**AUTHOR(S):** MACPHERSON, S. and WARRENDER, D.

**TITLE:** Human rights.

**YEAR:** 2018

**Publisher citation:** MACPHERSON, S. and WARRENDER, D. 2018. Human rights. In Cooper, D.B. and Cooper, J. (eds.) Palliative care within mental health: ethical practice. Abingdon: CRC Press [online], chapter 8, pages 91-109. Available from: https://www.crcpress.com/9781138609822

**Book 3: Palliative care within mental health: ethical practice**

**Chapter 8: Human Rights**

**Scott Macpherson**

**Lecturer in Mental Health**

**School of Nursing and Midwifery**

**The Robert Gordon University**

**Garthdee Road**

**Aberdeen**

**AB10 7QG**

**Scotland**

**UK**

**Tel: +44(0)1224 262977**

**E-mail: s.g.macpherson1@rgu.ac.uk**

**Dan Warrender**

**Lecturer in Mental Health**

**School of Nursing and Midwifery**

**The Robert Gordon University**

**Garthdee Road**

**Aberdeen**

**AB10 7QG**

**Scotland**

**UK**

**Tel: +44(0)1224 262954**

**E-mail: d.r.warrender2@rgu.ac.uk**

**Word Count: 8767**

Chapter 8

# Human Rights

Scott Macpherson and Dan Warrender

Human Rights are the fundamental rights and freedoms that belong to everyone, everywhere throughout their lifespan, by virtue of being human. They apply regardless of a person's thoughts, beliefs or behaviours and cannot be permanently removed... though there are some circumstances under which they can be restricted, including when a person commits a crime or when they are detained under mental health legislation.

Human Rights are based on values such as dignity, respect, equality and autonomy and are enshrined in law.

## The idea of 'rights'

In all likelihood the concept of 'a right' has likely existed (even if the word did not) for as long as there have been primitive human communities. It is likely that (as is the case today) these populations would have had rules stipulating permissions for certain individuals or groups to perform certain actions and, conversely, rules that others were not permitted to perform such actions. These rules can be used to ascribe rights to people or groups.

In their most basic sense rights can be seen as either negative or positive. Negative rights are entitlements not to be interfered with while positive rights are rights to the provision of certain goods or services.

Generally, when talking about the rights of vulnerable people we are talking about passive rights (claim-rights and immunity-rights in Hohfeldian terms - Hohfeld 1919). Claim-rights entitle their holders to freedom from physical interference or close observation of others, or to be free of undesirable conditions such as fear. For example, a person living with dementia in a nursing home has the claim-right to not be physically assaulted by the staff of the home. Immunity-rights entitle their holders to be free of the authority of others. For example, a person who has informal status in a mental health hospital has the immunity-right to not be held there against their will.

When talking about the rights of people in positions of relative power we are generally talking about active rights (privilege-rights and power-rights in Hohfeldian terms) which entitle their holders to act in particular ways. For example, a mental health professional has the privilege-right (the 'freedom to') read the confidential notes of the people in their care. The holders of power-rights have the normative ability to exercise authority in certain ways (Sumner 1987). For example, under particular circumstances, certain mental health professionals have the power-right to restrain a person in their care and administer sedative medication to them against their will.

Dworkin (1984) considered the idea of rights as trumps, with some rights having a higher power or priority over others. As in a game of cards, a king trumps a 9 and a 9 trumps a 6. Mill (1989 pp.20) wrote:

'If all mankind minus one were of one opinion, mankind would be no more justified in silencing that one person than he, if he had the power, would be in silencing mankind'.

In accord with the ideas of Immanuel Kant (1993) [1785] - explored further later in this chapter), consideration should be given to the possibility of any of us being the 'one person', and how we would feel to be powerless against 'all mankind'. Empathy for the person who is on the receiving end of a power right is a necessary step towards balanced discussion on the circumstances in which they can be justified.

The idea of some rights being more important than others is the sort of rationale that is used when justifying the detention of a person who is suicidal 'to protect their right to life'. The justification being that their right to life trumps their right to liberty and security. Even though the person may not value this right themselves, the right is sufficiently valued by society, based on an assumption that reason, rationality and a desire to live will return. In this way, 'mankind minus one' justify the removal of this human right, fully expectant that when the mental state of the 'one person' improves, that the person will be grateful and re-join their ranks.

Following the atrocities and massive loss of life during World War II and the creation of the United Nations, world leaders worked together to produce the Universal Declaration of Human Rights: a guidance document designed to guarantee the rights of everyone, everywhere, regardless of age, race, gender, religion, health status or any other defining characteristic, and thus protect against such atrocities occurring again (Donnelly 2013). Human rights, as set out in the declaration, are interdependent and interrelated, meaning that if one right is fulfilled it supports the fulfilment of others and, conversely, if one right is denied it makes the fulfilment of others more difficult.

Though not a legally binding document in itself, the declaration has inspired over 60 human rights instruments that deal with rights in relation to a wide variety of issues including war crimes, marriage, social welfare, physical and mental health and many more (Office of the United Nations High Commissioner for Human Rights (OHCHR) 2016). Together, these instruments provide a worldwide standard for human rights.

The application of human rights creates obligations through international law for States to respect, protect and fulfil human rights for all. States must not interfere with or remove human rights (respect), they must safeguard both individuals and groups from human rights abuses (protect) and they must be pro-active in enabling the realisation of human rights (fulfil). Whilst everyone is entitled to have their human rights respected, protected and fulfilled, there is also a universal obligation to ensure that peoples' actions or inaction do not infringe the human rights of others.

In Scotland, human rights are protected by the European Convention on Human Rights (ECHR), the UK Human Rights Act 1998 and the Scotland Act 1998.

The European Convention on Human Rights (ECHR - 1953)

The ECHR consists of 17 key articles, each of which is a brief explanation of a right along with any exceptions that can apply to it.

Reflective Practice Exercise 8.1.1

Time: 40 minutes

Consider these key ECHR articles pertaining to the rights of people accessing care for mental health issues and then answer the questions that follow (*See* Reflective Practice Exercise 8.1.2):

Article 2

The right to life. This is an absolute right and can be interpreted as a duty to not take anyone's life and also to take reasonable steps to protect people's lives.

Article 3

The right not to be subjected to torture or to inhuman or degrading treatment or punishment. Degrading treatment can be understood as treatment that is grossly humiliating and undignified.

Article 5

The right to liberty. In mental health treatment people often have their right to liberty (Article 5) restricted in the form of detention when they are assessed as a risk to themselves or others, and further restricted when they are placed on enhanced observations. Barker (2010) suggests that the prevailing use of risk assessments presents a real danger to liberty and human rights since they are founded primarily on subjective judgements which are set out as clinical judgements and, as such, cannot be challenged in a court of law.

Article 6

The right to a fair trial. The definition here includes other kinds of hearings such as mental health tribunals. When a person is detained under mental health legislation, it is the duty of

mental health professionals to ensure that they are aware of their rights to advocacy and legal representation' in order that they can challenge any concerns relating to the restriction of their freedom.

Article 8

The right to private and family life. This article is very broad ranging, covering rights to physical, psychological and moral wellbeing, with wellbeing maintained by preserving autonomy, choice and dignity.

Article 9

The right to freedom of thought, conscience and religion. This article allows that people should be free to hold a wide variety of thoughts and beliefs.

Article 14

The right not to be discriminated against. Peoples' human rights should be promoted and protected without discrimination on any basis, including the nine protected characteristics defined by the Equality Act (2010): age, gender reassignment, disability, marriage and civil partnership, sex, sexual orientation, pregnancy and maternity, race and religion or belief.

Article 25

The right to the highest attainable standard of physical and mental health. This includes both a right to healthy living conditions and a right to satisfactory health care. This article sets out that health care should be of good quality and be available, accessible and acceptable to those who need it.

Reflective Practice Exercise 8.1.2

Time: 75 minutes

- Consider ‘taking reasonable steps’ to protect someone’s life as is set out in Article 2. As a professional do you have a duty to do whatever you reasonably can do to prevent a person self-harming or completing suicide?
- How might this interpretation of your role infringe on some of the other ECHR articles? For example: Articles 3, 9 and 10?
- Consider the words ‘grossly humiliating and undignified’ as they relate to Article 3. Could it be argued that the enhanced observation of people in our care fits under this definition?
- Is the use of force and restraint in the name of mental health treatment ‘grossly humiliating and undignified’?
- Could it be argued that focusing on risk in mental health treatment actually creates risk? Have you seen any examples where this may have been the case?
- Are you fully aware of the rights of people you care for in relation to advocacy and legal representation? If not, how will you go about addressing this?
- Is it reasonable to restrict the right to private and family life (Article 8) when it comes to decisions the person might make about the use of particular drugs or whether to self-harm or even take their own life?
- In Article 8 ‘private life’ relates to wherever the person may be, not just in their own home. Consider some of the ways in which this right may be infringed when a person is detained in hospital. For instance, how might detention affect a person’s right to smoke cigarettes or to meet their sexual needs?

- Staying with Article 8 ‘family life’ should be understood to include relationships not just with family members, but also with friends and communities. Take a minute to think about how much or how little importance mental health professionals give to helping people fulfil this right.
- Also in Article 8 ‘correspondence’ covers all forms of communication including e-communications. Are the restrictions of communications that you may see in practice always fully justifiable?
- In relation to Article 9, consider whether it is the case that, within the field of mental health practice, people are really only allowed to think and believe things within the confines of certain, socially defined norms (which can differ markedly over time and place) and when their thoughts and beliefs breach these norms they can be said to be mentally unwell and treated against their will?
- Consider whether you have seen people discriminated against (Article 14) on the basis of their diagnosis or behaviour e.g. people who use drugs or who have been given a personality disorder diagnosis.
- An important component of Article 25 is that any health care provided should be acceptable to those who need it. Consider whether mental health care is always acceptable to those who are in need of it when a curative approach is taken rather than a palliative approach.

The UK Human Rights Act (1998)

The UK Human Rights Act (1998) enshrines the rights set out in the ECHR into UK law. All other UK legislation should be understood and applied in a manner consistent with this Act.

The Scotland Act (1998): This Act was passed to guarantee that parliament only passes laws consistent with human rights and that any laws passed are not in breach of either the ECHR or the UK Human Rights Act (1998).

Also important is the UN Convention on the Rights of Persons with Disabilities (UNCRPD - 2008) which, though technically not part of Scottish law, helps with understanding and interpreting the rights set out in the UK Human Rights Act (1998) in relation to people with disabilities. The Convention specifies the actions that should be taken to remove the obstacles that (among others) people with long-term mental health problems may encounter in realising their human rights.

The UK Human Rights Act (1998) provides the basis upon which the Mental Health (Care and Treatment) (Scotland) Act (2003) is applied. Consequently, both Acts are underpinned by similar principles. The PANEL principles (Scottish Human Rights Commission 2017) are a handy way of breaking down what an approach grounded in human rights should look like in practice:

- **P** – participation – people being truly and meaningfully involved in every decision about their care – being not just allowed but actively encouraged to participate in and own decisions affecting their lives.
- **A** – accountability – there should be effective monitoring of human rights standards, requiring appropriate means to rectify issues in order to secure these.
- **N** – non-discrimination and equality – prioritising the prohibition, prevention and elimination of all forms of discrimination. This requires prioritising people in the most

vulnerable situations who face the greatest obstacles in protecting and fulfilling their rights.

- **E** – empowerment – ensuring people understand their rights, are able to claim them when necessary and are fully supported to participate meaningfully in the development of policies and procedures that can affect their day-to-day lives.
- **L** – legality – practicing in a way that ensures the full range of human rights are respected, protected and fulfilled for all, recognising rights as entitlements enforceable by law. Grounding all approaches in human rights law (both domestic and international).

Will Brexit affect Human Rights in the UK?

The short answer is that our human rights as set out in the ECHR will not be affected by leaving the EU as the ECHR comes from the Council of Europe (which the UK is not leaving). The slightly more complex answer is that currently many of the human rights protections set out in EU law are also written into UK law, however after leaving the EU the government would have the ability to pass laws that repeal or weaken current rights to a standard below that of EU law rights (Equality and Human Rights Commission 2017).

The Mental Health (Care and Treatment) (Scotland) Act 2003

While mental health legislation differs across the UK, each country's mental health Act is built around similar ethical principles. In Scotland the Scottish Executive Millan Committee (2001) was commissioned by Parliament to make recommendations for a new Mental Health Act including consideration of an ethical underpinning for the compulsory treatment of people experiencing mental disorders. The committee developed a set of principles which

they recommended mental health law should be based on. These are now known as the 'Millan Principles':

Box 8.1 – Millan principles

1 Non-discrimination

2 Equality

3 Respect for diversity

4 Reciprocity

5 Informal care

6 Participation

7 Respect for carers

8 Least restrictive alternative

9 Benefit

10 Child welfare

(Scottish Executive Millan Committee 2001)

The Mental Health (Care and Treatment) (Scotland) Act 2003, details when and how people can be treated if they are deemed to have a mental disorder. This includes provision for when people can be treated or detained against their will. The Act also sets out what peoples' rights are and safeguards around these.

Under the Act, a doctor (ideally together with a mental health officer) can issue an Emergency Detention Certificate, which allows a person to be held in hospital for up to 72 hours while their condition is assessed. This allows for emergency treatment to be given to a person However, other than in an emergency, no treatment should be given to a person against their will under this type of detention. The person must be assessed by a doctor as soon as possible and must have information about their stay in hospital and their rights explained to them. There is no right of appeal against an Emergency Detention Certificate.

In terms of formal detention under the Act, the normal route into hospital should be through a Short-Term Detention, which can only be put in place if recommended by both a doctor and a mental health officer. A psychiatrist must be assigned as the Responsible Medical Officer (RMO) for the person and must speak with them about their wishes and seek to understand and follow their Advance Statement if they have one. An advance statement is written by a person when they are well and witnessed and signed by a health or social care professional. The statement details how a person would like to be treated if they become unwell. In the UK an advance statement is not a guarantee that the person's wishes will be followed. However, it does mean that they will be considered.

Advance Statements are not to be confused with Advance Decisions (Advance Directives in Scotland). This document (also known as a living will) is written by a person when they are well and sets out any treatment they would wish to refuse should they become unwell. This can include any situations where they would or would not wish to refuse such treatment. An Advance Decisions is legally binding as long as it:

- Complies with mental capacity legislation

- Is valid
- Applies to the person's situation.

Note: although it has not been tested in Scottish courts, an Advance Directive is likely to be treated as legally binding if it meets the criteria set out above.

If the RMO decides that the person is likely to require treatment, the person can be detained under a Short-Term Detention Certificate. This allows for the person to be detained for up to 28 days and grants the right to treat the person against their will if this is deemed necessary. Again, the person should be given information about their stay in hospital and have their rights explained to them. They should also be supported to get an independent advocate. The person or their named person has the right to appeal to the Mental Health Tribunal against this type of detention.

A named person is someone chosen by the person to help protect their interests if they are in need of treatment under the Act and unable to make decisions for themselves. The named person will have the right to be consulted about certain aspects of the person's care.

Longer-term detention is possible under the Act through the use of Compulsory Treatment Orders (CTO's). These can last for up to 6 months initially, followed by a further 6 month extension and then for periods of 12 months at a time if necessary. Applications for CTO's need to be made to the Mental Health Tribunal and consist of two medical reports, a mental health officer's report and a proposed care plan. The person also has the right to have their thoughts heard by the tribunal and, if a CTO is put in place, the person or their named person can apply to have it removed only after it has been in place for at least three months.

## Compulsion

If a person is convicted of a crime and the punishment is prison but the person is deemed to require treatment for a mental ill-health a decision can be taken to either detain the person in hospital or enforce treatment in the community under a Compulsion Order (CO), rather than detaining them in prison (Mental Welfare Commission for Scotland 2017). Similar to a CTO, a CO lasts for six months, can be followed by a further 6-month extension and then further extended by periods of 12 months at a time if necessary. Anyone subject to treatment in the community under a CO will be told by the court where they must go for care and treatment and also where they must live. The court can also add a Restriction Order (RO) to a CO if they think a person poses a serious risk to the general public. Under an RO any move to a different hospital or periods spent out of hospital must be approved by Scottish Ministers. An RO can be in place indefinitely but must be reviewed by the person's psychiatrist, who must submit an annual report to Scottish Ministers. Ministers must refer the person's case to the Mental Health Tribunal if their psychiatrist thinks their order should be changed, or that they should be discharged from hospital. If the Tribunal agrees, the person may be given a 'conditional discharge' meaning that they may leave hospital but must comply with certain restrictions as ordered by Scottish Ministers. This may involve restrictions on where the person may or may not go and on whether the person may use drugs or alcohol.

### Reflective Practice Exercise 8.2

Time: 20 minutes

Consider these restrictions on where a person may live, where they must access care and treatment, where they can go and whether they can use alcohol. If you were subject to these

restrictions, what might be the impact on your mental health? How might you feel about the status of your own human rights?

The Patient Rights (Scotland) Act (2011) was designed to support optimum healthcare for all people accessing health services. It is grounded in human rights principles and provides a framework for involving people in decisions about their own health and healthcare. The Act also grants people the right to give feedback and raise concerns about the care they receive. A requirement of the Act is the publication of a Charter of Patient Rights and Responsibilities (The Scottish Government 2012) which summarises the rights and responsibilities of everyone accessing NHS services in Scotland and details what a person should do if they feel their rights have not been respected. Underpinning The Patient Rights (Scotland) Act (2011) is the right to be treated with respect, dignity and compassion (which comes from Article 8 of the ECHR). There are times in mental health care when this right is restricted (examples may include the removal of possessions, seclusion or enhanced observations). However, while these restrictions may be allowed under certain circumstances by the Mental Health (Care and Treatment) (Scotland) Act (2003) they must be human rights compliant by being proportionate, time limited and kept under review.

Reflective Practice Exercise 8.3

Time: 40 minutes

Consider the practice of supervised urine sampling for people with substance use disorders who are prescribed substitute medication.

- Can watching a person pass urine be considered a proportionate measure if the risk it is used to mitigate against is that the person might otherwise lie about whether they have used illicit drugs?
- What if the person has sole care of a young child?
- Does illicit drug use itself provide sufficient evidence of risk to the child? This practice is carried out in the name of risk and aligns with a curative, medical model philosophy, that people who are prescribed a substitute medication should have no need to use illicit drugs.

De Facto Detention

'You are free – to do as we tell you' – Bill Hicks (2005, pp.132).

The right to liberty (Article 5 of the ECHR) can be limited under certain conditions (for example by detention under the Mental Health (Care and Treatment) (Scotland) Act 2003. However, a person who is in hospital informally and wishes to leave must not be placed in a situation where they feel that they must remain in hospital because if they do not stay they will be formally detained under the Act. This unlawful pressure is known as 'de facto detention' and puts restrictions on a person without providing them with the rights they would otherwise have if they were formally detained. The person's belief about the likelihood of them being detained if they don't comply with the wishes of staff is key in

deciding whether a de facto detention situation exists, rather than simply whether staff believe that this is the case.

Reflective Practice Exercise 8.4

Time: 30 minutes

Consider a situation where a person who is in hospital informally wishes to leave against medical advice and you are part of a staff team who feel this would not be safe. How could you avoid creating a de facto detention situation?

Dehumanization

Szasz (1973) argued that psychiatry's deterministic explanations & coercive treatments relieve individuals of their autonomy and moral agency. Szasz viewed psychiatric classification as dehumanizing, saying that it involves a 'mechanomorphic' style of thinking that 'thingifies' people and treats them as 'defective machine[s]' (pp. 200). Hinshaw and Cicchetti (2000) agree that stigma dehumanizes people experiencing mental disorders.

Kelman (1976) talked about the moral dimensions of dehumanization. Kelman argued that dehumanization involves denying a person 'identity': a perception of the person

… 'as an individual, independent and distinguishable from others, capable of making choices' (pp. 301), [and 'community': a perception of the other as] 'part of an interconnected network of individuals who care for each other' (pp. 301).

Kelman said that when people are treated in this way they are deindividuated, lose the capacity to evoke compassion and moral emotions, and may be treated as means toward vicious ends. Opotow (1990) worked on 'moral exclusion'. This can be understood as the process by which people are placed

… 'outside the boundary in which moral values, rules, and consideration of fairness apply' (pp. 1).

Exclusion from the moral community is promoted by social conflict and feelings of unconnectedness, and varies in intensity from genocide to indifference to another person's suffering. Dehumanization can also be seen in the healthcare context as a mechanism that practitioners use to cope with the empathic distress that comes with working alongside dying people (Schulman-Green 2003).

Reflective Practice Exercise 8.5

Time: 30 minutes

Consider the following:

Ethel is a sweet, 75-year-old lady who loves her daughters and her cat. Ethel has a keen sense of humour and enjoys watching crime dramas on television. Ethel was admitted to the ward you work on this morning. In addition, Liz, experiencing schizophrenia, was admitted to the word.

- Is there any difference in how you would feel about confiscating a pair of nail scissors on safety grounds from either Ethel or Liz?
- How about providing medication against Ethel or Liz's will?

- ...and restraining Ethel or Liz?

It is likely that it is easier to justify the use of coercion or restraint if we view the subject of these acts as an ill-health or 'defective machine' rather than as a human. It could perhaps even be argued that dehumanization, in this way, is a necessary condition for carrying out any coercive treatment.

Bar-Tal (2000) discussed 'delegitimizing beliefs'. These are:

'extremely negative characteristics attributed to another group with the purpose of excluding it from acceptable human groups and denying it humanity' (pp. 121-122).

These beliefs share extremely negative valence, emotional activation (typically contempt and fear), cultural support and discriminatory rejection of the outgroup. Delegitimizing beliefs exist not only around mental health but also within the field of mental health. Commonly these types of beliefs are held about people experiencing substance use issues, suicidal ideation and psychoses.

In contemporary healthcare a person's subjective experience is often neglected in favour of objective, technologically mediated information and a strong emphasis on interventions/tasks performed on passive individuals whose agency and autonomy are neglected. Student nurses and newly qualified nurses often express a desire to learn the important or common tasks for the area they are working in and value the learning of these tasks in practice over theory in

university: ‘I learned nothing in university, I learned it all in practice’ while also saying ‘practice is dangerously understaffed, there’s just no time for spending with patients/therapeutic work’. Opotow (1990) described this phenomenon as ‘technical orientation’. This can be understood as a focus on means-end efficiency and mechanical routine. The pressure to ‘fit in’ can mean that new ideas, criticism of existing practice and healthy professional debate are stifled, smothered under the reality or fear of ostracism. Meissner (1986) described a bullying culture in nursing (although it can be assumed that the same can happen within any large professional body), whereby nurses ‘eat their young’. In any profession which holds power over vulnerable people, professionals need to have the ability to speak their minds, making balanced ethical decisions based on the interests of people, not fearing the wrath of a comfortable ritualism. Decisions on human rights should never be reduced to tasks, with standardised routine answers.

Human rights would appear to be less a problem of the legal expressions of rights and duties than they are a problem of human classification, of who is counted as a full human being, deserving of the complete range of human rights (Agier 2011). Curra (2014) sees deviance in almost every form as a standard element of human societies and discourages the temptation to equate deviance with disease and abnormality.

Curra gives the example that, just as it would be wrong to conclude that eating dog meat instead of cow meat is an indicator of mental ill-health, so it must be wrong to conclude that people who inhale one kind of substance (for example heroin or marijuana) are more abnormal or mentally ill than those who inhale other substances (for example tobacco). Curra’s point is that deviance can be shocking to a person who is alien to it. However, this does not make this difference necessarily abnormal or ‘sick’ everywhere and across all time.

Mental Capacity

Every country in the UK has its own legislation in place around mental capacity, with each one based on the principles of justice, autonomy, beneficence and non-maleficence. The Adults with Incapacity (Scotland) Act (2000) is designed to protect the interests of people (age 16 and over) who cannot make some or all decisions for themselves. 'Incapacity' in terms of the Act means being unable to act on, make, communicate, understand or remember decisions due to mental disorder or inability to communicate due to physical disorder. The Act allows certain other relevant and appropriate people to take decisions on their behalf providing that any intervention is:

- Necessary and of benefit to the person
- The least restrictive option.

Anyone taking decisions for an 'Adult with Incapacity' must:

- Encourage the person to use any skills they have to make decisions for themselves and encourage the development of new skills
- Consider whether intervention is possible without the use of the Act
- Act in fitting with the person's wishes (present and past)
- Consult with relevant others.

The Act includes a number of safeguards which are intended to prevent abuse of these powers. These include preventing certain decisions being made on the person's behalf such as giving consent to marriage or the drawing up of a will, having the person admitted to a mental health hospital against their will or consenting to certain medical treatments on their behalf. The Act charges four public bodies with responsibility for the supervision and regulation of people who are authorised to make decisions for people who are deemed to lack capacity: The Mental Welfare Commission for Scotland, The Office of the Public Guardian (Scotland), local authorities and the courts. Variously, they provide advice and support, supervise financial decisions, investigate complaints and restrict or remove decision making powers.

Informed Consent

Each of the UK's Acts of Mental Health legislation make provisions for circumstances under which people can be compulsorily treated for a mental disorder without their consent. A person's capacity to consent to treatment can change over time and a lack of capacity to make decisions in one aspect of life does not necessarily mean that a person is incapable of making decisions in other aspects of their life. For these reasons, incapacity must never be presumed and instead must always be assessed with respect to each specific decision and for each given moment in time. Should treatment be provided against the wishes of a person who is capable of consenting this would violate their right to autonomy and can constitute assault.

In relation to consent to mental health treatment 'capacity' means that a person is capable of understanding the nature, implications and consequences of their decisions.

A person can be said to have capacity to consent to treatment if they:

- Can understand in simple terms what the treatment is, the purpose of the treatment, its features and why it is being recommended
- Can understand its main advantages, risks and other options and be able to make a choice based on these understandings
- Have a broad understanding of the potential consequences of not having the treatment.
- Can remember the information for enough time to enable them to weigh-up the likely outcomes in order to arrive at a decision
- Can communicate that decision to other people
- Can make the same decision consistently – this takes into account people who might have trouble remembering a decision but, given the same information at some other time, make a consistent decision.

There are many factors, both internal and external to the person that can influence a person's capacity to give informed consent such as their environment, the quality and type of information provided, how the information is communicated, any previous healthcare experience, and current physical or mental health problems.

Relationships can play a considerable role in the decisions people make. It is possible that a person may feel under undue pressure to accept or refuse a particular treatment due to the wishes of their partner, parent, children, carer or healthcare professional. If professionals ascertain that a person's ability to make an autonomous decision is affected in this way then they should follow adult protection procedures, as set out in the Adult Support and Protection (Scotland) Act (2007).

Case Study 8.1 - Magdalena

Magdalena is a 33-year-old woman, living with her parents and younger sister. She has an established diagnosis of schizophrenia, and has been prescribed antipsychotic medication. Against professional advice, Magdalena had stopped taking her medication over a period of a year. Her mental health had deteriorated and was causing her family some concern. She had isolated herself into an annexe of the family home, had stopped tending to her personal care, and had voiced strange ideas which had led to her sister feeling intimidated. She had spent all of her time painting surrealist images on large canvas, and was no longer engaging with her family. Her living conditions had become cluttered and untidy, with litter and food-waste collecting over a period of months. She had refused to engage with her consultant psychiatrist, General Practitioner (G.P.)/Medical Doctor (M.D.) and mental health officer.

Hugh is a mental health nurse. Magdalena's consultant tells him that he is detaining Magdalena on an emergency detention certificate so that she can be taken into hospital for up to 72 hours, for further assessment and with the aim of being re-established on medication. Alongside a support worker, Hugh has been assigned as a 'hospital escort', with detention papers acting as the legal authority under which Magdalena may be medicated and taken into hospital against her will. Hugh and the support worker attempt to engage with Magdalena, however, she refuses them entry to her annexe. There is an ambulance on hand as transport back to hospital.

Hugh and the support worker then use physical restraint to remove Magdalena from her home. She resists, becoming aggressive, angry and extremely agitated. In order to get her

into the ambulance safely, a decision is taken to administer intra-muscular medication to Magdalena to sedate her. Magdalena screams and pleads that she not be injected, saying 'please don't inject me with poison'! She is nonetheless sedated, and restrained until Hugh and the support worker feel she is sufficiently calm and will cooperate with her hospital admission. She enters the ambulance and is driven to hospital without incident. She sleeps for the rest of that day.

The next day, Hugh is on shift and is a named nurse for Magdalena. He asks her to speak with him in an interview room. She does not engage well with Hugh, who she says 'kidnapped' her. She has little insight, and does not share the belief of her consultant or family that she is unwell. After Magdalena is detained for a further 28 days, Hugh continues to act as her nurse, yet is unable to establish a therapeutic relationship. She appears guarded, unwilling to tolerate one to one discussions and never accepting that her mental health has been worthy of concern.

Magdalena begins different courses of antipsychotic medication, and with each new medication claims to have blurred vision. Despite professionals seeing no evidence of this, her subjective experience is accepted. At the end of a 6 week period of admission, Magdalena had still not engaged well with professionals or agreed with them regarding her mental state. She was discharged after discussion with her family, and sent home with a low dose of antipsychotic medication. Professionals involved in her care found it difficult to assess her due to her reluctance to engage, and were not convinced Magdalena would maintain her prescribed medication.

Self-Assessment Exercise 8.1

Time: 40 minutes

For each point, consider the multiple perspectives of Magdalena, her family and all involved healthcare professionals.

- Can Magdalena's initial emergency detention be justified?
- Are there any potential consequences of not admitting Magdalena to hospital? If so, what are they?
- Do any potential consequences outweigh the potential consequences of admitting her to hospital without consent?
- Describe the issues which may arise from Hugh's dual role as an agent of both therapeutics and containment. Consider both Magdalena's and Hugh's perspectives.
- Would coercion and forced treatment best fit into curative or palliative philosophies of care?

Case Commentary 8.1 - Ethics

Mental health care and treatment has long existed in an ethical grey area which can be explained as a moral triage of duties, consequences and virtues. The ethics in this case primarily exist in a fray, central to the tug of war between deontological and consequentialist thinking.

Duty

Deontological advocate Immanuel Kant (1993)[1785] asserted that morality was synonymous with rationality, and expressed this through his categorical imperative:

‘Act only on that maxim through which you can at the same time will that it should become a universal law’ (pp. 30).

In Kant’s view something such as stealing cannot ever be moral, given the irrationality it would take to look at this through the categorical imperative. Were we to justify stealing, we would also have to accept without complaint that we could be stolen from. This would entail a chaos of moral anarchy where no-one benefits. Moving this argument onto coercion in mental health care is nonetheless problematic due to the relativity of dignity. If we accept that a person who is considered a risk to themselves or others as a result of their mental state may be given treatment against their will, in order that this be moral, we must also accept this same rule for ourselves. The problem then lies in the subjectivity of what can be described as quality of life and dignity. Whilst one may look at Magdalena and describe her as being at risk to herself due to a lack of self-care, this is distinct from Magdalena’s reality and may also be for others. Life does not come with a rule book or guideline, and perceptions of what is ‘risk’ can then be heavily influenced by social norms, which can change over culture and time. The argument can then rapidly become sociological as we ask, who decides on what is the accepted norm? Intervention in this case may be justified as taking a curative approach to mental health, but also sociologically critiqued as a paternalistic and corrective approach to social deviance.

It is clear that despite Kant's claim that morality is rationality, this does not darken or lighten the grey of mental health care into black and white. Duties to respect a person's human rights may be superseded by duties to protect either the human rights of that person or others around them. The subjectivity of life leads to duty being altogether relative and open to interpretation.

## Consequences

Deontology is a useful foundation for exploring ethics, yet quickly gets lost as duties compete. Magdalena's detention may violate the duty to respect all people's human rights, although it can perhaps be justified in terms of perceived consequences. Given Magdalena's poor self-care and damaged relationships with family members, professionals may have felt obliged to intervene to prevent a spiral of detrimental effects. The consequentialist argument is utilitarian, which at its core looks for the greatest happiness for the greatest number of people. 'People' in this statement could relate to positive outcomes for not only Magdalena, but also her family. Whilst families and carers are hugely important in terms of supporting people experiencing mental health distress, and as persons themselves, if an action is done for their benefit it could be viewed as veering away from person-centeredness. Ideally the consequences should relate to the person whose human rights have been restricted.

Despite an infringement of human rights, the potential consequences of this may have been positive. Sometimes in the course of coercive treatment, people regain insight, repair interpersonal relationships and are grateful for the intervention they received. The darker side of the consequentialist argument is when we consider whether or not services can do more harm than good. This may be particularly true for people with histories of trauma, with professionals however unintentionally facilitating an institutional re-traumatisation (Sweeney

et al. 2016). In Magdalena's case, there were significant negative experiences for her with tentative benefits if any. In ascribing moral value, this act of involuntary detention would therefore have none. It may be frustrating for all to carry out and experience the removal of human rights, to little or no benefit.

## Virtue

As the protectors and breakers of duties, and agents of both positive and negative consequences, it may be of comfort to professionals to know that a third means of moral judgement exists. Virtue ethics describes moral value as being distinct from both duty and consequences, and lay in the character and intentions of the moral agent. Therefore, as moral agents, if professionals make decisions or take actions which are intended for the benefit of the persons they relate to, they could be described as moral acts. Whilst this may be a source of comfort for the professional working in the abyss of the ethical grey, it should nonetheless never negate the need to consider both duties and consequences alongside it. Each point of the triage has exploratory and explanatory power, yet can be altogether unhelpful in isolation. The three are needed when carefully considering each individual case.

## The application of ethics to Human rights

While each point in the triage can be impotent alone, the triage can act as a point of reflection for every professional involved in care which may remove a person's human rights. Some key questions for self-reflection could be:

- Duty

  <sub-bullets>

  - What are my duties?

- Who are these duties to?
- Do any of these duties clash, and if so, can I justify one duty superseding another?

- Consequences

  - What may be the consequences of restricting/removing human rights?
  - What may be the consequences if there is no treatment?
  - >

- Virtues

  - What are the genuine reasons behind my decisions and actions
  - Are my decisions genuinely for the benefit of the person, or are there other influences?

These questions will not suddenly make every decision easy, however, they will ensure a thoughtful professional, considering all avenues of morality.

Curative/palliative approaches

Specifically addressing the core premise of this book, that palliation rather than curative approaches may be most appropriate for mental health care, the restriction of human rights can be examined through the moral triage. Duties to respect human rights can and always will clash with perceived duties to protect and provide care for our most vulnerable. It could be argued that the virtue behind all restriction of human rights may be primarily a beneficent

curative intention, not to comfort but to rectify the distress. The argument then rests on whether it is better to harm in the short term to prevent harm in the longer term. This consequentialist tension may be viewed very differently depending on whether the professional has a curative or palliative focus. It certainly seems illogical that a palliative agent would attempt to relieve pain through delivering the pain that comes with human rights violation. Whilst it is clear the weight of consequences would need to be carefully considered, there is certainly an argument to be made that palliation would involve letting people be rather than forcing treatment. This debate will always fall within the context of society and what is deemed reasonable by its people. Palliative philosophy must pay particular attention to the potential institutional re-traumatisation involved in mental health care, and consider whether it may in some cases be of more benefit to do nothing, rather than an iatrogenic something.

Self-Assessment Exercise 8.2 – Answers on pp. xxxx

Time: 30 minutes

Using this chapter, address the following multiple-choice questions. Check your answers on pp. xxxx

1. In Hohfeldian terms, a right to be free from another person's authority is a:

a) Claim-right
b) Immunity-right
c) Privilege-right
d) Power-right

2. The PANEL principles stand for:

a) Participation, Accountability, Non-discrimination, Equality and Legality
b) Participation, Access, Non-discrimination, Empowerment and Legality
c) Participation, Accountability, Non-discrimination, Empowerment and Legality
d) Power, Access, Non-discrimination, Equality and Legality

3. An Emergency Detention Certificate allows for a person to be detained in hospital while their condition is assessed for a period of up to:

a) 24 hours
b) 48 hours
c) 72 hours
d) 7 days

4. An Advance Decision is legally binding if it:

a) Complies with mental capacity legislation, is valid and applies to the person's situation
b) Was written in Scotland, is signed by an RMO and sets out how the person wishes to be treated if they become unwell
c) Complies with the ECHR, is proportionate and is ratified by a tribunal

d) Complies with mental capacity legislation, is proportionate and sets out how the person wishes to be treated if they become unwell

5. A ‘de facto detention’ scenario is created when:

a) Staff detain someone using mental health legislation
b) A person is detained in hospital for a period of up to 28 days
c) A person is secluded for an unreasonable amount of time
d) A person believes that if they do not stay in hospital they will be formally detained under mental health legislation

6. If a person is deemed to lack capacity under the Adults with Incapacity (Scotland) Act (2000) certain other relevant and appropriate people can take decisions on their behalf providing that any interventions are:

a) Necessary and of benefit to the person and the least restrictive option
b) Necessary and agreed by a mental health officer
c) Included in a person’s Advance Statement and time limited
d) Compliant with the ECHR and approved by a mental health tribunal

References

Adults with Incapacity (Scotland) Act 2000. a.s.p 4. Available at: www.legislation.gov.uk/asp/2000/4/contents (Accessed: January 13, 2018)

Adult Support and Protection (Scotland) Act 2007. a.s.p 10. Available at: www.legislation.gov.uk/asp/2007/10/contents (Accessed: January 13, 2018)

Agier, M. (2011) *Managing the undesirables: Refugee camps and humanitarian government.* Cambridge: Polity Press.

Barker, P. (2010) *Mental Health Ethics: The Human Context*. Abingdon: Routledge.

Bar-Tal, D. (2000) *Shared Beliefs in a Society: Social Psychological Analysis*. Thousand Oaks, CA: Sage.

Convention for the Protection of Human Rights and Fundamental Freedoms (European Human Rights Convention) (Rome, 4 November 1950; T.S. 71(1953)); Cmd. 8969. Available at: www.echr.coe.int/Documents/Convention_ENG.pdf (Accessed: January 2018).

Curra, J. (2014) *The Relativity of Deviance*. 3rd edition. Los Angeles, CA: Sage.

Donnelly, J. (2013) *Universal Human Rights in Theory and Practice*. 3rd edition. Ithaca, NY: Cornell University Press.

Dworkin, R. (1984) 'Rights as Trumps', in Waldron, J. (ed.) *Theories of Rights*. Oxford: Oxford University Press, pp. 153–67.

Equality Act 2010. c. 15. Available at: www.legislation.gov.uk/ukpga/2010/15/contents

Equality and Human Rights Commission, (2017) *What does Brexit mean for equality and human rights in the UK?* Available at: https://www.equalityhumanrights.com/en/our-human-rights-work/what-does-brexit-mean-equality-and-human-rights-uk (Accessed 30 November 2017).

Finnis, J. (1980) *Natural Law and Natural Right*. Oxford: Clarendon Press.

Hicks, B. (2005) *Love All the People. Letters, Lyrics, Routines.* London: Constable.

Hinshaw, S.P. and Cicchetti, D. (2000) 'Stigma and mental disorder: conceptions of illness, public attitudes, personal disclosure, and social policy', *Development and Psychopathology*, 12(4), pp. 555-598.

Hohfeld, W. (1919) 'Fundamental Legal Conceptions', in Cook, W. (ed.) *Fundamental Legal Conceptions*. New Haven, CT: Yale University Press.

Human Rights Act 1998. c. 42. Available at: www.legislation.gov.uk/ukpga/1998/42/contents (Accessed: January 13, 2018).

Kant, I. (1993) [1785] *Grounding for the Metaphysics of Morals*. Translated by Ellington, J. W. (3rd edition.). Indianapolis, IN: Hackett.

Kelman, H.C. ( 1976) 'Violence without restraint: Reflections on the dehumanization of victims and victimizers', in Kren, G.M. & Rappoport, L.H. (eds.) *Varieties of psychohistory*. New York: Springer, pp. 282-314.

Meissner, J. E. (1986) 'Nurses: are we eating our young'? *Nursing*, 16, pp. 51–3.

Mental Health (Care and Treatment) (Scotland) Act 2003. a.s.p 13. Available at: www.legislation.gov.uk/asp/2003/13/contents (Accessed: January 13, 2018).

Mental Welfare Commission for Scotland, (2017) *Compulsion Order*. Edinburgh: Mental Welfare Commission for Scotland.

Mill, J. (1989) 'On Liberty and Other Essays', in Collini, S. (ed.), *On Liberty and Other Essays*, Cambridge: Cambridge University Press.

Office of the United Nations High Commissioner for Human Rights (OHCHR), (2016) *The International Bill of Human Rights, Fact Sheet No.2 (Rev.1).* Available at: http://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf (Accessed January 23 2018).

Opotow, S. (1990) 'Moral Exclusion and Injustice: An Introduction', *Journal of Social Issues*, 46(1), pp. 1-20.

Schulman-Green, D. (2003) 'Coping Mechanisms of Physicians Who Routinely Work with Dying Patients', *OMEGA*, 47(3), pp. 253-264.

Scotland Act 1998. c. 46. Available at: www.legislation.gov.uk/ukpga/1998/46/contents (Accessed: January 13, 2018).

Scottish Executive Millan Committee, (2001) *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*. (Chairman: Rt. Hon Bruce Millan). Edinburgh: Scottish Executive.

Scottish Human Rights Commission, (2017). *PANEL principles*. Edinburgh: Scottish Human Rights Commission.

Sumner, L. (1987) *The Moral Foundations of Rights*. Oxford: Oxford University Press.

Sweeney, A., Clement, C., Filson, B. and Kennedy, A. (2016) 'Trauma-informed mental healthcare in the UK: what is it and how can we further its development?', *Mental Health Review Journal*, 21(3), pp.174-192.

Szasz, T.S. (1973) 'Mental Illness as a Metaphor', *Nature*, 242, pp. 305-307.

The Patient Rights (Scotland) Act 2011. a.s.p 5. Available at: www.legislation.gov.uk/asp/2011/5/pdfs/asp_20110005_en.pdf (Accessed: January 13, 2018).

The Scottish Government, (2012) *Charter of Patient Rights and Responsibilities*. Edinburgh: The Scottish Government.

The Scottish Government, (2017) *Mental Health Strategy 2017-2027*. Edinburgh: The Scottish Government.

United Nations, (2008) *Convention on the Rights of Persons with Disabilities*. New York, NY: United Nations.

United Nations, (1948) *Universal Declaration of Human Rights*. New York, NY: United Nations.

To Learn More

Cohen, J. and Ezer, T. (2013) Human rights in patient care: a theoretical and practical framework. *Health and Human Rights*, 15, pp. 7-19.

Mental Welfare Commission for Scotland, (2017) *Rights in Mind: A pathway to patients' rights in mental health services*. Edinburgh: Mental Welfare Commission for Scotland.

Trachsel, M. Irwin, S. A. Biller-Andorno, N. Hoff, P. and Riese, F. (2016) 'Palliative psychiatry for severe persistent mental illness as a new approach to psychiatry? Definition, scope, benefits, and risks'. *BMC Psychiatry*, 16, pp. 260.

Answers to Self-Assessment Exercise 8.2

Time: 15 minutes

1. b
2. c
3. c
4. a
5. d
6. a