Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Ethics of treatment in correctional services

SCEP-EuroPris workshop on “Mental health in prison and probation”

Prof. Harry Kennedy, executive clinical director HSE National Forensic Mental Health Service, and
Clinical Professor of Forensic Psychiatry, Trinity College Dublin, Ireland

PATHWAYS MANAGEMENT

ACTIVE MANAGEMENT OF LENGTH OF STAY

WHO TO ADMIT

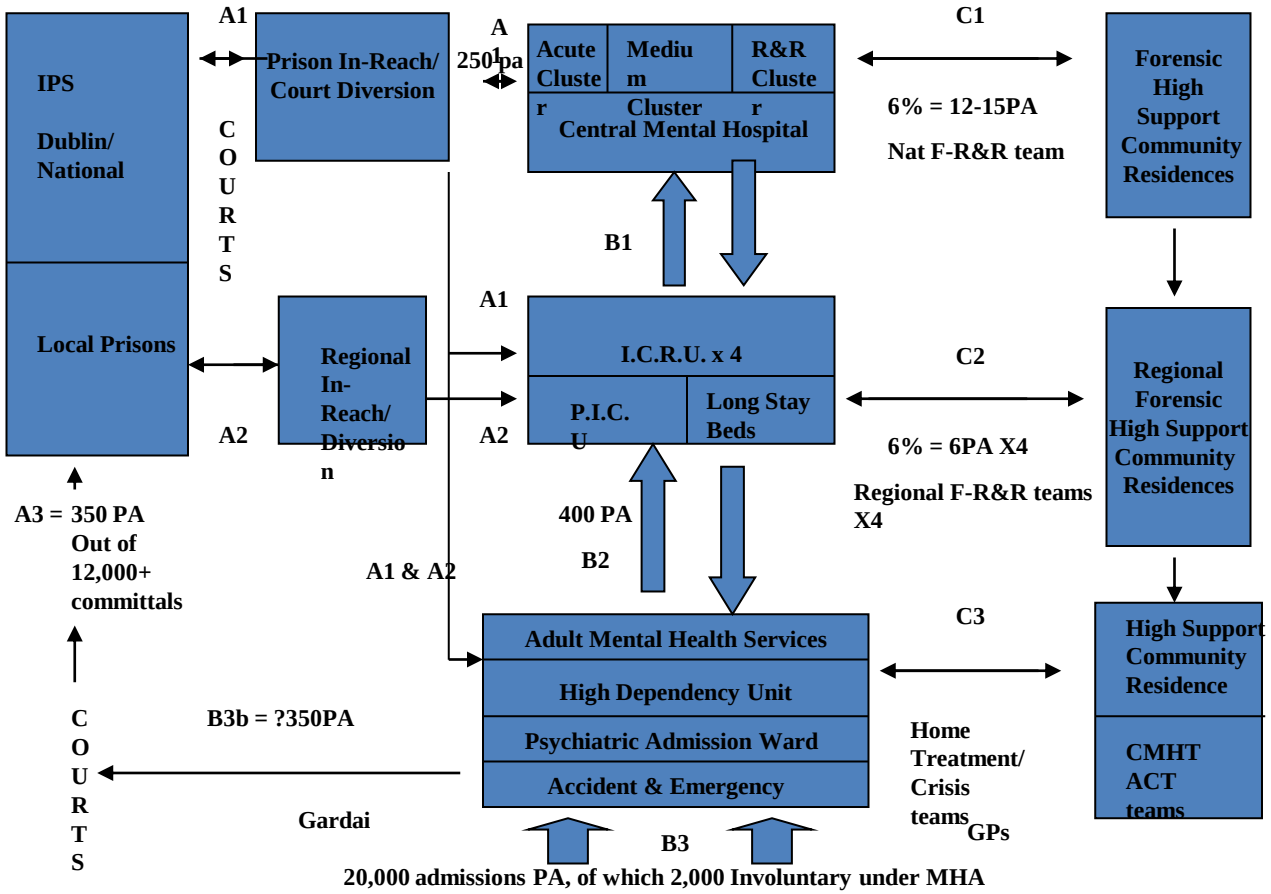
- AND TO WHERE

WHO TO ALLOW DAY LEAVE

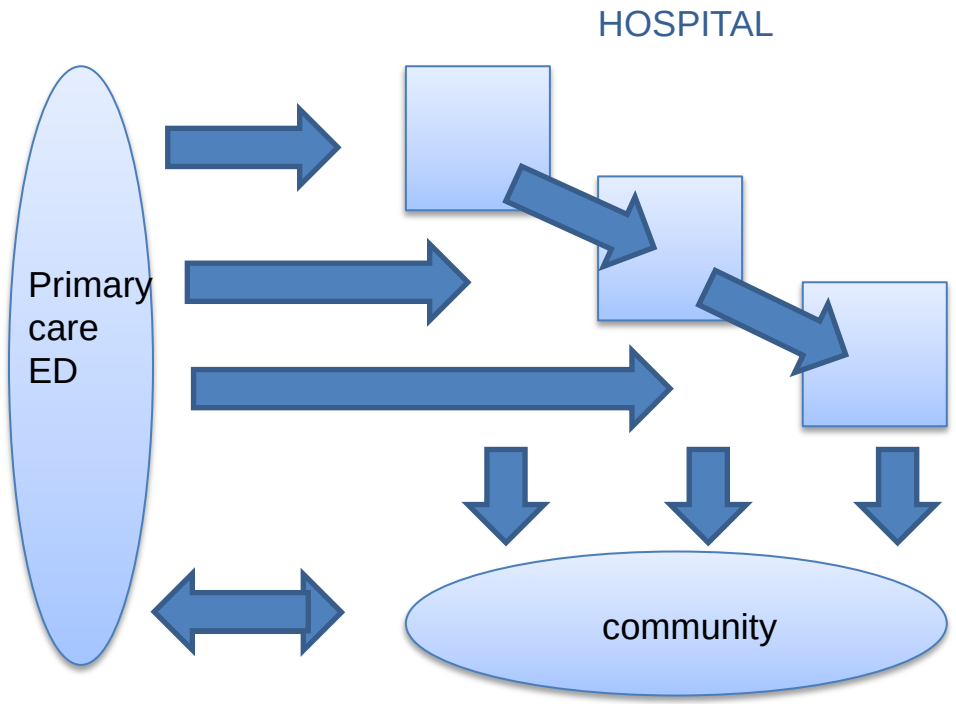
WHO TO CONDITIONALLY DISCHARGE

- AND TO WHERE

Service Model – Adult Mental Health + Forensic Mental Health



Mental Health Pathways in the Community



PICU?

Admission ward

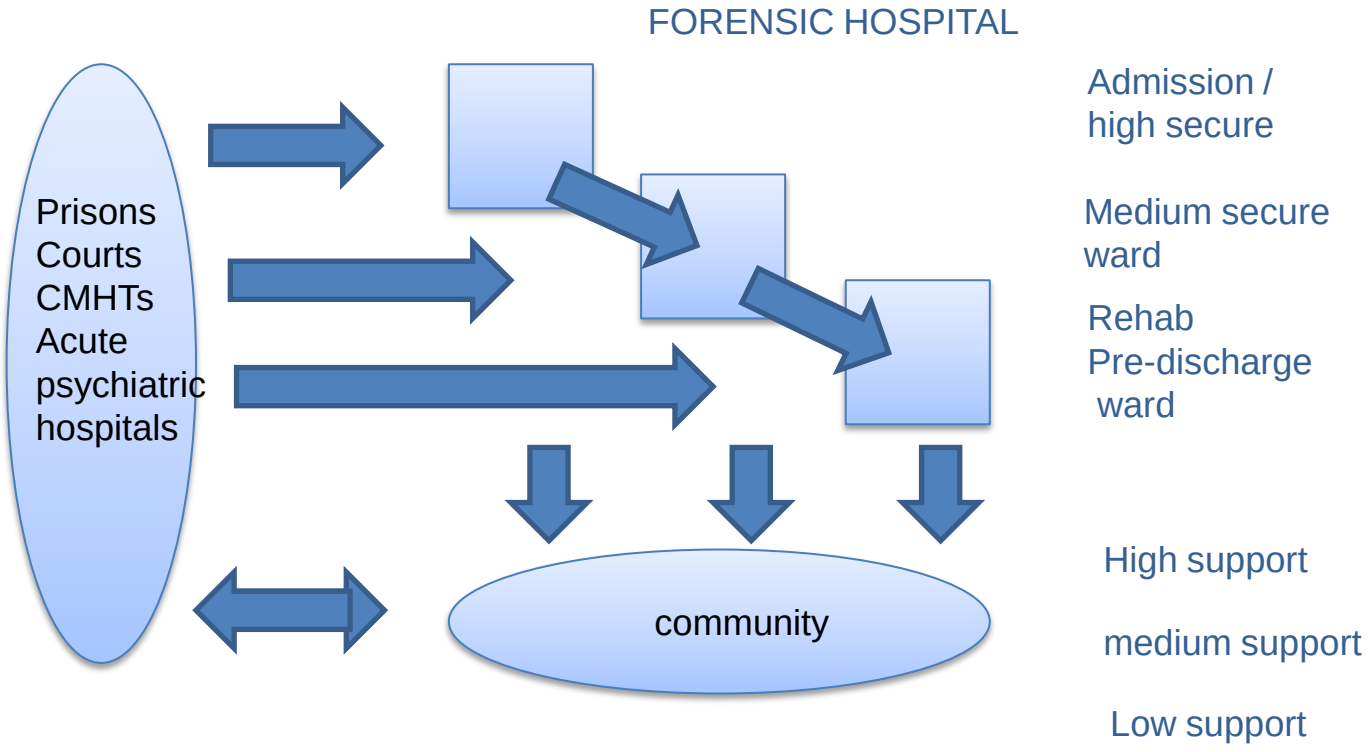
Rehab ward

High support

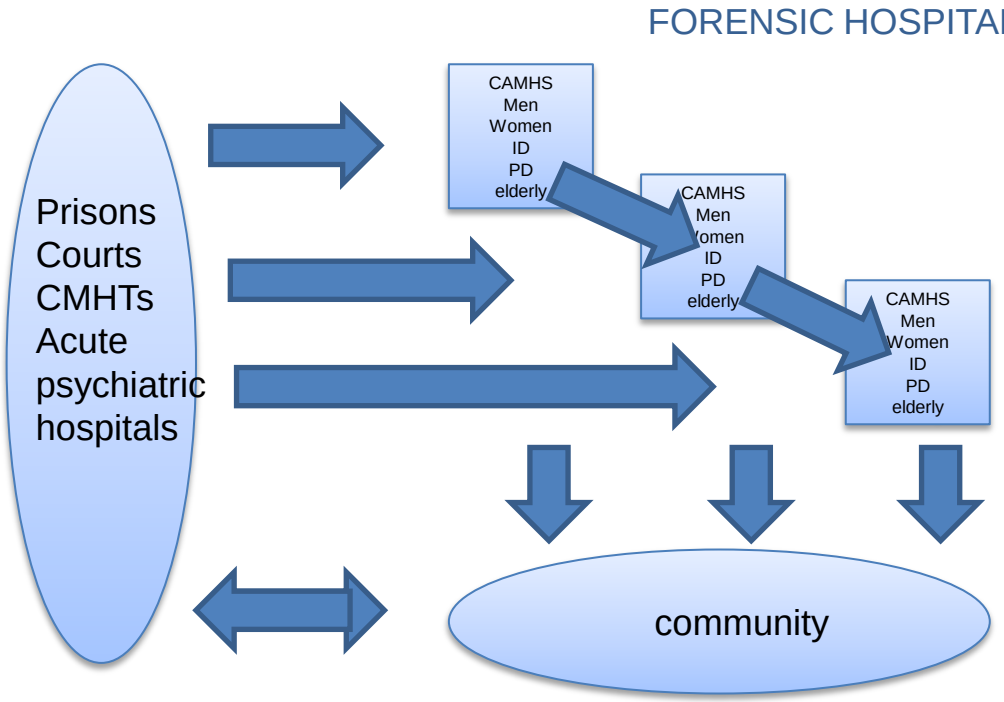
medium support

Low support

Forensic Mental Health Pathways



Forensic Mental Health Pathways



Admission / high secure

Medium secure ward

Rehab
Pre-discharge ward

High support

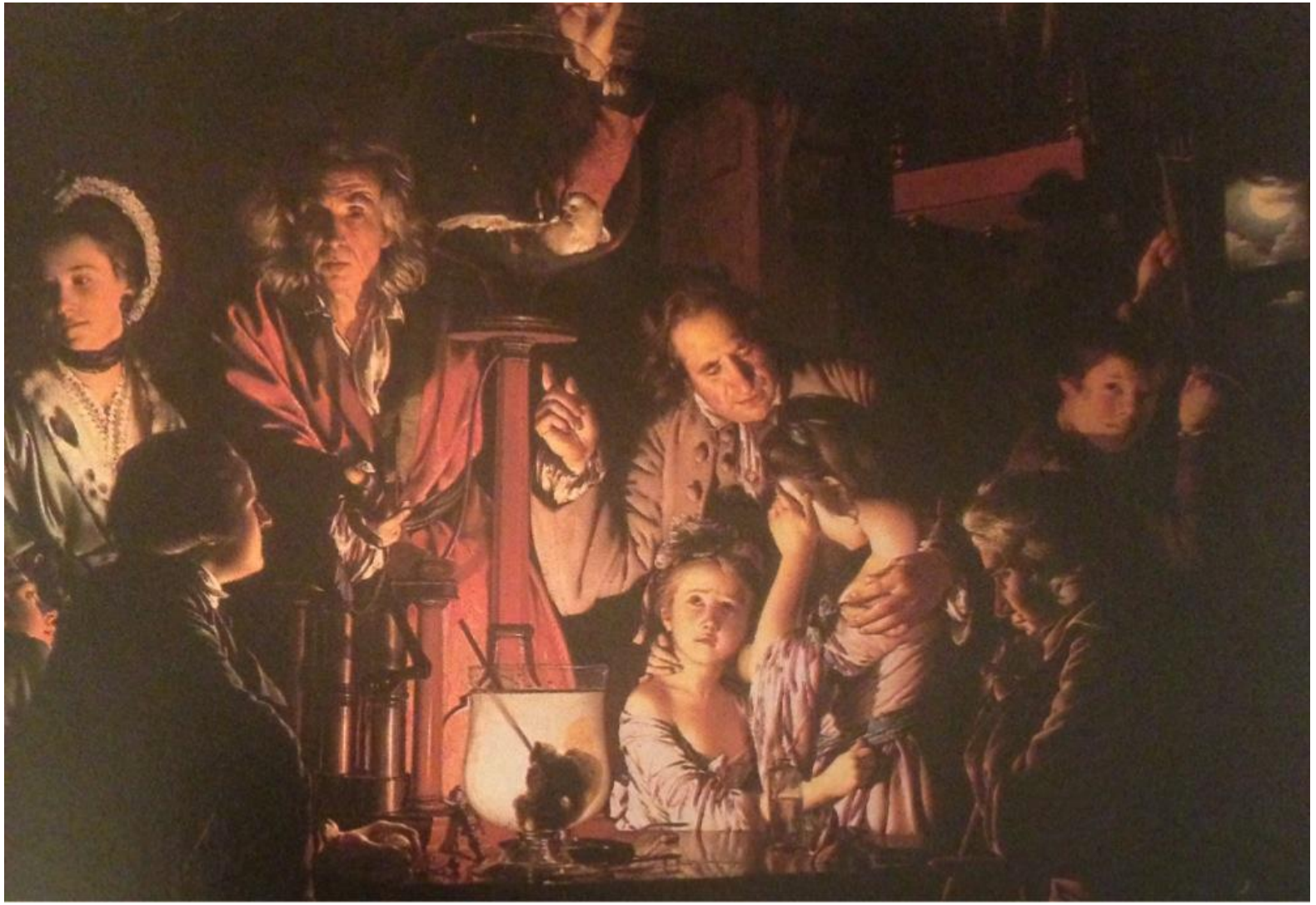
medium support

Low support

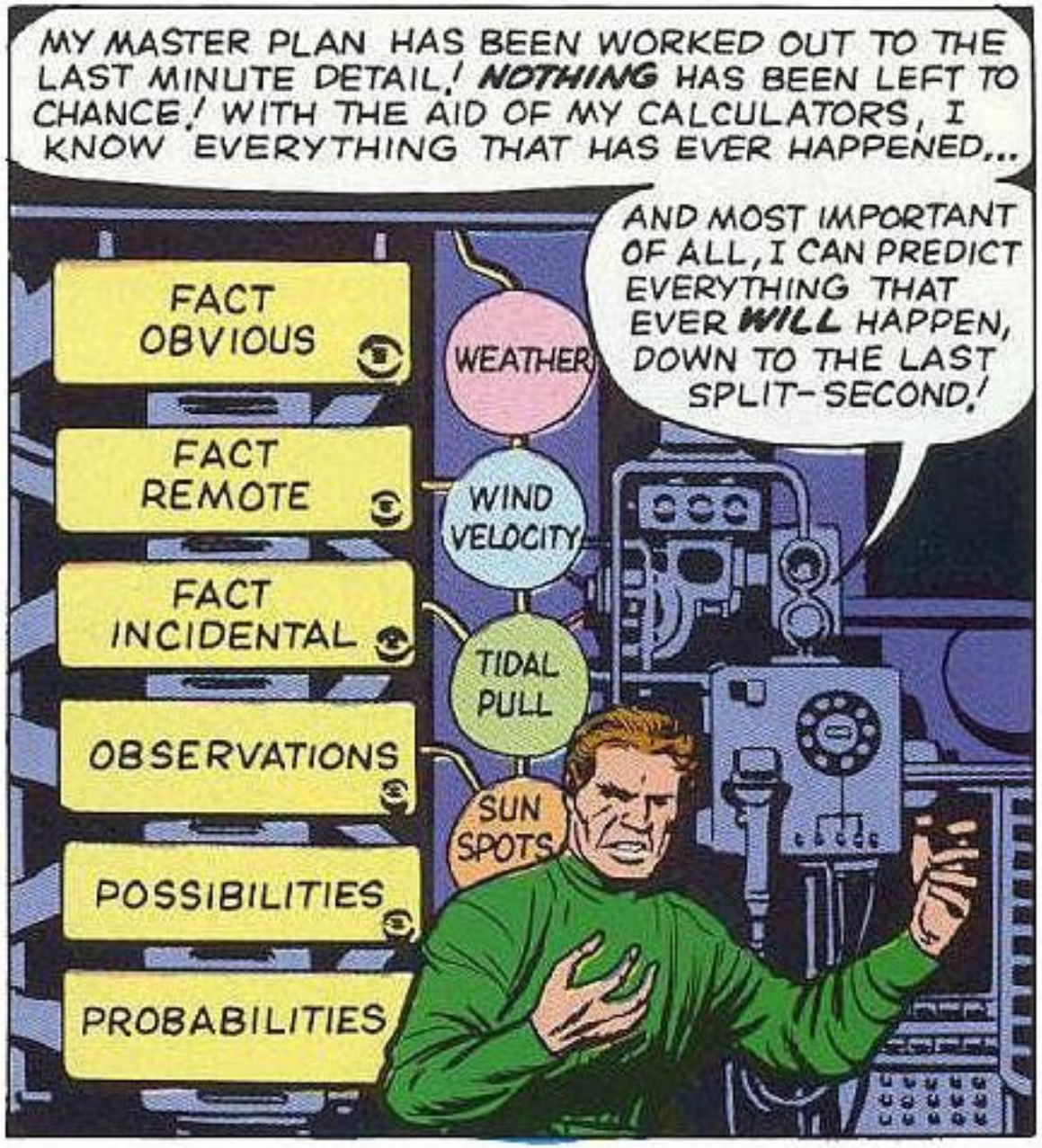
THE MODERN HISTORY OF RISK

“Dangerousness is a dangerous concept” according to Shaw (1973).

Scott (1977) quoted Shaw but went on to define dangerousness as the product of probability (risk) and gravity (seriousness).



Joseph Wright of Derby: An experiment with an air pump 1770


MY MASTER PLAN HAS BEEN WORKED OUT TO THE LAST MINUTE DETAIL! NOTHING HAS BEEN LEFT TO CHANCE! WITH THE AID OF MY CALCULATORS, I KNOW EVERYTHING THAT HAS EVER HAPPENED...
AND MOST IMPORTANT OF ALL, I CAN PREDICT EVERYTHING THAT EVER WILL HAPPEN, DOWN TO THE LAST SPLIT-SECOND!
FACT OBVIOUS
FACT REMOTE
FACT INCIDENTAL
OBSERVATIONS
POSSIBILITIES
PROBABILITIES
WEATHER
WIND VELOCITY
TIDAL PULL
SUN SPOTS

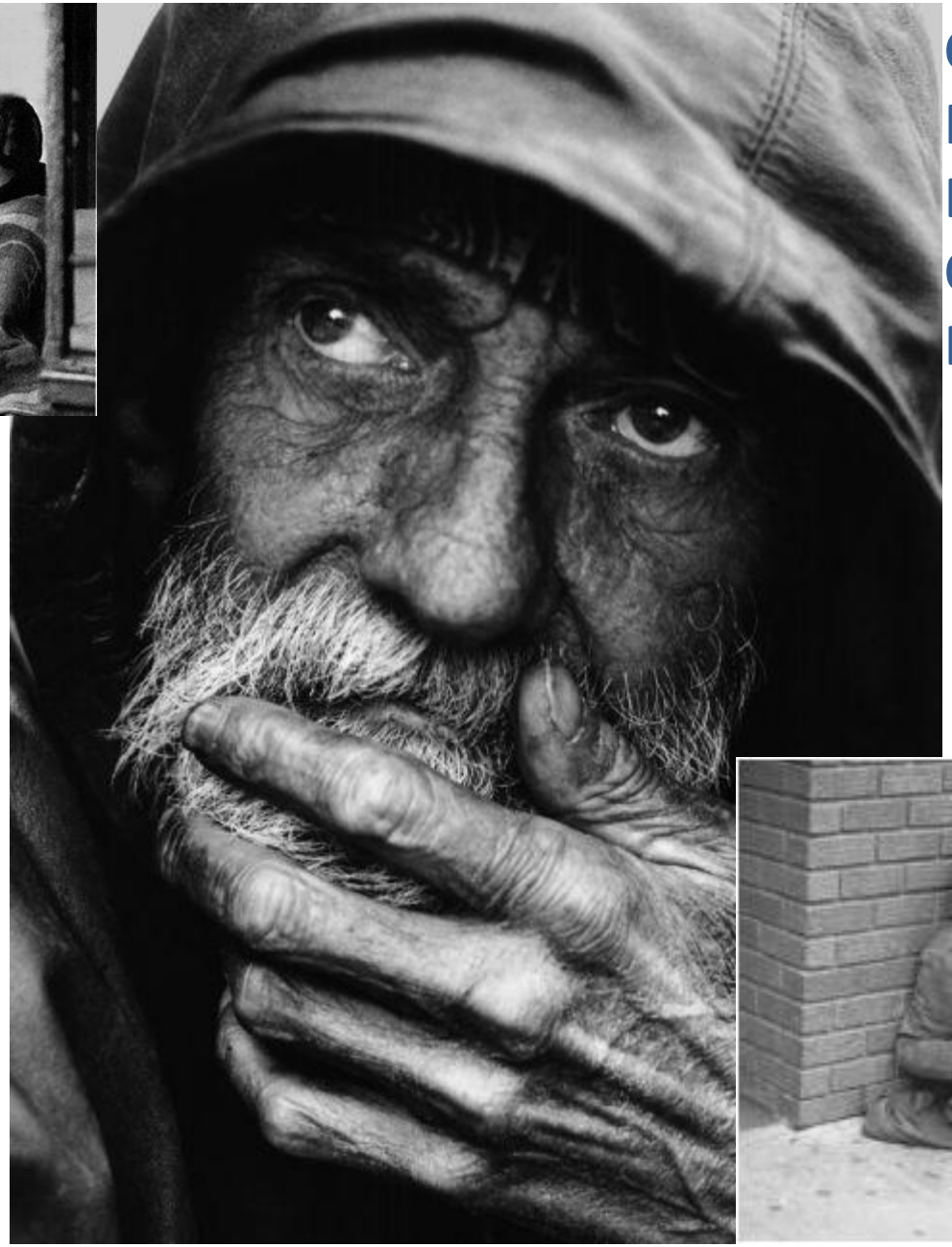
William Hogarth: The Rake’s Progress: Bedlam 1735

Francisco Goya: The Madhouse 1815

THE FATHER OF MODERN MENTAL HEALTH POLICY

THE POLICY OF DECARCERATION
WAS IMPLEMENTED BY POLITICIANS
ON FINANCIAL / ECONOMIC GROUNDS.

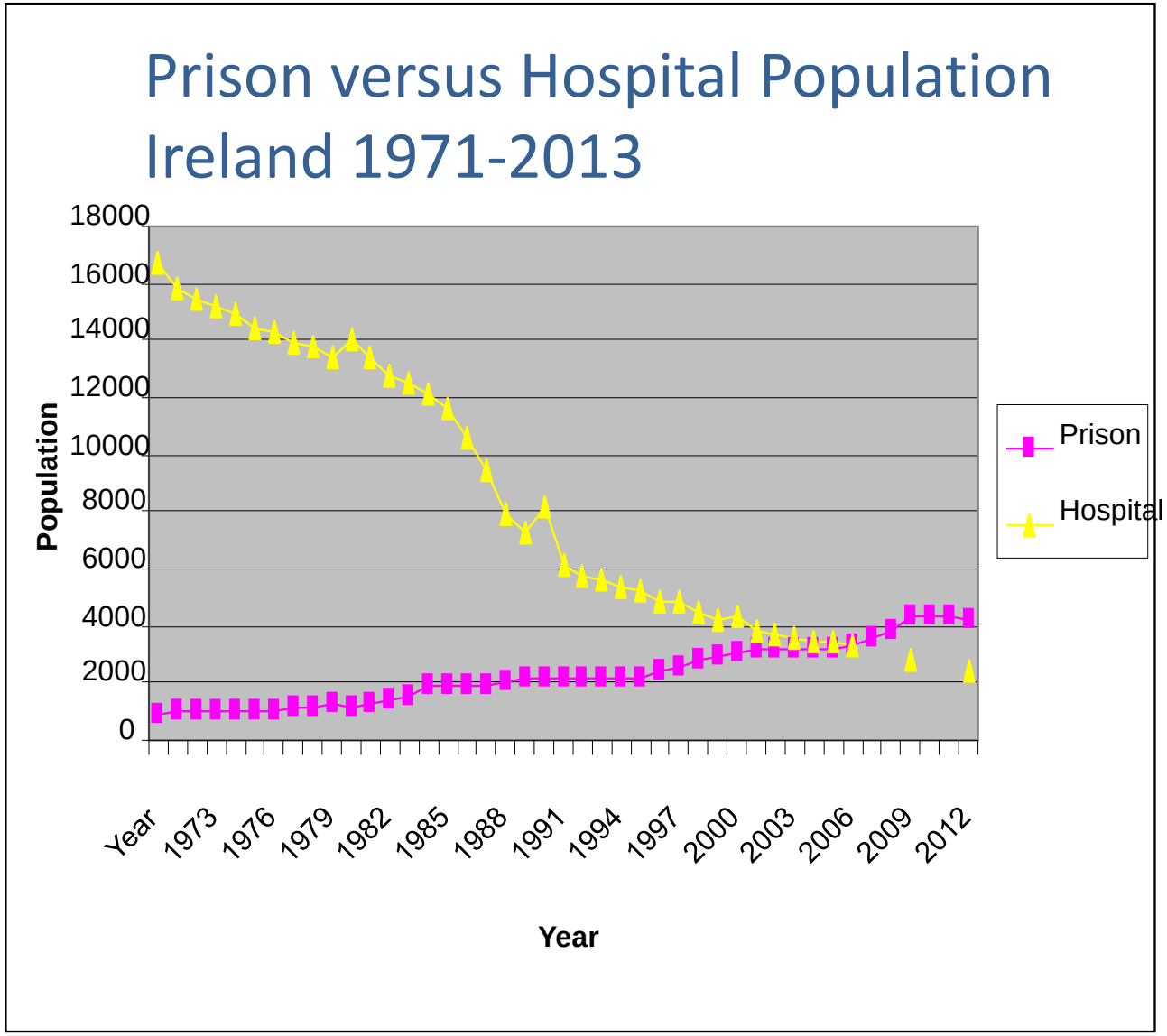
Enoch Powell



COMMUNITY PSYCHIATRY – DECARCERATION OR DIGNITY?

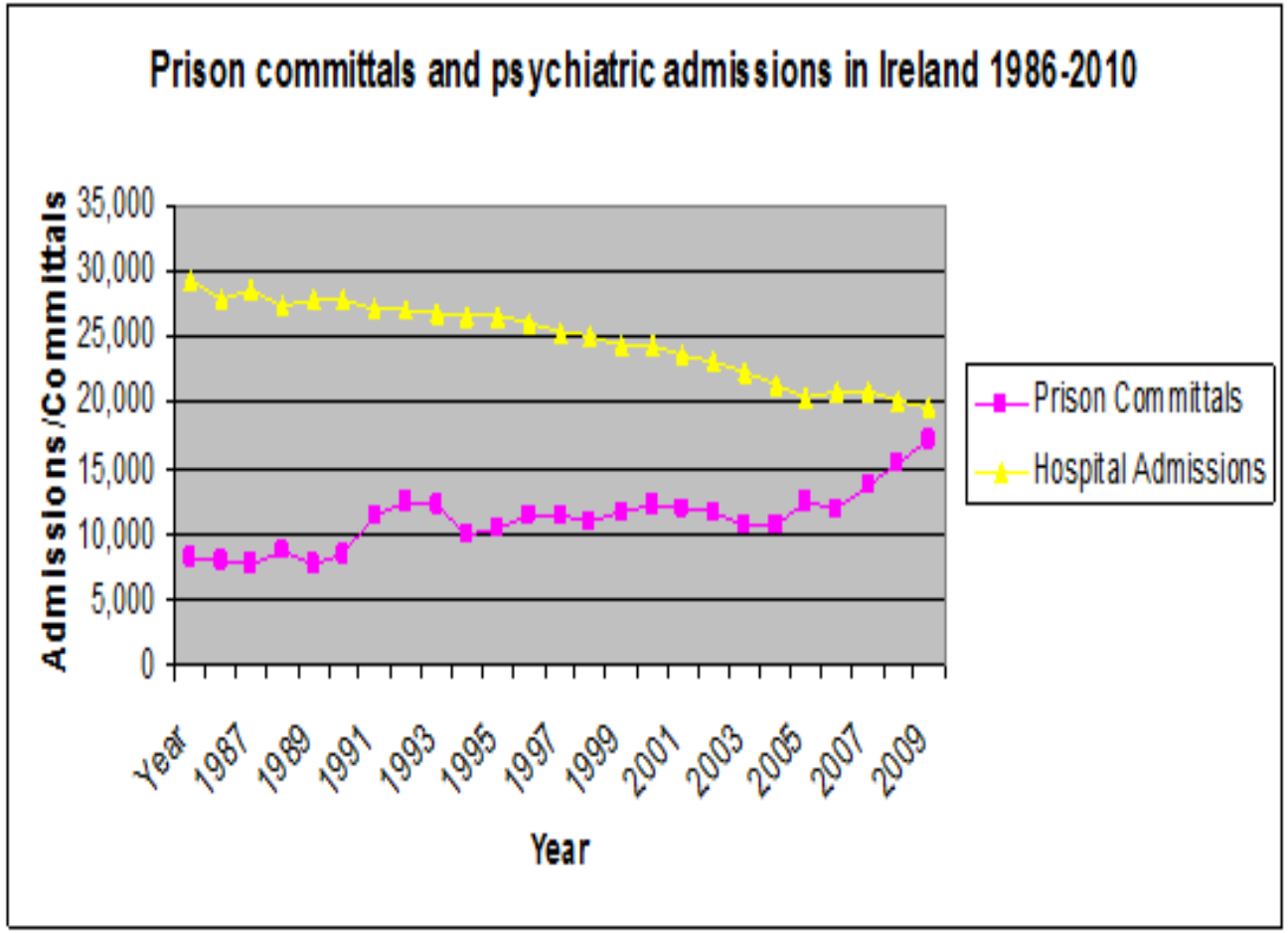
TRANSINSTITUTIONALISATION AND RE-INSTITUTIONALISATION (Priebe)

PENROSE:
NUMBER OF
PSYCHIATRIC IN-PATIENTS
AND PRISONERS IN
IRELAND,
1971-2013



Brendan Kelly, IMJ 2007, 100(2);373-374
& Conor O'Neill, up-dated.

PENROSE: NUMBER OF PSYCHIATRIC AND PRISONER COMMITTALS AND RECEPTIONS IN IRELAND, 1984-2009



Psychosis is found in prisoners around the world at remarkably constant rates

Articles

Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys

Seena Fazel, John Danesh

Summary

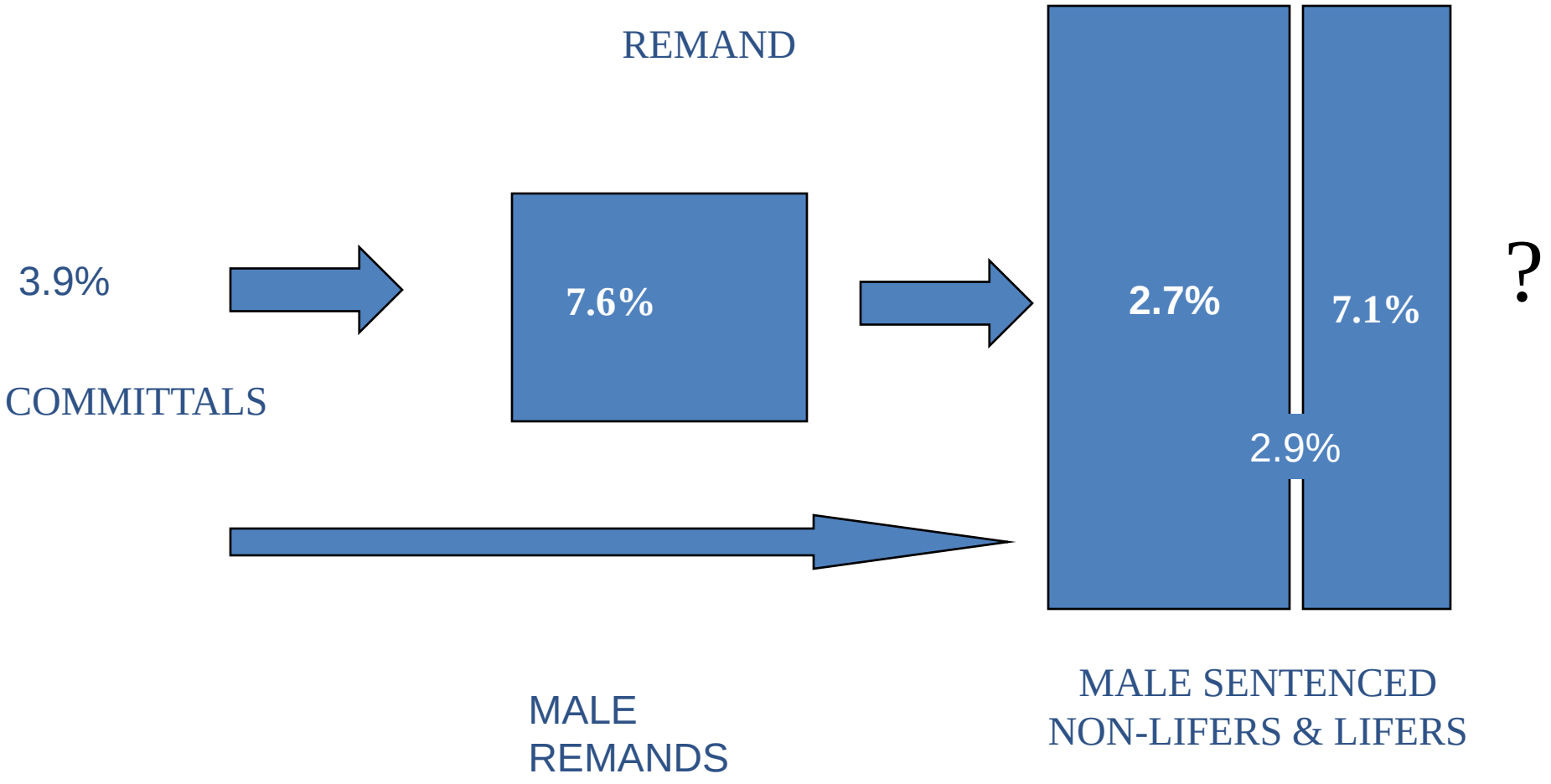
Background About 9 million people are imprisoned worldwide, but the number with serious mental disorders (psychosis, major depression, and antisocial personality disorder) is unknown. We did a systematic review of surveys on such disorders in general prison populations in western countries.

Methods We searched for psychiatric surveys that were based on interviews of unselected prison populations and included diagnoses of psychotic illnesses or major depression within the previous 6 months, or a history of any personality disorder. We did computer-assisted searches, scanned reference lists, searched journals, and corresponded with authors. We determined prevalence

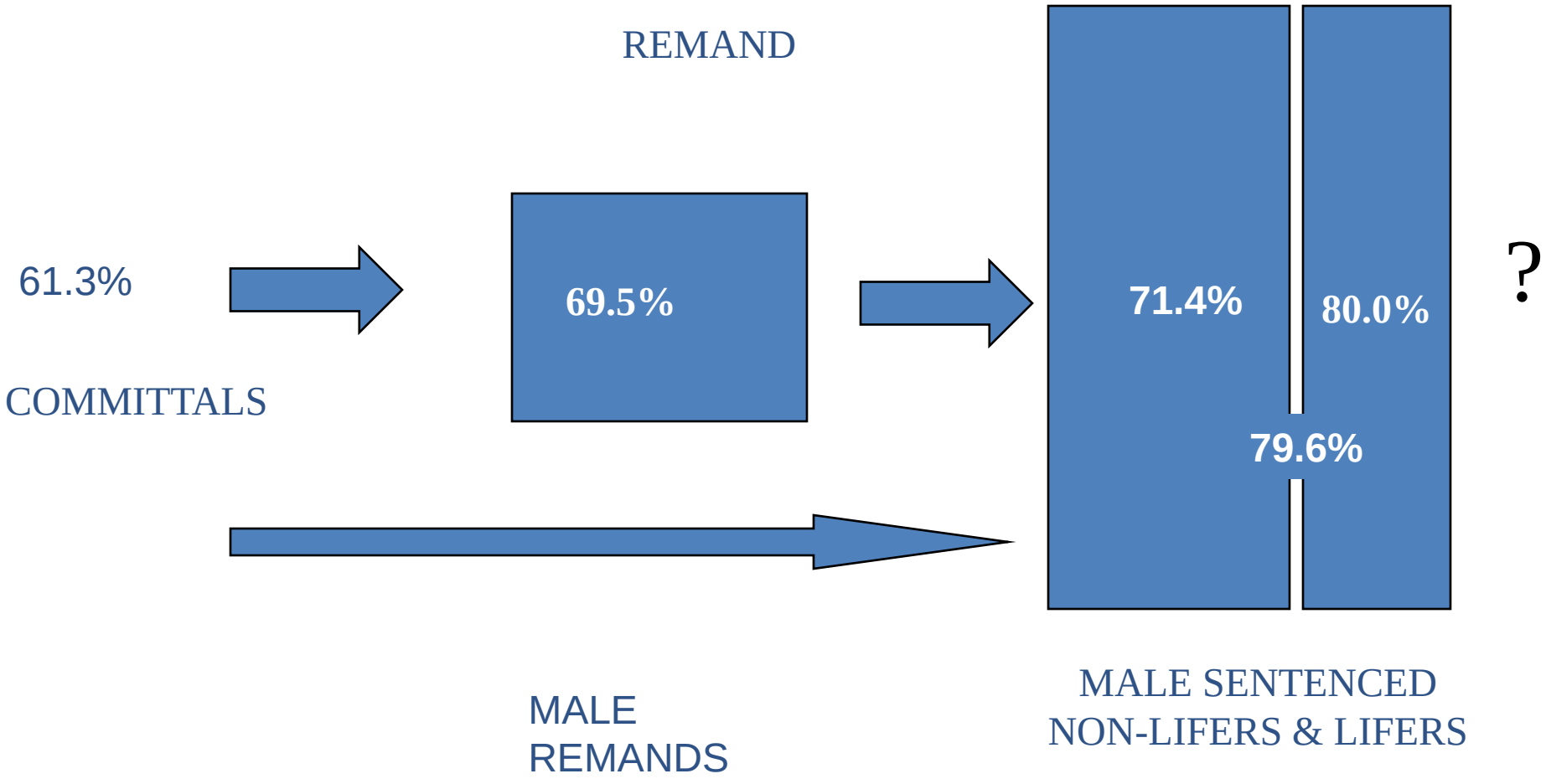
Introduction

About 9 million people are imprisoned worldwide, including 2 million in the USA and 70 000 in the UK.[1] Many psychiatric surveys have been done in prisons, but they have generally been small, have often included selected populations (such as prisoners referred to psychiatric services), and have not been assessed systematically. Indeed, three reviews included a total of only ten studies in general prison populations.[2–4] More reliable estimates of the prevalence rates of serious mental disorders in prisoners, such as psychotic illnesses, major depression, and antisocial personality disorder should help inform public policy and prison health services. We have done a systematic review of psychiatric surveys of people in general prison populations in western countries (with results

Psychosis in Irish prisoners: six month prevalence



Any Substance Misuse in Irish prisoners: six month prevalence



COMPARISON WITH INTERNATIONAL META-ANALYSIS.

	Irish prison study		Meta-analysis (Fazel and Danesh 2002)	
	Male Remand N=232	Male Sentenced N=438	Male Remand N=7193	Male Sentenced N=8854
Psychosis Six-month prevalence (%)	7.6 % [5.0 – 11.9]	2.7 % [1.7 – 5.0]	4% [3.6-4.5]	3% [2.7-3.4]
Major Depressive Disorder six month prevalence (%)	10.1 % [7.9 – 12.9]	5.0 % [3.3-7.5]	9% [8.4-9.7]	11% [10.4-11.7]

BJPsych | The British Journal of Psychiatry (2012)
200, 364–373. doi: 10.1192/bjp.bp.111.096370

Review article

Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis

Seena Fazel and Katharina Seewald

Background
High levels of psychiatric morbidity in prisoners have been documented in many countries, but it is not known whether rates of mental illness have been increasing over time or whether the prevalence differs between low–middle-income countries compared with high-income ones.

Aims
To systematically review prevalence studies for psychotic illness and major depression in prisoners, provide summary estimates and investigate sources of heterogeneity between studies using meta-regression.

Method
Studies from 1966 to 2010 were identified using ten

models, and we found a pooled prevalence of psychosis of 3.6% (95% CI 3.1–4.2) in male prisoners and 3.9% (95% CI 2.7–5.0) in female prisoners. There were high levels of heterogeneity, some of which was explained by studies in low–middle-income countries reporting higher prevalences of psychosis (5.5%, 95% CI 4.2–6.8; $P=0.035$ on meta-regression). The pooled prevalence of major depression was 10.2% (95% CI 8.8–11.7) in male prisoners and 14.1% (95% CI 10.2–18.1) in female prisoners. The prevalence of these disorders did not appear to be increasing over time, apart from depression in the USA ($P=0.008$).

Conclusions

Psychiatric hospital bed numbers have fallen across the developed world

BMJ Open

How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990

Winnie S Chow, Stefan Priebe

To cite: Chow WS, Priebe S. How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. *BMJ Open* 2016;**6**:e010188. doi:10.1136/bmjopen-2015-010188

► Prepublication history for this paper is available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2015-010188).

Received 7 October 2015
Revised 22 December 2015
Accepted 25 January 2016

ABSTRACT

Objectives: It has been suggested that since 1990, de-institutionalisation of mental healthcare in Western Europe has been reversed into re-institutionalisation with more forensic beds, places in protected housing services and people with mental disorders in prisons. This study aimed to identify changes in the numbers of places in built institutions providing mental healthcare in Western Europe from 1990 to 2012, and to explore the association between changes in psychiatric bed numbers and changes in other institutions.

Settings and data: Data were identified from 11 countries on psychiatric hospital beds, forensic beds, protected housing places and prison populations. Fixed effects regression models tested the associations between psychiatric hospital beds with other institutions.

Results: The number of psychiatric hospital beds decreased, while forensic beds, places in protected housing and prison populations increased. Overall, the number of reduced beds exceeded additional places in other institutions. There was no evidence for an association of changes in bed numbers with changes in forensic beds and protected housing places. Panel data regression analysis showed that changes in psychiatric bed numbers were negatively associated with rising prison populations, but the significant association disappeared once adjusted for gross domestic product as

Strengths and limitations of this study

- This is a large longitudinal study on different types of institutional mental healthcare, including prison populations, forensic beds and protected housing places, in Western Europe over a period of 22 years.
- The study includes countries from different regions within Western Europe and used what are arguably the best available data.
- The analysis of associations between hospital beds and prison places considered gross domestic product as a covariate representing other societal time trends.
- The accuracy of some of the data remains questionable, data on forensic beds and protected housing places were incomplete, and definitions of the different categories of institutions vary across countries.
- The number of data points is too small for reliable time series analyses, and there are no data on the characteristics of patients in the different institutions.

Although the term 'de-institutionalisation' has been used inconsistently in the literature,

Eurostat

THESE ARE THE EUROSTAT FIGURES FOR 1990-2012.

UNFORTUNATELY EUROSTAT DOES NOT BREAK DOWN ACCORDING TO ADULT, PSYCHIATRY OF OLD AGE, PSYCHIATRIC INTENSIVE CARE UNITS OR OTHER SUB-DIVISIONS.

BUT THEY DO PROVIDE FORENSIC AND COMMUNITY BED NUMBERS.

THEY ALSO PROVIDE PRISON NUMBERS AND PRISON NUMBERS ARE ALSO AVAILABLE FROM SALIZE'S GROUP IN MANNHEIM.

Fig. 1: Psychiatric hospital beds per 100,000 inhabitants from 1990-2012

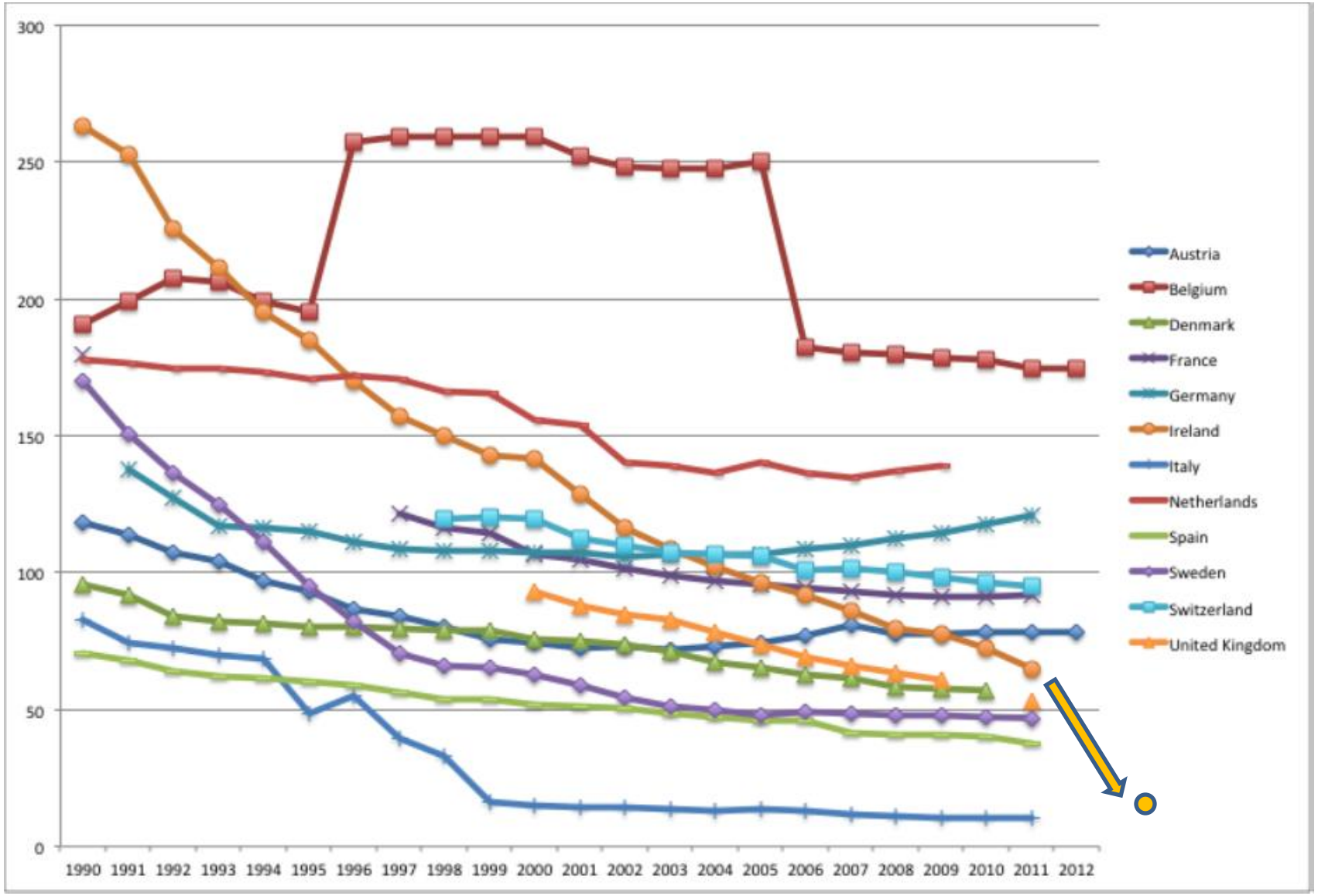


Figure 2. Prison Population per 100,000 inhabitants from 1990-2012

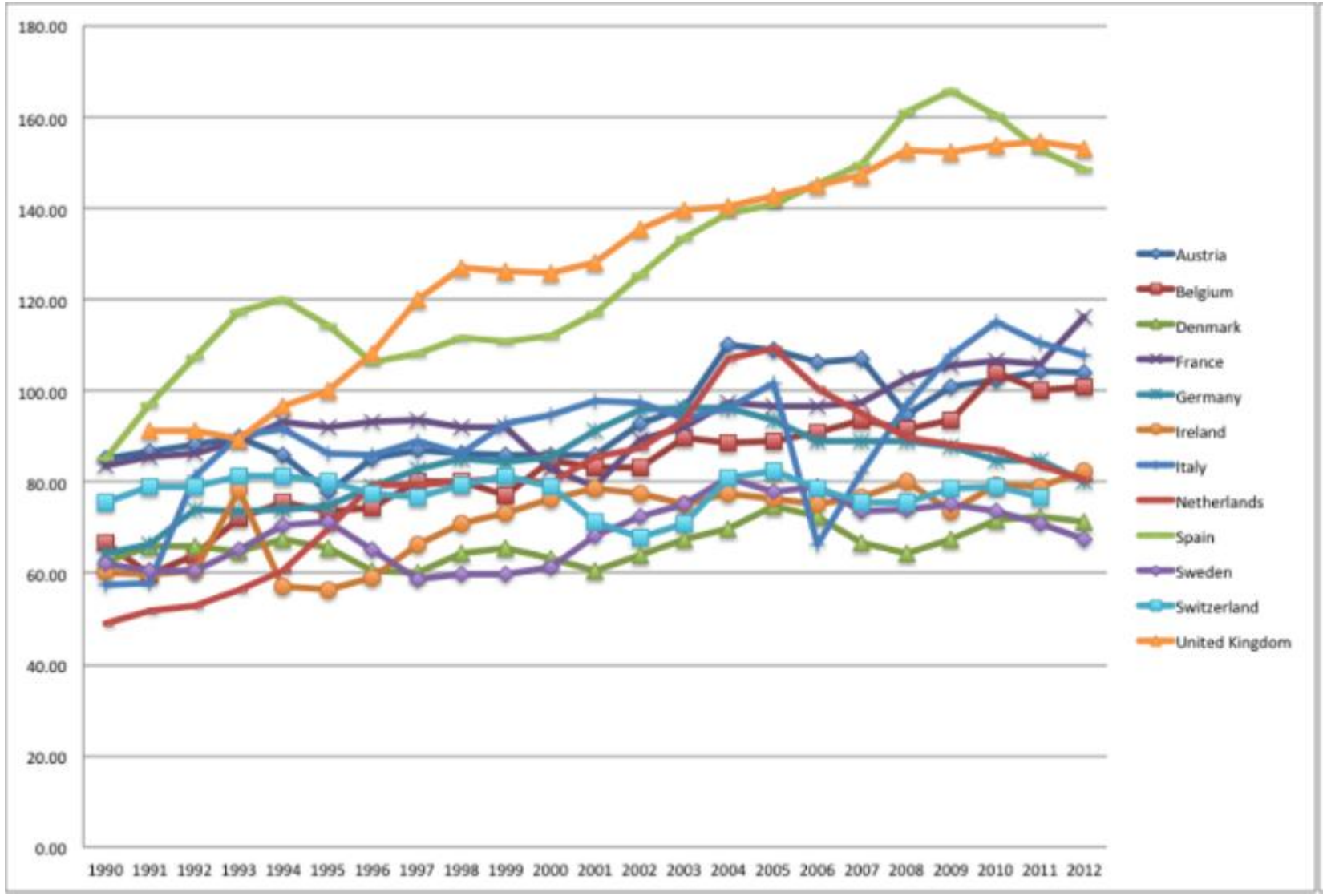
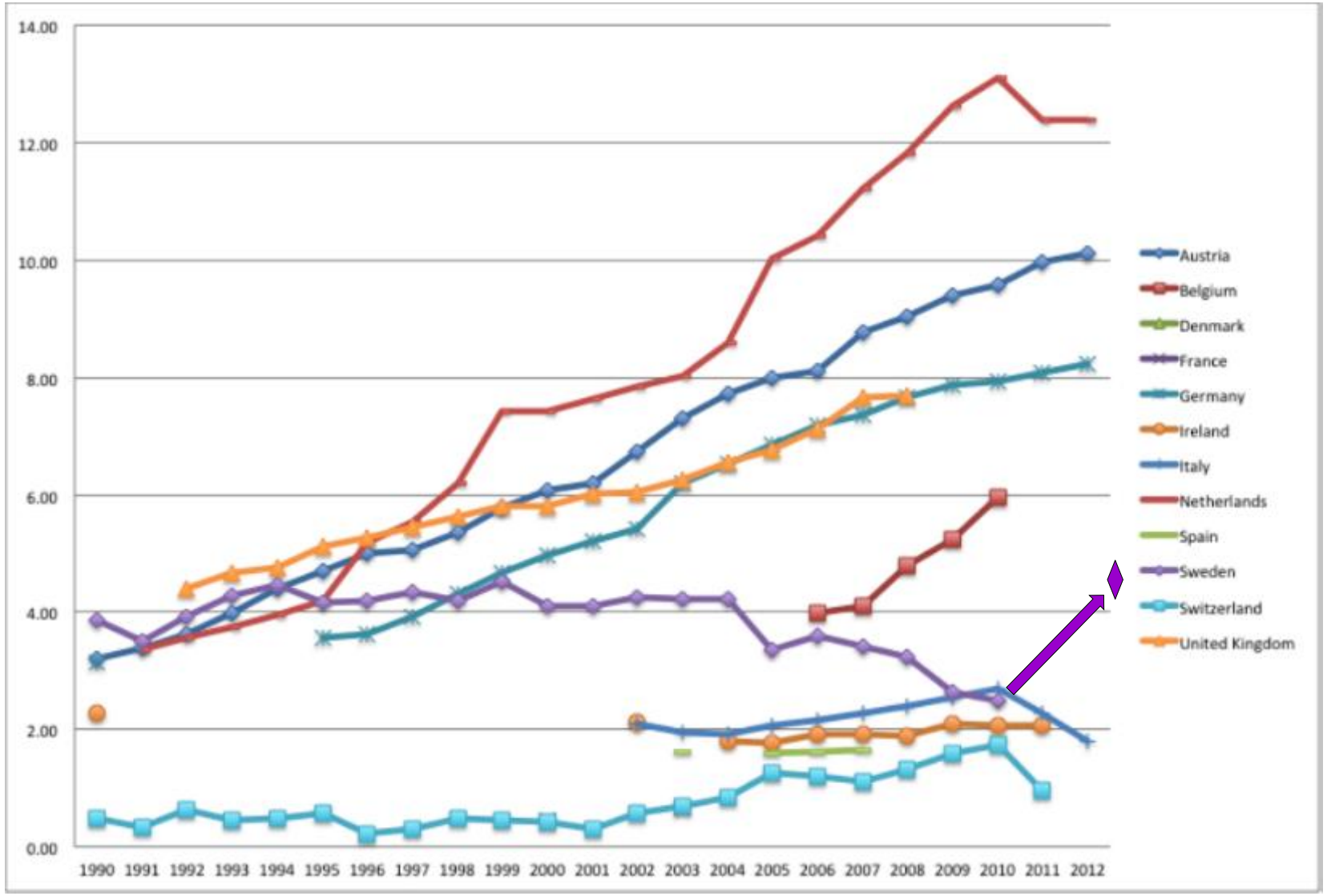


Figure 3. Forensic beds per 100, 000 inhabitants from 1990-2012



Acta Psychiatr Scand 2007: 116: 334–344

DOI: 10.1111/j.1600-0447.2007.01077.x

ACTA PSYCHIATRICA SCANDINAVICA

The role of mental disorder in attacks on European politicians 1990–2004

James DV, Mullen PE, Meloy JR, Pathé MT, Farnham FR, Preston L, Darnley B. The role of mental disorder in attacks on European politicians 1990–2004.

Objective: The only systematic studies of attacks on public figures come from the USA. These studies de-emphasize the role of mental illness and suggest threats are of no predictive value. This study re-examines these questions through a study of attacks on European politicians.
Method: All non-terrorist attacks on elected politicians in Western Europe between 1990 and 2004 were analysed.
Results: Twenty-four attacks were identified, including five involving fatalities, and eight serious injuries. Ten attackers were psychotic, four drunk, nine politically motivated and one unclassifiable. Eleven attackers evidenced warning behaviours. The mentally disordered, most of whom gave warnings, were responsible for most of the fatal and seriously injurious attacks.
Conclusion: A greater awareness of the link between delusional

D. V. James[1], P. E. Mullen[2], J. R. Meloy[3], M. T. Pathé[4], F. R. Farnham[1], L. Preston[1], B. Darnley[1]

[1]North London Forensic Service, London, UK,[2]Thomas Embling Hospital, Fairfield, Vic., Australia, [3]Forensis Inc., San Diego, CA, USA and [4]Threat Management Centre, Fitzroy, Vic., Australia

Key words: psychotic disorders; violence; assaultive behaviour

Paul E Mullen, Professor of Forensic Psychiatry, Monash University, Clinical Director, Victorian Institute of Forensic Mental Health, Thomas Embling Hospital,

Assassinations: politics, ethics, policy

NON TERRORIST ATTACKS ON EUROPEAN POLITICIANS 1990-2004 (JAMES, MULLEN ET AL)

23 ATTACKS (22 FATALITIES, 34 SIGNIFICANT INJURIES)

5 (18%) FIREARMS

8 (35%) KNIVES AND SWORDS

18 MALE

15 (55%) KNOWN PSYCHIATRIC HISTORIES (SCHIZOPHRENIA 9)

Anna Lundh
Swedish minister for Foreign affairs
Assassinated
September 2003

	High Secure	Medium Secure	Long Term Low Secure	All secure
Canada				**6.1**
Australia				**3.8**
New South Wales	1.8	1.0		2.8
The Netherlands		10.0		**>10.0**
Germany				**10.0**
England & Wales	0.8	3.6	3.2	**7.6**
Scotland (5.2m)	2.77	2.88	3.85	**9.49**
Northern Ireland (1,759,000)	?	1.93	3.58	**5.51**
Ireland CMH (4.4m)	0.64	0.73	0.79	**2.17**

SECURE FORENSIC BEDS VARIOUS JURISDICTIONS, 2011

Ethics and Forensic Pathways

Is this the least restrictive placement?

Is this level of therapeutic security proportionate to the need?

Can we preserve therapeutic relationships while

- depriving of liberty,
- Using restrictive and coercive practices
- Using substituted decision making?

V Donnelly, A Lynch, C Devlin, L Naughton, O Gibbons, D Mohan, HG Kennedy. Therapeutic alliance in forensic mental health: coercion, consent and recovery. *Irish Journal of Psychological Medicine* 2011, 28(1):21-28
V Donnelly, A Lynch, D Mohan, HG Kennedy Working alliance, interpersonal trust and perceived coercion in mental health review hearings. *International Journal of Mental Health Systems* 2011, 5:29 doi:10.1186/1752-4458-5-29.

CUSTODIAL OR THERAPEUTIC?

CUSTODIAL	**THERAPEUTIC**
Distant, non-interactive	Interactive, thinking, feeling, planning
Rewards conformity	Rewards engagement
Oriented to immediate goals of physical adjustment	Oriented to long term goal of social adjustment
Oriented towards good order and discipline now	Oriented towards recovery and rehabilitation
Physical structure constrains unwanted behaviour (bars, locks etc)	Relational structure (milieu) sustains expectations of socializing together
Ultimate goal is preventing antisocial and self-damaging behaviour during incarceration	Ultimate goal is effective autonomous functioning
Result of custodial care is institutionalisation, disability, worsening of strong pro-criminal sub-culture	Result of therapeutic care is increasing autonomy, taking responsibility for heath and pro-social orientation.

Principled

Fiat Justitia ruat caelum "*Let justice be done though the heavens fall.*"

Seneca: "Piso's justice"

In De Ira (On Anger), Book I, Chapter XVIII, Seneca tells of Gnaeus Calpurnius Piso, a Roman governor and lawmaker, when he was angry, ordering the execution of a soldier who had returned from a leave of absence without his comrade, on the grounds that if the man did not produce his companion, he had presumably killed the latter.

As the condemned man was presenting his neck to the executioner's sword, there suddenly appeared the very comrade who was supposedly murdered. The centurion overseeing the execution halted the proceedings and led the condemned man back to Piso, expecting a reprieve.

But Piso mounted the tribunal in a rage, and ordered the three soldiers to be executed. He ordered the death of the man who was to have been executed, because the sentence had already been passed; he also ordered the death of the centurion who was in charge of the original execution, for failing to perform his duty; and finally, he ordered the death of the man who had been supposed to have been murdered, because he had been the cause of the death of two innocent men.

Immanuel Kant 1724-1804

SITUATION EVALUATION

THE COURTS AND PRISONS ARE *DE FACTO* HAVING TO DEAL WITH AN INCREASING PROPORTION OF GENERAL ADULT PSYCHIATRY.

YOUNG MEN WITH ACUTE PSYCHOSIS (SCHIZOPHRENIA, BI-POLAR AFFECTIVE DISORDER) ARE CHALLENGING.

COMMUNITY MENTAL HEALTH SERVICES ARE UNABLE TO COPE WITH THOSE WHO CANNOT CONSENT TO TREATMENT AND ARE ACTIVELY HOSTILE TO HELP.

PRAGMATISM

Pragmatists contend that most philosophical topics—such as the nature of knowledge, language, concepts, meaning, belief, and science—are all best viewed in terms of their practical uses and successes.

The philosophy of pragmatism "emphasizes the practical application of ideas by acting on them to actually test them in human experiences".

Charles Peirce

META ETHICS

“Ars longa,

vita brevis,

occasio praeceps,

experimentum periculosum,

iudicium difficile.

PRIMUM NON NOCERE:

Life is short,

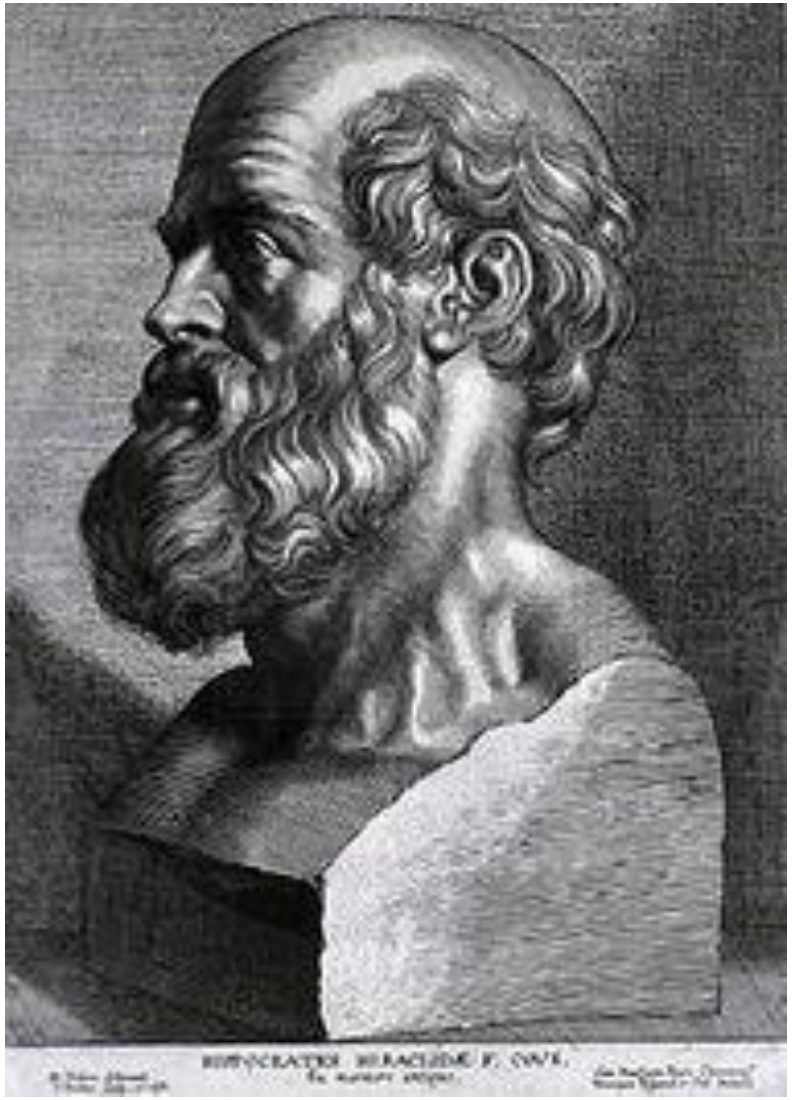
[The] art is long,

opportunity is fleeting,

experiment is dangerous,

judgment is difficult.

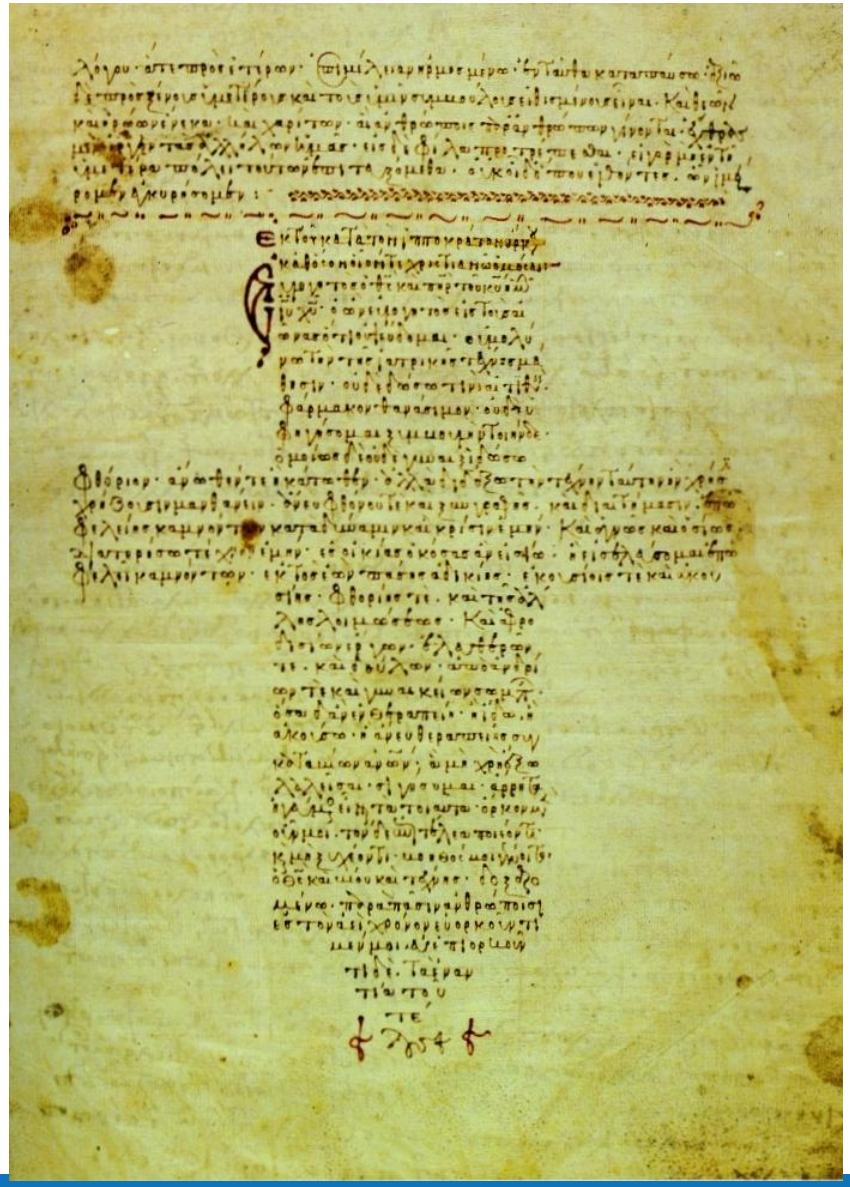
FIRST DO NO HARM”



Hippocrates

"Practice two things in your dealings with disease: either help or do not harm the patient”

Descriptive? Normative? Applied? META!



TELEOLOGICAL REASONING

Teleology or finality is a reason or explanation for something in function of its end, purpose or goal

Immanuel Kant used the concept of telos as a regulative principle in his Critique of Judgment.

penguinsyllogism.png

SYLLOGISTIC REASONING

All men are mortal.

Socrates is a man.

Therefore Socrates is mortal.

Some cats (A) are black things (B),

and some black things (B) are televisions (C),

it does not follow from the parameters that some cats (A) are televisions (C).

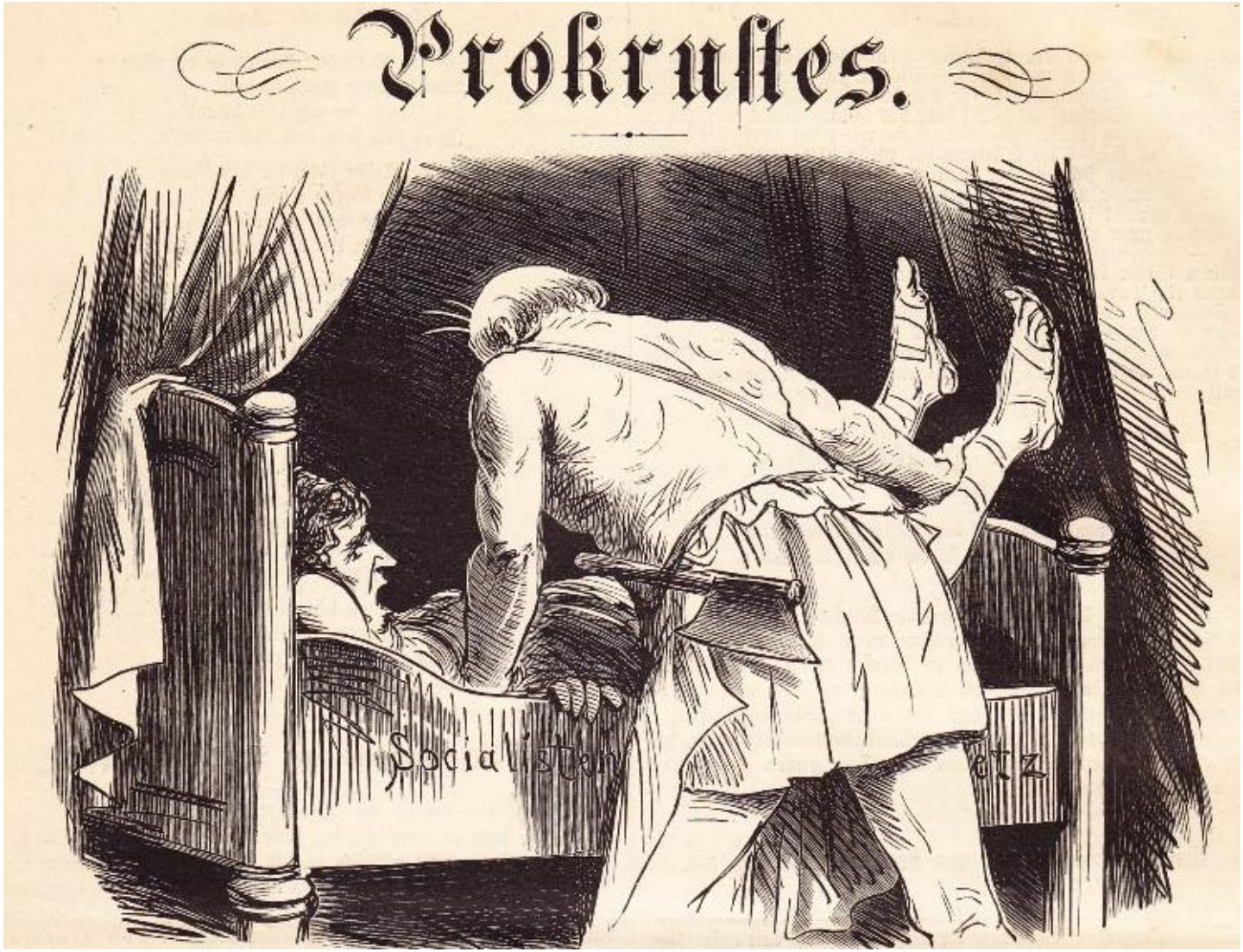
This is because in the structure of the syllogism invoked (i.e. III-1) the middle term is not distributed in either the major premise or in the minor premise a pattern called the "fallacy of the undistributed middle"

PROCRUSTES

You do not have a (mental) illness, therefore I cannot help you…I cannot help you, therefore you do not have a mental illness

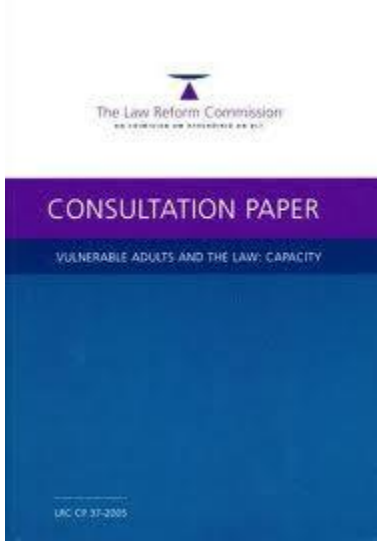
I have no hospital beds, therefore you do not need admission to hospital….

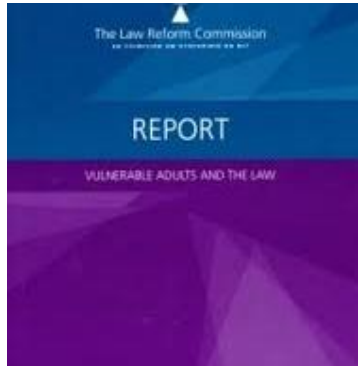
I do not have any (secure) hospital beds where you could be safely treated, therefore I cannot help you, therefore you do not have a mental illness and therefore you do not need admission to hospital….



Functional mental capacity

LAW REFORM COMMISSION/COIMISIÚN UM ATHCHÓIRIÚ AN DLÍ





AN BILLE UM CHINNTEOIREACHT CHUIDITHE (CUMAS), 2013

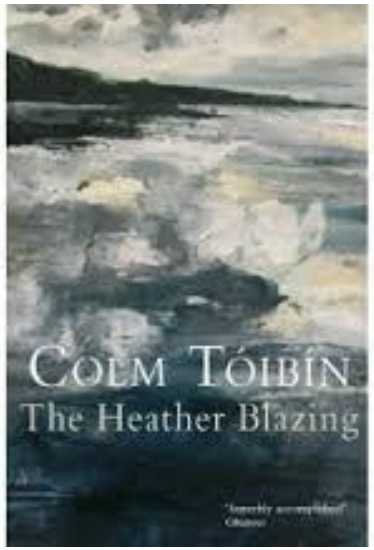
ASSISTED DECISION-MAKING (CAPACITY) BILL 2013

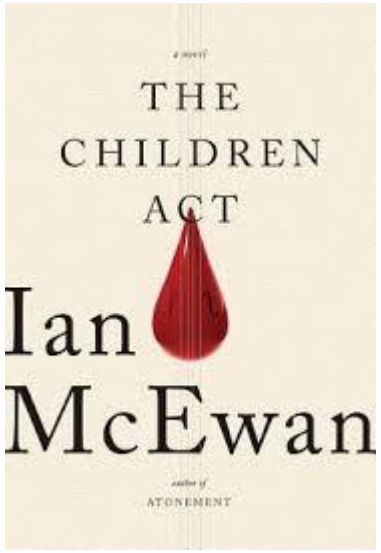
CASE LAW:

- Presumption of capacity
- Status test
- Outcome test
- Functional capacity test

Functional Mental Capacity and Best Interests

- Baroness Butler-Sloss
- Baroness Hale





PARENS PATRIAE AND FUNCTIONAL MENTAL CAPACITY

Parens patriae is a common law principle incorporated into constitutional rights

Often misinterpreted as ‘paternalism’

Actually means that the state has an obligation to protect and vindicate the rights of those who are vulnerable or incapable of acting in their own best interests.

It is generally held to be just only to make decisions for another person if that person lacks the mental capacity to make a competent decision for themselves.

The functional mental capacities necessary to make a competent decision about health, welfare or finances are

Understanding; Reasoning; Appreciation; ability to communicate the decision.

O'Reilly et al. BMC Psychiatry (2015) 15:155
DOI 10.1186/s12888-015-0548-0

BMC Psychiatry

RESEARCH ARTICLE Open Access

Prospective cohort study of the relationship between neuro-cognition, social cognition and violence in forensic patients with schizophrenia and schizoaffective disorder

Ken O'Reilly[1,2], Gary Donohoe[1], Ciaran Coyle[2], Danny O'Sullivan[2], Arann Rowe[2], Mairead Losty[2], Tracey McDonagh[2], Lasairiona McGuinness[2], Yvette Ennis[2], Elizabeth Watts[2], Louise Brennan[2], Elizabeth Owens[2], Mary Davoren[1,2], Ronan Mullaney[1,2], Zareena Abidin[2] and Harry G Kennedy[1,2*]

Abstract

Background: There is a broad literature suggesting that cognitive difficulties are associated with violence across a variety of groups. Although neurocognitive and social cognitive deficits are core features of schizophrenia, evidence of a relationship between cognitive impairments and violence within this patient population has been mixed.

Methods: We prospectively examined whether neurocognition and social cognition predicted inpatient violence amongst patients with schizophrenia and schizoaffective disorder ($n = 89$; 10 violent) over a 12 month period. Neurocognition and social cognition were assessed using the MATRICS Consensus Cognitive Battery (MCCB).

Results: Using multivariate analysis neurocognition and social cognition variables could account for 34 % of the variance in violent incidents after controlling for age and gender. Scores on a social cognitive reasoning task (MSCEIT) were significantly lower for the violent compared to nonviolent group and produced the largest effect size. Mediation analysis showed that the relationship between neurocognition and violence was completely mediated by each of the following variables independently: social cognition (MSCEIT), symptoms (PANSS Total Score), social functioning (SOFAS) and violence proneness (HCR-20 Total Score). There was no evidence of a serial pathway between neurocognition and multiple mediators and violence, and only social cognition and violence proneness operated in parallel as significant mediators accounting for 46 % of the variance in violent incidents. There was also no evidence that neurocogniton mediated the relationship between any of these variables and violence.

Conclusions: Of all the predictors examined, neurocognition was the only variable whose effects on violence consistently showed evidence of mediation. Neurocognition operates as a distal risk factor mediated through more proximal factors. Social cognition in contrast has a direct effect on violence independent of neurocognition, violence proneness and symptom severity. The neurocognitive impairment experienced by patients with schizophrenia spectrum disorders may create the foundation for the emergence of a range of risk factors for violence including deficits in social reasoning, symptoms, social functioning, and HCR-20 risk items, which in turn

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The recovery of factors associated with decision-making capacity in individuals with psychosis

Colin Fernandez, Harry G. Kennedy and Miriam Kennedy

Background
There is limited data on the recovery of factors associated with decisional capacity in patients with psychosis.

Aims
To study the relationship between changes in mental capacity, symptoms and global functioning using structured measures during treatment for psychosis.

Method
Fifty-six patients with psychosis were assessed for capacity to consent to treatment on admission and at 6 and 12 weeks following treatment. The MacArthur Competence Assessment Tool – Treatment, the Positive and Negative Symptom Scale and the Global Assessment of Functioning Scale were used to measure mental capacities, symptom severity and global functioning respectively. Treating consultants rated capacity to consent, masked to these measures.

Results
Greater impairments on all measures were found in patients assessed as lacking capacity. These improved with treatment over 12 weeks with significant effect sizes (0.5 to 0.6). Stronger correlations between mental capacities, positive symptoms (–0.47) and global functioning (0.56) were noted in the first 6 weeks.

Conclusions
Impairments in capacity in acute stages of psychosis are related to symptom severity and functional impairment. They improve during treatment, particularly in the first 6 weeks.

Declaration of interest
None.

PRISON HOSPITALS

- Penitentiary Psychiatric Centres (PPCs) and Forensic Hospitals (TBCs) in Prisons, The Netherlands
- Helsinki Prison Hospital, Finland and Helsinki University Forensic Hospital
- St John of God Hospital, Barcelona Prison
- Long Bay Prison and Long Bay Hospital, NSW
- Canadian Federal and Provincial Prison Hospitals and Forensic Hospitals

Vught Prison, Denbosch, Netherlands

PRISON HOSPITALS

- CONSULTANT PSYCHIATRISTS LEAD MULTI-DISCIPLINARY TEAMS (FROM HEALTH NOT JUSTICE)
- CLINICAL DIRECTOR: CONSULTANT PSYCHIATRIST RESPONSIBLE FOR ADMISSIONS AND DISCHARGES TO AND FROM PRISON WINGS
- SECURITY AND RESTRAINT PRACTICES ARE LED BY SPECIALLY TRAINED DISCIPLINE STAFF (HOSPITAL ORDERLIES?) MANAGED BY PRISON GOVERNOR
- FEWER NURSES, MORE SPECIFIC CLINICAL SPECIALIST NURSING ROLES WITHIN THE MDT.
- MENTAL HEALTH ACT (FORENSIC) PROTECTIONS APPLY
- FIXED TERM ASSESSMENT AND TREATMENT ORDERS TO FORENSIC HOSPITAL OUTSIDE PRISON, RETURN FOR MAINTENANCE TREATMENT TO PRISON HOSPITAL
- NGRI / NCR DISPOSALS STAY IN FORENSIC HOSPITAL

Domenico di Bartolo, *The Care and Healing of the Sick* (1440-1441)
Ospidele Santa Maia della Scala, Sienna

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Letter to the Editor

Moral cognition and homicide amongst forensic patients with schizophrenia and schizoaffective disorder: A cross-sectional cohort study

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ABSTRACT

Forensic patients with schizophrenia who had carried out a homicide scored higher on a measure of moral cognition (MFQ-30) than other violent patients. Neurocognitive impairment was associated with homicide by mediation via higher scores for in-group loyalty.

PRAGMATIC IMPERATIVES?

THERE IS A RECIPROCAL OBLIGATION TO PROVIDE TREATMENT TO RESTORE MENTAL CAPACITY AND AUTONOMY WHEN LIBERTY IS DEPRIVED. OR TO OPTIMISE QUALITY OF LIFE IF CAPACITY CANNOT BE RESTORED.

IT IS WRONG ‘NOT TO KNOW’. LAWS AND POLICIES SHOULD BE EVALUATED FOR OUTCOMES. TREATMENTS, HEALTH PATHWAYS (MENTAL HEALTH LAW) AND WELFARE SHOULD ALL BE AUDITED, TESTED IN CONTINUOUS RANDOMISED CONTROLLED POSITIVE TRIALS AND PUBLISHED.

WHAT ARE THE LIMITS OF AUTONOMY?

- PREVENT HARM TO OTHERS, INCLUDING CARERS AND PROFESSIONALS?
- SET A PRAGMATIC THESHOLD FOR FUNCTIONAL MENTAL CAPACITY?

Why Violence Has Declined

Tribal warfare

Homicide

Judicial torture

Child abuse

Animal cruelty

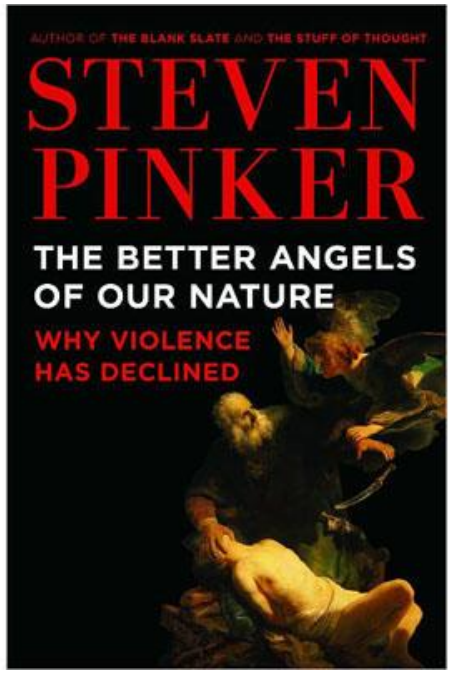
Domestic violence

Lynching

Pogroms

International wars

Civil wars



Pinker: The Better Angels of Our Nature

Five inner demons	Four better angels	Five historical forces
Instrumental violence	Empathy	Leviathan (state and justice)
Dominance	Self-control	Commerce (international free trade)
Revenge	Moral sense	Feminization
Sadism	Reason	Cosmopolitanism (literacy, mobility, mass media)
Ideology (extremism)		Escalator of reason

Landscape with the Fall of Icarus. Pieter Breugel the elder

School of Pieter Breugel the elder, Landscape with Fall of Icarus (Daedelus)

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Thank You