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Ulysses Contracts in Psychiatric Care: Helping Patients to Protect Themselves from Spiralling

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Abstract

This paper presents four arguments in favour of respecting Ulysses Contracts in the case of individuals who suffer with severe chronic episodic mental illnesses, and who have experienced spiralling and relapse before.

First, competence comes in degrees. As such, even if a person meets the usual standard for competence at the point when they wish to refuse treatment (time 2), they may still be *less* competent than they were when they signed the Ulysses contract (time 1). As such, even if competent at time 1 *and* time 2, there can still be a disparity between the *levels* of competence at each time. Second, Ulysses Contracts are important to protect people's *most meaningful* concerns. Third, on the approach defended, the restrictions to people's liberty would be temporary, and would be consistent with soft paternalism, rather than hard paternalism: the contracts would be designed in such a way that individuals would be free to change their minds, and to change or cancel their Ulysses Contracts later. Finally, even if one rejects the equivalence thesis (the claim that allowing harm is as bad as doing harm), this is still consistent with the claim that, in *particular cases*, it can be as wrong to *allow* a harm as to do a harm.

Nevertheless, controversies remain. This paper also highlights several safeguards to minimise risks. Ultimately, we argue that people who are vulnerable to spiralling deserve a way to protect their autonomy as far as possible, utilising Ulysses Contracts when necessary.

1. Introduction

The Charity SANE surveyed 108 people with a diagnosis of bipolar or schizophrenia, and stated:

> Of those surveyed, almost seven out of 10 people had experienced at least one relapse during the course of their illness. Many people had experienced more than one. Furthermore, of those who had experienced a relapse, 93% said they worried periodically about possible future relapse. [1]

And Ryan Spellecy describes Lucy's story, a female who suffers with schizophrenia:

> Lucy was diagnosed with paranoid schizophrenia after a particularly harrowing sophomore year of college…Since then, Lucy has become a successful professor of microbiology, although her illness now cycles through periods of activity and remission. When Lucy takes her medications, her condition is well managed with minimal side effects. However, periodically she ceases following her treatment regimen. Lucy thinks to herself, "I have been relapse free long enough that I don't need to continue taking my medication." Unfortunately, it is the medication that keeps Lucy relapse-free. When Lucy ceases to take her medication she begins to show signs of a relapse, which usually include increasing distrust leading to eventual paranoia and reports of voices. Eventually, Lucy disappears, lives on the streets, and finally is arrested. A police officer then brings her to an emergency room when he notices she "just isn't quite right." Lucy's condition is identified and stabilized with medication; she returns to work; and the cycle begins anew. [2]

Lucy's story exemplifies a typical pattern of an episodic mental illness, which are characterised by a pattern of remission, spiralling and relapse (discussed in section 1.2). On the face of it, there is good reason to believe that individuals such as Lucy could benefit immensely from the availability of Ulysses Contracts (defined in section 1.1), which would provide them with a means to break the cycle of their illness and live their life in accordance with their most meaningful concerns. Yet, quite reasonably, many people have concerns about Ulysses Contracts.

In this paper, we will argue that people who suffer with severe chronic episodic mental illnesses, such as bipolar disorder, schizophrenia and addiction, should have the option to pre-

commit themselves to a desired medical intervention period in the form of a Ulysses Contract, which should be honoured unless there is sufficient evidence that the individual has genuinely changed their mind. This argument will rely on the claim that there is something unique about the state of spiralling, which means that decisions made when spiralling demand special attention, such that (contrary to the norm) the default position would be that we respect the person's prior wishes, rather than their current decision, even if the patient is still competent.[1]

In the remainder of section 1, we will provide a brief introduction to Ulysses Contracts and will also describe the relevant medical terminology, highlighting the significance of spiralling.

In section 2, we will argue that we should accept that it is *sometimes* permissible to respect a patient's Ulysses Contract, and therefore honour their earlier decision, even if the patient is still competent enough to meet the usual threshold to be considered competent to make their own decisions. In this section, we present four individual arguments, each of which (we believe) is significant on its own. However, the arguments are not intended to be taken separately. They should be considered together, presenting a coherent whole, presenting a strong case in favour of Ulysses Contracts. In section 3, we highlight the safeguards that would be necessary to allow patients to genuinely change their mind at a later date, and to protect patients from the harm of having their autonomous choices over-ruled when they are not spiralling.

1.1. Ulysses Contracts

The Greek myth of Ulysses and the Sirens, tells the story of Ulysses, who made a pact with his ship's crew ordering them to block their ears with wax and tie him to the mast of the ship whilst they steered past an island inhabited by mythological creatures called Sirens. The Sirens sang to lure sailors to be shipwrecked. Upon hearing the Sirens' song Ulysses struggled to break free so he might join the Sirens which would have meant his death, but he was not untied, and the ship sailed past the Sirens.

The Ulysses Contract is based on the same principle, but a written contract takes the place of the physical binding. In the medical context, a patient could, for example, commit to a specified medical treatment at a future time under specific conditions, where the patient anticipates that they may be unwilling to consent at the specified future time [3]. The key point to emphasise is that, unless it is respected by others later, a Ulysses Contract is useless.

There is also an important distinction to be made between parity and disparity pre-commitment [4]. In section 2.1, we will offer an alternative way to understand parity and disparity in relation to competence, focusing on degrees of competence. However, on the standard view, parity pre-commitment refers to a competent agent pre-committing themselves where they anticipate they will still be competent at the future time. Disparity pre-commitment refers to cases of pre-commitment by a competent person who anticipates that they will be incompetent when the specified conditions occur. Cases of disparity pre-commitment are, of course, much less controversial, and these disparity cases will not be discussed here.

This paper, therefore, focused on cases in which the patient is still considered competent when the Ulysses contract would be invoked. These cases – considered "parity cases" on the standard view – are much more controversial because, under normal circumstances, competent patients should be allowed to make their own decisions. Therefore, it is natural to think that we should respect the agent's present competent decision, and reject the Ulysses Contract. As stated above, however, this approach defeats the purpose of Ulysses Contracts, rendering them useless, preventing patients from being able to manage their illnesses effectively, preventing them from developing a plan which could be effective in blocking the spiral into relapse. This conflict between the conviction that we should respect the wishes of a competent patient and the conviction (that many have) that patients should be able to make plans about how to manage their own treatment in order protect themselves from foreseeable harm is what makes Ulysses Contracts so controversial. This paper considers Ulysses Contracts specifically in the context of spiralling, which is an important phenomena currently being overlooked in much of the literature on Ulysses Contracts.

1.2. Remission, Spiralling and Relapse

An episodic mental illness is one which is characteristically made up of a series of events which show a remitting and relapsing pattern. The word chronic indicates a long-term condition, and examples of severe chronic episodic mental illnesses are bipolar disorder, schizophrenia and addiction. The stages of an episodic mental illness are remission, spiralling and relapse. Remission is classed as a symptom free period, where the individual is lucid and mentally well. A period of spiralling may follow after a certain length of time, in which certain symptoms present which are suggestive of imminent relapse. This period of spiralling is a critical period where prompt medical intervention may prevent a relapse from occurring.

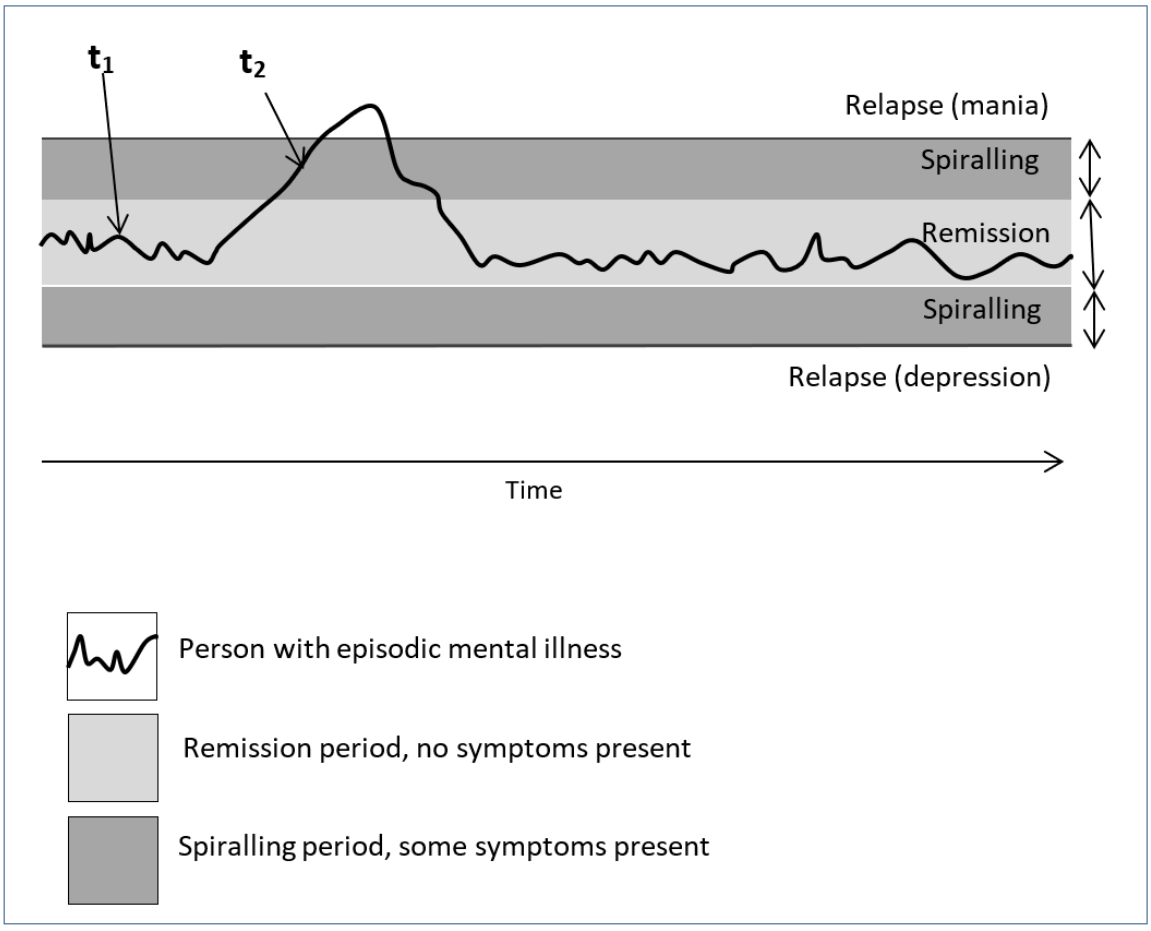
If no form of intervention occurs during spiralling, a relapse is likely to ensue. During episodes of relapse, people often behave uninhibitedly (for example, squandering money), and may exhibit abusive behaviour (to themselves or others). Thus, the long-term consequences of a relapse can be devastating and can persist for a long time after a relapse is over. Sometimes the consequences can be irreparable.

The re-emergence of the mental illness in a spiralling patient is likely to be indicated by certain changes, such as: an altered perception of priorities and desires, which may be due to delusions causing the agent to lose insight into their condition [1], a change in personality, a significant change in mood, unusual thoughts, a loss of contact with one's 'identity conferring concerns' [5], a failure to consider relevant reasons during decision making, demonstration of a faulty reasoning process when making decisions, etc. These changes are supported empirically, in being recognised by healthcare professionals as warning signs that a patient is approaching relapse [6].

The bullying forces of spiralling do not always limit someone sufficiently to fail a competence test, so many spiralling patients are deemed sufficiently legally competent. It is only when a person is deemed legally incompetent, or a significant threat to themselves or others, that they cannot refuse treatment. Thus, where a spiralling patient is deemed competent, their present dissent to treatment is respected over their former consent in the contract. This is problematic for spiralling patients, who are vulnerable to the threats posed by relapse.

Figure 1 below illustrates the typical pattern of an individual's experience of bipolar disorder, and "t1" and "t2" indicate how a Ulysses Contract could be used to prevent a patient from spiralling into relapse. At time 1 (t1), an individual writes a Ulysses Contract, whilst in remission. At time 2 (t2), an individual meets the terms of the contract, and is spiralling. T2, we suggest, is the moment when the Ulysses Contract should be enforced – breaking the cycle of mental illness, preventing the negative outcomes of a relapse, protecting the patient's critical interests.

Figure 1



2. How can a previously expressed competent wish demand more respect over a presently expressed competent wish?

In this section, we will present four arguments to support the claim that Ulysses Contracts should be respected. We claimed, in the introduction that, although each argument could be significant in isolation, the arguments are not intended to be taken separately. They should be considered together, presenting a strong case in favour of Ulysses Contracts. So how should they be taken together? Basically, the arguments are essentially accumulative. As in many cases in applied ethics, we have to weigh competing considerations. Taken in isolation, it may be debatable whether any of the individual arguments would be sufficient to justify Ulysses Contracts. *Taken together*, however, the considerations highlighted have considerable weight (and in some cases, the arguments also significantly *reduce* the force of considerations that are typically taken to count *against* Ulysses Contracts). This is why we say that the arguments should be taken together, not in isolation. (Also see sections 2.1 and 2.4 for more specific details of how these arguments are supported by the others.)

To many, this may suggest a commitment to Rossian pluralism. We are indeed influenced by Ross, and we would support Frances Kamm's claim that Ross's work (along with Kant's) can be seen as the 'spiritual roots' of contemporary nonconsequentialism.[7] However, we are certainly not committed to Ross's particular form of moral pluralism and we believe that it is a strength of the paper that it does not rely on any particular theory (which would add an unnecessary point of contention). We would prefer to let the arguments do the work, without committing to a moral theory which the reader may or may not be sympathetic to. If our arguments are consistent with a wide range of moral theories, this is an advantage not a weakness. (Also see [8], [9], [10], [11].)

In response to an earlier draft of the paper, one reviewer for this journal expressed the concern that the article reads like "a random collection of arguments". The arguments are not random. The arguments are based on reasoning and attention to morally relevant considerations, just as they would be if we also based our argument on a moral theory like

consequentialism. (If you share this reviewer's concern, we urge you to read David McNaughtan's "An Unconnected Heap of Duties?" [12])

2.1. Competence

Earlier, we acknowledged the distinction between parity and disparity pre-commitment. But these terms are ambiguous. Typically, when parity cases are discussed, they are described as parity cases in virtue of the fact that the person is competent both at t1 and at t2 [4]. (Also see [13].) But even if there is parity in the sense that the individual is judged to be competent at both times, there may still be disparity if we consider *degrees* of competence. If we reject the purely binary distinction, and instead talk of degrees of competence, we can recognise a new disparity: a disparity in *degrees* of competence. On this view, there is a disparity in competence any time the individual is more competent at t1 than at t2. On the face of it, if the patient is less competent at t2 (when they want to refuse their medication) than they were at t1 (when they signed a Ulysses contract), this appears to be a relevant consideration in favour of respecting the Ulysses contract.

We acknowledge that, for many, this commitment to degrees of competence is considered controversial. However, we suggest it should not be. Here we appeal to arguments presented by Rob Lawlor in his paper "Cake or Death". Lawlor comments that, in response to an earlier draft, a reviewer "expressed concerns about [the claim that competence comes in degrees], suggesting that… competence 'has traditionally been regarded as a threshold concept', and that this is 'what makes it a useful validating marker for either allowing or disallowing a particular legal status (such as decision making power)'." [14] Lawlor responded to this objection with the following two arguments:

> First, simply consider ordinary language. We can talk of degrees of competence in a way that we cannot, for example, talk of degrees of two-leggedness. The more I practice the guitar, the more competent I become. "Competent", unlike "two-legged", is a *gradable* adjective.

> Second, if the claim is that competence is a threshold concept, we have to ask, what is the threshold a threshold of? Some might answer, it is a threshold of "understanding", or of "reasoning abilities". But each of these, individually, is only *one* of the constituent parts. So it seems the threshold is a threshold of *all* of those things *put together*. But what is the concept to which those individual parts are the constituent parts? I suggest that the answer is, and can only be, competence. So the threshold we want – competence – is a threshold on the *scale* of competence. [14]

If we accept that competence comes in degrees, there are two ways in which we could proceed. First, we could reject the threshold approach and focus on degrees of competence, such that cases that were previously considered parity cases (because the patient was considered competent at both times) could now be considered disparity cases (because there is a disparity in *degrees* of competence). As noted above, the fact that a gradable approach allows us to see a disparity in degrees of competence could be an important consideration in favour of respecting Ulysses Contracts in cases where the patient is *more* competent at t1 than at t2.

Alternatively, we could continue with a threshold approach – but rethink the placing of the threshold for these cases. As Lawlor argues, the location of the threshold can depend on a number of considerations. For example: how difficult is the decision? How significant are the consequences of the decision? [14] On this view, the existence of a Ulysses Contract could be a further consideration which could give us reason to set the threshold higher than we would usually. (Also see [15] [16] and [17].) The *level* of competence that would be considered sufficient in a case where there is no history of spiralling, and no competing decision made beforehand, may not be sufficient to over-ride commitments that a patient has made in a carefully considered Ulysses Contract, particularly given that they made the Ulysses Contract *because* they have a history of spiralling, and because they want to protect their most fundamental interests and meaningful concerns.

Much more could be said regarding these two approaches. Here though we will simply present both as plausible options. On either account though, this line of argument will be further supported by the following arguments in this section. On the first approach (comparing *levels* of competence), the following arguments would give us more reason to treat as significant the claim that the patient was *more* competent at t1 than they were at t2.

On the second approach (raising the thresholds) the following arguments would add weight to the claim that we have reason to set the threshold for competence higher than we would otherwise in cases where a Ulysses Contract is in place.

2.2. Promoting meaningful concerns

In his book 'Being Mortal', the surgeon Atul Gawande discusses the way we deal with the process of death [18]. Gawande argues that, when approaching death, people's biggest concerns tend to be overlooked, due to a misguided focus on lengthening life with vast medical interventions. In contrast, Gawande claims that a dying person's biggest concerns typically revolve around protecting the things which make their lives meaningful. These things may be maintaining relationships with their loved ones, upholding their reputation, behaving in accordance with their fundamental principles, preserving their spiritual integrity, and so on. This insight is in line with our intuitions on what makes life valuable in general, not just when nearing death; and we propose that this should be reflected in the way we approach conflicting competent decisions in the spiralling patient.

Therefore, when it comes to determining which conflicting competent decision demands more respect, we believe a key question should be: which decision is most in accordance with the things a person finds meaningful in their life?

2.3. Soft Paternalism

In addition, Ulysses Contracts can be defended by appealing to the distinction between soft and hard paternalism. Dworkin presents a case where a man is walking across a damaged bridge and there is no way to verbally communicate to him that the bridge is damaged. Therefore, on the suspicion that he is unaware that the bridge is damaged, someone would be justified in physically preventing him from crossing the bridge [19]. Having stopped him, they can determine whether he was aware of the condition of the bridge. If it was determined

that he was intending to cross the bridge, voluntarily and in the knowledge that it was damaged, a soft paternalist would not prevent him from crossing the bridge any further. While a hard paternalist might continue to intervene, for example to prevent the man from committing suicide, the soft paternalist would argue that it would not be appropriate to interfere once we have established that the individual is competent and sufficiently well informed of the dangers.

We suggest that it is reasonable to suggest that an individual who appears to be spiralling into a relapse is relevantly similar to the person walking across the bridge. From their point of view, it may not be clear to the medical staff whether the individual has truly changed their mind, or whether they are spiralling.

According to soft-paternalism, we should not remove an individual's choice permanently. (Also see section 3.) In many cases, however, we can justify temporary interference. In the story of Ulysses, if Ulysses had a crew of soft-paternalists, they could tell him: "If you still want to visit the Sirens, even after we have passed them safely and their song can no longer be heard, you can always return later, and go to them, without tying yourself to the mast. But, right now, we are going to keep sailing until we can be confident that you are not under the spell of the song." Of course, this case is complicated by the fact that his crew are also at risk. To avoid this complication, imagine a modern version of the story with an autopilot system and a mast with constraints which will not release Ulysses unless a controller, who is on shore but in radio contact with Ulysses, chooses to release Ulysses. But the controller has agreed to respect Ulysses's contract, which states that he should not be released until Ulysses has safely past the sirens and their song.

Perhaps some will argue that we would need to test Ulysses' competence. However, given that one is not supposed to judge a person's competence based on our view of the decision they reach, we cannot assume that Ulysses would not pass the competence test. For example, he could make it clear that he understands that everyone who has tried to reach the Sirens has been killed on the rocks. He might insist (rightly) that this alone does not prove that it is impossible: it only proves that it is very risky, and no one has managed it yet. And he might insist that he was willing to take the risk – and at worst he would die happy, and would die trying to achieve something extraordinary (to be the first person to reach the

Sirens, and to live with them on their island), and he might insist that he could not think of a better death. As such, despite being under the spell of the Sirens and unable to resist, Ulysses might still be able to pass a test that focuses on his ability to comprehend and retain information, to think rationally and make a decision, and to communicate his decisions – the four constituent functions that are assessed when assessing a person's competence [20].

Now, notice how extreme your position would be if you opposed Ulysses Contracts even in the case above! When we consider this example, and consider the implications of our opponent's commitment to rejecting Ulysses Contracts, we should recognise that it is those who oppose Ulysses Contracts in *any* circumstances who hold the radical position. And the question should not be, *should* Ulysses Contracts be respected? The question should be: *when* should they be respected?

In our medical case, we suggest that doctors should respect the Ulysses Contract, to ensure that the patient does not spiral into relapse. Once the patient is stable, the medical staff could then discuss the Ulysses Contract with the patient, and to consider whether they would like to change the Ulysses Contract, or reject it, and the patient would then be free to make any decision they like regarding their future treatment.

2.4. Interpreting the Do No Harm Principle

The application of the do no harm principle to Ulysses Contracts somewhat reflects the debate that exists regarding the difference (or lack of difference) between *doing* harm and allowing harm through omission. According to the equivalence thesis, allowing harm is on a par with (or equivalent to) doing harm. [21] We reject the equivalence thesis. We believe that (in general) doing harm is worse than allowing harm. On the face of it, this would seem to present a problem for our argument, as many are likely to suggest that this should count against Ulysses Contracts, because treating a patient against their wishes would usually be considered assault (the *doing* of a harm) while refusing to treat a patient would only be the *allowing* of a harm.

We will argue that this is a mistake. The issues are much more complex than this simple argument would suggest.

First, the distinction between doing and allowing is often dependent on context. In general, killing an innocent person (doing harm) is typically worse than letting someone die (allowing harm). However, the distinction becomes less obvious in a case in which the victim is vulnerable, and dependent on others, and the second party is an individual with a *duty of care* towards that person. In this case, the "omission" is likely to be labelled "negligence". Or, if the act was deliberate, rather than merely negligent, a certain set of choices could be considered a particular way of killing someone, even if it involves inaction rather than a specific action. Consider, for example, John, a single parent, and his daughter Jane. (Jane's mother died during childbirth). John decides that he would like his two-week-old daughter to die. He considers two options. First, he could smother the child in her sleep. Second, he could simply refrain from feeding the child, and leave it to die slowly on its own. Believing that killing is worse than letting die, John chooses the latter.

What should we say about this case? Obviously, both options are morally impermissible. In addition, though, John seems to be wrong in thinking that the second option is somehow less bad than the first. But how can *we* say this if we reject the equivalence thesis?

To answer this question, we appeal to the work of Frances Kamm. She argues that we must distinguish between 1) the claim that a *particular* example of a killing is morally equivalent to a particular example of a letting die and 2) the claim that killing and letting die *per se* are morally equivalent. [7] Having made this distinction, we can make it clear that there is no inconsistency in stating both 1) that intentionally leaving the child to starve to death is just as bad intentionally smothering the child and 2) killing and letting die per se are *not* morally equivalent.

Kamm introduces the idea of exportable properties:

> [Defenders of the claim that killing and letting die are morally equivalent] could find examples of killing and letting die in which essential properties of one of the behaviors were exported to the case involving the other. Then, as long as the other morally relevant properties were equivalent in the cases, we would have identified a killing and a letting die that were morally equivalent. But that would

> not show that killing and letting die per se were morally equivalent; it would show just the reverse, since it would show that one of the behaviors (but not the other) has this particular morally significant exportable essential property. [7]

In support of the last claim in this quote, note that no one ever gives an example to argue that a killing is *just as bad* as a letting die. The comparison *always* goes the other way, which would appear to support Kamm's view.

Given that doctors have a *duty of care* to the patient, and given that a spiralling patient is vulnerable, and a patient is dependent on medical staff to protect his interests (because he is spiralling), and given that he has written a Ulysses Contract precisely because he foresees this eventuality, we suggest that there is a strong case for arguing that an omission here, refusing to provide the help and treatment requested in the Ulysses Contract, would be a form of neglect which would be comparable to *doing* harm.

On its own, this argument may not be sufficient to justify acting in accordance with the Ulysses Contract. Rather, it would appear to lead to a stalemate. We have only argued that this is a case in which an omission can be considered a form of neglect that could be on a par with *doing* harm. But this seems to suggest that we have a choice between two options which appear to be equally bad.

However, this argument should not be taken in isolation. It needs to be *combined* with the other arguments in this section – with the other considerations breaking the stalemate. In particular, we also need to consider and compare the seriousness of the potential harms on either side – and we also need to consider potential benefits on both sides. For example, as argued in 2.2, the potential harms from breaking the Ulysses Contract impact on people's most important concerns. Gremmen et al carried out interviews on people who have Ulysses Contracts, as well as others involved, and found that writing a contract "boosted agent's confidence and opportunities to cope with future crisis" [22], and helped them to gain insight into their illness and potential ways they could avert the need for coercive intervention. In addition, there is also empirical support indicating that earlier intervention leads to a shorter and less intense period of recovery compared to the recovery period which would likely follow a relapse. [23] [24] As such, if doctors refuse to respect the Ulysses Contract, it will likely not be long before relapse occurs in which severe destruction could occur, followed by a much

longer and more traumatic loss of autonomy. This longer term loss of autonomy will present partly due to the need for a longer course of therapy, and possibly due to the occurrence of a traumatic event such as sectioning under the Mental Health Act. [25] And if we consider the arguments in section 2.3, it seems that the loss of autonomy would be temporary, and would be consistent with soft-paternalism rather than hard-paternalism. Given these details, we suggest that doctors who refuse to respect the Ulysses Contract would in fact be wronging their patients.

There still remains a small chance that someone will be treated against their genuine changed mind when a Ulysses Contract is enforced. However, we do not believe that a small chance of this holds sufficient moral weight to disregard the considerations above. We do, however, believe that these risks give us reason to implement certain safeguards, which will be discussed in section 3.

3. Future Autonomy and Safeguards

J.S. Mill argues that the state should refuse to enforce agreements which irrevocably restrict future liberty, comparing such cases to a case where an individual requests to be sold into slavery. It may be in the name of their autonomy to respect their wish, but there is a paradox because in selling someone as a slave out of respect for their autonomous request, you are depriving them of their future autonomy. It would be questionable to respect someone's command, in the name of autonomy, if this deprives them of their autonomy long term [26][27]. Similarly, some may worry that Ulysses Contracts are similarly problematic if a choice made at t1 is final, taking certain options off the table permanently. We agree. On our account, the patient's future decisions would only be restricted in certain circumstances, and only temporarily, until doctors have time to establish that the patient is not spiralling. As such, on our account, patients would be able to change their minds, and to change, or cancel, their contracts. This means we can avoid Mill's objection, but it also raises questions. In particular: how do we distinguish between times when a person should be allowed to change their mind

and times when the Ulysses Contract should be enforced? And what safeguards should there be?

3.1. How can we deal with the possibility that the person may genuinely have changed their mind?

One of the most difficult issues, which those opposing Ulysses Contracts emphasise, concerns the possibility that an agent has 'genuinely' changed their mind at the time when the conditions of the contract are met [28] [13].

Our first response is simply to highlight the significance of the difference between two types of cases, here presented in relation to an agent, Jack, who has entered into a Ulysses Contract. In the first case, Jack makes an appointment to cancel his Ulysses Contract, explaining that he has changed his mind about the prospect of being given treatment against his wishes. In the second case, Jack has been arrested by Police, and Jack's friend, Jim, has explained that Jack has stopped taking his medication, and is probably spiralling. As a result, Jack's psychiatrist has been called, but Jack is refusing treatment, insisting that he is okay, and does not need his medication any more.

The contrast between these two cases may seem facetious, but the point we make is a serious one. An individual who has entered into a Ulysses Contract, but then changed their mind about their most meaningful values and about the Ulysses Contract, would seek to revise their Ulysses Contract, rather than waiting for the moment when a doctor is trying to medicate them against their will to state that they have changed their mind. And, as spiralling typically leads to an increase in spontaneous and impulsive actions [29], the spiralling patient is not likely to make an appointment to change their Ulysses Contract.

As such, it is important to emphasise that, on our view, a Ulysses Contract is not a contract that binds the agent permanently, preventing them from ever rejecting it, or preventing them from changing their treatment plan. Rather, the aim is to protect the individual, and to give more weight to carefully made decisions in the Ulysses Contract, which reflect the agent's

most important values, and to give less weight to decisions which are likely to be due to the influence of the bullying forces of spiralling rather than the result of a genuine change of mind.

Spellecy suggests that "it is the rational reconsideration of a plan which is sufficient to be labelled 'a genuine change of mind'" [2]. Spellecy appeals to the 'planning theory of intention' proposed by Michael Bratman, 1987, which evaluates rationality according to desires, beliefs, intentions and plans [2], and which is intended to improve on the desire-belief model. This theory asserts that intentions and plans have a special status over desires and beliefs; which is rooted in the way in which intentions are formed, their role in practical reasoning, and the means by which they are altered or rejected [2]. A desire-belief model suggests that someone chooses to do something because of their beliefs and desires, their strongest one determining their decision. However having a strong desire is not the same as creating a plan. Spellecy talks about plans in terms of *complex* intentions and inertia. By inertia, Spellecy means "a stable element of practical reason that resists change" [2]. Desires do not have this characteristic inertia which intentions do, and it is this inertia which makes plans special [2].

The planning theory places no focus on the end decision, so the investigation should be free of any bias or value judgement from the trained professional. This investigation would aim to ascertain whether or not the individual has rationally reconsidered their plan, as declared in the contract. If there is sufficient evidence of rational reconsideration of a plan, this would indicate a genuine change of mind and the contract should be overturned. However, if there is no evidence of rational reconsideration or if the individual is expressing false beliefs or desires which are significantly inconsistent with the patient's fundamental plans for the future, insufficient consideration of relevant reasons, or an unsound reasoning process, then the contract should be honoured. These findings would suggest that the bullying forces of spiralling are impacting an individual's decision-making process. (In particular, we should want to explore why the individual did not make the effort to change or cancel their Ulysses Contract prior to being in a situation where the conditions of the contract are met.) Judgements such as these are not fool-proof; but with adequate safeguards in place, the involvement of the agent's known psychiatrist and the involvement of an additional third party, we can significantly reduce the chance of error.

This argument does not completely eradicate the risk of treating someone against their genuine changed mind, but we will discuss further safeguards and proceed to demonstrate that it is a justifiable risk.

3.2. Safeguards

Dresser proposes a safeguard which could reduce the risk of serious harm. Discussing advance directives, Dresser discusses the need for a clause which allows the agent to state specific circumstances under which they would like their directive to be overridden [30]. This strategy could also be applied to Ulysses Contracts. For example, this clause could state the level of restraint which an individual would be willing to receive in order to have their contract honoured, and if anything beyond this threshold was required, the contract must be overridden.

Similarly, other safeguards could be implemented to minimise the risk of treating someone against their authentic wishes. Firstly, Ulysses Contracts must be initiated and developed primarily by the patient, to ensure no coercion, during a period of remission where they have satisfactory capacity to make decisions about their treatment, and they must have the diagnosis of a severe treatable mental illness which has an episodic pattern [2]. Candidates must initiate the writing of the contract themselves, and can only write a Ulysses Contract when they have relapsed (x) times[2] before, and ought only to be permitted to pre-commit themselves to a course of treatment which they have tried and found effective before [13]. This clause may seem unfair for people who are worried about spiralling for the first time, but it is vital in outlining the specific conditions of the contract that the individual has a previous experience of relapse. It is also a necessary clause to maximise an individual's safety, by minimising the risk of an unexpected event, allowing them to be confident in their response to the specified treatment. The agent must clarify how a relapse is indicated, who is permitted to intervene, what this intervention is, and when and how it is to be carried out (see [22]); and there must be a time limit set for the treatment to be carried out (see [25]). Ideally, the agent should also have access to a minimally acceptable support system, consisting of family,

a friend, colleague, neighbour and so on; who is fully informed of their illness and what signs to look out for to report suspected spiralling [2].

The specific terms of the contract must be developed alongside discussions with their psychiatrist and a trustworthy third party. [29] As far as is possible, the aim would be to ensure the development of a coherent, unambiguous and detailed contract, which would be straightforward to follow.

The contract must also contain detailed explanations of their motivations for the contract, acknowledging their most meaningful values, desires, and goals for the future. The agent must take responsibility for the consequences of the arrangement, have a full understanding and awareness of the seriousness of a Ulysses Contract, and must experience no pressure or coercion from others to make the commitment [22].

The terms of the contract must be frequently reviewed by the agent, to ensure continued support for the contract, and to demonstrate the consistency of the wishes expressed over time [2], and the contract must be approved by an appropriate medical-legal body [25].

Finally, as indicated above (when discussing Mill) the agent should be able to revoke the contract as long as they are not deemed to be incompetent or spiralling.

The above safeguards all promote the agent's autonomy, and minimise the risk of an agent being treated against their genuine change of mind.

4. Conclusion

In this paper, we have presented four arguments in favour of respecting Ulysses Contracts in the case of individuals who suffer with severe chronic episodic mental illnesses, and who have experienced spiralling and relapse before.

First we appealed to degrees of competence, emphasising that even if a person meets the usual standard for competence at t1 and t2, we may still see a disparity in the *level* of competence at each time (and a level of competence that is usually sufficient may not be

sufficient to justify the rejection of the Ulysses Contract). Second, we emphasised the significance of protecting people's most meaningful concern. Third, we emphasised that the restrictions to people's liberty would be temporary, and would be consistent with soft paternalism, rather than hard paternalism, and would be designed in such a way that individuals would be free to change their minds, and to change or cancel their Ulysses Contracts later. Finally, we appealed to Frances Kamm's idea of exportable properties to argue that, even if one rejects the equivalence thesis, one can still (in particular cases) argue that it would be as wrong to allow a harm as to do a harm, and that a doctor who ignored a patient's Ulysses Contract would be wronging their patient (unless there were exceptional circumstances to justify the rejection of the Ulysses Contract).

We believe that each of these arguments is persuasive on its own. However, the arguments should be considered together, each supporting the other, presenting a coherent whole, highlighting the importance of Ulysses Contracts and the importance of respecting Ulysses Contracts.

We do, of course, recognise that this is a controversial issue, and we also recognise that there are risks involved. However, we have highlighted several possible safeguards to minimise risks and, ultimately, our claim is that people who are vulnerable to spiralling deserve a way to protect their autonomy as far as possible, and this protection is what Ulysses Contracts offer.

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[1] Although this argument clearly relates to the law, the argument in this paper is a moral argument, not a legal argument, and none of our terminology should be interpreted as legal terminology.

[2] Further debate would be required to determine the appropriate number of times, whether just one relapse would be sufficient, or whether a person should experience more relapses before they can commit themselves with a Ulysses Contract. And, indeed, we would not rule out the possibility of having different answers in different cases.