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Confidentiality and privacy in the setting of involuntary mental health care: What standards should apply?

Confidentialité et intimité dans la mise en place de soins involontaires en santé mentale : quels standards adopter ?

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Summary Restriction of liberty for the purpose of psychiatric treatment raises practical, ethical and philosophical issues relating to privacy and confidentiality. As a result, the issue of confidentiality in mental health care is a subject of long-standing interest. The challenges are at once medical, legal, ethical and philosophical. In 1991, the United Nations' (UN) placed strong emphasis on confidentiality and privacy, an emphasis that was re-iterated in the World Health Organisation's ''Resource book on mental health, human rights and legislation'' in 2005. In 2006, the UN ''Convention on the rights of persons with disabilities'' articulated that ''no person with disabilities [which includes at least some people with mental illness], regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation'' (article 22). The Council of Europe's ''Convention for the protection of human rights and fundamental freedoms'' (''European convention on human rights'' [ECHR]) (1950) also articulates a ''right to respect for private and family life'', specifying that ''everyone has the right to respect for his private and family life, his home and his correspondence'' (article 8). In the setting of involuntary mental health care, however, it is apparent that this right, like the right to liberty, is a qualified right. A number of important UK cases and cases in the European court of human rights have explored this ECHR ''right to respect for private and family life'', ultimately demonstrating that interference with this right can be permissible, once such interference is proportionate, predictable, in accordance with relevant

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codes of practice (insofar as possible), and clearly justified, for reasons set out logically at the time. While these judgments assist significantly with interpreting international human rights standards and national laws, it remains the case that the practice of psychiatry is also shaped by many factors other than law. Day-to-day clinical work continually presents dilemmas which are not adequately covered by law and require solutions based in broader principles of good medical and ethical practice. In this context, formal medical ethical guidelines in most countries permit disclosure of information without consent if required by law (e.g. court order) or for the protection of the patient or others — despite the impossibility of predicting either homicide or suicide. As a result, while guidelines on breaching confidentiality without consent might well be useful in certain, limited circumstances, it is extremely difficult to determine when to do so, given difficulties assessing risk. There are three possible responses to this situation. The first is never to breach confidentiality due to apparent risk, on the basis that the negative consequences of such an action (i.e. reduced privacy) are certain, while the benefits (i.e. possibly preventing adverse events) are uncertain. The second option is to do our best to predict risk using our imperfect prediction tools; breach confidentiality when risk appears to exceed a certain (ill-defined) threshold; and simply pay a price in terms of reduced privacy. This is the chosen option in most jurisdictions. The third option is to reduce or avoid the dilemma by reducing the amount of privacy afforded to patients in the first instance, by, for example, creating a mandatory requirement for the involvement of third parties (e.g. family) in mental health care from the outset, even when there are no particular risks identified and even when the patient does not consent to this. This option was examined with care in Ireland in 2015 and was not adopted, in favour of the second option, according considerable weight to the right to privacy. Ultimately, however, while human rights form an essential bedrock for this discussion, the vast majority of human needs are fulfilled in ways other than claiming rights (e.g. through societal relations, charity, or political, rather than judicial, allocation of resources). The human need to connect with others and to share has a complex relationship with the need for confidentiality and privacy; further philosophical reflection on these two concepts — which are not necessarily the opposites they might appear at first sight — would help clarify these issues in the complex, important setting of involuntary mental health care.

MOTS CLÉS
Confidentialité ;
Liberté ;
Traitement psychiatrique ;
Droits

Résumé La restriction de la liberté dans le but d'un traitement psychiatrique soulève des questions pratiques, éthiques et philosophiques relatives à la vie privée et à la confidentialité. En conséquence, la question de la confidentialité dans les soins de santé mentale est un sujet d'intérêt de longue date. Les défis sont à la fois médicaux, juridiques, éthiques et philosophiques. En 1991, l'Organisation des Nations Unies (ONU) a mis fortement l'accent sur la confidentialité et le respect de la vie privée, accent qui a été réaffirmé dans le « Répertoire des ressources sur la santé mentale, droits de l'homme et de la législation » de l'Organisation mondiale de la Santé en 2005. En 2006, la « Convention relative aux droits des personnes handicapées » de l'ONU établit qu'« aucune personne handicapée [ce qui comprend au moins certaines personnes atteintes de maladie mentale], indépendamment de son lieu de résidence, ne doit être soumise aux arbitraires ou aux ingérences illégales dans sa vie privée, sa famille, son domicile ou sa correspondance, ou autres types de communication, ni d'atteintes illégales à son honneur et à sa réputation » (article 22). Le Conseil de l'Europe « Convention pour la protection des droits de l'homme et des libertés fondamentales » (« Convention européenne des droits de l'homme » [CEDH]) (1950) énonce également un « droit au respect de la vie privée et familiale », précisant que « chacun a le droit au respect de sa vie privée et familiale, de son domicile et de sa correspondance » (article 8). Dans le cadre des soins de santé mentale involontaires, cependant, il est évident que ce droit, comme le droit à la liberté, est un droit qualifié. Un certain nombre des cas britanniques importants, ou des cas devant la Cour européenne des droits de l'homme, ont exploré ce « droit au respect de la vie privée et familiale ». La CEDH, en fin de compte, a démontré que l'ingérence dans ce droit peut être admissible, si elle est proportionnée, prévisible et en conformité aux codes de pratique pertinents (autant que possible), et clairement justifiée, pour les raisons exposées logiquement à l'époque. Bien que ces jugements aident considérablement à l'interprétation des normes internationales des droits de l'homme et les lois nationales, il reste que la pratique de la psychiatrie est également façonnée par de nombreux facteurs autres que le droit. Le travail clinique quotidien