

Ethical issues in long term psychiatric management

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Abstract

Two general ethical problems in psychiatry are thrown into sharp relief by long term care. This article discusses each in turn, in the context of two anonymised case studies from actual clinical practice.

First, previous mental health legislation soothed doubts about patients' refusal of consent by incorporating time limits on involuntary treatment. When these are absent, as in the provisions for long term care which have recently come into force, the justification for compulsory treatment and supervision becomes more obviously problematic.

Second, Anglo-American law does not normally allow the preventive detention of someone who may be dangerous but has not actually committed any crime. The justification for detaining a possibly dangerous user of mental health services without his or her consent can only be based on risk assessment, but this raises issues of moral luck. Is the psychiatrist who decides not to take out a supervision order for a possibly dangerous patient with an initial psychotic diagnosis morally at fault if that person harms someone in the community, or himself? Or is the psychiatrist merely unlucky?

Recent UK legislation and changes in clinical practice make the management of psychiatric patients in the "community" a pressing ethical problem. More accurately, long term psychiatric management accentuates dilemmas which were already there. These difficulties have to do with voluntariness and consent, on the one hand, and with risk and responsibility on the other. In this article I use anonymised case material derived from actual clinical practice to illustrate both kinds of dilemma and to demonstrate that these ethical concerns are not merely academic.

Informed consent and long term supervision

In Anglo-American law it is normally the giving of either implied or expressed consent which absolves

the professional of a charge of a battery in touching the patient.¹ Lacking either such form of consent, involuntary treatment in psychiatry is often considered particularly problematic.² Although this statement must be qualified with respect to underage patients, and elucidated with the help of a body of case law, it still distinguishes other branches of medicine from psychiatry in two very important ways.

First, the psychiatrist may more frequently be called on to treat those who *actively resist* treatment. Although on the face of it this statement is obviously true, there must be some qualifications. Of course one might argue that voluntariness is also problematic in other kinds of medical practice: where treatment is a matter of last resort, or where treatment options are severely limited. Other branches of medicine, such as palliative care, may concern the treatment of non-competent, even comatose patients. In addition, even voluntary admissions for psychiatric treatment may reflect an element of coercion, perhaps by the family.³ But whereas palliative care may well treat those who are *incapable* of giving consent, psychiatry more typically may have to treat those who *actively refuse* their consent. Most importantly, the question is whether that refusal is occasioned *by* the psychiatric condition. If so, it is generally not valid against treatment *for* the *psychiatric* condition, although even the mental health service user's consent is still required for treatment in relation to a *somatic* condition.

Second, consent in psychiatry raises intractable problems about the patient's true wishes. Even where users of mental health services *have given* consent to particular procedures, courts have sometimes intervened on the grounds that the patient had not rationally considered risks and benefits.⁴ But likewise where patients have *refused* consent, they have often been overruled, even when their behaviour is intermittently lucid and confused.⁵ This implies that neither consent nor refusal by a user of mental health services is unambiguously "genuine"; that perhaps neither reflects the judgments of a fully autonomous person.

The Mental Health Act 1983 and the Mental Health (Scotland) Act 1984 soothe doubts about

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infringement of autonomy, among other ways, by incorporating fairly strict time limits. For example, compulsory admissions for assessment under section 2 of the MHA 1983 may not extend beyond 28 days and cannot be renewed. An emergency admission under section 4 of the 1983 act or section 24 of the Scottish act is only valid for 72 hours. Under section 3 of the 1983 act, admission for treatment, the patient may be detained for up to six months, renewable only if specified conditions are met. Although service user groups have queried how effective these limits are in practice, when limits are entirely absent – as in long term care – the justification for compulsory treatment becomes more obviously problematic, and the informed consent of the patient particularly critical.

Responsibility

In general the effect of informed consent, as I have argued elsewhere,⁶ is to transfer responsibility for ill-luck in outcomes from the doctor to the patient. On the surface, the question may appear to be who has authority to give consent; but in relation to long term consequences, the question is who bears responsibility if something goes wrong. This is not an excuse for irresponsibility on the doctor's part, but it does emphasise correct procedures in obtaining informed consent. No treatment has a one hundred per cent chance of success and a zero per cent rate of unwelcome side effects. Through sheer statistical necessity, some outcomes will be unfavourable, and the question raised by informed consent is who bears responsibility for those outcomes. The particular question raised by those who require long term psychiatric management is whether they *can* give an informed consent and take responsibility for their treatment, or lack of treatment. By virtue of having been discharged into the community, are they now to be construed as fully "autonomous"?

Implied or retrospective consent sometimes seems a solution to the particular problems of upholding autonomy with patients whose mental competence may be in doubt, but that notion is built on shifting sands. The argument here is that someone who cannot consent to a procedure whilst incompetent would be grateful for it later: retrospective consent. Even such radical interventions as ECT and psychosurgery without consent have actually been supported on the ironic grounds of autonomy: to improve the patient's chances of acting as an autonomous agent afterwards.⁷ But what if the patient turns out not to be grateful, or the intervention fails to improve the clinical condition?

Furthermore, any *post hoc* consent may be a product of the intervention itself. For example, a drug regime, or institutionalisation itself, may create dependency or docility. Finally, the notion of cognitive dissonance could also explain why patients might accept an intervention afterwards; but that is no

guarantee that they would necessarily have accepted it beforehand. It is psychologically painful to admit that my will has been overridden, less humiliating to persuade myself that what was done to me is what I really wanted all along.

A possible justification in English law⁸ for not disclosing all material risks in informing patients is therapeutic privilege, grounded in the patient's best medical interests: an argument from benevolence rather than autonomy. Given the convolutions into which retrospective consent can lead us, it has been argued that frank paternalism is actually the best and more honest policy.⁹ But that can only be justified if there is clear prospective benefit to the patient. If there is no benefit, even determined paternalists would have doubts about bypassing informed consent and downplaying patient autonomy on the grounds of the patient's best interests. Long term management, as under the new supervision register, raises particular problems, compared to the expressly limited time-frame of treatment under sections 2 or 3 of the Mental Health Act 1983, because there is simply more uncertainty about prospective benefit: there just *is* more future ahead.

The supervision register was introduced for England and Wales in 1994 in response to the Ritchie Report on Christopher Clunis, a former mental health patient who attacked and killed a stranger, Jonathan Zito. It was intended to provide heightened vigilance over ex-patients considered to be at risk of serious violence, suicide or significant self-neglect. The register was followed by a new aftercare under supervision order passed by parliament in 1995 under the Mental Health (Patients in the Community) Act. This authorises the allocation of a named supervisor (usually a community psychiatric nurse) and a community Responsible Medical Officer (RMO). It provides the statutory underpinning for the supervision register introduced the year before, although not all patients placed on the register would necessarily be subject to the supervision order or section.

Resource cuts

No new resources are made available to accompany these measures. Instead, it appears that resource cuts are driving the supervision register initiative. Patients are being discharged into the community when they are minimally able to cope – hardly the model of therapeutic benevolence, but the only alternative for hard-pressed practitioners. It may therefore be untenable to claim that patients should be placed on supervision registers for their own good. Indeed, there is considerable scepticism amongst some practitioners about whether the purpose of the supervision register is to benefit the patient following discharge, or to ensure that a key worker is identified and made formally responsible for the ex-patient's behaviour.

Supervision registers raise particular difficulties about informed consent. There is no requirement to inform users of mental health services that their names have been placed on the register, and no process of appeal, although there is a built-in process of review every six months. If there is no countervailing value of benevolence to offset this invasion of autonomy, there can be no argument from “best interests” for imposing registers without the consent of the ex-patient. Indeed, if the patient found out that he had been placed on the register without his consent, his clinical condition might actually worsen. An anonymised case from one mental health trust highlights consent issues and demonstrates the difficulties of treating an unwilling ex-patient in the community.

The case of Phillip C

Phillip C, a divorced man in his early forties, has served two prison sentences for indecent assault against schoolgirls. During his second imprisonment he was diagnosed as suffering from paranoid schizophrenia, and his illness was treated with injected antipsychotic drugs. However, he does not accept this diagnosis; at best he claims that his ordeal in prison accounts for his psychiatric problems, and at worst he denies that there is anything abnormal in his behaviour, including his sexual behaviour.

Since his final release ten years ago he has committed no further offences. He attends a psychiatric outpatient clinic but accepts only the very minimum level of medication by injection because he thinks that the drugs are poisonous. His clinicians feel that only an increased dosage would protect him in the long term from psychotic relapse, but Phillip C is very hostile to any such suggestions. It seems that he only attends the clinic because he fears being sectioned or imprisoned.

Recently, when interviewed in the presence of a young female medical student, Phillip C became extremely agitated. He stared at the student pointedly, shouting that the girls he assaulted had “asked for it”. Lately his behaviour has become extremely erratic in the clinic, and in the past year he actually disappeared altogether for several months, although he has since returned. In some respects he seems to be flourishing: recently he gave an exhibition of his amateur paintings. But whereas he told the clinical team that he painted landscapes, he is actually primarily interested in female nudes. However, he argues quite coherently that he has learned to channel his sexuality into his art.

The clinicians’ preferred management would be to increase Phillip C’s medication, see him more often, refer him to a forensic psychiatrist to get a risk estimate for re-offending, and finally, place him on the hospital supervision register. But if they broach one or all of these courses of action, Phillip C is likely to disappear for a longer period and to become even

less compliant with his medication. Placing him on the supervision register, unlike the other three courses, could be done without his knowledge or cooperation. But given that there are no new resources available, what would it achieve? Even if there were more money to be had, would we want Phillip C to get additional resources at the expense of other users of mental health services? Could it improve his compliance to keep the supervision register in reserve as a threat along the lines of section? – which he does seem to respect. In contrast, if Phillip C were to find out that he had been placed on the supervision register behind his back, it might only increase his hostility to the doctors.

Risk and moral luck

The example of Phillip C also illustrates the second general ethical problem in long term management: how much can be justified by *risk of harm*. It is usually axiomatic that someone who may be dangerous but has not actually committed any crime cannot be detained. What then is the justification for detaining a possibly dangerous person who is mentally ill without his or her consent? The rationale for preventive detention must be probabilistic, involving risk assessment; yet some studies of risk assessment in psychiatry reveal very low levels of agreement among practitioners on prognoses of dangerousness. In one such piece of research, 60 per cent agreement among group of assessors was achieved in only four out of 16 cases.¹⁰ (More recently, better correlations between psychotic diagnosis and dangerousness have begun to be achieved.)¹¹ Elsewhere, as in general hospital medicine, poor reliability amongst practitioners in agreeing levels of risk has also been demonstrated,¹² but that does not make the problem any less acute for psychiatry.

The supervision orders now available in England and Wales accentuate this difficulty because they appear to give a kind of police power to psychiatrists. This power of “arrest” (according to MIND) is given by the provision in the aftercare under supervision order that the ex-patient can be “conveyed” to a safe place, such as residential or day-care provision, without his or her consent. Under s2 of the Mental Health Act 1983, responsibility for getting the patient to hospital rests with the applicant (usually the nearest relative or a social worker, although the power may be delegated to ambulance staff). The task becomes that of the practitioner under supervision orders – all under the guise of giving clinicians additional *powers*, but really landing them with *responsibilities* without power.

Furthermore, practitioners in long term management situations may feel under pressure to “play it safe”, to recommend restraint when in doubt so as to avoid another Christopher Clunis controversy. That

in turn raises issues of *moral luck*: we generally hold people morally responsible only for that which was within their control, but in practice we regard actions as right and wrong partly according to what happens as a result of the moral agent's decision. Even if the psychiatrist decides in favour of a supervision order or registration, long term management in the community gives the practitioner less control over the patient, compared with the ward situation. And is the psychiatrist who decides not to take out a supervision order or to place a possibly dangerous person on a supervision register morally at fault if that person harms someone, or merely unlucky?

American precedents

In relation to the specific issue of supervision orders and the supervision register in England and Wales, there is clearly tension between deciding that a user of mental health services is well enough to be discharged, but not well enough to enjoy the civil rights accorded to those who have not been mental patients. What can possibly justify giving below-par rights to the ex-patient? – for example, not seeking his or her consent to being placed on the supervision register. There must be some suspicion that only political imperatives can explain this anomaly.

As so often happens, UK politics has mimicked American precedents. In the United States the de-institutionalisation movement of the 1970s, limiting involuntary admission for those who were a danger to selves or others, also provoked a backlash to reintroduce compulsory treatment, even for those who were not deemed dangerous. The American Psychiatric Association gave in to this pressure in 1982 with its *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*.¹³ Yet in the United States practitioners have still been found civilly liable for releasing patients who have since harmed others.¹⁴

The more immediate trigger in the United Kingdom, however, was outrage over patients in the community who were patently dangerous to themselves – like Ben Silcock, a schizophrenic who climbed into the lions' cage at London zoo – or to others – like Christopher Clunis. In the UK press and parliament, the initial reaction to the Silcock and Clunis cases was to demand more powers of intervention, such as drug treatment orders or early recall orders. Supervision registers and aftercare under supervision orders are a halfway house which lack the frank paternalism of drug treatment orders or early recall orders, but they are also less than satisfactory to autonomy-minded psychiatrists, ethicists and lawyers. Some critics even argue that long term patients' rights would actually be better served by community treatment orders incorporating due process – much as it may be fairer to have appeals against involuntary committal go to normal legal institutions, as in Scotland. However, other

ethicists have argued that supervised discharge does respect autonomy insofar as it allows patients who would otherwise be hospitalised to live in the community.

At the time the supervision register was introduced in 1994, the then Secretary of State for Health, Virginia Bottomley, used the example of child protection registers as a parallel. But this is a faulty simile. To begin with, there are procedural differences, in favour of the child: the child's consent – unlike that of the ex-patient – is actually required for some aspects of supervision orders.¹⁵ But the obvious difference is that it is the child – the potential *victim* of harm – who is placed on the child protection register, whereas the psychiatric supervision register lists possible *perpetrators* of harm.

Placing the child under a supervision or protection order may well infringe the parents' rights, but the child's best interest is the counterweight. When the discharged mental patient's rights are infringed by the supervision register, there is no countervailing interest except the rather vague one of "the community", premising a utilitarian argument about the "greatest good of the greatest number". In the case of Phillip C, there may be danger to the models he paints or to the schoolgirls he passes. But because these risks are only probabilities for a statistical aggregate, we cannot yet say for certain that any particular girl or woman is in danger.

The child named in a protection order is specific, by contrast, and his or her welfare is the paramount principle behind the protection order.¹⁶ The child is to be protected from the adult suspected of abuse, and the criteria focus on the likelihood of significant harm, defined quite tightly in the Children Act. Evidence that harm has occurred in the past or is occurring at present is not enough, unless it points to significant likelihood of harm continuing into the future.¹⁷ But the rationale of the supervision register has to be either that the "community" at large is to be protected from the ex-patient, or that ex-patients are to be protected from themselves – in which case they should arguably remain under section and not be out in the "community" at all. (It is important to remember that in England and Wales, although not in Scotland, *R v Hallstrom* forbids using s3 of the Mental Health Act to enforce treatment on out-patients.)¹⁸

What about long term management when the ex-patient is the possible victim of his or her own mental illness? That would seem to fit the parallel with child protection registers more neatly, insofar as both registers then list potential victims of harm. But there are still major conceptual headaches insofar as the ex-patient is still the perpetrator of harm; the child protection parallel actually becomes hopelessly confusing at this point. In addition, using risk to self as the criterion for imposing long term supervision may tempt clinicians into medicalising what is really only non-conformist behaviour.

The case of Alice L

Take the case of Alice L, who has had frequent hospitalisations under s3 of the Mental Health Act with a diagnosis of paranoid schizophrenia. When most recently admitted to hospital, she was described as ill-kempt; she was pre-occupied with religion, and laughed at "inappropriate" moments. These are subjective descriptions of behaviours which might be accepted or even venerated – in the case of Alice L's piety – by other cultures. In fact Alice L was rational enough in hospital to suggest her own (successful) drug regime to her consultant. She took her previous consultant to the High Court and won her case, contesting the hospital's overuse of section 3 orders to bring her in and out of hospital. She has sometimes been difficult to manage as an inpatient, but she has no history of violence.

Clearly any justification for placing Alice L on the supervision register or for imposing an aftercare under supervision order must then rest on risk to herself. She refuses outpatient medication or offers of supported accommodation, although she is homeless; she has frequently abused drugs, and has been found wandering by the police. Although her parents live locally, they are elderly and unable to offer much help. But does Alice's undoubted vulnerability justify imposing an order or registration without her consent when she is released? As with Phillip C, it is at least arguable that both would represent a barrier to a therapeutic alliance, and that the patient's condition would not be improved in the long run. So the argument from benevolence towards the patient would fail; but in Phillip's case, the argument from benevolence or duty to the community remains. In Alice's case, there is no countervailing risk to others which would justify invading her autonomy.

Conclusion

In long term care, clinicians face particular difficulties about the frequently used ethical principles of autonomy and benevolence. The justification for restricting autonomy had better be a good one to override the absence of accountability provided by appeal mechanisms for patients under section and the operation of time limits. But it is unlikely to be justified in terms of benevolence and the patient's own best interests alone: more often protecting the public seems the main concern. This is arguably a political concern, not an ethical one at all. The Clunis inquiry, for example, demonstrated that lack of housing resources was the key issue in that tragic case – not something that psychiatrists or community psychiatric nurses can control. Yet the political purpose of the Mental Health (Patients in the

Community) Act may well be to make doctors responsible for the after-effects of political resource decisions.

Clinicians now have to face rising public and parliamentary concern about dangerous ex-patients in the community, while at the same time encountering resource pressures to release patients into the community earlier. But they can go some way towards resisting those conflicting pressures simply by being aware that they *do* conflict.

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