001).

¹⁹ Geddes JR, Juszczak E, O’Brien F, Kendrick S, Suicide in the 12 Months after Discharge from Psychiatric Inpatient Care, Scotland 1968-92, *Journal of Epidemiology and Community Health* (1997), 51: 430-434.

²⁰ HO TP, The Suicide Risk of Discharged Psychiatric Patients, *Journal of Clinical Psychiatry* (2003), 64(6): 702-707.

²¹ Appleby L, Kapur N, Shaw J et al., *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales* (July 2013). University of Manchester. Available at: http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf

²² Meehan J, Kapur N, Hunt IM, Turnbull P, et al., Suicide in Mental Health In-Patients and Within 3 Months of Discharge: National Clinical Survey, *British Journal of Psychiatry* (2006), 188: 129-134.

²³ Bickley H, Hunt IM, Windfuhr K, et al., Suicide Within Two Weeks of Discharge from Psychiatric Inpatient Care: A Case Control Study, *Psychiatric Services* (2013), 64(7): doi: 10.1176/appi.ps.201200026.

²⁴ *Supra* 11.

²⁵ United Nations, *Convention on the Rights of People with Disabilities* (2006).

viewed as harmful and traumatic²⁶, associated with treatment dissatisfaction²⁷ and, possibly, result in negative outcomes of care²⁸ as well as poorer therapeutic relationships. It might also be regarded by patients and the wider community as being a move towards re-institutionalisation with the accompanying destructive social consequences. For instance, one 1996 Irish study which compared the attitudes of patients who were detained voluntarily and involuntarily prior to modern reforms of law and services, found that more than 50% of involuntary and over 20% of voluntary patients compared being in hospital to being in prison.²⁹

Capacity

Capacity is deemed to be central to the concept of autonomy and according to Mill, the right of autonomy is premised on “all the persons concerned being of full age and the ordinary amount of understanding”.³⁰ Capacity is often divided into four sub categories: understanding (i.e. the ability to retain new information relevant to the choice and basic understanding of the facts involved); appreciation (of the nature and significance of the decision to be made, including the ability to believe the personal relevance); reasoning (i.e. the ability to weigh the risks and benefits and evaluate potential consequences); and the ability to express a choice (where the choice is derived from processes of understanding and reasoning). These sub-categories form the basis of clinical assessments, such as the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), which involves semi-structured interviews between the assessors (psychiatrists) and their patients. Mental capacity is not regarded as an absolute, rather it is generally accepted that there are varying levels of capacity. Identifying the “cut-off” point between capacity and incapacity is difficult to determine and this has led to questions regarding the effectiveness of capacity assessment tools.³¹ For instance, while the MacCAT-T is regarded as a more nuanced approach to capacity assessment, concerns have been raised in relation to the role psychiatrists’ therapeutic instincts play in determining whether a person has the capacity to

²⁶ Nijman H, Bowers L, Oud N, Jansen G, Psychiatric Nurses’ Experiences with Inpatient Aggression, *Aggressive Behavior* (2005), 31: 317-327.

²⁷ Olofsson B, Nordberg A, Experiences of Coercion in Psychiatric Care as Narrated by Patients, Nurses and Physicians, *Journal of Advanced Nursing* (2001), 33(1): 89-97.

²⁸ Bonsack C, Borgeat F, Perceived Coercion and Need for Hospitalization Related to Psychiatric Admission, *International Journal of Law and Psychiatry* (2005), 28: 342-347

²⁹ Rooney S, Murphy KC, Mulvaney F, et al., A Comparison of Voluntary and Involuntary Patients admitted to Hospital, *Irish Journal of Psychiatric Medicine* (1996), 13: 132-137.

³⁰ *Supra* 12.

³¹ Kitamura T, Takahashi N, Ethical and Conceptual Aspects of Capacity Assessments in Psychiatry, *Current Opinion in Psychiatry* (2007), 20: 578-581.

refuse medical interventions that the psychiatrists might view as necessary.^{32,33,34} Determining whether someone has capacity is critical in striking a balance between respecting the autonomy of patients who are capable of making treatment decisions and protecting those who may be cognitively impaired.³⁵ If someone is incorrectly judged to be incapacitated, his/her right to autonomy may be seriously jeopardised, while incorrectly assuming that a patient has decision-making capacity could be equally detrimental.

There is broad agreement that a functional approach to capacity should be taken when assessing the ability to consent to treatment. This approach was adopted by the HSE in its *National Consent Policy* (2013).³⁶ The “functional” approach recognises that there is a hierarchy of complexity in decisions; that capacity is to be judged in relation to a particular decision to be made, at the time it is to be made; and that cognitive deficits are only relevant if they actually impact on decision-making. Some individuals will always be able to make simple decisions, but may have difficulty if the decision is complex or involves a number of options. Others may be able to make decisions at certain times but not at others because of fluctuations in their condition. It is important to give those who may have difficulty making decisions sufficient time and support in order to maximise their ability to make decisions for themselves. The functional approach to capacity dictates that there should be no presumption that a patient lacks capacity to make a decision solely because of age, disability, appearance, behaviour, medical condition (including mental illness), beliefs, apparent inability to communicate, or the fact that they make a decision that seems unwise or irrational. Nonetheless, it is important to recognise the fact that, in certain circumstances, (e.g. where an individual suffers with psychosis) capacity may be significantly impaired.³⁷

In light of this, there is now broad recognition of the importance of assisted decision-making in order to maximise the opportunity to and ability of people to choose their preferred

³² Donnelly M, From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights, *International Trends in Mental Health Laws* (2008), 26(2): 37-61.

³³ Richardson Report, *Review of the Mental Health Act (1983): Report of the Expert Committee* (1999), Department of Health, HMSO.

³⁴ Millan Report, *Report of the Review of the Mental Health (Scotland) Act 1984: New Directions* (2001), Scottish Executive.

³⁵ Applebaum P S, Assessment of Patients' Competence to Consent to Treatment, *The New England Journal of Medicine* (2007), 357(18): 1834-1840.

³⁶ Health Service Executive, *National Consent Policy*, Dublin, April 2013. Available at: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/consenttrainingresource/trainerfiles/NationalConsentPolicyM2014.pdf

³⁷ Kennedy M, Dornan J, Rutledge E, O'Neill H, Kennedy HG, Extra Information about Treatment is too much for the Patient with Psychosis, *International Journal of Law and Psychiatry* (2009), 32: 369-376.

course of action based on their own wishes. Indeed, the *Assisted Decision-Making (Capacity) Bill* 2013 enshrines the importance of giving effect, as far as practicable, to the past and present will and preferences of individuals in addition to their beliefs and values. The Bill states that it should be presumed that individuals have capacity and that where necessary, people should be assisted, as far as possible, in making their own decisions (either by way of a co decision-maker or assisted decision-maker). Nevertheless, the Bill does recognise that, where necessary, individuals should be able to nominate a decision-making representative to make decisions on their behalf or where this is not feasible allows for publically appointed decision-makers. In *M.X. v. HSE* (2012), Justice MacMenamin stressed the importance of adopting, where practicable, a functional approach to capacity as well as procedures for facilitating assisted decision-making. The case related to a woman suffering from treatment-resistant paranoid schizophrenia who sought to have medical decisions concerning her treatment made on the basis of assisted decision-making which would give sufficient weight to her own wishes.³⁸

Personal Freedoms vs. the Common Good

One of the key aims of the movement towards human rights-based mental health care has been to strike a balance between the interests of society on the one hand and the protection of individual rights and freedoms on the other. Personal rights are not absolute and cannot be upheld to their fullest extent in every situation because protecting the rights of one individual in a particular situation could have a negative impact on the rights of other people. This is symptomatic of the interconnection of all persons within society and, therefore, some form of balance needs to be struck. This need for balance was also recognised by Mill in his liberty principle. He considered that “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others”³⁹.

In order to achieve a fair balance, appropriate attention must be given to the ethical principle of proportionality. This principle requires that those considering limiting personal rights must balance the severity of the restrictions with the intensity of the social need for interference. In effect, it must be determined that the proposed interference is justifiable and appropriate in the circumstances. In the case of mental health, the intention should be to provide care rather than impose control on people with mental illness. Detention is most

³⁸ *M,X [Apum] –v- HSE & Ors*, 2012 [IEHC] 491 (2012).

³⁹ *Supra* 12.

often justified by the potential danger posed by someone suffering from a mental disorder. This might be a danger posed to the public order or to the safety of others (for instance, it has been shown that while the number of homicides committed by people with mental illness has steadily reduced, the majority of violence and homicides committed by this cohort is against family members).⁴⁰ In this sense, society rather than the individual is the main concern. However the counterargument to this particular concept of justice is that considering someone to be dangerous who has not committed an offence is an unfair reason for detention. Nevertheless, while research has shown that the association between mental illness and violent crime is small, it has noted a link between severe mental illness and substance abuse and that this comorbidity exacerbates the risk of violence associated with psychosis.⁴¹ However, it has been argued that treatment to reduce or manage risk of violence in severe mental illness, more often than not, does not require detention in mental health facilities, rather such deprivation of liberty is only required when the risk is most acute or the seriousness of the risk is most grave.

Duty of Care

Mental health providers, like all other medical practitioners, are bound by professional codes of practice, statutory obligations and ethical standards. Commentators have argued that detention is sometimes necessary in order for mental health professionals to fulfil their duty of care to both their patients and the wider community. Concerns have been raised that were psychiatrists to be prevented from detaining individuals for acute treatment there may be negative repercussions for patients (e.g. deterioration in health) and for professionals (e.g. allegations of professional misconduct). The *Rabone v Pennine Care NHS Trust* case highlighted these concerns. In this case a young woman was admitted to hospital as a voluntary patient following an attempted suicide and was diagnosed as suffering from a severe episode of recurrent depressive disorder. She made two further attempts to commit suicide whilst being treated and was assessed to be a moderate-to-high suicide risk. The patient made a request for home leave and this was granted (for two days) during a ward round despite her relatives voicing their concerns. On the second day of her leave, Ms Rabone took her own life. Her parents pursued a case to the Supreme Court and it was found that Ms Rabone was owed a positive operational duty under Article 2 (right to life) of the *Convention for the Protection of Human Rights and Fundamental Freedoms* (1950) by the

⁴⁰ *Supra* 17.

⁴¹ Fazel S, Långström N, Hjern A, Grann M, Lichtenstein P, Schizophrenia, Substance Abuse and Violent Crime, *Journal of the American Medical Association* (2009), 301(19): 2016-2023.

NHS Trust which should have taken preventative action to safeguard her life even though she was a voluntary patient not detained under mental health legislation.⁴² The judgment concluded that the Trust failed to do all that it could reasonably have been expected to do in order to prevent the risk of her suicide. While the Rabone case, dealt with a very specific set of circumstances, it demonstrates the importance of correctly and judiciously balancing the competing interests of personal autonomy on the one hand and duty of care on the other. The difficulty in achieving this balance was highlighted in the judgment, specifically by Lady Hale (at paragraph 107) who stated that:

“There is a difficult balance to be struck between the right of the individual patient to freedom and self-determination and her right to be prevented from taking her own life... [it] appears that there was no proper assessment of the risks before she was given leave and no proper planning for her care during the leave. Having regard to the nature and degree of the risk to her life, and the comparative ease of protecting her from it, I agree that her right to life was violated.”

Concerns have been raised that failures, on the part of mental health services, to fulfil their duty of care and adequately meet the needs of, in particular, young men suffering from the most severe cases of mental ill-health has led to the unintended consequence of them ending up in the penal system. It has been found that a significant number of the prisoners on remand who have been charged with minor non-violent offences (which in many cases do not lead to prison sentences) have been diagnosed with a current psychosis.⁴³ Prisons are essentially custodial rather than therapeutic in nature and it has been noted that while in prison, inmates may receive little access to appropriate mental health services and have been shown to be at very high risk of harm or death (suicide) following their release.^{44,45} While hospitalisation might be the most appropriate form of treatment in some cases (i.e. to reduce the risk of harm to self or others) it could be argued that ensuring adequately resourced community-based programmes of specialised care would go some considerable way in reducing the numbers of vulnerable people ending up in the criminal justice system.

⁴² *Rabone & Anor v Pennine Care NHS Foundation* [2012] UKSC 2 (8 February 2012).

⁴³ Curtin K, Monks S, Wright B, Duffy D, Linehan S, Kennedy HG, Psychiatric Morbidity in Male Remanded and Sentenced Committals to Irish Prisons, *Irish Journal of Psychiatric Medicine* (2009), 26(4): 169-173.

⁴⁴ Binswanger IA, Stern MF, Deyo RA *et al*, Release from Prison: A High Risk of death for Former Inmates, *New England Journal of Medicine* (2007), 356(2): 157-165.

⁴⁵ Stewart LM, Henderson CJ, Hobbs MS *et al*, Risk of Death of Prisoners After Release from Jail, *Australia and New Zealand Journal of Public Health* (2004) 28(1): 32-36.

Increased efforts are needed to stem the flow of young men who are falling through the net because they have not successfully engaged with mental health services, due to a lack of appropriate services or an unwillingness to engage with those services. High quality community-based care might also benefit patients who would prefer to continue their treatment outside of the hospital environment and who are deemed to be good candidates for discharge from in-patient care.

Dignity

Concerns have been expressed that the deprivation of liberty as a result of detention in a mental health care facility might negatively impact human dignity. The concept of human dignity has been widely integrated into international human rights instruments. For instance, Article 1 of the *Charter of Fundamental Rights of the European Union* (2000) states that, “human dignity is inviolable”. Human dignity is typically expressed as the requirement to treat people how they deserve to be treated solely because of their humanity and is regarded as the basis upon which all human rights are derived. However, while these basic ideas are universally accepted there is some divergence of opinion regarding the application of the doctrine. For instance, some would argue that human dignity is bound to the concept of respect for personal autonomy which should be protected against violations of personal will (e.g. perceived paternalism of the part of clinicians or the courts)⁴⁶, whereas others might associate dignity with the sanctity of life which automatically places limits on personal choice.⁴⁷ To this end some commentators have argued that human dignity can only be restored to someone suffering from a severe mental disorder with interventions such as detention and the provision of psychiatric treatment; while others argue that placing vulnerable people in locked wards and separating them from their families and communities is an affront to human dignity. Irrespective of one’s perception of human dignity, it might best be protected by ensuring that, where possible, patients are provided with the least restrictive methods of treatment in the most effective manner.

Stigmatisation and Discrimination

⁴⁶ Kass LR, Defending Human Dignity, *Human Dignity and Bioethics: Essays Commissioned by the President’s Council on Bioethics*, Washington D.C. (2008) p313.

⁴⁷ *Ibid.*

There are concerns that people diagnosed with a mental disorder will encounter stigmatisation, discrimination and marginalisation and an increased likelihood that their human rights will be violated.⁴⁸ Stigmatisation is characterised by a lack of knowledge about mental illness, fear and prejudice, while the term discrimination refers to behavioural responses to such prejudice e.g. treating people unfairly or denying them opportunities. Evidence has highlighted negative societal attitudes towards people with mental ill-health: in particular the view that they represent a danger to the community, a view often reinforced by the media and in culture.^{49,50,51} One common belief is that people with mental illness – irrespective of the underlying disorder – are dangerous, unpredictable and violent.⁵² This negative attitude can produce damaging results. On an individual level, it may lead to isolation and social exclusion.^{53,54} At a societal level, negative views and attitudes could lead to instances of inequity in e.g. insurance coverage, access to housing or employment, or in the reliance on prisons and homeless services to provide care and shelter for some of the most severely ill.⁵⁵

Difference between involuntary and voluntary detention

Admission to a mental health care facility as an inpatient is either voluntary, where the patient elects or agrees to being admitted or involuntary, where the admission is triggered by a relative, medical doctor or a member of the Gardaí and the person does not wish to be admitted. It is estimated that there are about 20,000 admissions to Irish mental health facilities every year and of these approximately 90% are classified as voluntary admissions.⁵⁶ A voluntary patient is defined in the MHA as “a person receiving care and treatment in an

⁴⁸ World Health Organisation, *WHO Resource Book on Mental Health, Human Rights and Legislation* (2005).

⁴⁹ McDaid D, *Countering the stigmatisation and discrimination of people with mental health problems in Europe* (2008) European Commission, Luxembourg.

⁵⁰ Lauber C, Nordt C, Sartorius N, et al., Public acceptance of restrictions on mentally ill people, *Acta Psychiatrica Scandinavica* (200)102, Supplement No. 407: 26-32.

⁵¹ Lauber C, Nordt C, Falcato L & Rössler W, Public attitude to compulsory admission of mentally ill people, *Acta Psychiatrica Scandinavica* (2002),105 (5): 385-389.

⁵² Lauber C, Nordt C, Braunschweig C & Rössler W., Do mental health professionals stigmatise their patients? *Acta Psychiatrica Scandinavica* (2006)113, Supplement No. 429: 51-59.

⁵³ Graf J, Lauber C, Nordt C, et al., Perceived stigmatization of mentally ill people and its consequences for the quality of life in a Swiss population, *Journal of Nervous and Mental Disease* (2004), 192(8): 542-547.

⁵⁴ Müller B, Nordt C, Lauber C, et al., Social Support Modifies Perceived Stigmatization in the First Years of Mental illness: A longitudinal approach, *Social Science & Medicine* (2006), 62(1): 39-49.

⁵⁵ Burns T, Catty J, Becker T, Drake R.E et al., The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial, *Lancet* (2007), 370 (9593): 1146-1152.

⁵⁶ Donnelly M, “Voluntary” Psychiatric Patients Need Protection, *Irish Times* (Opinion and Analysis) 9th February 2012. Available at: www.irishtimes.com/newspaper/opinion/2012/0209/1224311517820.html.

approved centre who is not the subject of an admission or a renewal order” namely someone who has not objected to being admitted rather than a person who has actually consented to admission. In Ireland, people who are voluntarily admitted to mental health facilities are not subject to the same legal safeguards as involuntary patients. For instance, unlike involuntary patients, voluntary patients (including those who are incapable of providing explicit consent) are admitted to mental health facilities without any requirement for external review of admission or detention. Treatment decisions e.g. medication and electroconvulsive therapy (ECT) for voluntary patients who lack decision-making capacity are also made without external oversight. These differences have led to concerns being expressed that, in effect, voluntary patients who lack decision-making capacity have less safeguards than involuntary patients.

From an ethical perspective, a person who gives unambiguous consent to entering a mental health care facility and receiving care which restricts his/her liberty is not considered to be unfairly detained. There is, however, a distinction to be made between apparent and actual consent. In order for detention to be deemed genuinely voluntary, a patient must make the decision to enter a mental health care facility unconstrained by coercion and the patient, once admitted, must be free to discharge himself/herself. However, in practice voluntary detention may not always be genuinely voluntary. The patient who admits himself/herself might not retain full control over his/her care and may face certain procedural and administrative obstacles to discharging himself/herself. Critics have suggested that voluntarism in the fear of compulsion actually represents coercion and that a patient may agree to enter or stay in hospital only because s/he knows that the alternative would be the use of compulsory measures e.g. involuntary detention under the MHA and fear of the potential stigmatisation attached. Some research has shown that many people admitted to mental health facilities on a voluntary basis do not actually believe that they are free to leave.⁵⁷ Even in situations when there is no overt coercion, consent to admission or continued hospitalisation might still reflect a person’s deference to the mental health care providers’ perceived position of authority or to the well-meaning wishes of family or friends.⁵⁸ It is also important to be aware that due to the fluctuating nature of capacity that

⁵⁷ Patrick H, *Autonomy, Benefit and Protection. How Human Rights can Protect People with Mental Health Conditions or Learning Disabilities from Unlawful deprivation of Liberty*, Discussion Paper prepared for the Mentalwelfare Commission for Scotland (2008).

⁵⁸ Richardson G, Coercion and Human Rights: A European Perspective, *Journal of Mental Health* (2008), 17(3): 245-254.

is associated with certain types of mental illness, a person who had decision-making capacity at the time of admission may no longer possess such capacity at a later point.

Voluntary patients can also include individuals who are deemed to lack decision-making capacity in relation to admission to a mental health facility e.g. people with severe and profound intellectual disabilities, elderly people with advanced dementia and people with serious mental impairment (e.g. as a result of brain injury). Concerns have been raised regarding the classification of such individuals as voluntary patients since they are unable to provide explicit consent to their admission to hospital and because their apparent acquiescence may result in their being unfairly deprived of their liberty.⁵⁹ The question of what constitutes the deprivation of liberty of persons lacking decision-making capacity was discussed in the case of *H.L. v The United Kingdom*.⁶⁰ The case, also known as the Bournemouth case, involved a series of legal actions culminating in an appeal to the European Court of Human Rights (ECtHR). The ECtHR found the UK to be in breach of Article 5 of the ECHR because L's detention amounted to an arbitrary deprivation of liberty since there was a lack of procedural safeguards for admission and no provision for an automatic independent review of the detention. As a result of the Bournemouth case, the law in England and Wales was changed and a more formal process for the admission of patients who lack decision-making capacity but who are not resisting hospitalisation was introduced via the publication of the *Deprivation of Liberty Safeguards*.⁶¹ These safeguards aim to ensure that there are appropriate protections in place when it is deemed that persons who lack decision-making capacity require care or treatment in a hospital or care home in circumstances that deprive them of their liberty. A request to detain someone in this fashion must undergo six separate assessments by a supervisory body. These assessments are based on the person's age; his/her previously expressed wishes; level of capacity; eligibility; and best interests. Some commentators have suggested that it might be beneficial for Ireland to implement similar measures in order to address comparable gaps in its legislation and to provide protections to the significant numbers of voluntary and long-stay patients in Irish mental health care facilities.⁶² Nevertheless, it is important to note that there has been some criticism of the *Deprivation of Liberty Safeguards*. Concerns have been raised regarding the

⁵⁹ Murray Claire, Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland, *Dublin University Law Journal* (2007) 29(1), p279-311.

⁶⁰ Application No 45508/99 Strasbourg 5 January 2004.

⁶¹ Department of Health (UK), *Mental Capacity Act 2005. Deprivation of Liberty Safeguards in England* (October 2008).

⁶² *Supra* 39.

lack of a clear definition of the term “deprivation of liberty”, the complexity of the safeguards as well as the fact they have been interpreted differently by clinical and legal professionals alike.⁶³

While the MHA represents an important development and a definite improvement in the treatment of involuntarily detained individuals it has not introduced similar safeguards for the majority of those detained i.e. people categorised as voluntary patients, to those established for involuntary patients. Many of these patients may be in an exceptionally vulnerable position e.g. they may lack decision-making capacity; they may have no alternative accommodation; or they may be “voluntary” only in the sense of having agreed to admission in order to avoid involuntary admission or by appearing to comply with the proposed treatment plan without actually providing consent. Voluntary patients have the same rights to autonomy, dignity and freedom from inhuman or degrading treatment as involuntary patients. However, the difficulty is that people in mental health care facilities may have little prospect of enforcing those rights.⁶⁴ This may be especially true for the large number of long-stay patients (one quarter of all inpatients), many of whom have been hospitalised for longer than five years with almost half of these being over 65 years of age.⁶⁵ A person’s consent to hospitalisation, or in the case of someone who lacks capacity – the consent of a representative, should be genuine and unambiguous as a lack of valid consent may render the person’s admission unethical, especially if the person’s hospitalisation amounts to a deprivation of liberty. Consequently the current definition of a voluntary patient, where neither consent nor capacity is taken into account is deemed to be problematic and is currently being considered as part of the review of the MHA.⁶⁶ In its 2014 *Concluding Observations on Ireland’s 4th Periodic Report on the International Covenant on Civil and Political Rights* the UN Human Rights Committee stated that the Irish State should “amend the definition of voluntary patient under the Mental Health Act, 2001 so that the term only refers to a person who consents to admission and treatment.”⁶⁷

⁶³ Cairns R, Brown P, Grant-Peterkin H, et al., Judgements About Deprivation of Liberty Made by Various Professionals: Comparison Study, *The Psychiatrist* (2011), 35: 344-349.

⁶⁴ Donnelly M, *Treatment for Mental Disorders and Protection of Patients’ Rights*, Paper delivered at the Mental Health and Human Rights Seminar, Centre for Criminal Justice and Human Rights, UCC (2007).

⁶⁵ Daly A, Walsh D, HRB Statistics Series 12, *Irish Psychiatric Units and Hospitals Census 2010* (2011). Available at: http://www.hrb.ie/uploads/tx_hrbpublications/HRB_Statistics_Series_12_-_Irish_Psychiatric_Units_and_Hospitals_Census_2010_Web_Version.pdf

⁶⁶ *Supra* 9

⁶⁷ *Supra* 13.

The Ethical Permissibility of Providing Treatment to People Who Refuse it

The provision of treatment to people who have not consented to it or who have indeed refused it raises serious clinical and ethical issues. Consequently, consideration should be given to the extent to which consent for treatment is required; the types of treatment (if any) that can be administered involuntarily; whether it is appropriate or beneficial to be detained in the absence of treatment; whether it is acceptable to preserve the individual freedoms of a patient over the interests of the community which might bear the cost of the treatment refusal; and whether the patient has sufficient capacity to make decisions regarding his/her treatment.

Consent

An adult who possesses decision-making capacity must give consent for medical treatment. Consent is based on the principle that patients are free to choose whether or not to accept a medical intervention or use a particular service and it protects and supports the right to autonomy. It is also associated with the concept of respect for persons, which requires that people's beliefs and opinions be valued and, where feasible, adhered to. However, as previously noted, ethical principles, such as respect for persons and autonomy must be balanced against other competing values, such as justice and the common good. The MHA places limits on consent with regard to the provision of treatment to involuntary patients. Part 4 (Section 56) allows for an exception to consent for treatment where the consultant psychiatrist who is responsible for the care and treatment of the patient deems the treatment to be necessary to safeguard the patient's life, to restore his/her health, to alleviate his/her condition or to relieve his/her suffering and where the patient because of his/her mental disorder is regarded to be incapable of giving consent. Section 57 allows for an individual with capacity who is detained involuntarily to refuse treatment. However, there remains legal and ethical uncertainty in respect of providing treatment to people categorised as voluntary patients in the absence of consent. Voluntary patients might be assumed to have given implied consent to receive treatment at the time of their admission to hospital. However, implied consent is ethically problematic in that it is at odds with the general requirement for explicit consent to treatment and it is questionable whether passive behaviour or indeed the absence of any behaviour could be construed as genuine consent. In addition, treatment programmes for certain conditions (e.g. anorexia nervosa) might involve a combination of therapies only some of which a patient may wish to avail and assuming broad, implied consent would not permit patients to limit the type/amount of

treatment received.⁶⁸ Voluntary patients might also be persuaded or coerced into accepting medication; face the possibility of having their status altered from voluntary to involuntary if they refuse treatment; or be discharged from the mental health facility in which they are being cared for.

Treatment Refusal

There are various reasons cited for treatment refusal and non-adherence in mental health care. Firstly, treatment refusal and non-adherence may be due to past experience, especially if that experience was negative. In addition, psychoses may be significant in some cases, particularly where the associated paranoia may lead to suspicion and fear. Some mental disorders may prevent patients from accepting that they need a medical intervention. Patients in these circumstances may understand the treatment proposed but still decline or refuse it because, in their opinion, they are not ill or do not require treatment. This is commonly referred to as a “lack of insight” into one’s condition. Commentators have argued that, in the case of a patient who, owing to psychosis, does not accept that an intervention is justified or necessary, the decision is not an autonomous one because it is determined by the mental disorder.⁶⁹ Nevertheless, it is important to note that the existence of a mental disorder does not necessarily prevent a patient from accepting his/her illness and the need for a medical intervention. Many patients, including those suffering from psychotic illnesses, do accept their condition and the need for medical intervention and, while some may not realise the full extent of their illness, they can, nevertheless, give consent.

Furthermore, the adverse effects of certain medications might also be a factor in treatment refusal or non-adherence.⁷⁰ Reported adverse effects of antipsychotic drugs include diabetes and dizziness as well as extrapyramidal symptoms, including parkinsonian symptoms (tremors), dystonia (abnormal face and body movements), akathisia (restlessness), and tardive dyskinesia (rhythmic involuntary movements particularly of the tongue, lips, face, hands, and feet). In addition, certain medications may interfere with a patient’s lifestyle e.g. patients have stated that some medications result in their feeling drowsy or lethargic, cause significant weight gain to the point of obesity or lead to sexual dysfunction, such as

⁶⁸ MacDonald C, Treatment Resistance in Anorexia Nervosa and the Pervasiveness of Ethics in Clinical Decision Making, *Canadian Journal of Psychiatry* (2002), 47(3): 267-270.

⁶⁹ van Staden CW and Krüger C, Incapacity to Give Informed Consent Owing to Mental Disorder, *Journal of Medical Ethics* (2003), 29(1): 41-43.

⁷⁰ Bartlett P, “The Necessity must be Convincingly Shown to Exist”: Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983, *Medical Law Review* (2011), 19(Autumn): 514-547.

impotence.⁷¹ One particular study showed that obese people were more than twice as likely as people with normal body mass ratio to cease medication,⁷² and other studies found that up to 42% of men failed to take their medication because of sexual dysfunction.^{73,74}

Compulsory medical treatment may have varying effects, both positive and negative and a number of arguments for and against its use have been put forward. Historically, when the prospect of an autonomy-based approach to mental health care was mooted the main arguments against it were that it would lead to large numbers of treatment refusals by patients; that psychiatric hospitals would effectively become detention centres; and that limited resources would have to be redirected away from patient care into the legal process. In an often cited article Applebaum and Gutheil argued that the way would be paved for “patients to rot with their rights on”.⁷⁵ This referred to a common fear attributed to psychiatrists that were patients to be routinely permitted to refuse treatment they would clog up the mental health system and would be left to deteriorate in hospital wards, ignored by society with little or no chance of recovery. However, it is important to note that the “epidemic” of refusals initially feared by psychiatrists did not, in fact, take place.⁷⁶ Studies cited by Applebaum suggested that on average less than 10% of patients refused anti-psychotic medication. The research showed that when patients expressed their desire to refuse medication their cases were generally sent for formal review by the courts (or similar body) and, more often than not, the patients were deemed not to have sufficient capacity to refuse. Therefore, the patients were rarely left untreated if their psychiatrists decided to pursue the matter.⁷⁷

⁷¹ Olfson M, Uttaro T, Carson WH, Tafesse E, Male Sexual Dysfunction and Quality of Life in Schizophrenia, *Journal of Clinical Psychiatry* (2005), 66(3): 331-338.

⁷² Weiden PJ, Mackell JA, McDonnell DD, Obesity as a risk factor for antipsychotic noncompliance, *Schizophrenia Research* (2004), 66(1): 51-57.

⁷³ Robinson DG, Woerner MG, Alvir JMAJ et al., Predictors of medication discontinuation by patients with first-episode schizophrenia and schizoaffective disorder, *Schizophrenia Research* (2002), 57 (2-3): 209-219.

⁷⁴ Lambert M, Conus P, Eide P et al., Impact of present and past antipsychotic side effects on attitude toward typical antipsychotic treatment and adherence, *European Psychiatry* (2004), 19(7):415-422.

⁷⁵ Applebaum P, Gutheil T, Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients, *Bulletin of the American Academy of Psychiatry and Law* (1979), 7: 306-315.

⁷⁶ Applebaum P, *Almost A Revolution: Mental Health Law and the Limits of Change*, New York, Oxford University Press (1994). Available at: http://books.google.ie/books?id=GbCS8TnG1GkC&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false

⁷⁷ *Ibid.*

Concerns have also been expressed that if patients, in particular voluntary patients, refuse treatment and are discharged as a result their decision, there will be a resultant “revolving door” system of hospital admission. During the twentieth century there was an immense rise in the number of admissions to psychiatric in-patient care. For instance, in 1923 there were 2,638⁷⁸ admissions which rose to 29,392⁷⁹ by 1986 and then fell to 20,288⁸⁰ by 2006. In 1923 the rate of readmissions constituted 19%⁸¹ of all admissions, whereas in 1986 the rate of readmissions was 72%⁸² a proportion that persisted to 2006⁸³. These figures highlight the fact that many categories of mental illness are persistent and recurrent in nature. A *Vision for Change* has noted this fact and has recommended more specialised rehabilitation services directed at severe and enduring illness. In the *Annual Report of the Inspector of Mental Health Services 2006*, concerns were raised regarding the lack of community services and poor staffing levels. The report concluded that in-patient treatment will remain the standard form of care and that there will be few alternatives if community mental health teams are not better resourced.⁸⁴

Compulsory Treatment

A lack of compliance with medication has been associated with quicker relapse and increased risk to self and others. This increased risk, it has been claimed, provides ethical and legal justification for detaining and treating psychiatric patients without their consent. When unwell, people with severe mental disorders can experience significant cognitive disruption, mood disturbances and, as a result, act in a way which may be dangerous to themselves and/or others. It is these risks that form the basis of the argument for compelling people to take psychiatric medication.⁸⁵ It has also been argued that the aim of medical intervention is to restore patient autonomy and that a restriction on the patient’s right to refuse treatment may be justified in order to achieve this higher goal.⁸⁶ Although,

⁷⁸ Department of Health, *Report of the Inspector of Mental Hospitals*, Dublin, Stationery Office (1923).

⁷⁹ O’Connor A, Walsh D, *Activities of Irish Psychiatric Hospitals and Units 1986*, Dublin, Health Research Board (1989).

⁸⁰ Daly A, Walsh D, Moran R, *Activities of Irish Psychiatric Units and Hospitals 2006*, Dublin, Health Research Board (2007).

⁸¹ *Supra* 78.

⁸² *Supra* 79.

⁸³ *Supra* 80.

⁸⁴ Mental Health Commission, *Annual report 2006, Mental Health Commission including the Report of the Inspector of Mental Health Services 2006* (2007).

⁸⁵ Jarrett M, Bowers L, Simpson A, Coerced Medication in Psychiatric Inpatient Care: Literature Review, *Journal of Advanced Nursing* (2008), 64(6): 538-548.

⁸⁶ Applebaum P, *Almost a Revolution: Mental Health Law and the Limits of Change*, (1994) New York, Oxford University Press.

this restoration of autonomy may not always be achievable e.g. in the case of severe dementia or intellectual disability. The rationale put forward is, if a patient is detained in a mental health facility, his/her freedom is already significantly limited, therefore, if treatment leads to the patient being discharged, its imposition would be ultimately less damaging to his/her rights. That is, sometimes it can arguably be in a person's best interests to get them to do something (or do something to them), even though it may be against their will. This modern interpretation of Rousseau's theory of 'forcing to be free' reflects the tension between autonomy and paternalism.⁸⁷ Indeed, it has been argued that, whenever the state deprives someone of his/her liberty on medical/psychiatric grounds, it has an obligation to provide well resourced, safe and effective treatment to restore autonomy or at the very least to alleviate suffering and restore dignity.⁸⁸ However, proponents of the right to refuse treatment have argued that some patients might actually prefer to live with the limitations of their condition as opposed to having treatment imposed upon them. Additionally, they argue that compulsory treatment negatively impacts on the relationship and trust built between the patient and his/her healthcare provider not least if the patient perceives the provision of treatment to be coercive.⁸⁹ Providing treatment to those who have refused consent has also been argued, although no judgment exists to date, to represent degrading treatment as described under Article 3 of the ECHR⁹⁰, which states that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment".⁹¹

Some commentators have suggested that patients will retrospectively approve and appreciate compulsory treatment. This argument centres on the idea that a person lacking decision-making capacity who is medicated in the absence of consent will concur with the course of treatment once decision-making capacity has been restored (known as the "thank you" theory).⁹² There is some evidence which backs-up this assertion. A 2009 study of people lacking capacity admitted to a mental health facility in London found that 83% of those regaining capacity gave retrospective approval for the initially involuntary treatment and indicated that they believed they needed their healthcare providers to make treatment

⁸⁷ Rousseau JJ, *The Social Contract or Principles of Political Right* (1762)

⁸⁸ *Supra* 11.

⁸⁹ Szmukler G and Applebaum PS, Treatment Pressures, Leverage, Coercion, and Compulsion in Mental Health Care, *Journal of Mental Health* (2008), 17(3): 233-244.

⁹⁰ *Supra* 48.

⁹¹ Fennell P, Best Interests and Treatment for Mental Disorder, *Health Care Analysis* (2008), 16(3): 255-267.

⁹² *Supra* 48 and *Supra* 5.

decisions on their behalf and that those decisions were correct.⁹³ On the other hand, in another study, conducted in 2010, it was shown that treatment satisfaction among people subject to compulsory treatment was lower than for those not subject to such treatment.⁹⁴

In dealing with cases of treatment refusal mental health care providers should seek to balance the desire to do good for the patient against the need to respect the patient's autonomy. Infringement of autonomy can be both ethically necessary (to preserve life, to avoid harm to others) and ethically problematic, not least because of the perceived power imbalance between healthcare professionals and their patients.

Decision-Making Capacity and Treatment Refusal

When considering the ethical permissibility of providing psychiatric treatment to those who have expressly refused it, it is essential to consider the level of a patient's decision-making capacity. If a patient has capacity then his/her decision about medical matters should be respected in recognition of his/her right to autonomy. As noted above, health and social care providers are expected to work on the presumption that every adult patient has the capacity to make decisions about his/her care, and to decide whether to accept, or refuse, an examination, intervention or treatment. Nevertheless, it is important to acknowledge the reality that, in certain situations decision-making capacity may be limited. However, while it may be the case that some individuals with mental disorders will be impeded in their decision-making as a consequence of their disorder this does not necessarily justify a system which denies all patients with mental disorders the right to make their own treatment decisions. If there is recognition that decision-making capacity forms the basis of the right to make treatment decisions in other respects, it could be argued that not do so in the case of people with a mental disorder would be discriminatory.⁹⁵ It is also worthy of note that the fact that a patient has been found to lack capacity does not make the imposition of treatment any less traumatic if the patient does not want the treatment.

It is widely agreed that, where feasible, people with impaired capacity should be provided with support in order to make treatment decisions rather than having decisions made on

⁹³ Owen GS, David AS, Hayward P, Richardson G, Szmukler G and Hotopf M, Retrospective Views of Psychiatric In-Patients Regaining Mental Capacity, *British Journal of Psychiatry* (2009), 195: 403-407.

⁹⁴ Katsakou C, Bowers L, Amos, T, Morriss R, Rose D, Wykes T, Priebe S, Coercion and Treatment Satisfaction Among Involuntary Patients, *Psychiatric Services* (2010), 61(3): 286-292.

⁹⁵ Donnelly M, From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights, *International Trends in Mental Health Laws* (2008), 26(2): 37-61.

their behalf. Support to assist a person with a disability to exercise his/her decision-making capacity is a requirement of the CRPD (Article 12), which guarantees the right of a person with impaired capacity to be involved, to the fullest extent possible, in decisions which concern them and this entails providing assistance to enable them to do so. As previously mentioned it is also required by the *Assisted Decision-Making (Capacity) Bill 2013*. A system of patient advocacy has been proffered as one possible way of providing such assistance. The Government's report *A Vision for Change* recognises the valuable role advocacy plays in patient recovery. It states that "all users of the mental health services – whether in hospitals, day centres, training centres, clinics, or elsewhere – should have the right to use the services of a mental health advocate".⁹⁶ In recognition of the functional approach to capacity, the upcoming *Assisted Decision-Making (Capacity) Bill 2013* specifically provides for assisted decision-makers as well as co-decision makers.

Family and friends often wish to be involved in decisions regarding the care and treatment of loved ones suffering from mental ill health. This may result in pressure being placed on patients to either accept or refuse treatment. As pointed out in the HSE's *National Consent Policy*, there is currently no legal basis for allowing family members and/or friends to consent on behalf of an adult who lacks decision-making capacity in the absence of any legal authority to do so (e.g. if the person was a ward of court or subject to an enduring power of attorney). Nevertheless, consultation with the family and/or friends of a person who lacks decision-making capacity should be encouraged in order to shed light on that person's will and preferences and their medical history. The role of family and/or friends in such circumstances, however, is not to make the treatment decision but merely to provide insight as to what they believe the patient would want. In cases where a person with a mental disorder has decision-making capacity, family and/or friends should only be consulted when the patient has consented to such consultation.

Psychiatric Advance Healthcare Directives

Another method of empowering people with mental ill-health would be to establish a framework for psychiatric advance healthcare directives (PADs). Mental illnesses are sometimes episodic in nature, and are often characterised by alternating periods of capacity and incapacity. A PAD is a document which is "intended to convey a person's preferences for psychiatric treatment should the person become incompetent in the future and unable to do

⁹⁶ *Supra* 3.

so for themselves”.⁹⁷ The main objective of a PAD is to maximise recovery, while attempting to minimise unwanted interventions and treatments and they have been recommended as a mechanism by which individuals with mental ill-health can retain some control over their treatment during these temporary periods of incapacity. For instance, a patient with a history of mental illness may be in a position to know, based on past experiences, what works and what does not work for him/her during a psychiatric crisis and, therefore, may be best placed to either refuse or request specific treatments. They may also be best able to identify potential alternative (proxy) decision-makers/advocates and/or identify individuals to be contacted during a crisis.⁹⁸ Research has indicated that PADs can significantly reduce the use of compulsory admission and treatment⁹⁹ and that those individuals who prepared some form of PAD had a significantly decreased prospect of experiencing coercive treatments and interventions than individuals who did not.¹⁰⁰

A PAD has the potential to give the patient a “voice” and a sense of being respected – especially in situations where the patient is otherwise powerless and vulnerable. Adequate communication can help foster trust and build a better therapeutic relationship between the patient and his/her health care team, thereby encouraging greater patient engagement, which can lead to increased therapeutic adherence. Indeed, a number of commentators have argued that the process of discussion and negotiation between the patient and his/her healthcare providers which is inherent in the preparation of PADs facilitates a more detailed discussion not only of the patient’s treatment preferences but also the rationale behind his/her decisions. This may in turn lead to increased treatment adherence and potentially better treatment outcomes. *A Vision for Change* which promotes a more person-centred approach involving greater patient participation, recommends the acceptance of support mechanisms such as PADs as well as enduring powers of attorney which allows the attorney to make “personal care decisions” (e.g. where and with whom the person will live, who he/she should see or not see and what training or rehabilitation he/she should get) on a person’s behalf once he/she is no longer fully mentally capable of taking decisions

⁹⁷ Campbell LA, Kisely SR (2009). *Advance treatment directives for people with severe mental illness (Review)*. Cochrane Database of Systematic Reviews 1: CD005963.

⁹⁸ Henderson C, Swanson JW, Szmukler G, Thornicroft G and Zinkler M (2008). A Typology of Advance Statements in Mental Health Care. *Psychiatric Services* 59(1): 63-71.

⁹⁹ Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K and Szmukler G (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *British Medical Journal*, doi:10.1136/bmj.38155.585046.63.

¹⁰⁰ Swanson JW, Swartz MS, Elbogen EB, Van Dorn RA, Wagner HR, Moser LA, Wilder C and Gilbert AR. Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health* (2008), 17(3): 255-267.

himself/herself. Ireland currently has no legislative framework for PADS and it should be noted that enduring powers of attorney do not presently extend to healthcare decisions. However, the forthcoming *Assisted Decision-Making (Capacity) Bill* 2013 is expected to provide a legislative basis for PADs and to extend enduring powers of attorney to include healthcare decisions.

The limits of psychiatric advance directives should also be considered. A PAD cannot 'direct' a healthcare professional to do something that would be illegal. A PAD probably cannot override the duty of care as indicated by the obligations under Article 2 of the *European Convention on Human Rights* (on the right to life)¹⁰¹ nor could a PAD be valid if it contained some directive or preference that was contrary to the Constitution or any statute.

Concluding Remarks

The effective protection of human rights and the potential for improvement in mental health may be secured by providing access to ethically acceptable treatments and services which are comprehensive, proportionate, patient-centred and recovery-oriented. In order to achieve this goal, patients should, as far as reasonably practicable, be permitted and encouraged to participate in any medical decisions that will affect them. In addition, if practicable and appropriate, the views of anyone nominated by the patient should be consulted, namely any carer or person interested in his or her welfare (e.g. family member or friend).¹⁰² Ireland needs to adopt a system that reflects a commitment to maximising the autonomy, dignity and bodily integrity of persons affected by mental health conditions. In particular, a system should be established which will ensure that voluntary admissions to treatment and services are genuinely voluntary. This should include a revised definition of the term "voluntary patient" whereby only those people who have decision-making capacity and who have provided genuine and informed consent for their admission and/or treatment in an approved centre would be included.

The National Advisory Committee on Bioethics would agree with the Steering Group on the Review of the Mental Health Act 2001's assertion that significant intellectual disability should not be used as a criterion for involuntary detention unless the person concerned has a co-morbid mental illness of such a severity that it meets the threshold for mental disorder

¹⁰¹ *Supra* 42.

¹⁰² Fennell P, Best Interests and Treatment for Mental Disorder, *Health Care Analysis* (2008), 16: 255-267.

and would suggest that severe dementia should also be withdrawn as a criterion. This committee would also point out that the current definition of significant intellectual disability does not reflect either the rights or behaviour of the persons concerned.

In recognition that involuntary mental health treatment poses a serious curtailment of liberty, it is the opinion of the National Advisory Committee on Bioethics that involuntary detention and treatment should be limited to instances where individuals pose a serious risk of physical harm to themselves or others and to circumstances when no less restrictive alternative will adequately address the risk. Such views are supported by national policy documents (e.g. Interim Report of the Expert Steering Group on the Review of the Mental Health Act 2001) and international human rights instruments (i.e. the *Convention for the Protection of Human Rights and Biomedicine* and the CRPD) and are in line with the increasingly accepted autonomy-based approach to mental health care.

In addition, and in line with *A Vision for Change*, there should be increased availability of well-resourced community-based treatment programmes which could act as an alternative to in-patient psychiatric treatment. The increased provision of community care might not only impact on the numbers of patients requiring in-patient care in the first instance, but might also combat the “revolving door” phenomenon caused by frequent and serious relapse.¹⁰³

In order to ensure that these standards are achieved and maintained, a number of safeguards should be in place. These safeguards should include a provision that consent is required for all medical care provided to persons who possess decision-making capacity and that where capacity is impaired decision-making assistance is provided to the person concerned. “Voluntary” patients who lack decision-making capacity should be offered the same protections as those involuntarily detained under the MHA in relation to external oversight, independent review and legal representation. Due to the importance of respect for autonomy in modern health care ethics, the simple fact that a proposed treatment stands to benefit a patient is not by itself sufficient to justify imposing that treatment. The desire to do good must be balanced against the need to respect patient autonomy. Nevertheless, different considerations need to be taken into account where there is a duty

¹⁰³ Daly A, Tedstone Doherty D, Walsh D, Reducing the Revolving Door Phenomenon, *Irish Journal of Psychiatric Medicine* (2010), 27(1): 27-34.

of care that obliges clinicians to act to preserve life or avoid serious harm.¹⁰⁴ Therefore, there should be a qualified right for both voluntary and involuntary patients to refuse treatment and/or medical interventions particularly if such treatments pose risks or are to be taken for extended time-periods.

It is difficult to imagine that compulsion is justifiable if consent (in cases where there is capacity) might follow from a full discussion of a treatment programme and its effects. Negotiation and compromise, for example agreeing other forms of therapy, using an alternate medication of the same class or initiating medication at a lower dose, may be helpful and allow for treatment to proceed. The ideal situation would be where treatment proceeded as a result of consensus rather than compulsion. In other jurisdictions, PADs have proven to be useful instruments for maintaining and increasing the autonomy of persons with mental health conditions. This committee would support the introduction of a legal framework [i.e. the forthcoming *Assisted Decision-Making (Capacity) Bill*] which would allow individuals with capacity and who have a mental illness to indicate, in writing, what treatment they would wish to refuse/receive should their decision-making capacity be impaired at a later date or to nominate someone who might make those decisions on their behalf.

¹⁰⁴ *Supra* 42.