

Ethico-legal issues in relation to end-of-life care and institutional mental health

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Abstract

Objectives: In view of the fact that there is a higher mortality rate for individuals with serious mental illness and that people with mental illness suffer excess mortality due to physical illness, the lack of attention to end-of-life care for patients with a serious mental illness needs addressing. This article seeks to put these issues on the agenda by beginning to explore important ethico-legal issues at the interface of palliative care and institutional mental health.

Methods: Data were collected from eight qualitative interviews conducted with mental health professionals at The Park, Centre for Mental Health, Queensland. The interviews were recorded verbatim, coded and thematically analysed.

Results: The findings highlight the inherent tension at the interface of compassionate, patient-centred end-of-life care and the participants' perception of the legal restraints imposed by virtue of being in a mental health institution. This article examines the participants' perceptions of the legal restraints curtailing the provision of palliative care in a mental health institution and considers these findings within an understanding of the limitations imposed by law. Our hope and expectation in undertaking this exploration is to clarify the legal limitations that operate to restrict the type of end-of-life care that can be offered to mental health patients, in order to provide an informed basis for practice.

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What is known about the topic?

There has been little study of the issue of end-of-life care in institutional mental health.

What does this paper add?

This paper reports on a study of eight mental health professionals working in a centre for mental health in Queensland in regard to their experiences surrounding the deaths of two patients.

What are the implications for practitioners?

The authors provide an overview of the relevant state legislation and suggest the need for mental health practitioners to develop a clear understanding of the legislation to balance their ability to provide palliative care with the imperative for coronial inquests with deaths in care facilities. ◆

TO DATE, THERE HAS BEEN a loud silence on the topic of palliative care in relation to patients in institutional mental health facilities. Indeed, the only references to mental illness in the palliative care literature focus on the role of psychiatry for mainstream hospice or palliative care patients and their families.¹⁻³⁶ In the literature, the focus is predominantly on cancer patients with psychiatric problems, rather than individuals with a mental illness coping with cancer or other physical illnesses. There is scant consideration of terminal illness from the perspective of those diagnosed with a serious mental illness, particularly in regard to the problems such individuals encounter during their dying trajectory in the mental health system. In view of the fact that there is a higher mortality rate for individuals with serious mental illness^{5,6} and that people with mental illness suffer excess mortality due to physical illness,⁷ this lack of attention to end-of-life care for patients with a serious mental illness is difficult to understand. Not only are those with a serious mental illness more likely to experience premature death,⁸⁻¹⁵ they are at a heightened risk of death from suicide throughout their illness trajectory.^{16,17} In short, the

close association between serious mental illness and dying argues for close attention to palliative care for this subset of patients. This article seeks to put these issues on the agenda by beginning to explore important ethico-legal issues for health professionals at the interface of palliative care and institutional mental health.

The ideology and philosophy of palliative care embraces a holistic, compassionate, person-centred approach for families coping with a member with a terminal illness. As defined by the World Health Organization,²² palliative care is:

The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.

Although palliative care is now understood as best practice for terminal care,¹⁸⁻²¹ the available evidence indicates that it is predominantly provided to cancer patients and accessed by the more privileged, middle-class, Anglo-Celtic patients who live in stable home environments with available caregivers and other supports.²³⁻²⁷ There is no literature on palliative care in the psychiatric or mental health setting. This paper presents findings from a qualitative research project on end-of-life care for patients in a mental health institution called The Park, Centre for Mental Health, located in Brisbane, Queensland. The findings highlight the quite significant obstacles that the legal imperatives associated with institutional mental health care impose on health care workers who wish to operationalise the compassionate palliative care philosophy.

The Park, Centre for Mental Health

Situated in the Brisbane suburb of Wacol, The Park, Centre for Mental Health (TPCMH), one of the largest psychiatric facilities in Australia, provides mental health and psychiatric services to the people of Queensland.²⁸ Established in 1865, TPCMH has recently decentralised its extended

care services as provisioned by the Ten Year Mental Health Plan for Queensland² by adopting a paradigm focused towards rehabilitation and recovery. Currently, TPCMH provides five clinical and rehabilitation services programs to 192 clients from central and southern Queensland, including Extended Treatment and Rehabilitation, Dual Diagnosis Services, Extended Secure Services, High Security/Forensic Care Services and Adolescent Rehabilitation Services. Support services available at TPCMH include General Health Services, School of Mental Health and Library, Centre Management and Research Services.

Research

The principal aim of the research project was to document the experience for health care workers of providing end-of-life care to patients in an institutional mental health setting. Ethical consent to conduct the study was obtained from the West Moreton Health Service District Human Research Ethics Committee. Participants were verbally informed of their rights in research, and written consent to participate was obtained.

Methodology

The theoretical framework for the research is situated in descriptive phenomenology, defined by Spiegelberg³⁰ as “direct exploration, analysis, and description of particular phenomena, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation”. The phenomenon in this case is the experience of providing terminal care for patients with a physical illness in an institutional mental health setting. Descriptive phenomenology is particularly appropriate where little is known about a group of people^{31,32} and is thus well suited to the study of palliative care in a mental health facility where there is no previous research literature. The experience of providing terminal care is documented through qualitative research using open-ended interviews with health care workers at TPCMH conducted by a Central Queensland University post-doctoral research fellow with a background in palliative care research.

Sample population

The two qualitative strategies of purposive sampling and snowballing enrolments guided the selection of participants. Because of the legal issues associated with end-of-life care, research and discussion relating to any death at TPCMH is highly sensitive, or taboo in the case of a death presently the subject of a coronial inquest. For this reason, participants had to be purposively sampled through those directly involved in the care of two patients who had died in the preceding year but who were no longer under legal consideration in relation to either police investigation or coronial inquest. Those involved in these two deaths were enrolled by use of the snowballing techniques of targeting key people involved in the care of those patients and asking those participants to recommend others who they would consider should be interviewed because of their significant role during the dying trajectory. The result was eight interviews, which covered a sample representing key people involved in care during the dying trajectory of the two specified patients.

Demographics

Because of the sensitive nature of the topic and the fact that the interviews were completed in a closed institutional setting, precautions to ensure privacy needed to be taken and assurance of such precautions given to participants during informed consent procedures. Such procedures were important to build a sufficiently safe environment where the interviewees could participate with confidence. Thus, the demographic information is provided in generalities only so that participants cannot be identified. Eight participants, including men and women, were interviewed. All of the participants had worked at TPCMH for a number of years, and some of the participants had very long work histories at the institution, so all were well placed to understand the fullness of the issues in relation to their workplace. The participants were involved in nursing, care coordination, education and advocacy roles at the institution.

Data collection and analysis

The participants nominated the time and location of the interviews. The interviews lasted for about 1 hour and were conducted in interview rooms at TPCMH. Participants were encouraged to speak of their experience caring for a terminally ill patient, prompted by the initial question of “Could you tell me in your own words and in your own way of your experience as a health professional caring for a patient in a mental health facility with a terminal illness?” Of particular interest was an exploration of factors that the participant believed either facilitated or hindered the provision of optimal end-of-life care. The momentum of each interview was maintained by the descriptive phenomenological method of “imaginative listening”.³³ The challenge in descriptive phenomenology is for the researcher to follow the ideas of participants rather than impose preformed assumptions on data collection.³⁴

The interviews were audio-recorded and transcribed verbatim. The language texts were then entered into the NUD*IST N5 (Non-numerical Unstructured Data Indexing Searching and Theorizing) computer program (QSR International Pty Ltd, Melbourne, Vic) — computer software that facilitates cutting and pasting interview transcripts into codes³² — and analysed thematically. As descriptive phenomenology is an inductive process which seeks to record experiences from the viewpoint of the individual who had them without imposing a conceptual framework, the thematic analysis was driven entirely by the participants’ insights.³² The coding was undertaken by an experienced post-doctoral researcher. The coder read all of the transcripts, then categorised every statement made by the participants into codes. The title of each code was usually drawn from the exact words of the participant. As Grbich³⁵ explains, such coding practices use minimal underpinnings to avoid data being forced into predetermined frames and to encourage uncontaminated themes to emerge from the data. There were 35 free nodes created. Once all of the participants’ comments were coded into free nodes, the list of nodes was then organised under thematic headings. As phenomenological descrip-

tion can never encompass the whole of the phenomenon but shows only particular aspects,³⁴ only the findings from the free nodes directly related to the impact of the legal framework on terminal care service provision are presented here.

Findings

All of the participants reported that the most significant factor impacting on their decision making in relation to end-of-life care was the prescriptive nature of the legal framework that defines their work. In particular, the necessities of a coronial inquest into all deaths at the institution and the legal imperative to engage in cardiopulmonary resuscitation (CPR) were the two factors that informed their response to patients during the dying trajectory. For the participants from this institutional setting, the legal framework of institutional mental health provides pressures and restrictions that inhibit the full integration of palliative care best practice end-of-life care.

A death within the family

It is important to set the following discussion in the context of the findings that indicate that for most long-term patients the staff and other consumers at the institution are a substitute family. The first reason for this is that most patients do not have family contact. The second reason is that for some patients (including the two who are the focus of this research) the institution provides total care and long-term nurturing relationships that can act as a substitute for family life:

We were [the deceased's] family . . . In the last days he made it clear that this was his home.

The outcome of this is that for some staff, usually those with long-term involvement who are open to compassionate caring, the death of a patient can involve the distress of grief:

And I think that helped with the grief reaction given that the staff wanted to say goodbye.

Thus, the following findings on the legal context of care need to be viewed in terms of the

significance of the “family” metaphor for both patients and staff.

Holistic, patient-centred care

The following findings need to be set in the context of further insights published from the study³⁶ that indicate that, for the staff interviewed from TPCMH, there is a substantial similarity and compatibility between the holistic mental health ideology and the compassionate, person-centred discipline of palliative care. This is not to argue that such a humanistic orientation is universal to mental health, but rather to indicate that there is evidence that it is the prevailing view of the staff interviewed at the institution studied. As one participant summarised the mental health philosophy:

We are supposed to be able to go to that person and take cues from the person about how they can handle it.

As documented in full elsewhere,³⁶ the findings indicated that for the participants in this study the modus operandi of care is humanistic with a focus on connecting with the patient as a person and a non-judgemental perspective on their mental illness:

It is humanistic . . . Our focus is connecting with the person, connecting with the person and forgetting the illness, reconnecting with the person and we are trying very hard to do that and it is not easy.

The perspective is holistic, incorporating a psycho-social and spiritual dimension of care:

We working in mental health are supposed to be holistic practitioners.

The legal dimension of care

The coronial inquest

Participants noted that it is a legal requirement for all deaths within the institution to be subject to a coronial inquest. At the point of death of a patient in a mental health institution a police inquiry is instigated from which the exact details surrounding the circumstances of the death are gathered.

Participants noted that the police inquiry, at a time when staff are experiencing the stress and grief associated with caring for someone who has died, can be acutely distressing. As the following participant described, the distress is reflective of a sense of being “on trial” about the care given:

You are questioned by three or four . . . they just shoot these questions at you . . . you feel all this stress all over and start questioning things which you wouldn't normally question. So I can tell you definitely it affects you. Even for the next two days. I was constantly, even at work, thinking all about the situation. If I gave the right statement or not? It was very hard on me.

As staff perceive a legal requirement to undertake CPR, there can be the added physical distress of exhaustion from trying to resuscitate a dying person:

And all this stress, I actually cried because I tried to revive him and I don't know if you try to do CPR for 10 or 15 minutes — it is very hard on you. Before we actually had any help whatsoever and before paramedics arrived so I was really, really stressed out from all the physical work.

The stress level of caring for a dying patient in a legal milieu is exacerbated by the knowledge that all actions will be scrutinised at a later date at the coronial inquest. The thought of having to give evidence or become involved in an inquest is frightening: “I know there had been some terrible Coroner's inquests over the years.”

The fear is particularly acute for those who have previous experience with coronial inquests, and is a predominant factor influencing their actions with the dying person:

We are all driven by our past, and I felt really sure that what was driving him was his unfortunate experiences he had with coronial inquests in the past.

It is now well documented that one of the significant factors that can interfere with effective pain relief for terminal patients is the mistaken fear on the part of health care staff that if they

provide the appropriate amount of morphine they may be seen to be accelerating death rather than relieving pain. It was recorded that this fear escalates in the institutional mental health setting where the fear of cross-examination before the Coroner as part of an inquest can interfere with decisions regarding appropriate levels of pain medication.

I explained that this person was in a lot of pain and my priority was to reduce that pain irrespective of what the end result was. But he disagreed because I think he had been involved in lots of Coroner's inquests . . . I hear that can be quite confronting to be involved in.

Resuscitation versus being allowed to die

In both health care literature and practice, there is now a clear distinction between the appropriate use of CPR in emergency situations and the inappropriate use of CPR in conditions deemed futile. Both the disciplines of bioethics and palliative care have clarified the difference between the appropriate timing of the use of CPR and the need to resist such intervention because of respect for the natural process of dying. There are now both legislation and consumer practices (such as Advance Health Directives) that enshrine the consumer's right to *choice* in such practices. The findings from this project documented the perception that in this mental health institution there is *no choice* for either staff or consumer. Rather, the necessity is to engage in resuscitation practices as a legal imperative no matter what the circumstances. The definitiveness with which this requirement was stated is clearly seen by the following statement:

You really have to do this [CPR] knowing that the law says you have got to do it as well.

The legal imperative is seen as operating against death with dignity:

You can't officially let die with dignity . . . you have got to give the whole “resus” . . . even though the doctors to their credit will learn to say “do not make resuscitative”.

The end result of such end-of-life intervention is described as physically very distressing for the patient:

If they say, look we are not going to try to “resus” this person because we just don’t want to see him this way, broken ribs and vomitus and you let that person drift away and that is fine. You can’t do that here; the law doesn’t allow you to do that here.

The reason behind the need for CPR is seen to originate from the difficulties associated with obtaining a legally valid consent. In the mental health context, the patients are seen to be incompetent and therefore unable to provide either a legally valid consent or a legally valid refusal of treatment. As the participants explained:

I think it is more difficult because if there is a death in the facility the police are involved. Most of the patients do not have the mental capacity . . . they don’t think . . . giving consent . . . so technically we have to resuscitate them.

As the following vignette demonstrates, Advance Health Directives are not seen as viable:

He wasn’t really able to . . . he understood he was dying . . . but he wasn’t able to process it or understand it on that level of his wishes . . . in fact we actually tried to go down the path of doing an Advance Directive . . . we went down that path and the doctor said, no. No competence.

In addition, the uncertainty and legal ambiguity surrounding medical legal cover for the staff in the form of Not for Resuscitation Orders (NFR) is described as follows:

. . . my understanding in Queensland is that NFR orders are not legal but a doctor can say if the resuscitative effort is unlikely to produce a positive outcome then if the doctor is willing to put it in writing then the staff can follow the instructions and be protected. The doctor is not protected, the doctor can still be prosecuted for essentially writing NFR order but the staff that follow it are protected.

Some staff spoke of the distress of conflicting interests and the complexity associated with a futile situation:

Staff were getting very stressed about this because they felt, “Well first of all it is going to be futile”. I mean this person was wasted away. He was definitely not going to be recoverable. All he wants was to die with dignity under those circumstances.

This is a situation of holistic care where staff have long-standing relationships with patients in an environment that is described as “home”. The nurturing desire to provide death with dignity rather than resuscitation is reported to be strongly felt by some of the staff:

At any moment he was going to switch off and they were in this really difficult situation of wanting to let him rest but not being able to do so and looking over their shoulder thinking, well do I personally take the risk of simply saying “Rest in peace” and walk away?

In essence the situation creates a personal ethical dilemma for some staff:

But if people are saying, well you know, “My God if I’ve got to resuscitate this man what for?” It is a personal dilemma.

There are differences among the staff with regard to beliefs about the appropriateness of the resuscitation practice. Other staff report the issue as a clear and simple notion that equates not doing CPR with “death making”, a practice they would never engage in:

I certainly do not think we should participate in death making . . . I mean I think we should never do that . . . whether that means that you resuscitate them endlessly I don’t know.

However, even for this staff member the issue becomes more complex if the patient voices a desire for the resuscitation to stop:

I mean I suppose there comes a point where the staff in charge have to make that decision. I don’t know. I mean it’d be different if

the person's there saying "I can't take this anymore".

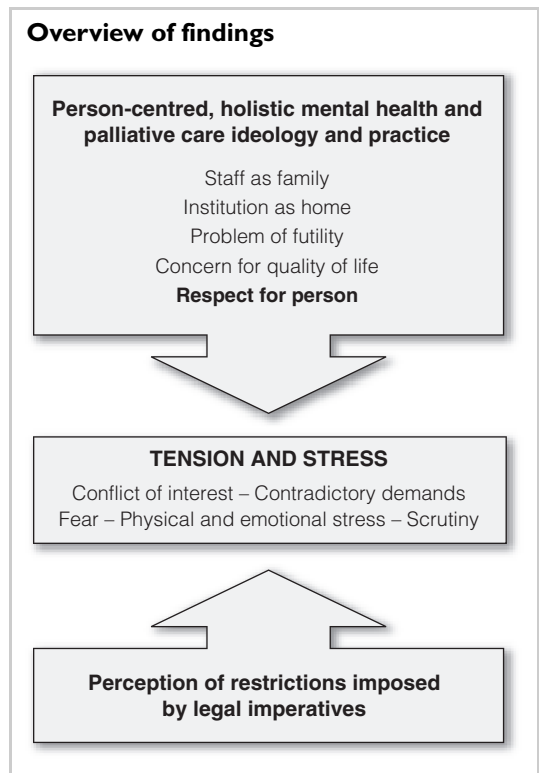
The only solution to the problem of resuscitation in end-of-life care is seen to be to remove the patient from the institution to the hospital or hospice where CPR is seen as no longer being a legal requirement:

We have got to actually actively resuscitate. If he died in the local hospital that would not happen.

Discussion

TPCMH's general policy and procedure document "Care of the deceased patient" defines the outcome of terminal care in clear palliative care principles as: "All deceased patients will be treated with respect, dignity and with due regard to their cultural and spiritual needs".³⁷ However, as summarised in the figure (see Box), the findings highlight the inherent tension at the interface of compassionate, patient-centred end-of-life care and the participants' perceptions of the legal restraints of a mental health institution. The tension is hinted at in TPCMH's standard of care for deceased patients which cautions that care must be provided "in keeping with the individual's cultural and religious norms, while remaining cognisant of the legal issues that apply to deaths in psychiatric facilities".³⁸ The results from the research indicate that the fears and restrictions imposed by the perception of the legal framework are *the* significant factor impacting on, and to a large degree inhibiting, the provision of palliative care in this mental health institution. In other respects for participants in this research, the ideology and practice of mental health care and palliative care clearly resonate with similarities based on a holistic, client-centred focus that gives priority to respect for person, quality of life and the importance of autonomous choice.³⁶

The intent of this article is to situate the participants' perceptions of the legal restraints on the provision of palliative care within the legal literature. The intended outcome of such an exploration is to clarify the situation with respect



to legal requirements and restrictions for mental health practitioners in order to provide an informed basis for practice. In order to retain the comparison with standard hospice care, the following discussion will be restricted to individuals who die as a result of physical disease progress. It is acknowledged, however, that on occasion staff of TPCMH must deal with death by suicide, which is covered by quite different legal and procedural frameworks.³⁸

Clarification of legal framework

In all Australian jurisdictions, the delivery of mental health services is regulated and controlled through specific legislative provisions. Consistent with legislation in other Australian states and territories, section 4 of the *Mental Health Act 2000* (Qld) provides not only for the involuntary assessment, treatment and protection of patients with mental illnesses but also establishes the legislative obligation to "safeguard their rights".

The delivery of mental health services, and the provision of medical, nursing and allied care within those services, takes place on a day-to-day basis in a significantly structured and regulated legal framework. In addition to the provisions of the individual mental health legislation there exists a wide range of obligations imposed in each of the states and territories under complementary and associated Acts. For example, in relation to the end-of-life care of institutionalised mental health patients, the most significant legislative provisions, as perceived by the health professionals interviewed in this study, were those contained in the Queensland *Coroners Act 2003*, *Criminal Code Act 1899* and *Powers of Attorney Act 1998*. It was the application of provisions under these Acts that was identified as dictating and defining how the health professionals managed and provided care to patients dying from terminal illnesses in the institutionalised mental health setting. The application of the individual sections of the respective legislation on a “stand-alone” basis appears fairly straightforward. However, in the particular circumstances under discussion the health professionals feel that the requirement for them to adhere to good palliative care practices, safeguard the rights and dignity of the patient and respect the patient’s decisions (where possible and appropriate) does not run parallel with their statutory obligations. Further, they consider that through practices such as the ongoing administration of increasing doses of pain relieving drugs or the decision not to initiate CPR they are at risk of becoming involved in future civil or criminal action. The requirement under the *Coroners Act 2003* (Qld) that the death of an involuntary patient within mental health institutions is a “death in care”, and therefore a “reportable death”, further affects the way the health professionals care for terminally ill patients. The possibility that the drug administration regime or the failure to commence and maintain CPR will be the subject of a coronial inquest into the death of a patient under their care appears not only to influence their clinical decision-making but also to create a significant moral dilemma. The data indicate a need to consider the interpretation and

application of legal obligations imposed on health professionals in circumstances where they are providing end-of-life care within the institutional mental health setting.

The Powers of Attorney Act establishes the means by which an adult with “capacity” may create an Advance Health Directive and thereby give direction for future health care when the person (referred to in the legislation as the principal) has lost the ability to do so. This legislation specifically provides for the situation where a principal has requested the withholding or withdrawal of life-sustaining measures in circumstances where they have a terminal illness or condition that is incurable or irreversible (Section 36).

The Powers of Attorney Act makes express reference to directions given in Advance Health Directives by involuntary patients under the Mental Health Act. Section 38 provides that the directions given by the patient, whether through an Advance Health Directive or otherwise, are to be preferred if they are consistent with the interpretation of the provisions of the Mental Health Act and the Powers of Attorney Act. While the legislation supports the legal rights of involuntary patients to make decisions about their care and treatment, the significant, and very real, obstacle in many circumstances is making a determination as to the patient’s legal “capacity” to create a valid direction. The requirement that the patient, at the time of giving a direction or refusing treatment, understands the “nature and likely effects of each direction” (Section 42) effectively precludes many involuntary patients who have become incapacitated due to the extent of their mental illness from giving a direction. It is this challenge to the legal capacity of the involuntary patient to comprehend and understand that also potentially invalidates their refusal of treatment under common law.

While the Powers of Attorney Act seeks to give effect to the rights of individual patients to make their own health care choices, the criminal law is directed to the identification and prevention of conduct which the state considers aberrant and inconsistent with the values of the society or

community. In Queensland, the Criminal Code Act establishes as criminal offences any conduct which brings about the death, or accelerates the death, of a person who is already suffering from a disorder or disease (Section 268), or assists or counsels another to bring about their own death (Section 311). It is, in the main, these provisions that concern health professionals who are involved in the end-of-life care of their patients. It is to these areas of the criminal law that nurses and medical practitioners refer when addressing the clinical decisions about how pain relief of the terminally ill patient is to be managed, whether CPR is to be initiated and how aggressively they are to treat secondary conditions. Amendments to the Criminal Code Act have attempted to clarify some of the issues that are particularly relevant to the administration of pain relief and the delivery of palliative care. Section 282A states that a person will not be criminally responsible for providing palliative care if that care is:

- provided in good faith with reasonable care and skill
- reasonable having regard to the person's state at the time and the circumstances of the case; and
- provided by a doctor . . . or ordered by a doctor who confirms the order in writing.

Though the section expressly prohibits any action taken to intentionally bring about the death of a patient, it provides protection from criminal action where the incidental effect of providing palliative care is to hasten the patient's death. In their application the provisions are referable to "good medical practice" defined within the Australian context of recognised medical standards and procedures.

In cases where health care institutions have sought directions from the courts in relation to the removal or withholding of life-sustaining measures, it has been to clarify their legal position in relation to the potential for criminal proceedings. The case law in these circumstances has consistently indicated that health professionals are under no legal duty to administer treatment which is futile, has no medical or therapeutic benefit and where the effect is only to prolong the dying process of the patient.^{39,40} In circumstances

where there was no Advance Health Directive and the patient had lost their capacity to give a valid refusal of treatment, the courts have considered the obligations of the health professionals in light of what was in the patient's best interests. In *Airedale NHS Trust v Bland*,⁴¹ where the patient was in a persistent vegetative state, Lord Goff said:

It is scarcely consistent with the primacy given to self determination in these cases in which a patient of sound mind has declined to give his consent, that the law should provide no means of enabling treatment to be withheld in appropriate circumstances where the patient is in no condition to indicate, if that was his wish, that he did not consent to it.

In *Northbridge v Central Sydney Area Health Service*,⁴² O'Keefe J stated the patient had the right to receive "ordinary, reasonable and appropriate (as distinct from extraordinary, excessively burdensome, intrusive or futile) medical treatment, sustenance, and support."

The *Coroners Act 2003* (Qld) identifies the death of involuntary patients who are detained in a mental health service under the Mental Health Act as "deaths in care" and therefore "reportable deaths" under Section 8 of the Act. The legislation imposes a statutory duty on health professionals to report the death to the Coroner who then initiates the necessary process as dictated under the Act (Section 11). On receiving notification, the Coroner is required to investigate the death of the patient and, in doing so, may seek assistance in terms of requiring a person to give verbal information, seek the production of documents or the release of confidential information. The investigation by the Coroner within the mental health context is directed to protecting the rights of involuntary mental health patients who, through their illness, may lack capacity. It is important therefore that health professionals working in the area of mental health are mindful that all action undertaken as part of the coronial process is directed to this aim. Where the outcome of the investigation is that the patient died

“in care” in circumstances that raise issues about the deceased person’s treatment and care the Coroner will hold an inquest (Section 27). Though the Coroner does not have the legal ability to make findings as to guilt or innocence, he or she may make recommendations to health care institutions and professional regulatory authorities, as well as the Department of Public Prosecution, as to what, if any, action should be initiated based on the inquest findings.

Implication for practitioners

While the discussion thus far has focused specifically on the Queensland legal framework, there is similar legislation in the other Australian jurisdictions. All states and territories have enacted legislation establishing the office of the Coroner and prescribing the roles and functions of the Coroners and the Coroner’s Courts. As described in relation to the Queensland context, the legislation in each of the other jurisdictions, though not identical, identifies certain deaths as “reportable” to the Coroner. For example in Victoria, section 3 of the *Coroners Act 1985* requires the reporting of the death of a “person held in care”, defined as a person who is “a patient in an approved mental health service within the meaning of the *Mental Health Act 1986*”. The Coroners Acts in the Northern Territory, Tasmania, Western Australia and South Australia have similar provisions. Section 13 of the *Coroners Act 1980* (NSW) states:

Coroner has jurisdiction to hold an inquest concerning the death if it appears to the Coroner or the Coroner has reasonable grounds to suspect . . . the person died while in or temporarily absent from a hospital within the meaning of the *Mental Health Act 1990* and while the person was a resident at the hospital for the purpose of receiving care.

While there is not the same degree of consistency between Queensland and the other jurisdictions in relation to the palliative care provisions (as contained in the *Criminal Code Act 1899* [Qld]), the case law recognises the principle of

“double effect” and the significance of the intention to relieve pain despite the fact that the pain relieving drugs may also have the effect of hastening death. The focus of the law is on the appropriateness of the care and treatment for each individual patient. Though the criminal provisions create offences in relation to the death of persons, these charges are based on the person causing the death having the requisite intention, which has no relevance to good palliative care practises.

The *Medical Treatment Act 1988* (Vic), *Medical Treatment Act 1994* (ACT), *Consent to Palliative Care Act 1995* (SA) and *Natural Death Act 1988* (NT) make provision for legally competent adults to refuse treatment in circumstances prescribed by the respective legislation. Where the patient is suffering from a terminal illness in the mental health context, however, the situation with respect to their legal capacity and competency to refuse treatment mirrors that in relation to the application of the provisions of the *Powers of Attorney Act 1997* (Qld). Across all jurisdictions there are similar practical obstacles to the application of legislation which promotes self-determination in a clinical context in which capacity and competency is frequently difficult to assess.

For mental health practitioners caring for a mental health patient in an institutional setting, an understanding of the legal framework is important in clarifying and highlighting a number of significant issues raised by the participants in this study. First, in circumstances in which involuntary mental health patients are suffering from terminal illnesses and clear decisions about end-of-life management must be made, the relevant sections of the *Criminal Code Act 1899* (Qld) provide protection for those health professionals who deliver palliative care in accordance with the legislation. Where the medical opinion is that given the advanced terminal condition of the patient further active treatment is futile and not in the best interests of the patient, there is no legal imperative that demands continuation of sustaining life treatment or, as it has been described, treatment which serves only to prolong death.

Second, the mandatory nature of the Coroner's investigation and, where considered necessary, the Coroner's inquest, is protective in nature and is not intended to drive the clinical decisions of health professionals in relation to the end-of-life care of involuntary patients within the mental health system.

Finally, in the context of institutionalised mental health care services, the legal capacity of patients to consent to treatment or refuse to consent to treatment is frequently problematic. This is more so when health professionals are required to make end-of-life treatment decisions about involuntary patients who are in the advanced stages of their terminal illness or disease, where capacity may frequently arise as an issue in making decisions about that treatment. It is strongly recommended that mental health workers in such settings are informed, both in writing and through educational courses, of their legal rights and responsibilities as set out above.

Potential limitation of the research

With regard to the potential limitation of the small participant group, it is important to note that a sample of eight is considered substantial in terms of the qualitative literature. The small number is directly related to the fact that there have been few recent deaths at TPCMH, and of those only deaths not under legal consideration could be targeted. In view of such restrictions and the seminal nature of the work being undertaken, it was considered satisfactory to base the findings set out in this article on a sample of eight. As there is no other work completed on palliative care and mental health, these interviews provide a unique opportunity to begin to place important ethico-legal issues on the agenda.

Conclusion

The insights from a concerned group of mental health practitioners point to the importance of a clear understanding of the legal framework for end-of-life care in a psychiatric institutional setting. Our hope and expectation is that the clarifi-

cation of the legal issues as outlined in this article will make a contribution to ensuring that mental health patients in an institutional psychiatric setting "will be treated with respect, dignity and with due regard to their cultural and spiritual needs".³⁷

Competing interests

The authors declare that they have no competing interests.

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