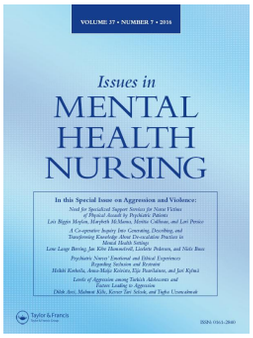

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Paradoxes of Personal Responsibility in Mental Health Care

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Personal responsibility is widely considered important in mental health recovery as well as in popular models of alcohol and drug treatment. Neo-liberal socio-political rhetoric around consumerism in health care often assumes that people are informed and responsible for their own choices and behaviour. In the mental health care context and especially in emergency or crisis settings, personal responsibility often raises particular paradoxes. People often present whose behaviour does not conform to the ideals of the responsible consumer; they may seek and/or be granted absolution from irresponsible behaviour. This paradox is explored and clinicians are urged to consider the context-bound nature of personal responsibility and how attributions of personal responsibility may conflict with policy and their own professional responsibilities to intervene to protect others.

Responsibility is a central, although far from unifying concept in mental health service provision, mental health promotion, addiction, and mental health recovery. People are generally considered responsible and accountable for their own behaviour. Those that clearly lack the capacity to reason, such as infants, people in extreme emotional states, and those considered insane may not be held responsible for their behaviour. This, however is rarely *cut and dried* in crisis intervention, emergency settings, and in some mental health care settings in which decisive action is expected of health professionals or where the individuals they encounter have a history of poor conduct (or irresponsible behaviour). Responsibility is a multifarious concept that frequently enters the discourse of health professionals. People they encounter may not behave responsibly, may seek to be absolved from responsibility for their behaviour, project responsibility for their behaviour, health or wellbeing onto others, and may (at least temporarily) be considered to lack the capacity to be held responsible.

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AUTONOMY AND RESPONSIBILITY FOR HEALTH AND ILLNESS

Such is the importance of personal autonomy in modern liberal societies that people may refuse medical treatment (even if it is clearly in their best interests) for any reason whatsoever, even when that decision leads to their own death. A person's autonomy, their right to self-determination, to make choices with understanding and without controlling influences over-rides the duty of beneficence of health professionals in all but exceptional circumstances. Service users of health and welfare services are frequently described as *consumers* with corresponding rights that pose a moral (if not contractual) claim on others such as health professionals. There tends to be less emphasis on *responsibilities* as consumers.

Benign paternalism has been the traditional (at least aspirational) model of the physician–patient relationship (whereby the physician assumes full responsibility and authority to determine the patient's best interest and to act to advance those interests; Pellerino & Thomasma, 1987). In modern medicine, the locus of responsibility for decision making around treatment of illness has shifted toward the individual with the primary duties of the clinician to inform, guide, and do no harm. In relation to health related behaviour the responsibility for engaging in such behaviour rests even more firmly on the individual.

Individuals are generally viewed as being self-directing, autonomous, and capable of being held responsible for their choices. Liebenberg, Ungar, and Ikeda (2015) note that this "responsibilising" of citizens for their health choices succeeds in "irresponsibilising" governments, or distancing the state from responsibility for structural inequalities or determinants of health that contribute to wellbeing such as poverty, access to opportunities, education, employment and so on." The state may attempt to influence people's behaviour through public policy, education, and sanctions for dangerous behaviour. However, the individual is considered responsible for their health behaviour (e.g., choosing to engage in harmful activities such as smoking, poor dietary habits, failure to exercise) and presumably the consequences of their behaviour (disease and illness). Enlightened societies educate citizens and provide resources to enable health choices with a view to increasing the health literacy of citizens

who then may be presumed to take responsibility for their health and make responsible choices.

PERSONAL RESPONSIBILITY AND MENTAL ILLNESS

Some groups such as young children, those with severe intellectual disability, dementia, or brain damage, may lack the cognitive capacity for reasoned autonomous action and thus cannot be held responsible for their actions. Such individuals generate a responsibility for care, protection, and promotion of their interests from society. Similarly, some people diagnosed with mental illness (particularly at the more serious end of the spectrum) may be considered to lack capacity for decision making, at least transiently. This perception of incapacity in mental illness may often be misplaced as poor decision making capacity appears to be correlated to cognitive deficits (common in the general population) rather than any particular mental illness (Jeste & Saks, 2006).

Despite incapacity in those diagnosed with mental illness often being transient and highly bound to context a presumption of incapacity is often made. Yalom (1992) observed, " … I find it remarkable that you are responsible for all of your thoughts and all of your deeds, whereas she by virtue of her illness is exonerated of everything" (p. 165). Indeed, a label of mental illness (whether actually impacting on the capacity for decision making or not) can effectively absolve the individual from responsibility for their behaviour. In criminal proceedings the *insanity defence* (whilst rarely used or successful) requires it " … be clearly proved that at the time of the committing of the act the accused party was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong" (Arboleda-Flórez, p. 475). The insanity defence sets a high threshold of evidence for incapacity commensurate with the seriousness of the crimes to which it is applied. As Rosenberg (2006) notes, a far more ambiguous and pervasive issue (rather than high profile criminal proceedings) is the large number of people who experience incapacitating emotional pain, have difficulties with impulse control, or who behave in ways that seem socially or morally unacceptable to many of their peers (p. 408). Lesser infringements of the law, etiquette, or civil behaviour are more often than not excused and people are not held to account for poor behaviour in any meaningful way.

Violence by patients towards emergency staff (Taylor & Rew, 2011), staff in general hospitals (Hahn et al., 2008), and in mental health units (van Leeuwen & Harte, 2015) is reported to be common and grossly under-reported. The remedy to this problem may not be about enforcing *zero tolerance* policies and criminal prosecution, but rather as Wand and Coulson (2006) suggest, skill development for front-line staff around communication and negotiation. However, the problem is illustrative of a general lack of responsibility or accountability for pro-social behaviour by consumers of health care and in some instances the conflation of irresponsible or assaultive behaviour with mental illness.

A person who is labelled as ill cannot be held morally responsible for the symptoms of their illness. This is more problematic for so called mental illness than other classes of health problems. For example extremes of mood or disinhibited behaviour may be considered *symptoms* of an illness and accordingly the individual cannot be held blameworthy for these experiences. However, the behaviour may also be considered dangerous, *irresponsible* or out of character and have a damaging impact on relationships and social functioning. The classical notion of the sick role theory suggests that cultural expectations of responsibility change under conditions of illness such that individuals who are sick are not held responsible for normal role behaviour (Parsons, 1951; Williams, 2005). They may, for example, be excused from schooling, employment, or engaging in social roles in order to assume the *sick role*, which involves acquiescing to or engaging in treatment. The person becomes responsible for striving towards recovery and resuming ordinarily social roles as able. Mental illness has long posed a challenge to this sociological theory with minimal evidence that relinquishing social roles is a helpful stance in response to diagnosis, contention around the epistemological status of mental illness (whether it is mere deviant behaviour in some instances) and the usefulness of medical treatment in addressing those diagnosed (Rosenberg, 2006).

MENTAL HEALTH RECOVERY AND PERSONAL RESPONSIBILITY

Personal responsibility is also a central to the idea of mental health recovery, which in recent decades has been described as the "guiding vision" (Anthony, 1993) of the mental health policy framework of most western countries. Mental health recovery has been operationalised as a process of maintaining hope, taking personal responsibility, and getting on with life beyond or regardless of illness (Noordsy et al., 2002). Taking responsibility for one's health and recovery is considered vital to recovery and involves "taking action and doing what needs to be done to get well and stay well" (Copeland, 2015) or managing illness and assuming a healthy lifestyle (Noordsy et al., 2002). Recovery as a process (rather than an outcome) entails progressively assuming greater responsibility for one's illness and lifestyle (arguably as long as the choices are health enhancing ones).

The recovery movement is powered by hopeful and transcendent stories of people overcoming adversity, trauma, and achieving successful outcomes sometimes despite a system, which they experienced as unhelpful. Nevertheless, many people involved with the mental health system who might be identified as being at the more serious or complex end of the mental illness spectrum, continue to identify having severely restricted personal agency, few genuine choices on how they might live their life, and may also have no desire to lead the prescribed healthy lifestyle (Milbourn, McNamara, & Buchanan, 2014).

The emphasis of recovery orientated health services to combat the constrained personal agency of service users has been *empowerment*. Research into the conditions needed for empowerment has emphasised largely factors extrinsic to service users, such as access to resources, incentives to be involved in decision making, supportive structures for decision making, availability of choices, and a supportive organisational structure (Linhorst & Eckert, 2003). Decision-making skills and relatively controlled symptoms have been considered conditions internal to clients (Linhorst & Eckert, 2003) but a minimal amount of consideration appears to have been given to people's motivation to make responsible choices, the effects of substance use and dependence, and psychological processes such as loci of control.

PERSONAL RESPONSIBILITY AND ALCOHOL AND DRUG USE

The concept of personal recovery in mental health has its origins in the alcohol and drug sector where recovery is viewed as a process and individuals are urged to take responsibility for their substance use. Leamy, Bird, Le Boutillier, Williams, and Slade (2011) identifies empowerment (which encompasses personal responsibility) as one of five categories of recovery processes derived from empirical literature (others being connectedness, hope and optimism, identity, and meaning in life). Interestingly, they map recovery stages onto what is known as the trans-theoretical model of change (Prochaska & DiClemente, 1982), which is most commonly used to consider how people overcome substance misuse issues. In this model the individual may demonstrate minimal if any personal responsibility or responsible behaviour during the crisis, precontemplation, contemplation, or preparation stages. Indeed, full responsibility and self-reliance is an aspiration until the maintenance and growth stages of recovery.

Alcohol and illicit drug use pose some interesting challenges to notions of personal responsibility and accountability. For example people who are caught driving whilst under the influence of alcohol may face considerable sanctions. On the other hand people frequently present to health services in states of intoxication and behave badly and with relative impunity. Alcohol related presentations to emergency departments (intoxication, accidents, assaults, and suicidal behaviour), hospitalisations due to alcohol related harms, social costs and the overall economic costs of alcohol use are vast (Lee & Forsythe, 2011). In some jurisdictions, anywhere up to 70% of emergency presentations can be for alcohol related problems on any given day (Parkinson et al., 2015).

Mental illness and substance misuse / intoxication can become conflated. In the state of Queensland, Australia (population 4.7 million), police or paramedics have been able to compel someone to attend hospital for assessment using an "emergency examination order." The number of people brought to hospital by this means has grown by 10% per year to over 12,000 in 2015 with less than 15% being assessed as needing an involuntary treatment order (Queensland Health, 2015). The majority of people are intoxicated on alcohol or illicit substances and behave in a manner which is risky and concerning whilst under the influence (often expressing suicidal ideas or intent). Their behaviour may be irresponsible but the individual is not held to account. Indeed, the responsibility for the person's next move and negotiating some kind of safe exit strategy is shifted to health professionals.

Whilst some level of responsibility for one's behaviour is expected even when an individual is intoxicated, intoxication much more dramatically and universally impacts on the capacity to make reasonable decisions than mental illness. Health professionals recognise this and have a duty to address the health consequences of substance use. That an individual may have voluntarily induced intoxication and a state of incapacity does not alter the presenting health problem, be it a physical injury or a suicidal state of mind. The health professional's responsibility, to treat or protect the individual during periods of vulnerability or incapacity sometimes conflicts with widely held opinions about people's personal responsibility and culpability for their own behaviour.

As Rumgay (1998) points out intoxication is invoked as an excuse for many acts of social and sexual impropriety, "when we seek the exoneration, understanding, forgiveness or leniency of family, friends, colleagues, strangers and law enforcers" (p. 1). Alcohol and drug use (particularly socially or physically hazardous use) has been largely recast as a medical problem or illness rather than a moral failing in many societies. This framing of substance use as an illness serves a useful function for the person who struggles to recover in a 12-step programme (that is to view themselves as in a struggle with an illness), but may also serve to absolve people from responsibility or accountability in other circumstances.

LIMITS OF PERSONAL RESPONSIBILITY AND THE NEED TO RESPOND TO IRRESPONSIBLE BEHAVIOUR

Not far removed from much irresponsible behaviour (whether framed as illness, addiction, criminal behaviour, or intoxication) are determinants of health (or general lack thereof). The same determinants of ill-health are often at play in those who develop problematic alcohol or drug use and symptoms suggestive of mental illness. Adverse childhood experiences (often entirely outside of an individual's control) are strongly related to early initiation and maintenance of problematic alcohol consumption (Dube et al., 2015). Substance misuse also amplifies the modest risk that people diagnosed with severe mental illness will be more violent than others, particularly those with experiences of childhood abuse, neglect, and household antisocial behaviour (Van Dorn, Volavka, & Johnson, 2012). This larger picture view may suggest that people are in part victims of their circumstances but it does not absolve people from responsibility for their behaviour that brings them to the attention of health professionals. Health professionals

may have little direct responsibility in addressing the social determinants of ill-health but they have a duty to respond to the individual who may present as violent, intoxicated, with apparent symptoms of mental illness or defiantly resistant to the idea of assuming responsibility for their own well-being.

How to best respond to various kinds of deviant behaviour has been a longstanding public policy conundrum. In western societies the medicalisation of all manner of problems (e.g., addictions, conduct disorder), which were previously framed differently (as moral, social or criminal) has had far reaching consequences. Szasz (1974, 1997), in particular, has been an outstanding critic of framing socially deviant behaviour as mental illness and, in turn, forcing *treatment* on nonconsenting people. Szasz viewed drug use as essentially a victimless crime, suggested that psychiatry was best practiced between consenting adults and asserted that people should be responsible and accountable for their own behaviour. The consequences of this for the organisation of health care would indeed be far reaching.

A further paradox is that the rhetoric of consumerism in health care suggests that consumers are reflective and thoughtful "experts by experience," who will engage as active and equal partners in recovery with health care providers. They are seen to have a preponderance of rights in relation to their health care encounter. In practice people "may pursue both the ideal-type 'consumerist' and 'passive patient' subject positions depending on the context in question" (Williams, 2005, p. 131). The socio-political context which views health as a business (much like any other), the treatment of ill-health a commodity and the relationship with health practitioners as a transaction imbued with rights may contribute to a diminishment of personal responsibility and paradoxically foster dependency and impede recovery.

CONCLUSIONS

Personal responsibility may best be viewed as an ideal state and the extent to which it is realized suggestive of individuals being engaged in a process of recovery. Users of health services often seek or are coerced to receive a service after behaving irresponsibly. In the case of the Queensland legislation mentioned previously, large numbers of people may be brought (ostensibly for a mental health assessment) when incapacitated through intoxication. The passage of time and re-establishment of sobriety is often sufficient for the acute mental health crisis to resolve. This is not the hard coercive edge of psychiatry as described by Szasz (1974, 1997) but rather a brief and softer form of coercion in the interests of protecting individuals from themselves. Paradoxically it may absolve the individual from personal responsibility and accountability in much the same way as a diagnosis of mental illness.

Acknowledgment of the paradoxical and often conflicting positions towards personal responsibility in mental health care makes the response of the clinician a challenging one. The recovery movement and mental health reform agenda often presents an idealised picture of service users as responsible and behaving responsibly. This often conflicts with the presentation of people in crisis and emergency situations exhibiting adverse consequences associated with their seemingly irresponsible decisions. Health professionals need to balance maintaining safety and their own responsibilities whilst being mindful of a person's capacity to make decisions and actively promote opportunities for people to take responsibility for their own behaviour, health, and wellbeing.

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