

Mad in Australia



The state's assault on the mentally ill

"We are forced to be compliant, broken down, life and energy sucked from our essence. They create sedated, manageable people not fit to function."

- Saeed Dezfouli



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1. Introduction

This report documents the history of abuse towards mental health patients worldwide, and in Australia. The report outlines the historical and cultural context of the abuse of mental health patients and identifies where the culture of doctors forcing medication on mental health patients began.

The history behind methods of mental illness treatment is stark. During the worst times treatment amounted to effectively killing patients by drowning them and then reviving them in the hopes to cleanse them of their 'unhappy condition'. But even the most barbaric 'therapies' were justified on the basis that the mentally ill were subhuman and should be disposed of.

This report also draws on the World Health Organisation's (WHO) eight-year study into the effectiveness of treatments in western and developing countries. In follow ups conducted after five years, **64% of mental health patients were asymptomatic in developing countries as opposed to a mere 18% in developed countries.**¹ The results indicate that **social support nurtures higher rates of recovery while medical intervention is harmful.** The project 'Soteria' had similar implications with **68% of patients who underwent neuroleptic treatment relapsing within the two-year follow up period** compared to only a 31% relapse rate for those who had undergone the community inclusion program and continued to avoid medication after the project.² These findings confront the presumption that neuroleptics effectively treat symptoms of mental illness. Empirical evidence suggests that the practice of forced medication, which is such a serious violation and infringement of basic human rights, has no justification.

This report then explores the legal and personal implications of forced treatment for mental health patients with reference to domestic and international principles, and practices. It raises the critical moral dilemmas of involuntary treatment and ultimately shows that disrespecting patients' rights to control their medication is wrong, unreasonable and counterproductive. It argues that the right of the individual to make choices about how their body is treated is inherent in civil recognition as a person. It states that personal control of health services is a fundamental human right and should only be overruled when critically necessary.

This analysis presents a reality that is functionally different than the legal and ethical framework claimed by the state. It focuses on the lack of human rights protection in Australia, particularly for involuntary patients.

In the widely circulated *Not for Service* report in 2005, by the Mental Health Council of Australia and the Human Rights and Equal Opportunity Commission, evidence of the issue was received and recommendations proposed. However governments have ignored it and the consumer voice is stifled.³

This document looks at international standards, particularly presented by the Mental Disability Advocacy Centre (supported by the Council of Europe), that recognise the rights of mentally ill patients. It considers the many jurisdictions that no longer allow forced treatment as an automatic result of involuntary confinement. This is contrasted with the Australian position that removes the rights from involuntary patients to be respected in treatment decisions, especially when it comes to practices of sedation.

1 Robert Whitaker, *Mad in America* (Basic Books, revised ed, 2010) 227-8.

2 Ibid 225.

3 *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, (2005) Mental Health Council of Australia and the Human Rights and Equal Opportunity Commission.

It then assesses the normative value of involuntary medication, arguing that it is unjustified within a principled framework of the relationship between state and citizen. Then it shows that involuntary treatment fails to achieve its intended effects. Research demonstrates that it disturbs rather than helps patients causing very significant side effects that they fear and detest. In fact by overcoming the consent of patients to decide whether and what chemicals are used in their treatment, it could be described as poisoning them. Whilst the paper concedes the value of forced medication in limited short-term situations, it exposes the reality of the regular breach of patients' integrity instead of discussing options with them and letting them make the decisions. It highlights the discriminatory nature of the forced injection, in the way it infringes on the right of disabled people to be treated with respect for their physical and mental integrity on an equal basis with others.⁴

The latter half of this paper proposes effective alternative approaches to forced treatment. These include patient-centered psychological treatment that is effective for patients in psychosis, as well as other measures proposed by patients themselves, that aren't currently considered but are consistent with domestic and international law. They require effort, patience and respect.⁵ This paper concludes with the proposition that consensual treatment is the only acceptable form of "care".

2. History- The Abuse of Mental Health Patients

At the start of the 18th century, the "insane" were typically viewed as wild animals, who had lost their reason⁶. They were subject to scorn and ridicule by the public, sometimes kept in madhouses in appalling conditions, often in chains and neglected for years or subject to numerous tortuous "treatments" including whipping, beating, bloodletting, shocking, starvation, irritant chemicals, and isolation⁷. Hateful rhetoric like 'poisonous slime' and 'malignant biological growths' further vindicated the liberal use of force in shockingly inventive ways like choking the patient by wrapping a wet towel around their neck and twisting it until they fell unconscious or slugging them to the same effect with a hard bar of soap in the toe of a sock.⁸

Moral treatment was an approach to mental disorder that emerged in the 18th century. The ex-patient Jean-Baptiste Pussin and his wife Margueritte, and the physician Philippe Pinel (1745–1826), are recognised as the first instigators of more humane conditions in asylums. In 1797, Pussin first freed patients of their chains and banned physical punishment, although straitjackets could be used instead⁹. Patients were allowed to move freely about the hospital grounds, and eventually dark dungeons were replaced with sunny, well-ventilated rooms.

Pinel used the term "traitement moral" for the new approach. At that time "moral", in French and internationally, had a mixed meaning of either psychological/emotional (mental) or moral (ethical). Pinel distanced himself from the more religious approach that was emerging in Britain, and considered that excessive religiosity could be harmful.¹⁰

4 Article 17 of the Convention of the Rights of Persons with Disabilities (CRPD).

5 The International Covenant on Civil and Political Rights; International Covenant of Economic, Social and Cultural Rights; Convention of the Rights of Persons with Disabilities and the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment.

6 Medieval and early modern theories of mental illness, R Neugebauer - Archives of General Psychiatry, 1979 - Am Med Assoc April 1979

7 Laffey P (October 2003). "Psychiatric therapy in Georgian Britain". *Psychol Med* 33 (7): 1285–97. doi:[10.1017/S0033291703008109](https://doi.org/10.1017/S0033291703008109); History Department, University of Western Australia.

8 Above n1, 69.

9 Weiner DB (September 1979). "The apprenticeship of Philippe Pinel: a new document, "observations of Citizen Pussin on the insane"

10 Louis C Charland (2008) A moral line in the sand: Alexander Chrichton and Philippe Pinel on the psychopathology of the passions. In [Fact and value in emotion](#),

With “moral treatment” patients were cared for with utmost diligence and humanity. Patients were housed in facilities to match that of a modest hotel and staff were selected according to specific job requirements such as “pleasantness of expression” and softness of tone”. Those in asylums were treated as humans, given lectures, responsibilities, and a quasi-family to operate with in an attempt to allow them to help themselves return to wider society.¹¹ These requirements made staff harder to hire and asylums more expensive to maintain.

The moral treatment movement was initially opposed by many madhouse keepers and medics, the latter opposed partly because it cast doubt on their own approach. By the mid-19th century, however, many medics had changed strategy. They became advocates of moral treatment, but argued that since the mentally ill often had separate physical/organic problems, medical approaches were also necessary. Making this argument stick has been described as an important step in the profession's eventual success at securing a monopoly on the treatment of “lunacy”.¹²

An increased institutionalisation and bureaucracy of the mental health sector led to the disregard of “moral treatment” and the rise of our modern formula of patient oppression in an attempt to regulate their stay at asylums and ease the financial burden on the mental care industry.

There have been many different theories¹³ about the cause¹⁴ of mental disease in patients. Theories such as bad spirits, unregulated blood flow, madness-causing bacteria, diseased brain cells, overstimulation of nerves and too many or too sensitive dopamine receptors were treated “scientifically” at varying points in history. These theories were sometimes used to attempt to justify various treatments, such as leeching, drowning, opiates, lobotomy, electroshock (actually increasing in usage in WA) and neuroleptics, which all had the common side effect of oppressing the patient and making them submissive. This reduced activity in patients is seen as being an improvement in their condition, and hence the supposed effectiveness of these treatments.

The definition of mental health treatment has changed over the decades resulting in the bad being replaced by more bad. Although the treatments appear to have changed, the main focus of today's “scientific” and widely accepted treatment of the mentally disabled is in fact a system of complete control and not the rehabilitation that one would want when in such a condition.

In Australia, many involuntary patients are sedated (and medicated) against their will, exemplifying the desire for mental health institutes to oppress and not nurture. Interestingly, treatments such as neuroleptics were in fact used to justify the theory of mental disease, where any reasonable man would expect the reasoning to be in reverse.

The treatment patients received at Chelmsford Hospital epitomise the mental health paradigm in Australia. Chelmsford Hospital's infamous deep sleep therapy left patients either more damaged or dead and yet almost half a century later, victims have yet to receive a formal apology.¹⁵

New neuroleptic medication is released every few years, under a new name and promising improvements over the old, the main difference being a reduced probability of Extrapyramidal symptoms (movement disorders). However, neuroleptics are used to calm and settle the patients, and still has controversial and debatable effectiveness in actually curing the disease in question, with the treatment rates of the old typical antipsychotic neuroleptic medication (Chlorpromazine, Haloperidol) being the same as the current atypical psychotic medication (Clozapine, Paliperidone).

11 Whitaker, R. (2002). “Mad in America”. Perseus Publishing. United States. An abstract of the novel can be found at <http://www.madinamerica.com/2011/11/mad-in-america/>

12 Crossley, Nick (2006). “Contextualizing contention”. *Contesting Psychiatry: Social movements in Mental Health*. New York: Routledge. ISBN 0-415-35417-X

13 Richard Noll, ‘The blood of the insane [History of Psychiatry, 2006](#), DeSales University.

14 The Myth of Mental Illness: Foundations of a Theory of Personal Conduct, by Thomas S. Szasz

15 Malcolm Knox, ‘The Big Sleep’ *Good Weekend* (Sydney), April 13 2013, 31.

There are non-medicinal treatments that offer alternatives to neuroleptics, but the simplicity of the “moral” method and the egos of the top psychiatrists prevented anyone from challenging the efficacy of neuroleptics, such as Mosher, Rappaport, Crane and Breggin, who all had their falling outs with the National Institute of Mental Health in the USA over alternatives to neuroleptics.

Loren Mosher started a moral treatment project named Soteria, which delivered unprecedented results “... subjects in both groups [who participated in the project] improved significantly and comparably, despite Soteria subjects not having received neuroleptic drugs.”,¹⁶ in terms of curing and preventing the relapse of schizophrenia. His work was replicated in Sweden, but was refuted in the USA by the NIMH who could not believe that ordinary people working in Soteria could treat mental illnesses more successfully than highly educated psychiatrists. “The importance of social inclusion to good mental health [as well as an effective and responsive] community-based approach”¹⁷ to good mental health further supports the notion that drugs are not necessary in treating the mentally ill as demonstrated in the Soteria project.

Perhaps one of the strongest indicators of the inadequacies of modern western treatments for mental illness is the WHO’s eight year study (which has been repeated) into three poor countries; India, Nigeria and Colombia (1969) revealed that at the two year and five year follow-ups, patients in these third world countries were performing significantly better than those in the USA and four other first world countries. After five years, 64% of those in the developing countries were asymptomatic, compared to 18% in developed countries. The notion that Third World Countries have more effective treatment in relation to better Mental Health due to Whitaker’s “conclusion that Africans and Asians were better off because they lacked the very drugs on which we rely.”¹⁸

Up to now, the generally accepted theory states that neuroleptics are able to treat symptoms mental illness such as schizophrenia by blocking dopamine signals (but not the actual illness). Any blockage of dopamine results in impaired concentration, reduced motivation, increased perception of pain and sometimes renders the person incapable of experiencing pleasure. Additionally, neuroleptic medication had been proven to increase a patient’s sensitivity to dopamine, as the restriction of dopamine due to neuroleptics forces the brain to produce more dopamine receptors. In addition to this, MRIs of patients taking this medication showed that frontal lobe size and white matter shrunk as the medication was continued, exacerbating symptoms of reduced cognitive abilities.

2.1 Recent Developments of Psychiatric Thinking

The significant literature of Bracken *et al*¹⁹ and Rosen *et al*²⁰ acknowledge that social inclusion should be the primary response to social disturbance. Recently, as a response to the upcoming publication of the DSM V, the British Psychological Society’s Division of Clinical Psychology (DCP)

16 Mosher, L. (1999). “Soteria and Other Alternatives to Acute Psychiatric Hospitalization A Personal and Professional Review”. *The Journal of Nervous and Mental Disease* 187:142-149 <http://www.moshersoteria.com/articles/soteria-and-other-alternatives-to-acute-psychiatric-hospitalization/#cohort1>

17 <http://www.mhcc.org.au/images/uploaded/MHCC%20Social%20Inclusion%20booklet.pdf>

18 Blumenthal, C. (2007). “Mad In America: So What Else is New? Controversial Book Examines Psychiatric Treatment for Schizophrenia.” http://www.nycvoices.org/article_554.php

19 Pat Bracken et al, *Psychiatry beyond the current paradigm* (BJPsych, 2012).

20 Alan Rosen, Tully Rosen and Patrick McGorry, ‘The Human Rights of People with Severe and persistent Mental Illness: Can Conflicts between Dominant and Non-Dominant be Reconciled?’ in Michael Dudley, Derrick Silove, and Fran Gale (eds), *Mental Health and Human Rights: Vision, praxis, and courage* (Oxford University Press, 2012), ch 16.

issued a statement expressing their concern for the overreliance of the biomedical model of mental distress by psychiatrists and calls for a 'paradigm shift' in how mental health is understood.²¹

3. THE REALITY OF FORCED TREATMENT

In theory and according to the law, forensic mental health facilities (such as Long Bay Forensic Hospital) provide for the care, treatment and control of persons who are classified as mentally ill or mentally disordered within the prison system. These facilities are intended to provide treatment to patients whilst also protecting their civil rights and allowing them to have access to appropriate care. There is, however, a fundamental disconnect between the way the system should operate and the way it really functions. The traditional reliance by patients on beneficial care and advice provided by health practitioners is overturned and subverted in a framework where treatment decisions are not made by informed and consenting patients, but rather made by the whims of the state.

Unlike prisoners, (who are treated as rational adults who face retribution for their crimes and, hopefully, reintegrate into the community after their sentence is served) patients in forensic mental health facilities can be forced into involuntary treatment programs indefinitely. Human dignity is inherent in all people, and this dignity does not diminish when it concerns mentally ill and disabled people.²² However, mental health patients are often condemned to a world where their fundamental rights as human beings are forfeited and they live at the mercy of the state's discretion.²³ This is sometimes asserted through the Mental Health Review Tribunals. It is evident that patients are often dehumanised in the course of their treatment; visitors are discouraged and sometimes refused entry; and social support is often seen as an unwanted disturbance rather than a constructive community right.

Forced medication is a regular form of 'treatment' for many such patients who are prejudicially assumed to be incapable of making any rational decisions. Saeed Dezfouli, a non-violent patient in Long Bay Forensic Hospital, is one such person. Saeed has been held indefinitely at the forensic hospital in Long Bay Jail since 2002 and is forced to take anti-psychotic medication on a fortnightly basis. Teams of burly doctors and nurses often have to physically restrain him, hold him face down and forcibly inject him. The use of forced injection, which would be considered battery in any other circumstance, is an unequivocal breach of Saeed's individual right to control of his body. Under the justification that he is incapable of making rational decisions, he has been given no opportunity to make decisions or question his treatment plan, without running the risk of his opposition being used as evidence of his mental illness. Any sign of resistance has been used to mark him as non-compliant. In turn, this has been used as a justification to keep him incarcerated longer.

The unfortunate reality is that health professionals and doctors are de-sensitised to the plight of their patients, with a focus on outcomes instead of patient wellbeing. In addition, health professionals in forensic facilities must not forget that the prescription of medication to a person should meet the

21 *British Psychological Society Division of Clinical Psychology, 'Division of Clinical Psychology Position Statement on the Classification of Behaviour and experience in Relation to Functional Psychiatric Diagnoses: Time for a Paradigm Shift' (Media Statement, 13 May 2013) <http://dcp.bcp/the_dcp/news/dcp-position-statement-on-classification.cfm>*

22 *Secretary Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218.*

23 Section 32 of the Mental Health (Forensic Provisions) Act 1990 (NSW) states 'mental illness' is provided as a defense in indictable proceedings. The definition of 'mental illness' is derived from M'Naghten Rules (1843) 10 CL & Fin 200 in NSW. It must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as to not know the nature and quality of the act he was doing, or, if he did know it, he did not know what he was doing was wrong. In all other jurisdictions defined by statute; *Criminal Code (Cth)* s7.3; *Criminal Code (Qld)* s 27; *Criminal Laws Consolidation Act 1935 (SA)* s 269(c); *Criminal Code (Tas)* s 16; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)*; *Criminal Code (WA)* s 27; *Crimes Act 1900 (ACT)* s 28; *Criminal Code (NT)* s 35.

health needs of the person and should be given only for therapeutic or diagnostic needs. It should not be given as punishment or for the convenience of others.²⁴ Furthermore, Saeed's experience demonstrates the ineffectiveness of the Mental Health Review Tribunal and Supreme Court in providing a supposed avenue of appeal for involuntary patients.²⁵

This abuse of individual rights becomes even more insidious when the case of Michael Riley is considered. Despite the fact that Michael has never been charged for an offence and does not have a record of violent behaviour, he has been in and out of mental hospitals as an involuntary patient for the last twelve years. During this time, he has been subjected to a whole host of involuntary treatment plans.

It is one thing to arbitrarily restrict individuals' autonomy because they might be dangerous to society; it is another thing entirely to take the last thing that matters to them after liberty – the control of their very body. Patients (like Michael) are trapped in a system where, by virtue of their mental disorder, have been coerced into "choosing" a specific treatment plan. This may consist of sedatives to make them more compliant, or being taken to hospital where the treatment plan is functionally forced upon him. Michael has consistently been assessed as not being a danger to either himself, or others, but due to his condition, has been preemptively locked up. Unsurprisingly, this flagrant abuse of his rights feeds into the patient's existing sense of paranoia and distrust with the system, which further complicates recovery efforts.

Forced medication is also at odds with the principles of recovery-focused person-centered care which is trauma informed. With the high proportion of mental health consumers having a past history of abuse, to force medication reinforces that trauma.

The reality for many patients in forensic mental health facilities in NSW is that, if they accept psychiatric treatment, they are deemed to have capacity and will be admitted to a voluntary treatment program. However, if the patient is opposed to the treatment, consequently they are subjected to a longer incarceration and involuntary treatment. Ultimately, this creates a situation where patients are only given the illusion of choice, which is at best coercive and at worst non-existent.

4. THE ISSUE OF HUMAN RIGHTS

Literature on the right to refuse treatment for mental health patients is grounded in the United Nations human rights ideals and international principles on the right of the individual. This includes, but is not limited to, *Principles of Persons with Mental Illness and Improvement of Mental Health* adopted by General Assembly Resolution in 1991, the *United Nations Convention on the Rights of Persons with Disabilities*, 2007, and the *United Nations Standard Rules for the Equalization of Opportunities for Persons with disabilities*, 1993.

These protections of International Law are insufficient for two key reasons. Firstly, despite Australia being a signatory to many international conventions promoting the protection of human rights, the power to enforce these treaties lies within the Federal government in passing those treaties into domestic law.²⁶ Secondly, even when the international agreements are enacted into domestic law

24 *Mental Health Act 2007* (NSW) s68(d).

25 *Mental Health Act 2007* (NSW) ch 6.

26 The most relevant of which are; The International Covenant on Civil and Political Rights; International Covenant of Economic, Social and Cultural Rights; Convention of the Rights of Persons with [Disabilities UN](#) and the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment.

(thus becoming enforceable and binding on every Australian citizen), they are usually written in such a way that facilities (such as Long Bay Forensic Hospital) can still abuse the rights of the patients and not suffer any real consequences.

Countries such as the United States and Canada have a constitutional Bill of Rights, and the United Kingdom has a statutory Human Rights Act, thus providing a legal basis by which action can be taken for violation of an individual's rights. Unfortunately, human rights in Australia are much less entrenched than in similar liberal democracies, relying on a few implied rights in the Constitution and common law protections. With the exception of the ACT²⁷ and Victoria²⁸, both of which have a Bills of Rights. These are evidently not strong enough to protect individuals from a paternalistic health department and interventionist state authority. The lack of explicit and enforceable human rights protections for mental health patients creates a farcical situation where the needs for individual people, which have been recognised time and time again in aspirational human rights statements, are ignored by bureaucratic inertia and systemic abuse.

5. INTERNATIONAL EXAMPLES

There are multiple international examples of where states have appropriately balanced the needs of the state with the rights of the individual, which serve as a valuable point of comparison with the Australia legal framework. In particular, note the distinction between involuntary confinement and the restriction of the right to refuse certain medical treatments.

A legal authority in Europe for the right of individuals to make decisions in relation to medical treatment can be found in the right to privacy in Article 3 of the European Convention on Human Rights (ECHR), stating the right to be free from inhuman treatment.²⁹

Further, the Mental Disability Advocacy Centre (MDAC), supported by the Council of Europe, states that 'the right to decide is not contingent on the convenience of economic efficiency to the state of the person being treated, nor whether the decision to refuse treatment by the patient is not the correct thing to do. It is simply a right that we enjoy.'³⁰

The MDAC argues that the relationship between compulsory detention and treatment does not necessarily follow.³¹ Theoretically there is nothing inconsistent with involuntary detention and allowing the individual the authority to make treatment decisions.³² Although it has been argued that justification of confinement was for medical benefit, this is not the way human rights law, and the ECHR in particular, have viewed confinement.³³ According to the MDAC, the Strasbourg Court has never suggested that for the justification of confinement there must be an effective treatment

27 *The Human Rights Act 2004 (ACT)*.

28 *Victorian Charter of Rights and Responsibilities 2007 (Vic)*.

29 European Convention on Human Rights (ECHR) cited in Lewis, O., Thoronld, O & Bertlett, P 'The European convention on Human Rights and the rights of people with mental health problems and/or intellectual disabilities' (2003) *Mental Disability Advocacy Centre* at http://www.mdac.info/documents/MDAC_ECHR_training_pack_-_English_2nd_edition.doc.

30 ECHR, MDAC, above n 11, 13

31 ECHR, MDAC, above n 11, 13

32 ECHR, MDAC, above n 11,

33 ECHR, MDAC, above n 11, 13

34 ECHR, MDAC, above n 11,

plan.³⁴ Confinement has been determined on dangerousness and severity, rather than treatability. Thus, even if a patient is confined on grounds of dangerousness, there should not be an automatic removal of a patient's rights to treatment decisions.

There is an increasing international view that if patients are able to understand relevant information in relation to treatment decisions, they ought to be able to decide, regardless of their place of residence. The Committee for the Prevention of Torture outlines this view:

Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or other medical intervention.³⁵

The MDAC advocates that the right to make treatment decisions should depend on capacity, rather than confinement.³⁶ What constitutes 'capacity' itself is a debated issue. The individual should have the intellectual capacity to understand the diagnosis and basic information. In New South Wales, for example, according to section 153(1) of the Mental Health Act 2007 the test for determining whether or not a person is mentally ill or mentally disordered is on the balance of probabilities (i.e. a member of the Mental Health Tribunal must be satisfied on the balance of probabilities that the person is a mentally ill or a mentally disordered person). It is the responsibility of the doctor to explain the treatment information in basic language. The United Nation reinforces this responsibility with Principle 11 of the *'Principles for the protection of Persons with Mental Illness'*:

Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and easy to understand information in a form and language understood by the patient on:

- a) The diagnostic assessment;
- b) The purpose, method, likely duration and expected benefit of the proposed treatment;
- c) Alternative modes of treatment, including those less intrusive; and
- d) Possible pain or discomfort, risks and side effects of the proposed treatment.

An invasion of a person's body is an interference with private life under Article 8 of the ECHR. However, Article 8(2) allows for medical treatment 'for the protection of health.' The courts have, however, emphasised the need for vigilance when assessing whether someone 'needs' medical treatment. *Bensaid v United Kingdom*³⁷ reinforced that 'mental health must be regarded as a crucial part of private life associated with the aspect of moral integrity.'

The Council of Europe has established that treatment without consent should be based on law and 'only relate to strictly defined exceptional circumstances'.³⁸ Treatment without consent must therefore be based on clear grounds related to the health or safety of the patient or to the protection of others.

Article 8 is clearly applicable to complaints that concern a matter of 'private life'; a concept that covers the physical and psychological integrity of a person.³⁹ It reiterates that a person's body concerns the most intimate aspect of private life. Thus, a compulsory medical intervention, even if it is of minor importance, constitutes an interference with this right.⁴⁰

35 Committee for the Prevention of Torture 'VI. Involuntary placement in psychiatric establishments' Extract from the 8th General Report [CPT/Inf (98)12] 2002.

36 ECHR, MDAC, above n 11.

37 *Bensaid v United Kingdom* [2001] ECHR 82.

38 The CPT Standards, Chapter VI, para.41 at <http://www.cpt.coe.int/en/docsstandards.htm>.

40 (see *X v. Austria*, no. 8278/78, Commission decision of 13 December 1979.)

In some Canadian jurisdictions, patients with the capacity to make treatment decisions are able to exercise the right to make those decisions. Although this has been the case for almost twenty years, the medical profession received this approach with great concern. Contrary to their fears, implementation raised few practical problems and with time the medical profession are broadly content with this approach.⁴¹ The recognition of the right to make treatment decisions has resulted in closer consultation and relationships between the treating doctor and patient.⁴²

In *Flemmings v Reid*,⁴³ a Canadian court found that an involuntary psychiatric patient expressed, while he was competent, that he did not wish to be medicated. The Court found that setting aside his competent wishes was contrary to his right to life liberty and security under section 7 of Canadian Charter.

American courts rejected the argument that involuntary hospitalisation equates to a patient's incompetence to make treatment decisions. In *Lessard v Schmidt*⁴⁴ it was established that only a finding of 'dangerous to self or others' is necessary in order to deprive a person of their individual freedoms. Furthermore, it was found that lengthy hospitalisation may increase symptoms of mental illness and make transition into society more difficult.⁴⁵

The court held, in *Rodgers v Okin*,⁴⁶ that hospitals could not forcibly medicate voluntary or involuntary patients with a mental illness except in cases of an emergency in which failure to do so would cause harm to the patient or others. The court also highlighted that;

1. Involuntary hospitalisation did not equate to incompetence;
2. Detained patients with a mental illness had a qualified right to refuse psychotropic and antipsychotic drugs;
3. Some kind of procedural mechanism taking into account the issue of side effects and other factors was necessary to ensure effectuation of the right.⁴⁷

In *Rennie v Klein*,⁴⁸ the district court took a similar approach and decided that, in the absence of an emergency, the right to refuse treatment is grounded on the emerging constitutional right to privacy. The court noted three factors when this can be overridden:

1. Whether or not the patient can be confined without endangering other patients or staff, and if the medication refusal would have curbed the dangerous tendencies;
2. Whether the patient is competent to make the decision; and
3. Whether or not there is a less restrictive alternative available.

Since *Rennie* and *Rodgers*, all states except Utah have recognise the right to refuse treatment separate from the involuntary hospitalisation treatment decision.⁴⁹

Likewise, Scottish law does not allow compulsory treatment simply based on involuntary admission. It requires a separate compulsory treatment order.⁵⁰

41 ECHR, MDAC, above n 11, 14.

42 ECHR, MDAC, above n 11.

43 *Flemmings v Reid* [1991] D.L.R 298.

44 *Lessard v Schmidt* 349 F. Supp. 1078 (ED Wis. 1972).

45 Fischer, 'A Comparative Look at the Rights to refuse treatment for involuntary Hospitalized Persons with a Mental Illness', 29 *Hastings International and Comparative Law Review* 153 (2005), 158.

46 *Rodgers v Okin* 478 F. Supp 1342 (D Mass 1978).

47 *Rennie v Klein* 462 F. Supp 1131 (D.N.J 1978); *Rodgers v Okin*.

48 F. Supp 1342 (D Mass 1978) in Fischer, above n 27.

49 Fischer, above n 27, 158.

50 Fischer, above n 27, 175.

6. DOMESTIC LEGISLATION

In some Australian jurisdictions, as in the United States and Canada, clinical standards alone are no longer considered a sufficient justification for the restriction and loss of liberty involved with the care of mentally ill patients.⁵¹ The statutory tests for compulsory treatment, although different depending on the jurisdiction, generally consist of a number of objective criteria superimposing a 'dangerousness' or harm prerequisite over a 'need for treatment'.⁵² The *Mental Health Act 2007* (NSW) for example, is more representative of the 'dangerousness' standard in its requirement that 'care, treatment or control of the person' must be necessary in order to prevent 'serious harm' likely to themselves and others from their mental illness.⁵³ The *need for treatment* and the benefits from such treatment, is the approach taken in the Victorian and ACT provisions.⁵⁴ The Victorian Act requires that the person's illness must require *immediate* treatment (in line with the standard preferred by the court in *Lessard v Schmidt*).⁵⁵

International legal frameworks may be contrasted to those in NSW, Victoria and the ACT, under which a person subject to an order authorising compulsory treatment may generally be provided with medication regardless of whether or not they object.⁵⁶ This stems from the understanding that involuntary patients are incompetent to make treatment decisions while in confinement.⁵⁷ However, this justification is far from compelling, given that there is no express incompetence prerequisite for compulsory treatment.⁵⁸

Regardless of the validation that is given in the legislation, in a practical sense, the NSW legislation, in particular, simply creates a blanket authority that an involuntary patient does not have any right to refuse treatment that the treating doctor 'thinks fit.' There is no need or requirement for external application to give a doctor this power; rather legislation assumes incompetence on behalf of the patient regardless of the specific circumstances of the individual.

Australian mental health statutes, specifically the *Mental Health Act 2007 NSW*, in addition to listing a set of objectives regarding the provision of care and treatment, also contains an attempt to give direction to decision-makers to implement those objectives with little or no input from the patient. This decision is left for the discretion of the treating doctor.⁵⁹

For example the objectives of the *Mental Health Act 2007* (NSW) are:

- a) To provide for the care, treatment and control of persons who are mentally ill or mentally disordered, and
- b) To facilitate the care, treatment and control of those persons through community care facilities, and
- c) To facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and
- d) While protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and

51 Carney, T, Tait, D, & Beupert, F. 'Pushing the Boundaries: Realising Rights Through Mental Health Tribunal' (2008) 30(2) Sydney Law Review, 7.

52 Carney et. al., above n 44.

53 *Mental Health Act 2007* (NSW), s14(1).

54 Carney et. al., above n 32.

55 Carney et. al., above n 32.

56 Carney et. al., above n 32.

57 Carney et. al., above n 32, 9.

58 Carney et. al., above n 32.

59 Carney et. al., above n 32.

- e) To facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.⁶⁰

However, section 84 governs the treatment of patients and states that:

An authorised medical officer of a mental health facility may, subject to this Act and the Mental Health (Forensic Provisions) Act 1990, **give, or authorise the giving of, any treatment (including any medication) the officer thinks fit to an involuntary patient** or assessable person detained in the facility in accordance with this Act or that Act.⁶¹

This broad authorisation allows involuntary patients to be treated against their will in NSW. There is little safeguard of the patients rights and no need for any other independent application to get authorisation to override lack of consent. The NSW position is not in line with any of the international standards and trends. As international law develops to recognise the right to refuse treatment, even for patients who are involuntary hospitalised, NSW has stood still in the protection of civil and human rights.

The *Mental Health Act 1996* (TAS) provides a more desirable approach to the treatment of involuntary patients than other jurisdictions in Australia. Under the Act, a patient in the Tasmanian jurisdiction cannot be forcibly treated merely when the treating doctor 'thinks fit.' Rather, an application has to be made under the *Guardianship and Administration Act 1995* and the Board determines whether to grant the application.⁶²

Tasmanian legislation appears to have favoured the rights of the patient and has created a rebuttable presumption that involuntary patients are competent, unless decided otherwise by the Board. The approach taken in Tasmania demonstrates that, while patients can be involuntarily detained, they are still able to maintain some level of recognition of their rights.⁶³

Ultimately, despite the good intentions in the objectives of the *Mental Health Act 2007* (NSW), which value the rights of the patient, in reality, the legislation has granted exceptional discretion and power to mental health professionals. If a patient refuses medication, a nurse or doctor in the facility has the power to force it via injection or orally – all in the "best interests" of the patient.⁶⁴ There is currently no independent body that authorises the use of forced medication, providing a necessary element of accountability over a process that could easily be abused.

6.1 The Practice of Sedation

The practice of sedation for involuntary patients, particularly in NSW, further highlights the abuse of rights and lack of respect shown to some of the most vulnerable members of society. Almost all forensic patients in and out of institutions are medicated against their will. It should be noted however, that research has shown that psychosis symptoms are best treated with psychological therapy and medication should only be used alongside psychological therapy.⁶⁵

60 *Mental Health Act 2007* (NSW), s3.

61 *Mental Health Act 2007* (NSW), s84.

62 *Mental Health Act 1996* (Tas), s32.

63 Langford, L 'The New Mental Health Act in Tasmania (1996): A comparative Review with the Former Act (1963): Can They Now Die with Their Rights on?' (2003) 10 *Psychiatry, Psychology and Law*, 140.

64 *Mental Health Act 2007* (NSW) s103(3)(a).

65 National Drug and Alcohol Research Centre, *Psychosis and Substance Abuse*, National Drug and Research Centre 2011, 6.

The NSW Health Policy Directive gives guidance to the sedation practices and clearly outlines the circumstances in which sedation may be used on a patient. The Policy Directive states that these 'chemical restraints' can only be used in 'extreme circumstances when other forms of management of a least restrictive nature have been proven unsuccessful.'⁶⁷ Furthermore, 'an injection without consent should be given only in the interest of the immediate physical safety of the patient or those in his or her vicinity.'⁶⁷ As noted above, any other unauthorised IV sedation that does not comply with this Policy Directive may be considered assault.

The Policy Directive also gives direction in relation to restraint in psychiatric in-patient facilities. Again, 'restraint should only be applied for the minimum time necessary and its application must take into account the principle of care in the least restrictive manner.'⁶⁸ On the surface, these principles of care within the Policy Directive are safeguards for vulnerable patients. However, when read in conjunction with the *Mental Health Act* (NSW), the safeguards that protect patients can be easily abused.

When a patient is held down and injected with a syringe, which functionally knocks them out, this should be classified as an IV sedation, and thus governed by the directives which states sedation should only be used in 'extreme circumstances.' However, the legislation has given treating doctors the ability to hide behind the notion of 'treatment.' If a patient complains that they are being sedated without justification, the treating doctor merely classifies the injection as 'treatment' and therefore is not bound by the Policy Directive. Thus the NSW Health system does not adequately protect the patient's rights. Power is placed in the hands of the treating doctor. Even with restrictions on sedation, the doctor has ultimate discretion to the treatment of the patient.

Criminal charges of assault can be laid for breaches of the Policy Directive and should act as deterrence to abusive doctors. The problem arises from the difficulty in separating 'sedation' from 'treatment.' The NSW health system needs to update their guiding principles of patient care and remove the ability for doctors to abuse the authority they wield over mental health patients. As well as collecting episodes of seclusion, the NSW health system should collect data on staff initiated PRN medication as this could be argued as being another form of chemical restraint.

7. OPPOSITION TO INVOLUNTARY TREATMENT

Using this framework in the current case, what are the normative justifications for involuntary treatment, that go beyond the principles of state intervention? The three justifications for involuntary treatment often provided are:

1. That the individual poses a threat to themselves and/or others;⁶⁹
2. That the individual lacks competency in making rational decisions about their treatment plans;⁷⁰ and
3. That there is a necessity to treat an individual's illness.⁷¹

In our view, the only valid justification is the first; that involuntary treatment is only ever justified in preventing immediate and tangible harm to others or the self. As such, when a patient is a clear

66 NSW Health 'Policy Directive: Seclusion Practices in Psychiatric Facilities' (2007) PD2007_054 at <http://www.health.nsw.gov.au/policies/a-z/s.asp>, 17.

67 NSW Health, above n 57.

68 NSW Health, above n 57.

69 *Mental Health Act 2007 (NSW)* s 14.

70 Carney, T, Tait, D, & Beupert, F. 'Pushing the Boundaries: Realising Rights Through Mental Health Tribunal' (2008) 30(2) *Sydney Law Review*, 7.

71 *Mental Health Act 2007 (NSW)* s 14.

danger to themselves, or other individuals, the use of medical practitioner discretion to use involuntary medication to calm and treat the patient is supported.

However, with respect to the second and third justifications, there are significant principled and practical problems. The theoretical rationalisation is that the individual, by virtue of having a mental disorder, is unable to consent to treatment that would ultimately be in their best interest. Thus, the government has the right to suspend their autonomy, and forcibly treat them for their own good. This balance is discursively coherent when the individual is a threat to others, or themselves in a direct and clear manner. These situations provide a mandate for the state to take some form of evasive action to avoid greater harm. However, it is unsustainable in many other cases. The reality is that not all mental disorders are equal, and they do not affect individuals in the same way. Mild bipolar disorder is not equivalent to paranoid schizophrenia. Nor is it the reality that a weakened ability to make rational choices is equivalent to no choice being made by the patient. Hence, children in palliative care are given limited control over pain medication and treatment plans despite the state's view that they are not competent to vote or make independent Do-Not-Resuscitate orders. The ability to make this choice for mental health patients is particularly important given the nature of the medication plans, which despite their proven benefits, also have serious proven side effects.

We, therefore, reject the idea that a mental disorder completely removes the individual's agency or capability to make valid decisions. The erroneous belief that mental illness negates the ability of patients to act rationally is a major contributing element in the debate on involuntary treatment.⁷²

Research has shown that mental illness does not make a person incompetent to make decisions about their treatment. The *MacArthur Treatment Competence Study* has shown that, in relation to the ability to make treatment decisions, there is little difference between those with a mental illness and those without.⁷³ This has led to the push for involuntary detained persons with a mental illness to be assumed competent, unless proved otherwise, and therefore be given the right to refuse or consent to treatment. Furthermore, the use of advance directives demonstrates the absurdity of the current policy; if medication can be used to stabilise a patient and to make them more capable of interaction, why can they not then issue an advance directive in their supposedly more stable state, when they are better equipped mentally at assessing the relative value of their treatment plan?

The absurdity of patients being denied the ability to choose their own medication is demonstrated by the use of the anti-psychotic medication Clozapine. Clozapine is very effective anti-schizophrenia medication, but also results in a wide variety of side effects ranging from weight gain, drooling, constipation, muscle stiffness, sedation, tremors, hyperglycemia and many others.⁷⁴ It also highly reduces the amount of white blood cells in the human body, resulting in greater vulnerability to infections, with potentially fatal effects. Consequently, Australian facilities are required to monitor patients on clozapine on a regular basis to monitor the side effects.⁷⁵ They even require patients to sign a consent form waiving the liability of the hospital for any physical or mental detrimental consequences arising from the treatment. This then begs the question of how patients, apparently not rational enough to choose their own treatment plan, are considered competent enough to sign a legal document waiving their rights. Three forensic patients spoken to, who must remain unnamed

72 Alfred Allan, 'The Past, Present and Future of Mental Health Law: a Therapeutic Jurisprudence Analysis.' (2003) 20 *Law in Context*, 24-53, 33.

73 Paul, S. and Appelbaum & Thomas Grisso, 'The MacArthur Treatment Competence Study: I. Mental Illness and Competence to Consent to Treatment,' 19 (1995) *L & Hum. Behav.* 105 in Fischer, 'A Comparative Look at the Rights to refuse treatment for involuntary Hospitalized Persons with a Mental Illness', 29 *Hastings International and Comparative Law Review* 153 (2005).

74 NSW Ministry of Health (2012), 'Policy Directive: Clozapine Induce Myocarditis-Monitoring Protocol,' *Clinical Patient Services*, document no. PD2012_005.

75 Ibid.

as per section 162 of the Mental Health Act,⁷⁶ noted how due to the other medications they were forcibly treated with, they had no idea what they were signing or its significance. Those who were reluctant to sign and be treated with Clozapine were threatened with indefinite detention in the forensic hospital.

Furthermore, the notion of incompetence is also associated with the idea of a 'need for treatment', implying a duty or an obligation to meet those needs.⁷⁷ Some jurisdictions justify compulsory treatment on the notion of treating that, which is 'dangerous'. It could be argued that 'dangerous' could be seen as a weaker requirement, merely *permitting* the state to interfere as opposed to an *obligation* to interfere. Although both standards are used in different jurisdictions, changes in such wording have not shown to affect commitment rates.⁷⁸ Appelbaum concludes that lawyers and judges bend the wording so to conform to 'fixed' or shared moral institutions.⁷⁹ Therefore, regardless of the justification for compulsory treatment, either a 'dangerous' or a 'need to treat' approach; there is a lack of security and minimal safeguards of the rights of the patient. When determining whether patients have the capacity to decide on their own treatment plan, those involved must examine the specific context of each situation. Appelbaum has found that, out of the mere 10% of inpatients that have refused treatment, most did so for a short amount of time and their reasons for refusal was often dislike or distrust of their medication's side effects.⁸⁰

In addition, the therapeutic benefits of involuntary medication are questionable. According to Dr Penny Weller, involuntary treatments can 'mask, rather than relieve the symptoms of mental illness'.⁸¹ She argues that such treatments often have sedative effects, which are used as chemical restraints. At other times, they have disabling side effects that mimic symptoms of mental illnesses, which lead to interpretations by medical officers that patients' behaviours reflect escalations of mental illness.

These findings have furthermore been complemented by other studies done in this field. In the Cochrane review entitled "Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders", it was revealed that there is little evidence that community treatment orders are effective for competent health care. That study concluded that statistically it takes 85 community treatment orders to prevent one re-admission, 27 to prevent one case of homelessness and 238 to prevent one arrest.⁸² This evidence is just another indication of why involuntary treatment is normatively inappropriate for mental health patients. It also indicates a clear waste of public expenditure in mental health treatment. Instead, such funding could be used to promote effective mental health care in accordance with fundamental human freedoms, such as treatment with free and informed consent.

Ultimately, the trade off of benefits against side effects is a decision that must be left to the individual. They alone are qualified to assess the comparative benefits and detriments of the medication as it affects them. The problem with the status quo is that it goes too far in assuming that a mental disorder gives the state a blank cheque that enables the choices of patients to be disregarded. With the exception of those who are a clear threat to them, and those around them, there is no part of social contract theory that suggests a surrender of one's own agency and autonomy is justified by notions of either empowering individuals or utilitarian notions of the greater good.

76 *Mental Health Act 2007* (NSW) s 162.

77 Radden, J 'Forced Medication, Patients' Rights and Value Conflicts' (2003) 10 *Psychiatry, Psychology and Law*, 4.

78 Radden, J, above n 4, 4.

79 Radden, J, above n 4, 4.

80 Appelbaum, P (1997) *Almost a revolution*, Oxford University Press cited in Radden, J, above n 3, 5.

81 Weller (2010) 'Developing Law and Ethics: The Convention on the Rights of Persons with Disabilities', 35 *Alternative Law Journal* 1, 2.

82 Kisely SR, Campbell LA, Preston NJ (2011). 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders.' *Cochrane Database of Systematic Reviews*, Issue 2.

The National Mental Health Consumer & Carer Forum has taken a similar stance in calling for an end to seclusion and restraint (for further reference please see Appendix B or <http://tinyurl.com/audbspa>).

8. DISCRIMINATORY NATURE OF FORCED TREATMENT

*'The delivery of a non-discriminative, autonomy-based legal framework for all treatment has been the goal of many reformers.'*⁸³

It has increasingly been recognised that 'wherever possible the principles governing mental health care should be the same as those governing physical health.'⁸⁴ It has been argued that mental health legislation discriminates against a category of people because of their mental disorder. Reviews have demonstrated that legislation governing involuntary patients demonstrates a lower degree of respect and patient autonomy than is afforded to other patients.⁸⁵ The *Mental Health Act 1986* (Vic) and the *Mental Health Act 2007* (NSW) remove a patient's ability to refuse treatment, as the treating psychiatrist can override lack of consent by the patient.⁸⁶ Although there is another right to a second opinion, the ultimate decision lies with the treating psychiatrist.

The differential treatment of involuntary patients should require further justification than merely their 'involuntary status.' It has been found that the increased risk arising from mental disorders is low in comparison to other factors such as age, gender, socio-economic status, drug or alcohol usage, or family breakdown.⁸⁷ Thus, it is difficult to argue, as a general proposition, that the risk involved with involuntary patients justifies the restriction of civil and human rights. Right to autonomy may be impeded for a number of reasons such as 'intense pain, anxiety, temporary lapses in consciousness, or other forms of vulnerability.'⁸⁸ Undeniably there may be more patients suffering a mental disorder that are impeded in their decision making by the underlying disorder, than those suffering a physical illness. However, this does not provide justification for a legal system that denies treatment decisions for those suffering a mental illness.⁸⁹ Furthermore, the assumed inability to make a 'correct' decision for mental health patients about treatment is not in line with other social standards. Refusal of life-saving treatment is a right that physical patients have. Self-harm does not justify interference with an individual's right of autonomy.⁹⁰

Courts in the United States have recognised that individual autonomy in treatment decisions extend 'equally to mentally ill persons who are not to be treated as persons of a lesser status or dignity because of their illness.'⁹¹ It can be inferred that any legislation that removes all treatment decisions from patients, purely because of their involuntary confinement status, is in fact discriminatory.

83 Donnelly, M 'From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights' (2008) 26(2) *Law in Context*, 37.

84 The Richardson Report (1999) *Review of the Mental Health Act 1983: Report of the Expert Committee* London: Department of Health cited in Donnelly, M, above n 8.

85 Donnelly, M, above n 9.

86 *Mental Health Act 1986* (Vic), s 12D.

87 Donnelly, M, above n 9.

88 Matthews, E (1999) 'Mental and Psychical Illness: An Unsustainable Separation?' in N Eastman and J Peay (eds), *Law Without Enforcement: Integrating Mental Health and Justice* Oxford: Hart Publishing cited in Donnelly, M, above n 9.

89 Donnelly, M, above n 9.

90 Donnelly, M, above n 9.

91 *River v Katz* (1986) 67 NY 2d 485 cited in Donnelly, M, above n 8.

9. ALTERNATIVES TO FORCED TREATMENT

There has been a push for involuntary detained persons with a mental illness to be assumed competent, unless proved otherwise. They should be given the right to refuse or consent to treatment. Just as the legal system assumes innocent unless proven guilty, so too should the burden of proof favor the presumption that involuntary patients are competent, unless proven otherwise. Patients are the suitable party to make evaluations on both the effectiveness and side effects of the medications,⁹² and independent groups such as the Consumer Organising Committee have made attempts to facilitate communication between mental health patients in formulating viable solutions.⁹³

In order to review a patient's capacity in the specific context in which it occurs, a medical practitioner, independent of the treating team, should be required to assess the patient and provide an opinion of the patients' capability to be involved in decisions that affect them.

The ability to refuse treatment by patients is also seen by some as therapeutic, as it recognises the right of the patient to privacy, competency and autonomy. Refusal of treatment has also been seen to encourage practitioners to communicate more effectively with the patients and be more patient oriented. In turn, this may encourage a patient's compliance.⁹⁴ Ignoring a patient's right to refuse treatment can also lead to disempowerment. Allan argues that 'there is evidence that practitioners take more care when the medication they recommend is appropriate, monitor its effects well, and listen to the concerns of the patient.'⁹⁵

Ignoring a patient's right to refuse treatment can also lead to disempowerment, and entrenches a sense of resentment with authority, hurting attempts at future rehabilitation and recovery. Greater transparency in the treatment process contributes to the overall recovery of the patient. Psychiatric medication is also often accompanied by severe side effects and can be highly invasive. Allowing patients to make treatment decisions utilises a patient's ability to understand themselves and their body's reaction.⁹⁶

Consensual treatment is the ideal form of therapeutic care. By allowing patients to make decisions, it enhances the psychiatrist-patient relationship and patients gain greater trust and confidence in the treating psychiatrist. It increases motivation for rehabilitation, as patients are said to respond better to treatment if they are explicitly involved and internally motivated to comply with treatment as opposed to externally coerced.⁹⁷

When determining whether patients have the capacity to decide on their own treatment plan, each patient must have their specific context and situation analysed by those involved.

To address the human rights infringement associated with involuntary treatment plans, mental healthcare authorities should provide voluntary alternatives that act as either:

- a) An intervention program before involuntary treatment, and
- b) That allows patients access to their rights, including medication, beds, meals etc.

⁹² Radden, J, above n 3, 4.

⁹³ Pitcher, S (2000) 'The Most Important Issues Affecting People with a Mental Illness or Disorder', Consumer Organising Committee.

⁹⁴ Allan, above n 2.

⁹⁵ Allan, above n 2, 34.

⁹⁶ ECHR, MDAC, above n 18.

⁹⁷ Donnelly, M, above n 9.

9.1 Patients Proposals for Alternatives

Patients who have been subjected to forced medications have suggested some alternatives as a way to avoid the severity of forced medication by the mental health hospitals on its patients.

These include:

- 1) Refuge where patients are serviced and kept privately and safe in a non-judgmental environment;
- 2) Access to a trusted organisation or person whom they nominate in advance so that when they suffer a period of mental illness they have agreed support;
- 3) A nominated primary carer; with power of intervention where necessary
- 4) An Advance Directive: An advance directive is a document that sets out what the patient wants to happen in the future if they are deemed incapable of making decisions. It can include what treatment is to be given and whether particular drugs should be given. However, at the moment Advance Directives are not recognised by legislation. In effect, this means that the Advance Directives of involuntary patients may be overridden to fall in line with the Mental Health Act. A Court would also be unlikely to overturn any decisions that have been made by the hospital for the patients treatment and care;

Further, the Consumer Organising Committees of TheMHS 2000 and 2010 around the 23 Big Issues noted the lack of available information on prescribed medication and their side-effects as a barrier for patients to make informed decisions concerning their health. Through discussion groups between consumers, the committees proposed the following solutions:

- 1) Consumer advocates at point of prescription;
- 2) More focus on therapies which involve discussing issues and information provided on alternative therapies;
- 3) Information and explanation about side-effects which may occur every time a prescription is administered – consumers can be advised to ask certain key questions to their clinicians;
- 4) Doctors to be made more aware of drug reactions and interactions – a checkbox scale tool can be used to gauge patients' quality of life following medication;
- 5) Consumers can unite and raise awareness of medical prescription issues through online communication.⁹⁸

It is essential to look at these alternatives from the perspectives of patients themselves; their suggestions are vital to ending forced treatment. As highlighted by the *Not For Service* report, there is expressed concern that clinicians are placing too much emphasis on medication as a means of mental health treatment while patients feel that there are no alternatives to medication. Further complicated by the lack of patient and carer participation in the planning, implementation and the evaluation of mental health services, this calls greater attention in the area of patient voice as a viable means of resolving issues in our current system.

The options mentioned above would create an environment where patients' rights are prioritised. These alternatives would provide a chance for people with a mental illness to realise the need to choose to comply or further action/rights will be taken away. However this provides a step between

98 Pitcher, S (2000) 'The Most Important Issues Affecting People with a Mental Illness or Disorder', Consumer Organising Committee, TheMHS 2000.

being uncared for and involuntary treatment. Giving patients the right to freedom is beneficial for their state of mind and allows them to assume control over their lives.

10. CONCLUSION

Mental health facilities have been granted extraordinary discretionary power to force forensic patients to take medication whenever professionals deem it appropriate.

Saeed and Michael Riley are just some of the many patients who are subjected to this type of 'treatment', where their basic rights over their body are legally stripped away. Mental health patients should possess the same human rights as any other individual in Australian society. According to both international and national law, they should be treated as equals, and mental health facilities have a duty of care to their patients in a humane and justified method. The reality, however, does not reflect the objectives of these laws. Ultimately, awareness must be raised in order to achieve any progress in this fundamental and controversial issue of involuntary patients and their right to refuse treatment.

An independently funded body, responsive to consumer's concerns needs to be established, as proposed by the OUR PICK Report,⁹⁹ which will have the power to oversee policies and cases where patients have been and/or are to be subjected to involuntary medication.

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12. Appendix



NMHCCF Advocacy Brief

Issue: Seclusion and Restraint in Mental Health Services

Background

Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.

There are three distinct types of restraint – physical (e.g. manual, handcuffs, harnesses, straps), chemical (e.g. sedative medication) and emotional (e.g. fear of expressing views, coercion, threats).

The key factor that differentiates seclusion and restraint from other forms of care or medical treatment is intent. Seclusion and restraint are often used to restrict the movement or behaviour of a person because of a failure to provide proper mental health care. Seclusion and restraint are being used on a daily basis, despite the evidence they can contribute to negative health outcomes.

In the NMHCCF position statement Ending Seclusion and Restraint in Australian Mental Health Services Professor Ian Hickie notes, “The frequent requirement to seclude and restrain people with an acute mental illness highlights the ongoing failure of the mental health system to provide high quality care”.

While protection from harm may be one reason for implementing measures to restrain someone, there are clinical, ethical and legal issues which practitioners must consider before restraining a patient:

- Impact of physical restraint on a patient and their family/carer;
- Consumers rights and autonomy;
- Myths and misconceptions about the use of restraints;
- Ethical aspects of restraining people;
- Legal and legislative aspects of restraint use and restraint minimisation;
- Dangers involved in the use of physical restraints resulting in adverse outcomes; and
- Considering alternatives to restraint.

Unless alternative locations for care and services are established, people requiring mental health care will be forced to attend psychiatric units which are notorious for their use of seclusion and restraint - not as a measure of last resort, but as the default means of keeping order.

Key Points for Mental Health Consumers and Carers

The NMHCCF released its position statement Ending Seclusion and Restraint in Australian Mental Health Services in September 2010. It is available at www.nmhccf.org.au/Publications-info.

It is the position of the NMHCCF that involuntary seclusion and restraint is:

- Currently used at unacceptably high levels in mental health services;
- An avoidable and preventable practice;
- Highlighting a failure in care and treatment when they are used;
- Commonly associated with human rights abuse;
- Not an evidence-based therapeutic intervention
- A cause of short and long term emotional damage to consumers and/or their family/carer;
- An inhibitor of developing trust and respect between consumers, carers and clinical staff;

The trauma of seclusion and restraint contributes to consumers' fear of treatments and they are much less likely to seek help again if subjected to seclusion and/or restraint. Similarly families and/or carers may feel reluctant to seek treatment for a consumer.

Attracting and maintaining a dedicated mental health workforce will be hindered if the care provided continues to be associated with patient harm rather than positive health outcomes.

In under-resourced and inappropriate mental health services, seclusion and restraint are the accepted practices. This is totally unacceptable and there are alternatives available for the safe management of dangerous behaviors.

Recommendations for change and Key Issues for the Future

The NMHCCF has identified six key strategies to end seclusion and restraint in Australian mental health services:

1. Better Accountability
2. Implementation of Evidence Based Approaches to Ending Seclusion and Restraint
3. Adherence to Standards and Public Reporting
4. Support for Mental Health Professionals Towards Cultural and Clinical Practice Change
5. Better Care Planning
6. Review Relevant Mental Health Legislation

Name of Nominated NMHCCF contacts on this issue

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