BELGIAN ADVISORY COMMITTEE ON Bioethics

Opinion no. 21 of 10 March 2003 on "Involuntary Treatment during Involuntary Commitment to a Psychiatric Institution"

Request for an opinion of 11 February 1999

from Dr. Hendrik Bryon, psychiatrist and medical doctor, head of the Involuntary Commitment Department at the St Joseph's Medical Centre (*Medisch Centrum St.-Jozef*) in Bilzen.

"Is it allowed to involuntarily administer (i.e. without consent) a contraceptive injection (i.e. an intramuscular injection of a hormonal preparation that acts as a contraception for 2 to 3 months) to a female patient who has been involuntarily committed?

"This question has been raised several times, knowing:

1) that the patient takes "the pill" very irregularly
2) that the patient would not be able to handle another pregnancy, otherwise she would destabilise
3) that the patient takes medication (and consumes alcohol) which would be harmful to any potential foetus
4) that the patient is somewhat of a "nymphomaniac", and allows or seeks sexual contact (too) rapidly
5) that her other children have had to be placed in foster care due to neglect.

"If it is not allowed to administer a contraceptive injection, what are alternatives that are ethically and legally responsible? Or should the medical doctor further restrict the freedom of the patient?...

"The question is whether the general human right to procreation may be restricted during periods of involuntary commitment under certain (which?) conditions. If this is not the case, what is the potential liability of the doctor if the patient becomes pregnant? Should the doctor then pay for the child?"

TABLE OF CONTENTS

SECTION I: DEFINITION OF THE QUESTION

A clear distinction should be made between involuntary commitment and involuntary treatment. Involuntary treatment can occur in a variety of contexts, without necessarily being associated with involuntary commitment. In judicial contexts, there are various methods by which criminal clients can be subjected to involuntary treatment. Examples include the legislation surrounding internment, the legal framework around probation and that around the treatment of drug addicts and sexual offenders (as an alternative to "traditional" punishments).[1] We further observe that the government is increasingly resorting to the possibility of involuntary treatment for non-hospitalised patients (outpatients), for a range of psychiatric disorders.

The Committee has decided to restrict itself to the discussion of involuntary treatment in the civilian context, as provided for in the Law of 26 June 1990 on "Protection of the Mentally Ill". Involuntary treatment in criminal contexts is therefore beyond the scope of this opinion; it could possibly be addressed in a separate opinion.

It should similarly be noted that we will not be dealing with the issue of experimentation in this context.

The Committee has decided not to restrict the question to involuntary contraceptive treatments, but to open the question to all forms of involuntary treatment.

Involuntary treatment is all forms of intervention – whether of a physical, psychological or social nature – that have a therapeutic purpose, and are applied to a person displaying a psychiatric disorder who is either capable of giving his/her consent to the treatment and does not give this consent, or is not capable of giving consent and refuses the treatment. The notion of *force* (or involuntariness) should be understand as a variable on a continuum, ranging from passive acceptance on the part of the patient to treatment that the doctor administers in spite of the patient's refusal.

The recommendations in this opinion are primarily concerned with the ethical aspects of involuntary *treatment*. There are also several observations made on involuntary *commitment* to a psychiatric institution and the Law of 1990 on the Protection of the Mentally Ill. The Committee is of the opinion that no ethical assessment of involuntary treatments can be made without an assessment of the legal and institutional context in which they occur.

The fundamental questions that must be addressed are:

- *Can a patient who has undergone involuntary commitment* ipso facto *undergo involuntary treatment?*
- *When, in which situations and to what extent can the doctor provide care without the free and informed consent of the patient who has undergone involuntary commitment?*

1 Cf. the law of 1 July 1964 on the protection of society against abnormal and habitual offenders, Belgian Law Gazette (B.L.G. – M.B. in French, B.S. in Dutch), 17 July 1964; the law of 29 June 1964 on suspension, deferment and probation, B.L.G., 17 July 1964 (+ erratum 24 July 1964); the law of 13 April 1995 on the sexual abuse of minors, B.L.G., 25 April 1995; the law of 5 March 1998 on parole and as amendment to the law of 9 April 1930 on the protection of society against abnormal and habitual offenders, replaced by the law of 1 July 1964, B.L.G., 2 April 1998; the Cooperation Agreement between the Federal State and the Flemish and Wallonian Communities on the guidance and treatment of sexual abuse offenders of 8 October 1998; the law of 28 November 2000 on the criminal protection of minors, B.L.G., 17 March 2001.

SECTION II: ETHICAL ISSUES

This section of the current advice presents a general explanation of the Committee's ethical approach regarding involuntary treatment.

The question occupying us is constituted, from an ethical point of view, by the tension between (1) the medical and social duty to care and (2) the risks that involuntary treatment will harm the (2.2) autonomy and (2.3) integrity of the patient. The (2.4) distinction between and the respective limits of what belongs to medicine and the judiciary also play a crucial role in this issue. We will firstly consider each of these different aspects of the issue one by one. We will then discuss the (3.1) fundamental principles adopted by the Committee regarding involuntary treatment in the context of involuntary commitment. This general approach will bring us finally to the analyses and recommendations formulated in sections III, IV and V of this opinion, which constitute the concrete application of the guidelines described in this section.

1. Justification for involuntary treatment

1.1. The duty to care: giving autonomy back to the patient

The primary objective and the justification for involuntary treatment in the context of involuntary commitment are always – directly or indirectly – the preservation, restoration or enhancement of the autonomy of the patient which has been weakened by a psychiatric disorder. Involuntary treatment is thus only justified if the patient, because of his/her mental disorder, is incapable of providing free and informed consent to the care that is judged to be necessary given his/her condition. This means offering the severely ill and suffering patient all medically possible means. The possible risks of intervention by the doctor or the judge should be hereby considered. The concept medicine is here understood in the broadest sense, namely *to care* as well as *to cure.* Caring means indeed not only and not always curing an illness. Caring also means the improvement of the patient's life by helping to restore, temporarily or permanently, his/her health. We wish to especially emphasise the sometimes spectacular progress made in the last 50 years in the improvement of the capacities of psychiatric patients, the relief of their sufferings, and the creation of environments that offer them help. The duty to act for the benefit of the patient stems from all of these possibilities for treatment and care.

1.2. Attention to and concern for vulnerability

The will and the duty to care – or the principle of beneficence or assistance – is one of the most fundamental principles of medical ethics. This principle expresses in practice, in relationships and within the walls of medical institutions a more general ethical principle, namely the consideration and care that both society and the direct environment should give to the vulnerability or fragility that characterise every individual. Illness, whether physical and/or psychological, is one of the most basic forms of this vulnerability.

1.3. Solidarity

The concern for individual vulnerability which is demanded constitutes an aspect of the very general principle of solidarity or of responsibility (with respect to others), which is essential in both direct interpersonal relationships (family, friends etc.) and at the level of social (meaning institutional or anonymous) relationships. At a social-legal level, the right to health and care (and the related duty to care) is here relevant.

1.4. Protection of third parties

It should be clarified that both personal and social solidarity and concern, as well as the responsibility to care, could be relevant, not only towards the patient him/herself, but also as regards third parties in cases where the patient, through his/her illness, puts them in grave

danger.

2. Ethical issues: prudence, threats to the autonomy and integrity of patients, the limits of democratic (government) power and medicine

2.1. The necessity for caution

The situations in which the duty to care is appealed to in order to force treatment without the patient's consent, should be treated with the utmost caution. Not only history but also the situation in other countries and even a few current accounts in this country, reveal a number of highly questionable practices which were formerly used in psychiatric care and which can arise even today: abuse in the making of the decision for involuntary commitment or continued stay in an institution; abuse or shortcomings regarding treatments (a too one-sided relationship between patients and caregivers, questionable or insufficient treatments); abuse or shortcomings at the level of the living conditions imposed on patients (exaggerated force or excessive isolation, degrading inactivity, etc.).

The duty to care must therefore be accompanied by the greatest possible caution, and must be allowed to be continually questioned by other equally important principles such as the principle of consent to treatment, the principle of respect for the integrity of the patient, the principle of distinctions between institutions and between a legal way of thinking on the one hand and a medical way of thinking on the other hand.

2.2. The necessity of consent

Involuntary treatment is a problem from an ethical point of view primarily because it occurs without the free and informed consent of the patient. This consent is a basic condition and at the same time one of the most fundamental principles of medical ethics. We will explore in more depth later in this text the criteria regarding the patient's health situation that are necessary before the patient is treated without his/her consent; we wish to first clarify what this requirement for consent means, in order to be able to understand it in a broader context.

2.2.1. Consent cannot be reduced to the decision itself by which the patient declares their agreement that the treatment be started; instead, consent should be considered as a factor which continually structures the relationship between the patient, the caregiving staff and the medical institution. This relationship can be considered to be a purely medical relationship given the fact that it is, in principle, a bilateral relationship in which two partners generally and of course each in a different way are involved. The doctor conducts the treatment. The patient has need of medical care, provides consent and cooperates. In this way the patient is actively involved in his/her treatment and assists in his/her cure. Both parties must remain open for each other: if the patient consents to the treatment proposed by the doctor and conforms to it, the treating doctor for his/her part should pay attention – both in the diagnosis and during the treatment – to the expectations, plans, reactions and feelings of the patient, and this for the duration of the treatment. In the light of this it is therefore understandable that a lack of consent forms an ethical problem. In such a situation, the structure that is usually contained in the relationship between doctor and patient disappears. There is then a high risk that this relationship will be reduced to a unilateral relationship, in which the patient simply undergoes treatment, and the treating doctor decides and acts alone.

2.2.2. The principle of consent is in no way a rule that is only applicable in medical practice: this principle is a translation in medicine of the most fundamental ethical, legal and political principles. It is first and foremost an expression in medical practice of the principle of autonomy. Although all of the principles discussed here can be interpreted in many different ways, there exists a broad consensus regarding how the term autonomy should be understood. A person's autonomy equals the capacity and right to control his/herself, i.e. an individual determines his/her own life, both in his/her day-to-day actions and in his/her decisions and choices. This autonomy is one of the

essential components of human dignity.

2.2.3. It can also be noted that the requirement of consent is more specifically a concrete expression of the principle of equality. Equality between individuals requires that all people who are involved in a given situation, relationship or practice participate in what they are involved in, and this in as equal a way as possible. This requirement applies even if participation is different and the relationships are asymmetrical, such as in the relationship between patient and caregiver. This equality implies that the patient is not allowed to be considered as an object of care that simply undergoes the treatments offered by the caregiving staff (who are the only actors in such a relationship).

2.3. Respect for integrity

Another difficulty or risk associated with involuntary treatment relates to another aspect of the autonomy and dignity of the patient, namely the patient's integrity – physical but mainly psychological and existential integrity. Although this concept can also be interpreted in a number of ways, and different aspects can be emphasised, integrity can be described as that which gives an individual a concrete inner unity and an own identity. It is the cohesion or coherence – which is of course always moving and never finished – of a physical, psychological, existential personality. The requirement of respect of the integrity of an individual plays a central role in medical ethics, and it is gaining in importance as increasingly more possibilities become available in medicine to intervene in the various aspects that make up the existence and the personality of an individual.

Compared with purely somatic treatments, psychiatric treatments are unique mainly because of the fact that they do not (or do not only) aim to act on the physical condition or a physiological function, but directly or indirectly aim to act on a type of attitude or behaviour; on a relationship with oneself, with others and with the world; in short, on the way of being that is specific to the patient. In addition, institutionalisation in a psychiatric hospital – certainly if this is extended, such as for a number of "chronic" patients – changes the life trajectory of an individual in an important way. And this life trajectory forms the individual's identity. For these reasons, and in the situations that concern us, the integrity of the patient is at stake and in a very exceptional way – the patient is after all not capable of consenting to the proposed treatments at the moment at which the treatment must begin.

2.4. The limits of medicine and judicial power

It is not only because the patient is incapable of giving consent that the issue of involuntary treatment is so specific in the eyes of the law. It is also due to the fact that medical treatment is administered in the context of a legal decision and obligation. Certainly, any medical practice takes place within a well-defined cultural and social framework, but in the cases of concern here this framework is shaped very particularly by a legal procedure and obligation (i.e. enforceable by force). This accumulation of medical and judicial power results in a number of significant risks for each of the institutions or areas involved.

2.4.1. Democracy is based, amongst other things, on a reasonably clear division between the private and the public spheres, with a restriction of the prerogatives of political power and the autonomy of the private sphere. Under normal circumstances, the provision of medical assistance to individuals belongs exclusively to the private sphere. When medical care is imposed by the judiciary, there is a real risk that the boundaries of public power and the private sphere – characteristic of a democracy – will be blurred. If we focus more specifically on the statute of the patient, it can be observed that this shifts from the statute of a citizen equal to other citizens – assuming that the patient has the ability and right of controlling his/her own life – to the statute of a patient over whom guardianship (i.e. supervision and medical assistance) is imposed by the social power.

2.4.2. There is simultaneously the risk that the medical relationship, practice and institution may simply be manipulated by the social power in favour of a number of objectives of public order and

security, and thus diverted from their core function of caring for each patient and in which the well-being of the patient comes first.

2.4.3. This possible instrumentalisation of medicine by the judiciary can be seen in the framework of political strategies (such as those in certain countries where political opponents were/are "psychiatrised"); this instrumentalisation can also be abused in the service of other philosophies or to supplement other institutional arrangements: e.g. legal institutions (medicalising instead of sanctioning, e.g. the case of a drug addict who commits theft), or social institutions (a request for involuntary commitment for a violent spouse instead of daring to ask for a divorce; locking up people on the margins, with the excuse that they do not have access to a bathroom or heating). The Committee draws attention to the fact that the increasing use of medicine, in particular psychiatric care, may be part of a philosophy of desocialisation: the medical sector treats people and situations individually, while these difficulties could have been addressed by collective and non-medical measures. Finally, there is a temptation to appeal to the imagined and attributed omnipotence of the doctor, as if his/her role consisted of providing solutions to all the dangers, failures, tensions, and limitations that face society and individuals. In contrast to this temptation, it might be helpful to remember that we cannot claim that everything can be treated by medicine. We have to accept that we can be confronted in life and in society by situations or people "with problems" or who "cause trouble".

3. Ethical discussion: how can we associate respect for autonomy and integrity with the offer of assistance and help, and with force?

The ethical problem consists of connecting each of the various principles which we have just clarified together; although none of them can be applied in isolation, there remain tensions between them.

In this context, the Committee sought to meet the following objectives:

a) to determine, as accurately as possible, the criteria needed to identify situations in which the duty to treat outweighs the requirement of consent;

b) to identify and clearly describe the means that, in such cases, will ensure the best possible equilibrium between the various relevant ethical principles: concern and respect, support and autonomy, intervention and integrity;

c) to seek the best possible coordination between the medical institution and the judiciary, in such a way that each of them, according to democratic principles, can continue to fulfil their own role.

3.1. Connecting the principles of autonomy and assistance

3.1.1. Key thoughts

The search for the best possible way of connecting these two principles will be determined by several key thoughts:

a) There is first and foremost the fundamental rule of medical practice involving consent and, especially and as much as possible, respect for the patient's integrity and the restoration of the patient's autonomy. This fundamental rule remains as reference point, and should guide the whole treatment, even in cases where the patient, initially and/or at certain moments, is *de facto* not capable of giving free and informed consent;

b) The fact of involuntary treatment does not give caregivers more freedom, but more responsibility. The caregivers will have to be even more concerned for the integrity of the patient (given the fact that the latter is less capable of guarding this integrity him/herself). As a consequence, the fact of involuntary treatment results in stricter therapeutic limitations than

would normally be the case, alongside more conscientious prudence and respect.

3.1.2. Support and respect

Respect for the autonomy (and thus for the dignity) of the patient is not limited to the request for consent at the start of treatment, nor does it disappear if this consent is absent. Even if the patient undergoes involuntary treatment, his/her capacities must always be respected:

> (a) there is after all (almost) always the possibility of a potential, partial, progressive capacity for consent on the part of the patient, which enables him/her to a certain extent to give consent. These elements should always be carefully looked for; they deserve to be respected, at each stage of treatment;
>
> (b) above all, it should be remembered that the very aim of treatment is to restore or preserve this potential, partial, progressive autonomy as much as possible.

This means in practice that there exists a whole spectrum of relational and institutional resources between complete cooperation and pure force. The fact of an initial lack of consent, which led to the court decision, does not have to definitively determine the direction and development of the relationships: the caregiving staff has to attempt as much as possible over the whole course of the treatment to consult with the patient and to look for a maximum degree of agreement with the latter. We can therefore postulate that, even in the case of involuntary commitment, the patient should be treated as far as possible as if he/she were capable of giving his/her own consent. This means that efforts should continually be made to inform and convince the patient. Moreover, this principle requires that a necessary amount of patience and attention be given to following the patient's evolution, and that his/her opinion should be continually and genuinely taken into account. Concrete recommendations in this respect are formulated in section IV of this opinion.

3.1.3. Duty of restraint

On the other hand, a situation of force gives all responsibility to the caregivers, while this is usually shared between caregivers and the patient. This extra responsibility entails the need for extra caution. This means the obligation to stay vigilant regarding treatments. Special attention is also required for the integrity of the patient and the respect for this integrity:

a) In a situation of involuntary treatment, the only psychiatric treatments which are legitimate are those which relate to the condition that led to the involuntary commitment;

b) The treatment of other pathologies requires the informed consent of the patient, unless the disorder is of such a nature that the physical integrity of the patient is endangered (e.g. a severe infection, severe hypertension, a heart attack), and the refusal of treatment is related to the patient's psychiatric disorder. The treatment of pre-existing conditions which the patient has previously refused (before the appearance of his/her psychiatric disorder), must not be undertaken without the patient's consent;

(c) Treatments should be restricted in accordance with the limited duration of the coercive measure decided upon by the judge;

(d) The only treatments that should be administered are those considered to be effective on the basis of a broad medical consensus.

3.1.4. Respect for the living conditions

The living conditions imposed on the patient who is institutionalised are part of the patient's care in the broadest sense. The consent of the patient should be aimed at in this area too, alongside the necessary caution and vigilance. In short, the same principles that are applicable to purely therapeutic measures, also apply here. In particular, concrete constraint measures (prohibitions or obligations) related to activities, schedules, relationships, communications etc. should be limited as much as possible and clearly justified: the almost unlimited power of caregiving staff, the infantilising and sometimes even humiliating measures are real risks for psychiatric medicine in the context of involuntary treatment. Once again, the situation of involuntary commitment should not be interpreted as an extension of the freedom of caregivers. Involuntary commitment means instead heavier responsibility for caregivers: they need to respect and promote the dignity,

autonomy, own responsibility and the integrity of the patient.

3.2. Connecting medicine and judicial power

In cases in which a medical relationship and a court order are brought together, certain measures are required in order to avoid any sort of confusion between the two domains (medicine and the judiciary), and which ensure that their respective roles (care and treatment vs. legal enforcement and obligations) remain as distinct as possible. Careful reflection is needed on the difficulties that arise due to the dual role played by caregiving staff in general and the medical director of the institution to which the patient is entrusted in particular: that of therapists, and that of "guards" exercising a judicial decision which gives them a significant amount of power over the patient and his/her living conditions. This dual role (and the weight given to the medical advice used to extend the period of involuntary commitment) runs the risk of blurring the distinction between medical and legal practice. It is therefore necessary to develop and implement measures that can provide a structure to this involuntary therapeutic relationship, and in such a way that is different to a purely asymmetric confrontation between doctor and patient.

One example of such a measure is the introduction of a third party into the relationship between doctor and patient. The patient (and his/her lawyer) is thereby offered more possibilities, by providing a system in which the patient can be represented by a person of trust in interactions both with the doctor and the judge. Such a measure could moreover be used in order to explain the rules which the institution imposes on the patient, so as to avoid arbitrariness in this area.

SECTION III: THE LAW OF 26 JUNE 1990 ON "THE PROTECTION OF THE MENTALLY ILL" (Belgian Law Gazette 27 July 1990)

1. The legal framework

*1.1. The **cumulative grounds** for involuntary commitment*

The grounds for involuntary commitment are described in article 2:

- The patient must be suffering from a mental illness (article 1 uses the term "mental disorder").[2] This concept is not defined in more detail. The Law does however clarify that that non-conformism in terms of moral, societal, religious, political or other values may not in itself be considered to be mental illness;
- There is no other appropriate treatment possible;
- The involuntary commitment of someone who is mentally ill can be required for two reasons: either because the person in question "is a serious danger to his/her own health and safety", or because he/she "poses a serious threat to the lives or integrity of others."

*1.2. The **procedure** (normal and emergency)*

The normal procedure (articles 4-8) – Any interested party can submit a written appeal to the justice of the peace, requesting that another person be committed for observation. An extensive medical report must be submitted together with the written appeal. This report must be based on an investigation conducted within the last 15 days, and describe the health status of the person whose involuntary commitment is requested. The written appeal must also describe the symptoms of the disorder, and establish that the conditions determined in article 2 are met. The doctor who writes up the medical report must not be related in any way to either the person with the mental disorder or the applicant, nor connected to the psychiatric unit where the person is currently a patient (if applicable). On receiving the written appeal, the justice of the peace must ask the president of the Bar of lawyers or the legal aid office to appoint a lawyer without delay. Within 24 hours, the justice of the peace must state a day and time at which he/she will visit the person whose commitment for observation has been requested, and also the day and time for the hearing.

Within the same period, the person with mental illness (and, if applicable, his/her legal representative) must receive a legal letter informing him/her of the written appeal. This letter must mention the name and address of the lawyer who has been appointed, as well as specifying further that the person with mental illness has the right to choose another lawyer, a medical psychiatrist and a person of trust.

During the hearing, the justice of the peace hears the person with mental illness as well as all other persons whom he/she considers must be heard, in the presence of the lawyer of the person with mental illness. The justice of the peace must additionally collect all relevant medical and social information.

The justice of the peace must pronounce a detailed and justified judgement within ten days of the appeal's submission.

If the justice of the peace grants the request for involuntary commitment, he/she must also signal which psychiatric unit the person with mental illness will be referred to for observation.

The emergency procedure (article 9) – This procedure begins by going through the Crown

2 The term "mental disorder" covers mental illness, mental disability and personality disorders. The Committee refers to the concept of mental disorder described in the *International Classification of Diseases and Related Health Problems, Tenth revision* (ICD 10) from the World Health Organisation (1992), or to that in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth edition* (DSM IV) of the American Psychiatric Association (1994).

prosecutor responsible for the area where the person with mental illness resides. In emergency cases, the prosecutor can decide that the person with mental illness be admitted for observation in the psychiatric unit that he/she designates.

The intervention of the prosecutor follows reception of either a written opinion from a doctor appointed by the prosecutor or a written appeal from an interested party (this appeal must be accompanied by an extensive medical report). The advice or appeal must demonstrate the urgent nature of the request.

Within 24 hours of the prosecutor's decision, the prosecutor must notify the relevant justice of the peace and file a written appeal. At the same time, the prosecutor must give notice of his/her decision to the following people: the person with mental illness, his/her legal representative (if applicable), the person with whom the person with mental illness resides, and the interested party who filed the original appeal to the prosecutor (if applicable).

The justice of the peace will then follow the same procedure described in "the normal procedure" (the appointment of a lawyer, determining the day and time for a visit of the person with mental illness and the hearing, etc.).

If the prosecutor does not submit his/her written appeal to the justice of the peace within 24 hours, or if the justice of the peace does not pronounce a judgement within ten days of the filing of the written appeal, any decisions or measures taken by the Crown prosecutor become obsolete.

*1.3. The **further sequence of events**, once the patient has been involuntarily committed*

The conditions regarding admission, possible extension of the stay in the institution and the termination of the extended stay are determined in articles 10 to 21.

(Initial) admission (articles 10-12)

The duration of commitment for observation must not exceed 40 days.

Patients who have been involuntarily committed may, "on the grounds of a decision of a doctor of the unit and subject to his/her authority and responsibility", leave the institution, for limited duration, alone or under supervision. It is also possible for a patient to reside part-time in the institution (during the day, or at night).

It is possible that the commitment for observation be terminated before 40 days have expired, if this decision is made by one of the following:

- the justice of the peace who issued the court order for commitment for observation (this occurs rarely). This judgement is rendered at the request of the patient or an interested party. The opinion of the medical head of department must always be sought;
- the Crown prosecutor who made the decision for commitment for observation, if the justice of the peace has not yet decided (this occurs rarely);
- the medical head of department who argues in a written report that the patient's condition no longer justifies involuntary commitment (this occurs in the majority of cases). This must be communicated to the patient and to the director of the institution. The latter must then inform the following: the judge who had made the original decision, the justice of the peace who heard the case, the Crown prosecutor and the person who had requested the commitment for observation.

The (possible) extension of the stay in the institution (articles 13-18)

If, after the observation period of 40 days, it appears that a continuation of the stay in the institution is necessary, the director of the institution must provide the justice of the peace with a detailed report from the medical head of department. This report must confirm the need for a continuation of the patient's stay, and must be received by the justice of the peace at least 15 days before the expiration of 40 days.

The justice of the peace must determine the duration of the extended stay. This must not exceed two years. The patient can request a doctor of his/her choice to compose a written opinion,

according to article 13: “If the patient provides a written opinion from a doctor of his/her choice which differs from the opinion of the medical head of department, the judge must cross-examine the two doctors, in the presence of the patient's lawyer.”

At the end of the extended stay, the director of the institution discharges the patient, unless it is decided that the patient should remain at the new institution for a new period (of maximum two years). As was the case during the initial period of admission, the patient may be granted permission during this extended stay to leave for a limited amount of time, either alone or under supervision, on the grounds of a decision of the responsible doctor and under his/her authority and responsibility.

The medical head of department may decide at any time in favour of follow-up care outside the institution, accompanied by a supporting report and with the patient's consent. This follow-up care may last for up to one year. In such cases, the conditions for residence, medical treatment or social welfare care must be determined. The medical head of department may likewise decide at any time to terminate the follow-up care (if he/she judges that the patient's condition allows this), or decide that the patient should be re-admitted to the institution (if he/she judges that the patient's condition requires this, or if the conditions of the follow-up care are not respected).

During the extended stay, the patient may be transferred to another psychiatric unit. The medical head of department can make such a decision only in agreement with the medical head of department of the other unit. This decision can be made as a result of the first medical head of department's own initiative, or at the request of an interested party, or at the request of the authorised medical inspector.

The patient must be informed of the decision to transfer him/her. The patient (or the patient's legal representative, his/her lawyer, or his/her doctor) is able to oppose this decision.

Termination of the extended stay (articles 19-21)

The medical head of department, either on his/her own initiative or at the request of an interested party, can decide that a further extension of the patient's stay in the institution is no longer necessary. This decision must be justified in a report.

An extended stay is also terminated if no decision regarding readmission is made during the year of follow-up care.

Within five days of the mailing of the registered letter which states that the medical head of department judges an extended stay to be unnecessary, the person who had originally requested the commitment for observation can oppose this decision by filing a written appeal to the authorised justice of the peace.

*1.4. What does the Law say about **involuntary treatment**?*

One of the conditions for involuntary commitment states that there must be no other “appropriate treatment” possible (cf. above: article 2). This implies that the legislator considers involuntary commitment to be an instrument for the purpose of treating the mental illness.

In contrast, the Law also continuously refers to observation as the purpose of commitment (cf. the title of Section I, articles 4, 5, 7, 8, 9, 12 and 13). Articles 11 and 12 refer to “commitment for observation”.

The most important point of article 11 is: “The duration of the observation may not exceed 40 days. During this period the patient is to be monitored, thoroughly investigated and treated, taking into account the limited duration of the court order.” Article 15, on an extended stay in the institution, explains that “the patient is monitored and treated”. Article 18, on the transfer to another unit, states that the patient may be transferred to another psychiatric unit during his/her extended stay “in view of a more appropriate treatment”.

1.5. Legal remedies

Both the patient (even if he/she is a minor) and his/her legal representative or lawyer, as well as all interested parties, have the right to appeal the judgement of the justice of the peace, within 15

days of the pronouncement of this judgement.

The Crown prosecutor and the patient (accompanied by a lawyer and, if applicable, a medical psychiatrist of his/her choice) are to be heard when an appeal is made.

*1.6. Involuntary treatment in **practice**: some epidemiological data*

Approximately 4 000 psychiatric patients are involuntarily committed in Belgium each year, which equals 5.34% of the total number of psychiatric commitments. In 1998, the most recent year for which complete data is available, there were 3 945 involuntary commitments, versus 73 855 voluntary commitments. 63% were men, and 37% women. The proportion of voluntary commitments is equal across genders (50%-50%). In 80% of cases, the emergency procedure was applied, while the normal procedure was applied in the remaining 20% of cases. There is no difference between the numbers of voluntary and involuntary commitments regarding the sociological variables "education level" and "education type". More unemployed (a difference of 10%) and people without an occupation (a difference of 6.5%) are involuntarily committed.

The most common psychiatric diagnoses for involuntarily committed patients are: psychotic disorders (40.5%), substance abuse (22%), mood disorders (13%), personality disorders (4.6%), and acute adaptation disorders (3.8%). The majority of psychoses fall under the conditions for involuntary commitment. The issue is more complex when it comes to substance abuse. Some do not consider addiction to be a "mental disorder". They are of the opinion that addiction can only be called a "mental disorder" if its causes or consequences constitute a psychiatric disorder.

The majority of involuntarily committed patients are aged between 19 and 34 years (44%). There are also a number of involuntarily committed patients between the ages of 35 and 54 (36%). It is striking that only a small number of those who are involuntarily committed are over 75 years of age, and that the number of minors between 15 and 18 years old is rising.

The difference in treatment applied to those involuntarily committed versus those who are voluntarily committed can be outlined as follows (with a difference of at least one standard deviation) – more cases of a prohibition to leave the institution; stricter supervision in the isolation room; increased monitoring of the risk of suicide and fatal accidents; more medical-legal consultations; more social support; more frequent administration of antipsychotic medication; less frequent administration of antidepressants; reduced use of group psychotherapy.

An extension of the court order is requested for approximately half of all psychiatric involuntary commitments, and in more than 90% of cases the justice of the peace grants the request. Slightly less than half of all involuntarily committed patients is confronted with readmission during their follow-up treatment period.

Since 1993 there has been an increase in the number of patients who submit an appeal against the court order for their commitment for observation (from 0.4% in 1993 to 3% in 1998).

2. Discussion: The conditions for involuntary commitment

In view of an ethical evaluation, in what follows the Committee will first investigate the legal conditions for an involuntary commitment: (1) the presence of a mental illness, (2) a danger for the patient or for others, and (3) the impossibility of treatment without involuntary commitment. This investigation will be carried out on the basis of the principles set out at the beginning of this opinion (cf. Section II.1): the legitimacy of an involuntary commitment depends upon the societal

and medical duty to restore the patient's autonomy as much as possible, an autonomy that is impaired by the patient's illness.

To start with, it should be recalled that both the interpretation and the application of the Law of 1990 should be considered in the light of the foundational idea that led to the drafting of this Law: namely the desire to avoid the abuses that characterised the practice of “collocation” in the past.

2.1. Mental illness

The establishment of the presence of a mental illness is essential, as this implies that the patient is not capable of giving informed consent. However, this judgement is often of course problematic. Nevertheless, it is important to state this condition in order to justify involuntary commitment. Only in this way can we avoid psychiatry being assigned a function of pure social normalisation. In this sense, psychiatry, the law and the courts do not consider purely eccentric behaviour, or actions that show poor integration in society, to be mental illness (cf. article 2, part 2 of the Law of 1990).

The Committee wishes to draw attention to the fact that this psychiatric diagnosis can only justify an involuntary measure if it is the result of an investigation that is as thorough and scrupulous as possible. Even in cases where the party involved forms a real and grave danger to self or others, this does not suffice as a justification for involuntary commitment. It must be proven that the party involved has a mental illness:

(a) in the case of danger to the party involved him/herself and when no mental disorder has been determined, the duty to support must be restricted according to the necessity to respect the person's freedom and integrity. There is a risk when it comes to replacing someone in the determination of their own destiny: this has to do with the limitations, sometimes dramatic, of solidarity, at whatever level (familial, friendship, societal).

(b) in the case of a threat to others, and if there is no connection between this danger and a “mental illness”, no appeal can be made to medicine. In such a case, assistance must be sought from the relevant social structures which aim at the mutual security of citizens. In the case of conflict situations, especially within families, the police, the social services, and the courts have to intervene, not necessarily and not exclusively a doctor armed with tranquillisers.

2.2. A danger to self or third parties

(a) The concepts of danger and risk should be used with the utmost care: these are variables that are determined by society, and which are ultimately left to the discretion of the judge and the consulting experts. Prudence is therefore needed, keeping the following fact in mind: there exists a large, culturally determined variability between what is understood by an outright offence and a pathological danger, between what falls under the authority of the judge or the doctor. It is impossible to escape this cultural relativism when considering the concept danger. However, one can and must not allow oneself to be uncritically locked up in a way of thinking which calls itself “common sense”.

(b) Regardless of the difficulties in putting this condition of danger into practice, this legally imposed condition emphasises the limitation that the duty to support must respect: only in severe cases can concern and the duty to support outweigh respect for freedom, and can involuntary measures be used. Furthermore, these involuntary measures must be proportionate to the severity and the probability of the dangers involved.

It should perhaps be emphasised here that a significant danger is required in order to ethically justify an involuntary measure. There is increasingly the idea in various areas of a socio-cultural requirement of “zero risk” and a security way of thinking. As already mentioned above, it should be emphasised that human existence, both individual and social, contains risks and is sometimes dramatically exposed to accidents, mistakes and suffering.

(c) Moreover, it is clear that intervention is only justified if its purpose is to protect either the patient him/herself or others (article 2 of the Law). This legally imposed condition is thus not restricted to the authorisation of involuntary commitment: it also specifies a purpose to this commitment, namely the avoidance of a grave threat to life and integrity, and the elimination of the threat through treatment as a consequence.

Finally, this provision sets a limit to involuntary commitment: involuntary commitment is only legitimate for the duration of the danger.

2.3. The necessity of treatment

Although the Law is almost silent on the subject, it must be confirmed that involuntary commitment is only justified to the extent that it forms the framework for an appropriate treatment (a) in proportion to the reasons for the commitment, and (b) which is impossible outside of this framework due to the patient's refusal. In other words, the person with mental illness and the resultant dangers can only be effectively treated in the context of involuntary commitment, and there is no other possible solution.

This is an important point in order to avoid the manipulation of medical care by the judicial powers in order to maintain order: the purpose and the justification for the involuntary commitment is treatment, and this treatment must result in the disappearance of the justification for this measure. In other words, it is not just about removing the present danger by simply taking away the patient's freedom; it is also and primarily about treating the illness.

In the numerous cases in which it currently appears that the pathology cannot be completely cured, involuntary commitment is still justified if it is the only possibility to alleviate a severe condition and to avoid the present danger associated with the pathology.

The members of the Committee are in agreement that the legal conditions stated in article 2 paragraph 2 of the Law of 1990, as explained above, are ethically justified.

SECTION IV: RECOMMENDATIONS

In concluding the above considerations, the Committee argues in favour of the following recommendations:

1. As is the case with all treatments, involuntary treatment that is administered to patients who continually refuse this treatment must meet what is called "good medical practice". If the decision is made to resort to involuntary treatment measures, the Committee is of the opinion that the following criteria must be met:

- The aim of the treatment must be the treatment of the mental illness that led to the involuntary measure
- The treatment must not exclusively serve the interests of third parties, or exclusively provide a solution for the administrative, legal, familial or other situation of the patient
- The treatment must always have a therapeutic[3] purpose that will directly benefit the patient involved
- The treatment must be adapted to the severity of the psychiatric and psycho-pathological symptoms
- The psychiatrist must carefully and scrupulously administer only that involuntary psychiatric care which conforms with the current scientific knowledge generally accepted by the scientific community

2. Even if the patient is involuntarily committed, the doctor must determine the patient's capacity to make decisions and, as with all other patients, ask for the patient's informed consent for the proposed treatment. The doctor is only allowed to impose treatment if it is obvious that the patient is incapable of making decisions. There must be no alternative treatment or measure possible instead of the involuntary treatment that, with the patient's consent, could achieve the same goal.

The acceptable amount of force is the minimum amount of force needed in order to start or continue a treatment that is deemed necessary.

In such cases, the practice is that the treating psychiatrist inform the patient's relatives or person of trust about the proposed or already conducted treatment.

Moreover, even if it is observed that the majority of involuntarily committed patients do not refuse their treatment, it is necessary to question the value of this consent, given these patients' questionable judgement capacity and the fact that they find themselves in an involuntary situation. Such consent does not relieve caregivers of their duty to proceed with the necessary caution (as set out above).

Finally, the capacity to make decisions is not a static or monolithic element that is either present or absent, but a dynamic element that varies over time. One of the aims of involuntary treatment is to restore the patient's capacity to make decisions. As soon as this aim is realised, the doctor should recognise this and seek the informed consent of the patient regarding the further planning of the treatment.

3. Involuntary treatment for another pathology can only be justified in the case of: an emergency situation; a pathology that forms a severe threat to the patient's health; and the patient's refusal of treatment for this pathology can be reasonably attributed to the patient's psychiatric disorder in question.

4. Involuntary treatment measures must be part of a treatment plan that is formulated, applied

3 The word "therapeutic" means "that which treats", and not necessarily "that which cures"

and adapted by the treating psychiatrist under the general responsibility of the psychiatric head of department. All data related to the treatment plan and any changes should be recorded in the patient's individual medical file. This file must be available to be freely consulted by the trusted doctor designated by the patient and/or the authorised doctors responsible for monitoring compliance with the law and the quality of care delivered, if they so wish.

5. The members of the Committee recommend that every service and unit where patients are involuntarily committed take the necessary measures in order to implement the very recent Law of 28 August 2002 on the Rights of the Patient (Belgian Law Gazette 26 September 2002). More specifically, attention should be given to correctly informing the patient, his/her relatives, and his/her person of trust or legal representative about the patient's rights and how to enforce these during the patient's stay in a psychiatric unit. The patient is *de facto* in a disadvantaged position due to the severity of his/her psychiatric disorder and his/her restricted freedom of movement. This justifies our proposal to take extra precautions in order that these vulnerable patients be sufficiently informed. For example, a plan of action or information brochure, specific to each department where involuntary commitment takes place, should be developed under the auspices of the medical head of department in consultation with the department's treatment team, and must be approved be the medical and administrative board of the hospital. Regarding the ethical aspects of such a plan of action or brochure, it is desirable that the advice of the local ethics committee of the hospital in question be sought.

Besides giving information on the names and functions of the team staff members and on how the unit operates, this plan of action or information brochure should provide clear information on the following points:

(a) How contact with the outside world will take place: the possibility of restrictions regarding access to telephone calls, mail, or visits; information on the schedules, activities and internal regulations of the unit; a description of the relationships with the nursing staff and relationships between patients; etc.

(b) The means that the patient will have at his/her disposal in order to contact his/her person of trust, lawyer or treating physician quickly, from the unit where the patient has been committed. This is a fundamental right of the patient, but the patient does have to know how he/she can exercise this right if he/she so chooses.

6. There must be a clearly described procedure available to be followed if the patient desires a conversation with the ombudsperson (see below) or desires to file a complaint with the chief physician of the hospital. At the time of drafting this opinion, not all hospitals had an ombudsperson, given that they were only legally required to provide an ombudsman service as of 6 October 2002, the date on which the aforementioned law of 22 August 2002 on patient rights went into effect.[4] The Committee supports this establishment of an ombudsperson in hospitals. This function must aim at various goals: to restore communication between the patient and the various doctors and nursing staff, to inform the patient of his/her rights and duties, and to help the patient exercise his/her recognised rights. The ombudsperson can in no way replace the treating medical psychiatrist, who remains the only one responsible for the patient's treatment.

In addition, the Committee calls for hospitals to strengthen their quality control of their care processes in general, and more specifically the care processes applied in the case of involuntarily committed patients.

7. In the context of involuntary treatment due to involuntary commitment, the principle of the patient's free choice of doctor is unable to be respected. According to the accepted deontological rules, a patient should always be able to consult another doctor for a second opinion. The Committee believes that involuntarily committed patients should also be able to exercise this right.

4 Note that at the time that this opinion was written (January 2003), the Royal Decree implementing the law of 22 August 2002, in which the conditions under which the function of ombudsperson can be exercised through a cooperation agreement between hospitals are described, had not yet been published.

The implementation of this possibility must be left to the free initiative of the patient; no advance authorisation should be necessary. If the patient him/herself is not capable of asking for a second opinion, this can occur through his/her lawyer, person of trust, or the ombudsperson. This possibility enables the patient to be informed regarding the proposed treatment (its effects, whether alternatives are available, etc.) by a doctor chosen by the patient.

At the patient's request, the doctor designated by the patient can meet with the treating psychiatrist, to ask questions and state his/her opinion if deemed necessary.

The Committee repeats its commitment to the possibility of a second opinion. It is regrettable that the exercise of such a right often raises difficulties in practice: on the one hand, treating psychiatrists may interpret this desire of the patient to be a lack of confidence, or they can assert that the patient, due to his/her illness, is not capable of exercising his/her rights in a "rational" way; on the other hand, there can also be financial hindrances if the patient for instance cannot afford to consult a second doctor. The Committee believes that the fee for such a consultation should be included in the list of medical expenses that can be reimbursed.

This procedure of requesting a second opinion does not detract from the possibility for the patient to appeal to the justice of the peace, either to request that article 3 of the law of 1990 be implemented so that a psychiatric expert is appointed, or to reopen the question of the patient's situation. If applicable, the patient can apply the conclusions of the second doctor (chosen by the patient) on this occasion. The Committee notes that if the treating psychiatrist keeps to the treatment in spite of the firm and explicit opposition of the patient or a contrasting second opinion, the justice of the peace may legally and at any time decide to have the patient transferred to another institution.

8. The Committee advises that the hospital keep written proof of all of the various appeals and requests of the patient (as described above), and of the way in which these appeals and requests were responded to.

9. Should formal opposition to the treatment, or the request for a second opinion or to be referred to the justice of the peace, lead to a suspension of the disputed treatment? The Committee is of the opinion that the answer to this question depends on the medical urgency of the involuntary treatment. In principle, it could be postulated that in the case of an appeal, the treatment be suspended unless the treating psychiatrist believes this would be detrimental to the patient.

10. The Committee also wishes to make recommendations regarding the law of 26 June 1990 on the protection of the mentally ill, particularly regarding a number of aspects that influence the treatment and the quality of this treatment:

a) The Committee has identified gaps in the controls used in psychiatric units where involuntary commitments occur. Under article 33, this refers to the local justice of the peace where the unit is located, the Crown prosecutor, and the doctors (psychiatrists) of the Health Board of the communities.

b) Although the person of trust is foreseen in the law of 1990, he/she appears to rarely exist in reality. The Committee considers this role to be important, and believes that the patient, once committed, should be able to designate a person of trust from an association of (families of) patients, if he/she does not know of anyone else.

c) The Committee insists that the courts should provide the necessary amount of support to the lawyers who are often appointed to assist patients in the context of "legal aid". Furthermore, the courts should make the lawyers aware of the legal requirements, so that the latter can compensate for any possible inexperience by an increased level of diligence. The Committee believes that the lawyer's power is very broad, in that – and this is a unique case – the lawyer can appeal against a decision, even against the advice of his/her client (the patient). For this reason, this role should be carried out in the best possible way.

11. In general, the Committee is of the opinion that patients who are involuntarily committed must be given the same guarantees and the same protection as other patients at every stage of the

involuntary treatment, regardless of whether the patient consents to or refuses part of this treatment.

SECTION V: INVOLUNTARY CONTRACEPTIVE TREATMENT

The specific case which led to this opinion requested of the Committee was related to the legitimacy of administering involuntary contraceptive treatment without the patient's consent as a precaution whenever this patient leaves the institution during their involuntary commitment.

In this chapter we will discuss the ethical aspects of involuntary contraception. This opinion is not concerned with the general question of whether people who suffer from a mental illness are capable of responsible parenthood. In general, the members of the Committee wish to recall the fact that judgements on this question are often strongly coloured by ideological choices, and the fact that doctors may not impose their choice on their patients. The present issue dealt with by the Committee is restricted to the administration of contraception involuntarily to patients, and more specifically to patients who have been involuntarily committed.

As a rule, it is not desirable that involuntarily committed patients become pregnant or become parents. Some members of the Committee prefer the term “become parents”, given that “become pregnant” can only refer to female patients. These members argue that it can also be desirable in some circumstances that men not have children. This does not take away the fact that, alongside the situation that temporary and reversible contraception for men is not yet available, the problem of contraception is more acute for women than men because becoming pregnant forms an additional problem in terms of the potential psychiatric (over-)burden. In practice, the issue of administering contraception involuntarily will therefore mainly arise in the case of involuntarily committed girls and women. This issue is of course only relevant for those who can still have children and who are sexually active during their involuntary commitment. This most probably applies only to a minority of patients, as most patients will not be engaged in sexual relations due to their pathology, and the rest will accept the contraception without question. However, even if we are only talking about a minority of patients, the issue of the legitimacy of involuntary contraception remains relevant.

Sexual relations within the walls of a hospital are often discouraged or even forbidden for practical reasons inherent to life in an institution. Furthermore, this prohibition in psychiatric contexts is, according to some members of the Committee, justified on the basis of the fragile mental condition of the patients. This fragility leads to the necessity of a suspension of sexual relations, as it were. While it is far from certain according to other members of the Committee whether the mental condition of involuntarily committed patients enables them to reflect on the possible consequences of sexual relations, it is nevertheless of fundamental importance to respect the private life of the patient, and it is undesirable to prohibit him/her to have sexual relations within the walls of the hospital. Regardless of whether sexual relations are forbidden or not, the possibility of sexual relations can never be completely excluded. If this were done, this would be at the expense of a minimum level of respect for the patient's private life. Alongside this difficulty is the question raised by the situation in which a decision must be made regarding whether a patient who refuses contraception – against the judgement of a doctor who sees contraception as necessary – should receive permission to temporarily leave the institution (e.g. “to go away for the weekend”).

1. From a legal point of view

The provisions regarding treatment which are very succinctly stated in the law of 26 June 1990 have been summarised on Section III: 1.4. of this opinion, and a legal and ethical interpretation of these provisions has been discussed on Section III: 2.

More specifically, turning to the particular issue of this chapter, the decision not to administer contraception involuntarily to a patient who refuses all forms of contraception raises the question of the responsibility of the doctor and/or the institution in the case of pregnancy. In general, two situations could arise: on the one hand, conception that occurs during the involuntary commitment at the institution or, on the other hand, pregnancy that occurs at a time when the patient temporarily leaves the institution (during the holidays, for a weekend, if the patient leaves the institution for a trial period, etc.).

a) Conception occurring during the involuntary commitment at the institution

a-1. Since the Law of 26 June 1990, the debate regarding whether or not to involuntarily administer contraception to a patient can no longer be restricted to the systematic and general imposition of measures which restrict the freedom of movement (e.g. through isolation) or the freedom of contact (e.g. only contact with other women) of the patient.

Article 32 – on the same level as the right to treatment (articles 11 and 15) - confers other rights to involuntarily committed patients, namely the right to protection of privacy by respecting the secrecy of correspondence, respect for freedom of opinion and freedom of religion and philosophy, the right to social and family contacts, and the right to receive visitors unless there are medical contraindications.

Therefore, such a restrictive measure can only be taken on the basis of a medical contraindication, which assumes an individual examination, in a therapeutic framework, valid for temporary duration and in a proportionate manner.

a-2. Articles 11 § 1 (commitment for observation) and 15 (extended stay) determine the patient's supervision and treatment. What do these provisions mean in the context of avoiding pregnancy?

a-2.a. On the basis of our preparatory work, it appears that the supervision has a lot to do with the physical and medical surveillance of the patient. The example often used is suicide prevention. Measures are taken to avoid the patient escaping or acting in a way that would cause harm to the patient him/herself or to third parties. It is an undertaking focussed on means not on results. It is thus impossible to excuse *a priori* the institution and/or the staff from all responsibility. Nevertheless, it is possible to *a priori* weigh this obligation of supervision against respect for the patient's intimacy and privacy. Additionally, it is not advisable to supervise too strictly or to develop a type of supervision in which any risk of pregnancy is completely excluded, given that this would create unfavourable consequences for the patient's supervision and accompaniment.

Some psychiatric units have internal rules in place that regulate sexual relationships in the same way that violence is prohibited. Such internal rules often include a clause that states that the institution denies all responsibility in cases of non-compliance when harm is done as a consequence of not respecting the specified prohibitions.

Given the fact that we are dealing here with patients whose judgement capacity has changed or is non-existent – evidenced by their involuntary commitment – it is questionable whether such a disclaimer is legally valid. There is a danger that, given the deficient mental state of the patients, it is actually the task of the institution to ensure that the prohibitions that it lays down are complied with. In this case, the institution and its staff are no longer faced with an undertaking focussed on means, but on results.

a-2.b. Regarding the treatment, the law determines neither which treatments are authorised nor which treatments are prohibited. While from a legal point of view it is clear that a commitment for observation does not justify any and every form of treatment, the removal of the patient's liberty must always be associated with the treatment of a mental disorder. Pathologies that are unrelated to this mental disorder can only be treated in emergency situations.

Treatment must meet general legal conditions, except for consent which is inapplicable in this case. Alongside the requirement for the professional qualification/s of the doctor, the treatment must be aimed at a therapeutic or preventive end, it must be sufficiently necessary, and there must be more benefits than risks.

Applying these principles to the case of avoiding pregnancy, it will be necessary to investigate, in each case, whether or not specific medical precautions should be taken in order to prevent the patient from becoming pregnant, for the good of the patient's health. These precautions may take the form of involuntary contraception or special supervision measures. Failing to take any precautions may lead to the doctor committing an error of omission.

The legal characterisation of this act of omission as an error will take place in the framework of our system of civil and criminal liability. This question will raise other questions such as the responsibility of third parties (since there will also be a father involved), whether pregnancy can be legally characterised as damages, etc.

b) Pregnancy occurring at a time that the patient temporarily leaves the institution (e.g. during holiday periods or for the weekend)

Articles 11 § 2 and 15 of the Law of 26 June 1990 state that, "On the grounds of a decision of the treating physician and under his/her authority and responsibility, the person with a mental illness may temporarily leave the institution."

The authority of the doctor is referred to in these articles in order to exclude legal intervention. The responsibility explicitly refers to legal liability: the doctor has to consider the danger that the patient poses to him/herself and to others. The doctor is only liable if he/she should have known, at the moment that he/she gave permission to the patient to leave the institution, that this decision might lead to problems. An unintentional error is not an error of omission.

In the case of a decision by which the patient is allowed to leave the institution for a trial period, the assessment is even more delicate, given that this relates to a longer period and the risk of a relapse is therefore higher. Finally, in the case of an escaped patient, the institution or the responsible physician is legally obliged to inform the authorities. If they fail to do so, they can be found responsible. The responsible physician must estimate the extent to which the patient is a danger to him/herself and he/she must pass on this information, so that the most appropriate measures can be taken to find the patient.

Finally, the doctor can at the very least be said to be responsible if he/she, knowing that a pregnancy is not advisable and that there is a definite risk of conception, allows a patient who refuses all forms of contraception to leave the institution without taking precautions.

Given the lack of a clear legal position or interpretation, the following two interpretations can be defended:

- the doctor can postpone the moment that a patient who refuses all forms of contraception leaves the institution:
- the doctor can favour the right to treatment and consider going on holiday or leaving the institution as important aspects of this treatment. In this case, the doctor can prescribe involuntary contraception, which may already have been started as part of the patient's commitment.

2. From an ethical point of view

As detailed above, the Committee is of the opinion that, except for treatments that relate to the pathology that directly led to the involuntary commitment, the treatment of other disorders is only admissible in emergency situations. It therefore has to be determined whether or not the administration of contraceptive measures that the patient refuses falls under an emergency situation.

The assessment of the administration of involuntary contraceptive measures depends on various ethical values. The first value is respect for autonomy, particularly important when it relates to someone's sexuality and his/her right to procreate. The second relevant value is protection of those whose judgement capacity is temporarily impaired: it can be imagined that the onset of pregnancy or parenthood – as a consequence of rash sexual behaviour – is more of an impediment to their well-being and the restoration of their autonomy. Finally, the well-being of the future child is also a relevant value in these situations. Different people will attach different levels of importance to these values, and an assessment will also always depend on numerous characteristics that are specific to each situation. Therefore, it does not appear to be appropriate to determine a single "good practice", in the face of choices that must be assessed case by case.

It goes without saying that the administration of contraception is something that always has to be discussed with the patient. In the majority of cases, patients accept contraception without a problem. It is only in a restricted number of cases in which the patient refuses that the issue discussed here comes up; in other words, the issue of an ethical justification for involuntary contraception. If involuntary contraception is necessary, it can be administered in consultation with the nursing team and after an educational dialogue with the patient.

One of the objectives of any form of involuntary treatment is to return to the patient (as soon as possible) his/her autonomy or judgement capacity, in order that the measure of involuntary commitment can be lifted as quickly as possible. It is obvious that the involuntary contraception must be stopped immediately as soon as the patient, as a consequence of the treatment, has regained sufficient judgement capacity, specifically with regard to the desire to have children.

All members of the Committee agree with the principle of administration of involuntary contraception if the doctor judges that this measure is necessary for urgent medical reasons of a somatic nature. Such reasons might relate to the mother/parent or the foetus. All members of the Committee are of the opinion that it is indeed part of the doctor's responsibility to administer contraception, involuntarily if needed, if the medication taken by the patient may have teratogenic effects on her offspring. In this case, involuntary contraception would be administered in an emergency situation, justified by the risk of giving birth to a malformed child.

In addition to these points of consensus, the following two points of view emerged amongst members of the Committee:

a) **Objections to the use of involuntary contraception**

Some members of the Committee are very reluctant when it comes to the use of involuntary contraception for non-medical-somatic reasons. They emphasise that the psychological value of a refusal of contraceptive measures cannot be viewed in the same way as the refusal of other medications, even those medications that have psychological effects. A majority of patients, especially those who refuse, feel that contraceptive measures directly affect their sexuality and femininity, which in turn raises important emotions or moods. Therefore, both the administration of involuntary contraceptives and its refusal are specific and highly symbolic acts.

On the other hand, the question of the administration of involuntary contraception is usually only raised along with the possibility of leaving the institution for a trial period. In that case, the treating psychiatrist is of the opinion that the patient's situation has sufficiently improved such that the patient is no longer a danger to herself or others. To impose contraception in these circumstances implies that the patient has not yet completely regained her judgement capacity, and more specifically and especially at the level of her sexuality and possible desire for children. Such situations will only rarely arise. If the doctor is indeed of the opinion that the patient because of his/her disorder is not yet capable of acting responsibly in sexual matters and regarding parenthood, it is more logical to refuse to let the patient leave the institution than to have to check the consequences of sexual behaviour that is considered to be irresponsible.

These members of the Committee believe that if there is no risk of teratogenicity, the administration of contraception can never be justified by invoking an emergency situation. They believe therefore that this would be ethically unacceptable. Moreover, they are of the opinion that sexual relations during a hospital stay should be discouraged.

b) **Arguments in favour of the legitimacy of the administration of involuntary contraception**

Some members of the Committee consider that it might be appropriate to administer temporary and reversible contraception to some involuntarily committed psychiatric patients for reasons that are not medical-somatic. According to these members, it is fundamentally important in this context to maximally respect the patients' private lives in the institution, even if these patients

stay against their will. It is consequently impossible to prevent all sexual relations during the patient's stay in the institution. These members also believe that it is important, for therapeutic reasons, to give the involuntarily committed patients permission as soon as possible to leave the institution during the weekend. Indeed, the current psychiatric advice is that patients should be confronted with life "outside the institution" as soon as possible. This is to avoid that patients withdraw themselves behind the walls of the institution, and prevents these patients' conditions becoming chronic conditions. Once the mental condition of the patient has improved to such an extent that he/she can leave the hospital, even for a trial period, this does not yet mean that the patient no longer finds him/herself in a condition of relative sexual disinhibition – e.g. because the "mania" has ended – and that the patient will not once more start a relationship with someone with whom, in a normal situation, the patient would never consider raising a child with. The administration of involuntary contraception is in this case justified in the interests of the patient, who has regained part of her freedom as soon as was possible, as well as in the interests of a possible future child. For these members of the Committee, this counts as an emergency situation. For therapeutic reasons, a tightening of the controls around the patient during his/her stay and extended stay within the walls of the institution should be avoided. However, the conception of children at a time when the future parent is not capable of anticipating what it means to raise children and/or has sexual relations with any partner who passes by, should also be avoided.

There is a definite distinction between this vision and the sort vision that says "Person X is not allowed to have children", or "no one with disease Y is allowed to have children", or "involuntary contraception may automatically be administered to an involuntarily committed patient".

These members of the Committee wish to emphasise here that the question is not so much determining whether someone would be a good parent, but rather about avoiding a situation in which someone becomes a parent in circumstances that are too difficult, for example because of the fragility of the possible relationships formed in such circumstances. If a patient is not aware of the consequences of his/her actions, it can be appropriate to protect this person from him/herself and from pregnancy. If, because of severe psychiatric problems, a patient is not open to reason and is incapable of making a well-considered decision about contraception, the doctor has the ethical responsibility of intervening in order to prevent the patient being burdened by parenthood or giving birth to a child whose chances at development are far from guaranteed. It does not seem to make sense to first officially certify that the freedom of a patient who finds him/herself in such a situation must be taken away from him/her, and that they can be involuntarily treated if necessary, and then to state that there is still one domain left in which in principle the patient's competency remains intact at all times, namely in the area of decisions about reproduction (and therefore contraception).

These members of the Committee wish to add that involuntarily committed patients, given their vulnerable position, even more than other patients, fall under the competence and ethical responsibility of the doctor. After all, the more fragile the patient, the greater the power (and thus the ethical responsibility) of the doctor towards the patient. If the doctor judges that it is necessary to (temporarily and reversibly) administer contraception to a patient, he/she must accept his/her responsibility for that patient. The members of the Committee who support this point of view believe that it is ethically unacceptable to forbid a patient to leave the institution (for a trial period, if applicable) because the patient refuses contraception and runs the risk of inappropriate sexual behaviour. These members argue that this restricts the autonomy of the patient even more than involuntary contraception would.

These members of the Committee consider that the emergency situation is even more justified in this case, given that the patients fall under the ethical responsibility of the doctor during their involuntary commitment. This doctor must not only protect the patients against themselves or society against the patients; he/she must also protect any possible offspring. Nothing suggests that children who are conceived by parents who find themselves in a situation of mental decompensation that justifies an involuntary commitment, are wished for in a conscious and lucid way by their parents. Furthermore, nothing suggests that these children will be able to grow up in a good environment.

The opinion was prepared in the select commission 99/2, consisting of:

Joint chairpersons	Joint reporters	Members	Member of the Bureau
P.Cosyns	G. de Stexhe	A. Duchaîne	L. Cassiers
A. Duchaîne	S. Sterckx	M. Dumont	
		G. Lebeer	
		G. Leunens	

Member of the secretariat
B. Orban

Experts consulted
Justice of the Peace Benoît, of Brussels
Dr. S. Bouchez, psychoanalyst
Dr. H. Bryon, psychiatrist, Department Head, St Joseph's Medical Centre (*Medische Centrum Sint Jozef*) in Bilzen
Dr. P. Castro, neuropsychiatrist, Head of the Clinic CHT-Charleroi
R. Daem, Chair of the non-profit organisation "Uylenspiegel", and Eric, witness for the non-profit organisation "Uylenspiegel"
M. Dechaine, of Theux, for the non-profit association "Similes"
Dr. R.Desnyder, psychiatrist
J. De Wagenaere, psychologist
J. P. Goorissen, psychologist
P. Nedergedaelt, lawyer
Dr. M.-J. Peeters, psychiatrist
Justice of the Peace Vandenbranden, of the First District of Antwerp

The working documents related to the select commission 99/2 – request for opinion, personal contributions of the members, minutes of the meetings, documents consulted – are stored as "Annexes BC 99/2" at the Committee's Documentation Centre, where they may be consulted and copied.