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Hunger strikes in prison: a legal perspective for psychiatrists

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Abstract

Hunger strikes in a custodial setting are complex to manage clinically, with associated legal and ethical complexities. Hunger strikes in Irish prisons have received, and are likely to continue to be the focus of, considerable media attention. Whilst there is an internationally accepted consensus ethical position, there is limited legal guidance available for psychiatrists to draw upon in such cases. In this paper, we review recent case-law and discuss the legal considerations in the management of prisoners on hunger strike.

Key words

Hunger Strike, Prison, Law, Detainee

Introduction

"He has chosen death: Refusing to eat or drink, that he may bring disgrace upon me; for there is a custom, an old and foolish custom, that if a man be wronged, or think that he is wronged, and starve upon another's threshold till he die, the Common People, for all time to come, will raise a heavy cry against that threshold"
(Yeats, 1904, The King's Threshold)

A "hunger strike" is by definition food refusal as a form of protest or demand (Crosby, Apovian & Grodin, 2007). Hunger strikes in prison have been reported in several countries including Turkey, South Africa, Ireland and the US Naval base at Guantanamo Bay, Cuba (Crosby, Apovian & Grodin, 2007). In Ireland, these came to the forefront of national attention in 1981, after the death of 10 individuals protesting against the withdrawal of special category status

for paramilitary prisoners by the British Government of the day (Beresford, 1997). Food refusal has been noted as a 'particularly Irish form of protest' (*Governor of X Prison v McD.* 2015). Hunger strikes are relatively uncommon but nonetheless challenging. Recent hunger strikes reported by the Irish media have included protests against water charges (Lally, 2015) and prison conditions (*Governor of X Prison v McD.* 2015). Most hunger strikes are motivated by political concerns and are self-resolving, and where short term or feigned food refusals occur, they are less clinically problematic than sustained refusal of food and fluid.

A psychiatrist is usually called to assess individuals who are refusing food and/or fluid. Their role extends to excluding an underlying mental illness and may include assistance in the assessment of capacity. Mental illness, whilst overrepresented in Irish prisons (Kennedy et al., 2004) and prisons worldwide (Fazel & Seewald, 2012) is rarely the cause for food refusal (Brockman, 1999; Larkin, 1991). Having said that, the psychiatric examination needs to exclude causes (Sullivan and Romily, 2009; Brockman, 1999) including, but not limited to severe depression wherein an individual is refusing food in order to end their life, psychosis wherein an individual may falsely believe their food is poisoned, eating disorders wherein there may be a morbid fear of fatness or autism spectrum disorder with associated sensory difficulties.

The role of the medical professional in this context is fraught with legal and ethical complexities. Guidelines for medical professionals have been drafted (World Medical Association, 2006) and suggest a position to adopt ethically. They favour autonomy over beneficence and stress the importance of neutrality of involved physicians, who otherwise would be subject to a dual loyalty conflict. They unambiguously state that force feeding of an individual with capacity who refuses the same is not acceptable. Key principles relating to the role of medical professionals in relation to prisoners on hunger strike as outlined in international literature (Gulati et al, 2017; Getaz et al, 2012; Sakelliadis, Spiliopoulou & Papadodima**,** 2009; Brockman, 1999) in keeping with the Declaration of Malta (World Medical Association, 2006) agree that the issue of capacity and consent is central to guiding management.

Clinicians involved in assessing and treating prisoners on hunger strike should ideally have an understanding of capacity related legislation, mental health legislation and a knowledge of recent case-law. We aim to summarise these considerations in relation to the jurisdiction of the Irish republic.

Case-law

Until recently, there was no Irish case-law on the issue of food refusal in prison while precedents from other common law jurisdictions were inconsistent. This inconsistency is evident in a series of cases in the US which reached differing conclusions on whether prison authorities should be permitted to force feed prisoners against their wishes and contrary to their right to self-determination (*In re Caulk*, 1984; *Thor v Superior Court*, 1993). More recently, there was some US case-law which sanctioned force-feeding of prisoners in Guantanomo Bay (*Al-Adahi v Obama*, 2009; Easton, 2013). In England, the courts had originally stated that prison governors had a duty to preserve the health of prisoners, a duty which extended to force feeding. Thus, they were permitted to force-feed hunger striking

suffragettes at a time when suicide was illegal (*Leigh v Gladstone*, 1909). The crime of suicide was abolished by the Suicide Act 1961 but the offence of aiding and abetting suicide was retained. Prison medical staff may have been concerned about possible criminal liability for aiding and abetting suicide. In 1995, it was held that it was lawful for the prison authorities not to intervene if a prisoner with capacity was on hunger strike (*Secretary of State for Home Department v Robb*, 1995). Drawing on an earlier case relating to the withdrawal of life sustaining treatment from a young man injured in the Hillsborough disaster (*Airedale NHS Trust v Bland*, 1993), the court declared that death following food and fluid refusal by a patient with capacity, is an exercise of self-determination and does not constitute an act of suicide. Therefore medical staff who fail to administer treatment in accordance with the patient's wishes do not aid and abet a suicide. The court did not have to decide if it would have been lawful for the authorities to force-feed the prisoner (Kennedy, 1995). However, if a hunger striking prisoner was also detained under the Mental Health Act and lacked capacity, they could be force-fed (*R. v Collins ex parte Brady*, 2001). The European Court of Human Rights has also explored this issue and held that force-feeding a prisoner on hunger strike was not a breach of the Convention, provided there was a "medical necessity" and the method used was humane (*Nevmerzhitsky v Ukraine*, 2006).

The legal principles to be applied in Ireland have recently been discussed in the significant cases of *Governor of X Prison v McD.* (2015), *Nash v Chief Executive of the Irish Prison Service* (2015) and *A.B. v C.D.* (2016).

In *Governor of X Prison v McD.* (2015), the prison was not seeking to force feed Mr McD., instead it was seeking guidance from the court as to whether it was lawful to withhold medical and nutritional assistance from Mr McD. The prisoner had been assessed by a psychiatrist to have full capacity, with no mental illness but with borderline personality disorder. Baker J. (High Court Judge) issued a declaration that the prison could withhold assistance. She followed the principles in *Fitzpatrick v F.K.* (2008) in assessing Mr McD's capacity. These principles include the following: "(1) There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment. (2) In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made…" (*Fitzpatrick v F.K.*, 2008).

Having concluded that Mr McD. had full capacity, Baker J. noted that the European Court of Human Rights case-law did not mean that failing to forcibly administer food or medicine is a breach of human rights (*Governor of X Prison v McD.*, para. 104). Baker J. went on to approve of the reasoning of Thorpe J. (High Court Judge, England) in *Secretary of State for Home Department v Robb* (1995), including his emphasis on the competent individual's right to self-determination. It was held that it was well established that an adult person with full cognitive capacity is entitled to refuse medical treatment, even if that refusal is likely to inevitably lead to that person's death. While it could not be said that a person has a right to die by suicide, the person has a right to freely elect to refuse food, provided his/her choice is full, free and informed and he/she does not require assistance to achieve that end (para. 105). She

distinguished this case from *Fleming v Ireland* (2013), where it was held that a competent person does not have an entitlement to the benefit of assistance to end her life. Baker J. also stated that the prison should respect Mr McD's advance directive regarding his future care (para. 126), for the first time providing a binding ruling on the legal status of advance healthcare directives (Mulligan, 2015).

The reasoning in *Governor of X Prison v McD.* was quoted with approval in *Nash v Chief Executive of the Irish Prison Service* (2015). In that case, the applicant was reported to have been suicidal and had not been eating for a number of weeks. Kearns P. (President of the High Court) noted: "there is no suggestion that the applicant lacks mental capacity to make his own decision as to whether or not he wishes to end his life by starvation." While the outcome of the case turned on other issues which are not directly relevant to this article, including possible threats to the applicant from other prisoners, the court approved of the reasoning in *Governor of X Prison v McD* and the Supreme Court decision in *Creighton v Ireland & Ors* (2010) to the effect that prisoners may continue to exercise a variety of constitutional rights which do not depend on liberty, including the right to bodily integrity. The court also clarified that threats of suicide may not be used by prisoners to achieve their own objectives: "Any suggestion that prisoners can or should be detained in the prison of their own choosing, or avail of hunger strike or suicide threats to secure their own objectives, would create chaos in prisons and fatally compromise the proper administration of our prison system."

However, a very different approach was taken by Humphreys J. (High Court Judge) in a more recent High Court decision, *A.B. v C.D.* (2016), which concerned a prisoner, Mr D., who was admitted to hospital due to a self-inflicted injury to his neck. Mr D. was refusing life-saving treatment, was reported to have "likely schizophreniform psychosis" and was assessed as lacking capacity to refuse treatment. The hospital sought court authorisation for all necessary medical and surgical treatment to protect Mr D's life and bodily integrity. Humphreys J. did not make an explicit finding as to whether Mr D. lacked capacity on the basis that he did not have sufficient information to decide on capacity and the case did not hinge on Mr D's capacity in any event. Rather, he preferred to decide the case on the question of whether prisoners may refuse medical treatment where such refusal would put his/her life at risk and thereby, fail to complete the sentence handed down by the court. The court disagreed with Baker J's approach to prisoner autonomy in *Governor of X Prison v McD.* for various reasons. Humphreys J. analysed US case-law and concluded that the vast majority of US cases find no legal violation in forced medical treatment, feeding or nutrition of mentally competent adult prisoners. He also disagreed with Baker J.'s reasoning in *McD.* as it involved reliance on the English case of *Secretary of State for the Home Department v Robb* (1995) which in turn had heavily relied on the unrepresentative Californian case of *Thor v Superior Court* (1993). Ultimately, Humphreys J. made an order compelling treatment as "a prisoner in custody under a court order… is not simply entitled to refuse treatments where this would either directly or ultimately put his life at risk and thereby frustrate the verdict and order of the court" (para. 52), that is, to ensure that a prisoner completes the prison sentence imposed by a court of law.

Despite this, Humphreys J. did not disagree with the outcome in *McD.* as the court had granted a declaration that the Prison Governor was entitled to give effect to the prisoner's

wishes not to be fed or treated. Humphreys J. stated: "If a prisoner wants to starve to death or die by medical neglect, it is a matter for executive discretion as to whether to allow them to do so in all the circumstances: it might be too prescriptive in the modern era to declare a positive duty to force-feed a person of full age and capacity in particular, at least in all cases" (para.50). Humphreys J. was also adamant that a prisoner "simply does not have any legal entitlement to cheat justice, and the court should not co-operate in him or her attempting to do so." The approach of the court in *A.B. v C.D.* is significantly out of line with current thinking on autonomy of prisoners in Ireland and is likely to be challenged in later cases.

This case also highlights a matter of complexity wherein courts make decisions based on "prisoner" status of an individual (even if the individual is in hospital) as opposed to health professionals who view the individual as a "patient". In their determination, the court must be cognizant of the status of the individual as prisoner. Under Irish law the "normal constitutional rights [of prisoners] are abrogated or suspended during the period of imprisonment…" (State (*McDonagh) v Frawley*, 1978; *Murray v Ireland*, 1991; *Breathnach v D.P.P. & ors,* 2001). As such, cases involving prisoners must be approached differently than those involving non-prisoners. When considering cases involving prisoners, the court must consider whether the rights in question, including the right to self-determination or bodily integrity, have been abrogated, suspended or limited for the period of imprisonment. In his recent decision in A.B v C.D (2016) Humphreys J. held that while "a prisoner retains the right to bodily integrity in prison in the sense that he or she cannot be harmed or neglected by the State… it by no means follows from a prohibition on harming prisoners that the prisoner's full rights of autonomy have to be recognised." *A.B. v C.D.* (2016).

Mental Health Legislation

Mental illness although overrepresented in Irish prisons (Kennedy et al, 2004), is rarely the underlying cause for food refusal (Brockman, 1999). If a prisoner has a mental disorder, he/she may be transferred from a prison setting to a Designated Centre, currently the Central Mental Hospital under s.15 of the Criminal Law (Insanity) Act 2006. Section 3 of this Act defines a Designated Centre. Mental disorder as defined in the Criminal Law (Insanity) Act, 2006 includes "mental illness, mental disability, dementia or any disease of the mind but does not include intoxication" (Irish Statute Book, 2006). This is broader than the definition for the same concept in the Mental Health Act, 2001, Section 3 of which defines mental disorder as "mental illness, severe dementia or significant intellectual disability…". Once in the designated centre, issues of treatment are governed by Part 4 of the Mental Health Act 2001 (Whelan, 2009). If the person has capacity, he or she can refuse treatment. If he/she lacks capacity, treatment may be administered under the terms of sections 56-60 of the 2001 Act, as amended by the Mental Health (Amendment) Act 2015. Section 57 of this Act states "The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent."

There is no *reported* (the word "reported" being used in a legal context) Irish case-law on the question of whether force-feeding constitutes treatment of a mental disorder. However, recent cases have been noted in media wherein the High Court has authorized tube feeding and ancillary measures for individuals with eating disorders (Carolan, 2015) or severe psychotic depression (Carolan, 2014). European and English cases mentioned earlier may be of some assistance to any future Irish court faced with this question (See also *B. v Croydon Health Authority*, 1995).

Arguably the case for treatment under Mental Health legislation would not arise in the case of a true hunger strike as defined earlier (Crosby, Apovian & Grodin, 2007). However, should there be refusal of food as a direct consequence of mental disorder such as a paranoid delusion that food is being poisoned as in the case of someone with a paranoid schizophrenic illness, or a refusal of food as a suicidal act in the case of someone who is severely depressed, or indeed the refusal of food arising from a "morbid fear of fatness" in the case of someone with an eating disorder, treatment of the underlying psychiatric condition would be in accordance with the principles of consent or provisions of Section 56-60 of the Mental Health Act, 2001 as amended by the Mental Health (Amendment) Act 2015. Hence the need to differentiate, by a thorough psychiatric evaluation, the concept of food refusal in the latter cases from a true "hunger strike" motivated by a demand or protest.

Capacity legislation

The Assisted Decision-Making (Capacity) Act 2015 has been enacted into law by presidential assent on 30 December 2015 but most sections have yet to be commenced (some sections from Part 1 and Part 9 were commenced in October 2016). The assessment of capacity would be based on the functional test set out in the legislation, rather than the principles from *Fitzpatrick v F.K.* (2008) as outlined earlier.

The assessment of capacity would be a matter for the attending general practitioner/physician who may request psychiatric expertise. In practice, a joint consultation may be indicated wherein the physician provides information as to the potential risks of prolonged fasting, risks and benefits of treatment and the psychiatrist assists the general practitioner/physician in reaching a decision about the capacity. This is not an isolated event and good practice would involve gathering collateral information from multiple sources such as the prion officers, the prisoner's family doctor and family members prior to the assessment to ascertain the presence or otherwise of mental or physical disorder. The test for capacity encompasses evaluating the individual's ability to understand the information presented to him, retain this long enough to make a decision, weigh up the pros and cons of alternative courses of action and communicate their decision. The individual should have been advised of the likely consequences of their intended action, including the possibility of death and keeping in mind, any existing physical illness which may potentially hasten the latter. This test for capacity is specific to the matter being assessed and whilst the primary assessment would be of the capacity to refuse food and/or fluids, further assessments may be necessary in relation to the need for physical health monitoring such as the need for blood tests. The test for capacity is also time-specific, and repeated examinations of capacity may be necessary and indeed advisable, given the progression of both psychological and physiological changes as hunger strikes persist (Fessler, 2003).

The 2015 Act defines Capacity as "decision-making capacity" and it is the ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time. Despite the fact that this is the first legislative adoption of the functional approach, this approach to the assessment of capacity has been used in practice in Ireland already (Health Service Executive, 2013; Medical Council, 2016).

The 2015 Act also proposes three types of decision-making support options to respond to the range of support needs that people may have in relation to decision-making capacity. With each of the three decision-making support options (assisted decision making, co-decision making or a decision-making representative) decisions can be made on personal welfare, property and finance or a combination of both (Department of Justice and Equality, 2015).

Following the decision in *Governor of X Prison v McD.* or once this law is enacted, under the Assisted Decision Making (Capacity) Act, an individual with capacity could make an advance refusal of treatment in case of deterioration in health following food refusal. Treatment, in the presence of a valid directive would then be illegal. However, in the case of a prisoner, this is less clear given the decision in *A.B. v C.D.* (2016). Based on the reasoning in that case, while the state is not mandated to force-feed prisoners, it is entitled to authorise force feeding against the wishes of a prisoner with capacity o*r* a prisoner with a valid advance healthcare directive in order to fulfil the court order, that is, to ensure he/she completes the prison sentence.

Conclusions & Discussion

Psychiatrists in the prison setting may find themselves in a clinically, ethically and legally complex situation when faced with someone on hunger strike. The role of the psychiatrist in assessing prisoners on hunger strike is not limited to the diagnosis and treatment of mental illness but extends to assisting the assessment of capacity to refuse food as well as the motivation behind the hunger strike (Getaz et al, 2012; Brockman, 1999). From a clinical perspective, an interagency and multidisciplinary approach with regular case conferences may be helpful to guide decision making.

Whilst there is a consensus governing the ethical position (Gulati et al, 2017; World Medical Association, 2006), we discuss, in this paper, the relevant case-law and legislation, including the Criminal Law (Insanity) Act, Mental Health Act and the new Assisted Decision Making (Capacity) Act that the Irish prison Mental Health Practitioner can draw upon in practice. With changing capacity legislation, there will likely be additional case-law to refer to in the coming years.

In practice however, most prison hunger strikes are short lived (Garcia-Guerrero & Vera-Remartinez, 2015) and, where they persist, and in particular, in complex circumstances wherein there is no mental illness but issues around capacity, the prison mental health practitioner may wish to seek legal advice from solicitors for the health service and their own medical indemnity organisation given the limited and complex national case-law existent at this time.

Conflict of Interest

Gautam Gulati has no conflict of interest to declare. Darius Whelan has no conflict of interest to declare. Eimear Spain has no conflict of interest to declare. David Meagher has no conflict of interest to declare. Colum P Dunne has no conflict of interest to declare.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this perspective paper was not required by their local REC.

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