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Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?

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Recent challenges to conventional mental health laws concerning involuntary detention and treatment of persons with a mental disorder have led to proposals, or indeed an insistence, that fundamental reform is necessary. A key theme has been the need to eliminate unfair discrimination against people with a mental disorder because their human rights are not respected on an equal basis with other people. Some proposals depart radically from conventional assumptions concerning the justification of involuntary detention and treatment. One is a "fusion law," a generic law applying to all persons lacking the ability to make a treatment decision, whether resulting from a "mental" or "physical" illness. An authoritative interpretation of the UN Convention on the Rights of Persons with Disabilities (2006) goes so far as to maintain that involuntary interventions are a violation of the Convention.

Key words: coercion/human rights/capacity/disabilities

Introduction

People rarely question the appropriateness of the involuntary detention and treatment of people with a mental disorder if they should present a risk of serious harm, either to themselves or to others. The need for protection seems clear. Indeed, this combination of a diagnosis of a mental disorder and risk to self or others has been the justification for involuntary detention, and usually treatment, for centuries. The technicalities—who can authorize the detention, for how long, the operation of appeals and reviews, and so on—have varied, as has the balance to be struck between legal process vs medical discretion.[1] However, acceptance of the fundamental criteria has rarely been challenged, that is, until now.

Discrimination and Rights

The critique, gaining ground especially over the past 10 years or so, is based on arguments that conventional mental health law discriminates unfairly against people with a diagnosis of a mental disorder. When it comes to involuntary interventions, their human rights are not respected in the same way as they are for people who have nonpsychiatric disorders. Two sets of analyses propose fundamental reform aimed at eliminating the discrimination. One is significantly more radical than the other. The first calls for the justification for involuntary interventions in the case of those with a mental disorder to be the same as that for all other patients. The second, based on the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006),[2] calls for more profound reform.

Proposal 1: A Law for Those With a Mental Disorder That Is Like the One for Everyone Else: A "Fusion Law"

In countries with well-developed health law, people with "physical" or nonpsychiatric disorders—in contrast to the position of people with a "mental disorder"—are free to make treatment decisions, even ones that may pose a serious risk to their health or life, provided they have the relevant "decision-making capacity" (or "competence").[3–7] "Capacity" usually requires the ability to understand, appreciate the relevance of, and use, weigh or reason with the information relevant to a decision, in the light of what is important to the individual; and, to communicate a decision. Only when the person lacks the capacity to make a specific decision at a specific time does the possibility of an involuntary intervention arise. Such an intervention is then warranted when it would be, in some sense, in the "best interests" of the person. "Best interests" is a contested notion. Some propose that it refers to an assessment of what would be "objectively" in the interests of the person's well-being. Others, and increasingly so, construe "best interests" as "subjective," viewed from the person's perspective, determinations giving special regard to the person's wishes and feelings or beliefs and values.[3]

Conventional mental health law, based on the "status" of having a mental disorder diagnosis and being deemed to pose a significant risk to self or others, does not require any consideration of the person's decision-making ability nor of the person's best interests from the person's perspective. It is here that the discrimination lies; the autonomy or right to self-determination is not respected as it is for others, those who do not have a mental disorder diagnosis.[1]

People with a mental disorder are subject to another form of discrimination—they are singled out as liable to a form of preventive detention, albeit usually in hospital, solely on the basis of putative risk to others. For the vastly greater number of people posing an equal (or greater) risk to others, but without a mental disorder, detention can only follow the commission of an offence. Fairness demands that if preventive detention is to be allowed for those with a mental disorder solely on account of their risk to others, so should it be for everyone—or for no one, including those with a mental disorder.[1]

At the core of conventional mental health law lie 2, deeply rooted negative stereotypes of people with a mental illness—that they are necessarily incompetent to make sound judgments (hence inquiry about decision-making capacity is misguided) and that they are intrinsically dangerous. Research evidence clearly fails to support either.[8–15]

If the same justifications are to apply to involuntary interventions for *all* persons who may have a significant difficulty in making a serious treatment decision, it follows there is no need for a separate mental health law. A single, comprehensive, generic law could apply regardless of the cause of impaired capacity—a head injury, postepileptic confusion, schizophrenia, confusion due to an adverse drug reaction or infection, Alzheimer's disease, and so on. Such a law has been termed a "fusion law" as it brings together the strengths of current capacity-based laws—ie, a respect for autonomy—with the strengths of civil commitment law—ie, clear regulation of detention and involuntary treatment (authorization, duration, reviews, appeals). These areas are generally left unclear in the former.[16–18] A fusion law has been passed in Northern Ireland.[18]

We shall return to "capacity" and "best interests" after an examination of the second analysis of discrimination against persons with a "mental disorder"—or "mental health disability" or "psychosocial disability."

Proposal 2: A Law Based on the UN Disability Convention

The UN Convention on the Rights of Persons with Disabilities (CRPD)[2] is described as representing a "paradigm shift" in our understanding of the position of people with disabilities. Although some patients (or "service users") who have experience of the mental health system are reluctant to accept the ascription of "disability," the majority nevertheless embrace the rights expressed in the Convention. Though arguably not new rights, their articulation is tailored to the position of people with disabilities. A key driver behind the CRPD was the realization that generic international rights treaties have failed to engender real change in persons with disabilities' rights in relation to autonomy, dignity, access to healthcare, education, employment, community participation—the social connectedness essential to human flourishing. Their personhood should be respected as subjects, and not as objects of care or charity, or to be managed.[19]

The CRPD has to date been ratified by 179 countries, though the United States—while a signatory—is not one. The CRPD is the first UN treaty in which persons directly affected were intimately engaged in its creation. Few dispute that the CRPD, if implemented by states parties, would radically transform for the better the standing of those with a disability in society. Over 32 countries have initiated processes for reforming legal frameworks to accord better with CRPD principles.[20]

But there is a major challenge for mental healthcare. Space does not allow a detailed account of the legal thinking underlying the meaning of a key Article, 12 (Equal recognition before the law), of the Convention.[21] However, the upshot of its interpretation by the UN CRPD Committee, the authority established by the UN to oversee the Convention, can be quite simply stated. All persons are equal before the law and are entitled without any discrimination to the equal protection and benefit of the law. The existence of a disability must never be grounds for discrimination. All persons, regardless of their decision-making capabilities, must enjoy "legal capacity" on an "equal basis with others." "Legal capacity" means the right to be recognized as a person before the law, as well as the right to legal agency: ie, to have one's decisions (eg, concerning health or social care) legally recognized.

The Committee goes on to insist that "substitute decision-making," a common consequence of the denial of "legal capacity," is in breach of the Convention. A "substitute decision" is one made by another person, one who can be appointed against the will of the person with a disability, and not based on the will and preferences of the person with disability, but typically on what is believed to be in their "best interests." The preservation of "legal capacity" means that the "rights, will and preferences" of persons with disabilities must be respected, as they are for all other persons. With appropriate support—that under the CRPD, the state is obliged to provide—the Committee argues people with disabilities should be able to express their "will and preferences." Where this proves impracticable, the Committee states that one should strive for the "best interpretation" of the person's "will and preferences," with the help of people who know the person. Furthermore, involuntary detention and treatment—forms of "substitute decision-making"—even where there is a risk to the person or to others, are held to violate the Convention.[22] This rules out conventional mental health, and indeed capacity-based, legislation.

Not surprisingly, the Committee's radical position has been contested by a range of legal and clinician critics.[23–26] Though supported by a number of other UN bodies, it is also at variance with statements from other UN bodies who do not take an "abolitionist" position on "substitute decision-making" and involuntary treatment.[27] However, the central roles of "supported decision-making" and respect for the person's "will and preferences" are generally endorsed. It is in relation to these 2 themes that the CRPD has so far been most influential.

Supported Decision-Making

"Supported decision-making" constitutes a "reasonable accommodation" aimed at ameliorating the extent to which a person's "impairment" comes to constitute a "disability." As ramps and elevators are accommodations for those with a mobility impairment, so is "supported decision-making" for those with difficulties in expressing their "will and preferences" in making a decision, eg, about whether to consent to a proposed treatment. The model of "disability" is a social one: society's accommodation to a person's impairment—physical, sensory, intellectual, psychosocial—determines whether, or to what degree, it becomes a "disability."

Unlike common practice with intellectual disabilities, little attention has been given to methods of supported decision-making for those with a serious mental illness. What are the most effective methods, eg, for engaging the person; clarifying issues relating to their predicament and the proposed treatment (including its implications for the person's life plans or values); ensuring support during treatment; developing an "advance directive" following recovery; and so on?

The amount of research devoted to reducing recourse to involuntary detention has been lamentably small. A useful review of the research to date shows a number of leads not further evaluated.[28] Many patients who have been detained and treated involuntarily say, in retrospect, that they believe they needed help—but the way it was delivered, or the lack of alternatives offered, was unacceptable. A reason, perhaps, for such little research interest is a sense that the process of involuntary detention is not part of the "real" treatment, but a prelude to it. This view is certainly not shared by patients; for many, it becomes their worst experience of mental health services. This has become clearer as the patient "voice" has grown louder in many places.

Much work remains to be done in researching supported decision-making and in discerning how far such approaches can reduce, if not eliminate, recourse to coercive interventions. Some international models may offer ways forward.[29–32] Service user organizations also argue increasingly that research into effective, accessible, safe, and more desirable alternatives than admission to a psychiatric ward during serious mental health crises will further reduce recourse to coercion.

"Will and Preferences"

Respect for a person's "will and preferences" is seen in the CRPD as being key to respect for the person. However, those words have not been defined by the CRPD Committee. What if in an advance directive a person expresses a "preference" for treatment should a relapse of a psychosis occur, and predicts on the basis of past experience that he or she, when ill, will express a "preference" against treatment, which the person directs should be overridden? Which of the conflicting "preferences" should be respected?

One solution follows from an examination of common language usage of the words "will" and "preference," as well as accounts of the "will" in the philosophy of mind and action; they mean different things.[26] "Will" may refer to a resolute or determined intention based on a person's relatively stable, deeply held beliefs, values, commitments, or personal conception of the good; a "preference," on the other hand, is a wish, desire, or intention expressed in the moment, or in the present. By and large they run together. It is when they point in different directions that a problem may arise, especially when a serious decision needs to be made. The purpose of an advance directive is the expression of the person's "will" (based on deeply held beliefs, values, commitments) requesting that an anticipated "preference" inconsistent with that "will" in the future should be overridden. The directive is an instruction from the person that their "will" should be privileged over predicted "preferences" in the circumstances foreseen.[26,33] The person's autonomy (taken as the ability to form values and to act on those values) is thus to be respected. An intervention to give effect to the person's "will" could thus be justified. Where there is no written advance directive but where the person's values (or "will") have been expressed and are evident to others, a similar response might be warranted—but only after serious efforts at supported decision-making have failed to realize a coherence, perhaps not immediately evident, between the person's "will" and "preferences." If the CRPD is to be interpreted as absolutely prohibiting coercive interventions, this approach may not be accepted. However, an absolute prohibition, no matter the circumstances, is unlikely to be seen as credible, at least in the near future.

In any case, the CRPD supports a special regard for a person with disability's beliefs and values. Harking back to the discussion of the determination of "best interests" in relation to capacity-based law, this is consistent to a significant degree with the respect to be given to the person's "wishes and feelings," "beliefs and values," past, and present. Both capacity-based law and the CRPD share this key element in their common aim to eliminate the discrimination in current mental health law against people with a mental disorder (or disability). The chief difference arises in that one sees a role—as a last resort, when support has failed to resolve conflicting values and intentions—for "substitute decision-making," while the other, in at least one authoritative interpretation, does not.

Key principles drawn from the CRPD, including the right to legal capacity and realizing supported decision-making, also form the basis of the WHO QualityRights Toolkit aimed at supporting the human rights of patients in mental health services worldwide.[34,35]

Other Aspects

It is not possible in a short article to cover other important aspects of the approaches described. These include "disability-neutral" methods for dealing with emergencies where serious harms may appear imminent, forensic implications including the interests of third parties (not necessarily excluded), the way in which a focus on values may counter the disproportionate use of coercion in ethnic minority groups, and the guidance offered by these nuanced approaches in a community context across the whole range of "treatment pressures" commonly exercised in mental healthcare.[1]

Are we edging toward a paradigm shift? An impetus for reform is evident. How far it will progress is uncertain.

Conflict of Interest

The authors have declared that there are no conflicts of interest in relation to the subject of this study.

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