

Is Involuntary Psychiatric Treatment

“Reasonable, Necessary, Justified and Proportionate”?

David Webb¹

Abstract

Victoria’s new Charter of Human Rights and Responsibilities seeks to protect the basic civil and political rights of people in Victoria. One of the most fundamental of these is the right to be protected against medical treatment without consent. Despite this, involuntary psychiatric treatment remains the foundation of Victoria’s Mental Health Act, without which there would be no need for the Act at all. Section 7 of the Charter allows for an individual’s right to be limited if it can be demonstrably justified in a free and democratic society, but imposes some constraints so that any such limitations must be reasonable, necessary, justified and proportionate. These constraints are used in this paper to perform a human rights analysis of the criteria for involuntary psychiatric treatment in the Mental Health Act.

This analysis shows that the only possibly legitimate criterion in the Mental Health Act for limiting a person’s basic human rights is the risk of suicide. From this analysis, it is then proposed that the Mental Health Act be abolished and replaced by a Suicide Prevention Act that permits the involuntary detention of a suicidal person to a safe environment as a demonstrably justified limitation of that person’s rights. The analysis also shows that the contrived construct of “mental illness” that lies at the heart of the Mental Health Act lacks sufficient scientific, medical evidence to justify it as a criterion for limiting a person’s basic human rights. This is reinforced by reference to the recent United Nations Convention on the Rights of Persons with Disabilities, which prohibits discrimination on the basis of disability. The analysis further shows that involuntary psychiatric treatment must be prohibited by the proposed Suicide Prevention Act because it not only fails the human rights test that it is must be demonstrably justifiable, but that it also fails the pragmatic argument sometimes offered that it saves lives.

Some basic human rights principles

A good place to start our discussion on the human rights principles around involuntary psychiatric treatment is in fact the Charter itself. Section 10 of the Charter specifies one of the most fundamental civil and political human rights, the right to protection from torture and cruel, inhuman or degrading treatment.

Human Rights Charter

Section 10 – Protection from torture and cruel, inhuman or degrading treatment

A person must not be—

- (a) subjected to torture; or
- (b) treated or punished in a cruel, inhuman or degrading way; or
- (c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

It is significant that it is this section on torture that includes the prohibition of medical treatment without full, free and informed consent². Like the prohibition on torture, it recognises the physical and mental integrity of a person as a very serious and fundamental right that is violated when medical interventions are imposed without consent. Indeed there is a strong argument based on well established human rights principles that involuntary psychiatric interventions meet all the internationally recognised definitions of torture³. Although the finer legal points of this argument are still being debated in international human rights forums, the point here is that the Charter regards medical treatment without full, free and informed consent as a very serious human rights violation that is at least in the same ballpark as torture. This is further supported by the enormous anecdotal evidence, from all over the world, that many people who have experienced involuntary psychiatric treatment found it cruel, inhuman and/or degrading.

On the face of it, it would appear that Victoria’s Mental Health Act, which exists solely in order to impose psychiatric treatment without consent, is a clear breach of the Charter. We’ll look more closely at the Mental Health Act soon, but first we need to see how the Charter manages to accommodate laws, such as the Mental Health Act, that seem to be so obviously in breach of the Charter.

Limitations on rights

In human rights debates there is always a tension between individual and collective rights, between an individual’s personal rights and the collective rights that a society might claim for the “greater good” of the community and that might sometimes require depriving an individual of their personal rights. The clearest example of this is when the community claims the right to deprive an individual of the right to liberty if they commit a criminal act, which is the basis of our sophisticated criminal justice system.

Section 7 of the Charter permits the limitation of an individual’s rights, with some constraints.

Human Rights Charter

Section 7 (2) – Human rights—what they are and when they may be limited

A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including—

- (a) the nature of the right; and
- (b) the importance of the purpose of the limitation; and
- (c) the nature and extent of the limitation; and
- (d) the relationship between the limitation and its purpose; and
- (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

History shows that asserting a collective, social right over an individual's personal rights is fraught with danger, which lies behind many of the careful checks and balances of our criminal justice system. There are too many examples of a privileged majority or powerful elite claiming the right to limit an individual's rights under false pretences with the inevitable consequence of great harm and suffering. One example of such false pretences is when society claims that limiting a person's rights is "for their own good", with perhaps the clearest example of this in Australian history being the Stolen Generation when aboriginal children were forcibly taken from their parents "for their own good".

The Charter therefore seeks to protect against the misuse of collective rights by imposing some constraints, as shown above, for when society might wish to limit an individual's rights. The Victorian Equal Opportunity and Human Rights Commission (VEOHRC), which has new powers under the Charter, puts these constraints into plain language by saying that any attempt to limit an individual's rights must be demonstrably:

- reasonable, and
- necessary, and
- justified, and
- proportionate

UN Convention on the Rights of Persons with Disabilities

Before we put the Mental Health Act under some human rights scrutiny, it is useful at this time to briefly mention the recent UN Convention on the Rights of Persons with Disabilities (CRPD)⁴. After about five years of negotiations, the CRPD finally took effect as international law on May 3 this year. Although Australia has not yet ratified the Convention, it is expected that it will before the end of this year. This legal technicality does not matter for our discussion here because

Section 5 of the Charter explicitly recognises that international law, such as the CRPD, is relevant to the interpretation and application of the Charter.

Although the Charter makes no specific mention of the rights of people with disabilities and limits itself to civil and political rights, a couple of key features of the CRPD are relevant to our discussion here. Most importantly, there is the fundamental principle that underpins the entire CRPD, which is that it *prohibits any discrimination on the basis of disability*. In particular, this is spelled out in Article 12 of the CRPD, which recognises that people with disabilities have *legal capacity on an equal basis with others in all aspects of life*. This is especially relevant to the interpretation and application of Section 8 of the Charter on “Recognition and equality before the law”. And like the Charter, Article 25 of the CRPD also prohibits medical treatment without consent.

Convention on the Rights of Persons with Disabilities

Article 12 - Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.
5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

When the CRPD was adopted by the UN General Assembly in December 2007 it was hailed by the then Secretary General of the UN, Kofi Annan, as a “new era” for the rights of people with disabilities. It has also been described as a “paradigm shift” for how societies are to respect the human rights of people with disabilities. At the centre of this paradigm shift is a move away from substituted decision-making models of care that deprive a person of their legal capacity, such as our Mental Health Act, towards a *supported decision-making* model based on human rights. The

human rights spelled out in the CRPD are not new rights for people with disabilities. Rather, they simply assert the rights of people with disabilities as full citizens equal to all others in society. It is these fundamental citizenship rights that the Charter now needs to also protect for people with disabilities.

Victoria's Mental Health Act

The primary purpose of Victoria's Mental Health Act is to limit a person's human rights. This is evident in Section 8 of the Act which specifies the criteria for involuntary treatment, without which there is no need for the Act at all.

Mental Health Act

Section 8 – Criteria for involuntary treatment

- (1) The criteria for the involuntary treatment of a person under this Act are that—
- (a) the person appears to be mentally ill; and
 - (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
 - (c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
 - (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
 - (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

Discrimination on the basis of disability

The first thing to notice in Section 8 is that all five of the criteria make reference to “mental illness” as the basis for involuntary treatment. This contravenes the fundamental principle of the CRPD by discriminating against a person on the basis of a medical diagnosis – i.e. on the basis of psychiatric disability, though with the CRPD the preferred term now is *psychosocial disability*. This should in itself be sufficient grounds for a major re-think of our mental health laws and perhaps this will occur once Australia ratifies the CRPD.

The validity of “mental illness”

Alongside the discrimination on the basis of a medical diagnosis in the Mental Health Act is the medicalisation of psychosocial disability. This is a controversial topic where the scientific validity of both psychiatric diagnosis and of psychiatric treatments is hotly contested. There is not space here to present the substantial evidence that challenges the

validity of psychiatric diagnoses and treatments, but it can be summed up by quoting Michael B. First, a leading US psychiatrist working on the next revision of the DSM (DSM-V), the "Bible" of psychiatric diagnosis produced by the American Psychiatric Association:

At the risk of making an overly broad statement of the status of neurobiological investigations of the major psychiatric disorders noted above, it can be concluded that the field of psychiatry has thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacologic treatment.⁵

In plain language, here is a leading figure in psychiatry saying that a genuine scientific, medical basis for psychiatric diagnosis and psychopharmacologic treatments has not yet been substantiated. The best that can be said about the current scientific status of psychiatric diagnosis and psychiatric treatments is that they perhaps have some scientific merit as hypotheses. But despite a massive, global research effort over recent decades to test, validate and substantiate these hypotheses, to date this effort has been, as Michael B. First points out, totally unsuccessful. Many psychiatrists will claim that this is because still more research is required into the complex biology of the brain before such medical evidence is revealed. But there are many others who argue that the problem is much deeper, that there are fundamental flaws in the assumptions behind these hypotheses of modern psychiatry⁶.

One argument offered by psychiatry to get around its lack of scientific validity is to distinguish validity from utility and claim that psychiatric treatments have high utility, even in the face of low validity. To have high utility though, it must be demonstrable that psychiatric treatments have reliable, predictable outcomes. But this is also not the case, which is perhaps best illustrated by two major studies undertaken by the World Health Organisation that showed longer term outcomes for people with schizophrenia were markedly better in developing countries than in developed countries. This was despite only 16% of patients in the developing countries were on continuous anti-psychotic medication, compared with 61% in developed countries.⁷

For this paper (if we allow ourselves for the moment to overlook the CRPD's prohibition against discrimination on the basis of disability), the point here is that such flimsy scientific, medical evidence cannot legitimately form the basis for limiting such a fundamental human right as the right to refuse medical treatment.

The medical vs social model of disability

The central place of "mental illness" in the Mental Health Act reveals that it is a law based on a medical model of psychosocial disability. Even if psychiatric diagnoses and treatments had any scientific validity, the medical model of the Mental Health Act is out of step with contemporary thinking on disability. The disability community have fought for many years to move from a medical to a social model of disability that is based on human rights rather than medical status, which is now enshrined in the CRPD. Given that

the primary function of the Mental Health Act is to limit a person's human rights, it's obsolete, medical-model assumptions should have come under more stringent scrutiny with the introduction of the Charter. With the arrival of the CRPD, hopefully this long overdue human rights scrutiny of the Mental Health Act will now occur and will be based on the social model of disability.

Risk of harm to others

Perhaps the greatest concern of the wider community about people with psychosocial disabilities is that they are dangerous, either to themselves or others. The distinction between the risk of harm to self or to others is conflated in the Mental Health Act but it is necessary to distinguish between them as two distinct and quite different issues, so we'll look at self harm separately below.

The risk of harm to others is first and foremost a matter for the criminal justice system. To use a psychiatric diagnosis as grounds for pre-emptively detaining someone when there is no substantial threat represents a particularly pernicious and punitive limitation of their human rights. It is also discrimination on the basis of disability. The laws that should apply here, now enshrined in the CRPD, is that any detention by the state must be on the basis of a person's *behaviour* and not on the basis of disability. Whatever rules a state adopts for such detention must be applied equally to all people without discrimination.

Psychiatric detention panders to irrational and unjustified fears in the community that are sadly often encouraged by the popular media. But if we were serious as a society about making laws to pre-emptively detain those who pose a risk to others then it is very clear from the data that it would be young, drunk men who need to be detained, *not* people with a psychosocial disability. This glaring example illustrates well one of the key principles of the CRPD that all laws must apply equally to all people without any discrimination on the basis of disability.

Risk of harm to self

The data is also clear that people with psychosocial disabilities are more likely to be victims, rather than perpetrators, of crimes. This raises issues that both the Mental Health Act and our mental health system fail to respond to adequately. Although this too has a human rights dimension, it is outside the scope of this paper.

The risk of harm to self that the Mental Health Act seeks to protect people from is self-inflicted harm, and in particular suicide. The focus of the discussion here is on suicide but it must be mentioned in passing that not all self-harming behaviour is suicidal, which is another complex issue outside the scope of this paper though some of the discussion that follows applies also to non-suicidal self-harming behaviour.

One of the important differences between "risk to self and others" is that suicide is not illegal. Although the police are often called upon to intervene with someone who appears to be suicidal, suicide is not a crime and therefore, unlike threatening another person, is not a

matter for the criminal justice system. Rather, it is the Mental Health Act that is called upon to intervene in such situations. It is the Mental Health Act that asserts the community's collective right to intervene and limit the right of an individual.

Most people would accept that it is reasonable for a community to claim a collective right, indeed that it has a responsibility, to intervene when someone is actively suicidal and at imminent risk of great harm or even death. In terms of the Charter, most people would regard it as “demonstrably justified” to intervene at such times. But we also have to look at the other constraints in Section 7 to test whether an intervention is, in the language of the VEOHRC, “reasonable, necessary, justified and proportionate”. This is where the Mental Health Act demonstrably fails to pass any reasonable human rights scrutiny.

Involuntary detention vs involuntary treatment

Unlike some jurisdictions elsewhere in the world, our current Mental Health Act makes no distinction between involuntary detention and involuntary treatment. Once you are detained under the Act, no further legal hurdles or human rights considerations are required in order to impose treatment without consent. Whereas the detention of actively suicidal people can be justified in human rights terms, involuntary psychiatric treatment not only fails the test of human rights scrutiny, it fails the test of any rational analysis of the benefits that are claimed for it.

It is well documented that many people experience involuntary psychiatric treatment as an assault. Some describe it as similar to rape where the assault strikes to the core of your body, mind and soul. As with sexual assaults, our mental health system needs to respect the very basic human requirement at such times that “No” means “No”. It is also well documented that many suicidal people are struggling with complex personal histories of trauma. For these people, involuntary psychiatric treatment further traumatises them, often worsening or indeed sometimes triggering suicidal feelings. More generally, if we understand suicidality as a crisis of the self – i.e. rather than the consequence of some “mental illness” (see below) – then it simply does not make sense to further attack an already fragile sense of self. It is hard to imagine anything *less* helpful for the suicidal person than to be assaulted by those you seek help from at a time of such crisis.

The medical argument for involuntary psychiatric treatment

The medical argument offered in an attempt to justify involuntary psychiatric treatment of the suicidal also does not stand up to scrutiny. Suicidality is not a medical illness, even according to the diagnostic criteria of psychiatry. Nor is it the direct consequence of some “mental illness” such as depression, despite the public relations of organisations like *beyondblue*. None of the psychiatric disorders, or so-called mental illnesses, is a terminal illness. Depression does not *cause* suicide. Suicide is a conscious, deliberate, cognitive, psychological *decision* that a person takes to end their life.

A further weakness of the medical rationale for involuntary psychiatric treatment is that the treatments currently offered are so unreliable and unpredictable. As seen in the words of Michael B. First, the leading US psychiatrist quoted above, both psychiatric diagnosis and psychopharmacologic treatments lack solid scientific evidence to support them. Furthermore, it has become apparent in recent years that some psychiatric medications can trigger suicidal feelings in some people, though it is impossible to predict who might respond well to a particular medication and who might have an adverse reaction⁸.

Involuntary psychiatric treatment also fails a fundamental principle of medical ethics, though the rest of the medical profession chooses to turn a blind eye to this. Although some people might receive some benefit from involuntary psychiatric treatment (but see also below), it also clearly pushes some people over the edge. To say it crudely, while it may save lives, it almost certainly contributes to the death of others. The problem here is that we have no way of predicting who might respond one way or the other. Imagine a new treatment for some terminal illness, say for HIV/AIDS, that cures some people but kills others, but that there is no way of identifying who might be cured or killed by the treatment. Would such a treatment be approved?

The pragmatic argument that forced treatment saves lives

If we dare to put human rights principles to one side, then this brings us to the *pragmatic* argument for involuntary psychiatric treatment, that it saves lives. Such a pragmatic approach also requires that this argument must be balanced by asking how many people are pushed over the edge into suicide by such treatment? That is, the pragmatic question has to be, does force save more lives than it costs? This is a gruesome formula to ponder, but one that we must, given that we can be certain that involuntary psychiatric treatment contributes to the suicide of at least some people.

Unfortunately, the answer to this question is not known for the simple reason that there is virtually no research into it⁹. Although complicated by the fact that we cannot hear testimony from the dead, there is significant circumstantial and anecdotal evidence to know that it does occur. There are many first-person testimonials of those who have experienced involuntary psychiatric treatment as an assault, along with many others who describe how they survived *despite* rather than because of psychiatric treatment. One particular telling report I have heard is of people who say that they had never even contemplated suicide until they found themselves on the psych ward. The crucial point here is that at the very least there is a significant question mark over the claim that involuntary psychiatric treatment saves lives.

The personal testimonial – “Forced treatment saved my life”

Related to the pragmatic argument above is the claim sometimes heard (including I suspect at this forum) that “involuntary psychiatric treatment saved my life”. While such personal testimonials are important, the analysis above shows that by itself this does not constitute a sufficient rationale for involuntary psychiatric treatment. In particular, as an element of the pragmatic argument, such testimonials have to be weighed against those who have suffered

greatly, and sometimes died, as a consequence of psychiatric force. But even more than this, and returning to human rights principles, although some people may be prepared to sign away their human rights, they are not entitled to sign away mine.

Are there “less restrictive” means available?

One final criterion for involuntary treatment under the Mental Health Act must be mentioned because it links directly to one of the constraints specified in Section 7 of the Charter¹⁰. This is the requirement that the purpose of the limitation cannot be achieved by any “less restrictive” means. This is also a large topic the detail of which is beyond the scope of this paper, though a few points can be made. First, it is kind of ridiculous to claim that there are no less restrictive means than psychiatric force when there are none offered, or even considered as an option, by our mental health system. The most critical, immediate need for a person in a suicidal crisis is to find a place of safety, which our psychiatric wards are demonstrably not. It is not difficult to imagine what a safe environment might look like – the word ‘sanctuary’ comes to mind – but there is virtually nothing available in our mental health system that offers this for people in crisis. So it is rather disingenuous to claim that the severe and extreme limitation of psychiatric force is the least restrictive means. Furthermore, there are numerous good examples overseas of very much less restrictive services and practices that work well for people in crisis, including a suicidal crisis. A useful reference for this is Peter Lehmann’s compilation of “Alternatives Beyond Psychiatry”¹¹

Summary and Conclusions

The critical human rights issue in mental health is involuntary psychiatric treatment. All major human rights instruments, including Victoria’s Human Rights Charter, recognise the right to refuse medical treatment as a fundamental civil and political right. Despite this, involuntary psychiatric treatment remains the foundation of Victoria’s Mental Health Act, without which there would be no need for the Act at all. Furthermore, the Mental Health Act conflates involuntary detention with involuntary treatment.

Any genuine human rights scrutiny of the Mental Health Act shows that it is seriously flawed. First, it contravenes the underlying human rights principle of the Convention on the Rights of Persons with Disabilities by limiting a person’s basic human rights on the basis of a medical diagnosis – i.e. discriminates on the basis of disability. Second, the Mental Health Act relies on two unjustified assumptions that do not stand up to scrutiny as the basis for this discrimination, or limiting of rights. The first of these is the assumption that “mental illness” is a diagnosable and treatable medical condition despite only weak evidence to support this claim, and certainly not enough to justify imposing psychiatric treatment without consent. The second is the assumption that people with a so-called mental illness are more dangerous than other sectors of the community.

We need to deconstruct this assumption about the dangerousness of people with psychosocial disabilities to distinguish between the risk of danger to others and the risk of danger to themselves. The risk of danger to others is not supported by the evidence, which was highlighted above by pointing out that if society was serious about this concern then it would be young, drunk men that would be targeted by such discriminatory laws, not people with psychosocial disabilities. The myth that people with psychosocial disabilities pose a danger to others is contrived and unjustified. Furthermore, any *real* threat of danger to others is a

matter for the criminal justice system and not a matter to be judged by the medical profession (although medical evidence may have a role in sentencing and/or rehabilitation once the criminal justice system has established that an offence has occurred).

The risk of self-harm, however, has some validity for people with psychosocial disabilities, in particular the risk of suicide. We need to be careful here, though, to not exaggerate the risk of self-harm among people with psychosocial disabilities. Not all self-harming behaviour is suicidal and not all “high risk” behaviour is done with the intent of harming the self. Again we must be guided by the CRPD that people with disabilities have rights equal to everyone else so that if society wants to claim a collective right to limit an individual’s rights then this must be based on criteria, rules and laws that apply to all people. To say this another way, people with disabilities have the same rights as everyone else to take risks.

The *only* substantive issue then for limiting a person’s basic rights in a law like our Mental Health Act is the risk of suicide. There is a reasonable, indeed compelling, argument to justify the community asserting a collective right that limits an individual’s rights in order to protect that person from suicide. Unlike the Mental Health Act, however, this must be based on a person’s actual behaviour and, in particular, must *not* be based on a psychiatric diagnosis. In the Mental Health Act a psychiatric label has been employed as a convenient contrivance to justify involuntary treatment to protect a suicidal person. But it does not stand up to scrutiny as a valid justification. Furthermore, the use of psychiatric labels for this purpose brings other consequences that are often unhelpful, sometimes harmful, and occasionally fatal, for the person concerned.

Replace Mental Health Act with Suicide Prevention Act

It is time to replace the Mental Health Act with a Suicide Prevention Act as a lawful way of limiting a person’s right in order to protect them from suicide. But such an Act must not be based on discrimination against people with disabilities, nor on the fiction of mental illness. It would also distinguish between involuntary detention, which the Act would allow, and involuntary treatment, which would be prohibited.

We can now test this proposal for a Suicide Prevention Act against the human rights of the Charter, and also of the CRPD. First, it satisfies the CRPD prohibition against discrimination on the basis of disability. Given that the detention powers of the proposed new Act would limit a person’s rights, we then need to test them against Section 7 of the Charter. The following table summarises the human rights considerations, based on Section 7, of the proposed power to detain a suicidal person.

The nature of the right	Fundamental – the right to liberty
The importance and purpose of the limitation	High – to prevent suicide
Nature and extent of the limitation	Severe – loss of liberty Requires suitable criteria for assessing suicidality, including checks and balances to protect against misuse.
Relationship between limitation and its purpose	Strong – ensures safety of suicidal person
Any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve	Could be reasonably available and achieves purpose with minimal restriction – but requires checks and balances as noted above.

Involuntary detention for the purpose of suicide prevention
Human Rights Analysis using Human Rights Charter, Section 7

Based on this table, we can also apply the criteria recommended by the VEOHRC for testing whether a limitation is appropriate and acceptable according to the Charter. That is, we can ask whether detaining a suicidal person is “reasonable, necessary, justified and proportionate”? With the proviso included in the table that careful criteria are required for assessing suicidality, including checks and balances against misuse of these criteria, then I think most people in the community – i.e. “in a free and democratic society” – would regard detention of actively suicidal people can be “demonstrably justified”.

It is necessary to contrast this with a similar human rights analysis of involuntary psychiatric treatment. Following the analysis in this paper, and again using the Section 7 criteria, the following table summarises the human rights considerations for involuntary psychiatric treatment for the purpose of protecting suicidal people.

The nature of the right	Fundamental – right to refuse medical treatment and to physical and mental integrity
The importance and purpose of the limitation	Questionable – mental illness inadequate for assessing suicidality
Nature and extent of the limitation	Extreme and risky – loss of physical and

	mental integrity, risk of suicide
Relationship between limitation and its purpose	Weak – little evidence that it saves lives, significant evidence that it can cause harm
Any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve	Less restrictive means exist but are unreasonably unavailable, weak link between limitation and purpose

Involuntary psychiatric treatment for the purpose of suicide prevention
Human Rights Analysis using Human Rights Charter, Section 7

From this it is apparent that involuntary psychiatric treatment cannot be demonstrably justified in a free and democratic society as an appropriate response to protecting suicidal people. There are therefore no circumstances when involuntary psychiatric treatment is reasonable, or necessary, or justified, or proportionate.

Endnotes

¹ This paper was prepared for and presented at a forum on the “Victorian Charter of Human Rights and Responsibilities and Mental Health Rights” in Melbourne on May 20, 2008. The forum was co-hosted by the Victorian Mental Health Legal Centre and the Victorian Mental Illness Awareness Council, the peak NGO representing mental health consumers in Victoria. It was sponsored by the Victorian Equal Opportunities and Human Rights Commission, which has a major role and new powers under the Charter.

² Along with torture and slavery, medical experimentation without consent is often regarded as one of the few non-derogable or inviolable human rights – that is, rights for which there are no circumstances whatsoever that can justify any limitation on them. Given the lack of solid scientific evidence for current psychiatric diagnostic methods and (bio)psychiatric treatments (mainly psychopharmacological medications but also ECT), all such diagnosis and treatment must be considered experimental. Gheami and Goodwin (2007), analyse the ethics of medical experimentation of this kind, which they call “clinical innovation”, pointing out that it is a common and indeed often useful practice throughout medicine. They stress, however, the ethical requirement that such clinical innovation must meet a higher standard of informed consent. Contrast this with the no consent required at all for involuntary psychiatric treatment (innovation, experimentation). This contrast is even more stark with some of the more obvious medical experimentation in psychiatry that frequently occurs without consent, such as drug dosages above the maximum recommended by manufacturer and multiple drugs being imposed on people even though no scientific tests have been performed on the efficacy or safety of these drugs in combination.

”The ethics of clinical innovation in psychopharmacology: Challenging traditional bioethics”, S. Nassir Ghaemi & Frederick K Goodwin in *Philosophy, Ethics, and Humanities in Medicine* 2007, 2:26 doi:10.1186/1747-5341-2-26, <http://www.peh-med.com/content/2/1/26>

³ Tina Minkowitz, “The United Nations Convention of the Rights of Person with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions” in *Syracuse Journal of International Law and Commerce*, Vol 34:405.

⁴ UN Convention on the Rights of Persons with Disabilities and Optional Protocol, available online at: www.un.org/disabilities/documents/convention/convoptprot-e.pdf

⁵ *A Research Agenda for DSM-V*

David J. Kupfer, Michael B. First and Darrel A. Regier, (Editors)

Published by the American Psychiatric Association, Washington, D.C. 2002

Available online for free, as a 332 page pdf document, at: <http://appi.org/book.cfm?id=2292>

See also the following where it is explicit that First is the author (not just an editor):
“A Research Agenda for DSM-V: Summary of the DSM-V Preplanning White Papers”
Published in May 2002, <http://dsm5.org/whitepapers.cfm>

⁶ Perhaps the best entry point into the extensive literature questioning psychiatric diagnosis and treatments is *Madness Explained: Psychosis and human nature* by Richard P. Bentall (Penguin 2004).

⁷ The two WHO studies looking at the differences in longer term outcomes of people diagnosed with schizophrenia in developing countries compared to developed countries are just one example among many of the unreliable, unpredictable and indeed unexpected outcomes of psychiatric treatments. The results of the first study (WHO Report of the International Pilot Study of Schizophrenia, 1973) surprised many people when it indicated a remarkably better long term prognosis for people in developing countries than in developed countries. A more rigorous follow-up study was then undertaken (WHO Schizophrenia: an international follow-up study, 1979), which confirmed “a markedly better overall outcome of schizophrenia patients in India and Nigeria at 2-year and 5-year follow-up” (Jablensky & Sartorius, 2008). Jablensky and Sartorius, who were both involved in these studies, further state that “Patients in developing countries experienced significantly higher periods of unimpaired functioning in the community, although only 16% of them were on continuous anti-psychotic medication (compared with 61% in the developed countries)”. In looking for explanations for these unexpected results, they highlight that the studies raise more questions than answers, concluding with:

The sobering experience of high rates of chronic disability and dependency associated with schizophrenia in high income countries, despite access to costly biomedical treatment, suggests that something essential to recovery is missing in the social fabric.

Jablensky, A & Sartorius, N, “What Did the WHO Studies Really Find?” in *Schizophrenia Bulletin* vol. 34 no. 2 pp. 253–255, 2008
doi:10.1093/schbul/sbm151
Advance Access publication on January 18, 2008
Accessed May 18, 2008

⁸ There is now an ongoing debate within the medical profession, with an extensive literature, on the extent to which suicidal ideation is actually caused by some psychiatric medications (especially but not only SSRI antidepressants). This has come about not because of any scientific rigour in the research and testing of these drugs. Rather, it arose from a few cases of legal action taken against drug manufacturers, which forced the disclosure of test results, previously suppressed by these companies, showing a significant risk of suicidal ideation from these drugs. Public concern followed by public enquiries, most notably a US senate inquiry, subsequently led to warnings about suicidal ideation now being required in the labelling of these drugs in the US and the UK (but not yet Australia).

⁹ One of the very few studies looking into the risks of involuntary treatment is of special interest and relevance to us here in Victoria (Segal & Burgess, 2006). The study seeks to assess the protective value of what Segal and Burgess call “conditional release”, which is more commonly known as involuntary outpatient treatment or, here in Victoria, as Community Treatment Orders (CTOs). It was a large study of nearly 24,973 people with a history of psychiatric hospitalisation over a 13.5 year period; 8,879 had experienced at least one “conditional release” (i.e. CTO), and 16,094 had not. The potential protective value of CTOs that the study assessed was mortality risk, though unfortunately it did not distinguish between types of death, such as suicide. Despite this, it is a large, thorough and rigorous

study that is a significant, meaningful and useful attempt to measure the benefits, or otherwise, of CTOs.

What makes it especially interesting for us here in Victoria is that the data analysed came from the Victorian Psychiatric Case Register and the Australian National Death Index. It appears that part of the reason Victoria was chosen as the data source for the study is the high use of CTOs here following the rapid deinstitutionalisation of psychiatric services here in the 1990s, along with the high quality of our databases.

The paper that reports on this major study has a very curious peculiarity in it. After noting that patients who had been hospitalised showed higher mortality risk than the general population, the abstract then highlighted that “Patients exposed to conditional release ... had a 14% reduction in probability of noninjury-related death”. The abstract then concludes that, “Conditional release can offer protective oversight for those considered dangerous to self or others and appears to reduce mortality risk among those with disorders severe enough to require psychiatric hospitalization”.

The curious thing, however, is that buried in the body of the paper is the observation that “men on orders (97 of 119 men, or 82 percent) were significantly more likely to die than men not on orders (154 of 224, or 69 percent)”. First of all, it is quite extraordinary that such a significant difference between the sexes is not highlighted in the results and conclusions of the study. Second, the study’s conclusions that a CTO “appears to reduce mortality risk” and that they “offer a less restrictive alternative than hospitalization” would appear to only apply to women with quite the reverse being the case for men. Third, when we add to this the suicide data that men are roughly four times more likely to suicide than women, then this small piece of data buried in the report becomes especially significant, and alarming.

The point here – again – is that there is little, if any, solid evidence that supports the status quo assumptions that involuntary treatment (whether inpatient or outpatient) saves lives.

Steven P. Segal & Philip M. Burgess, “Effect of Conditional Release From Hospitalization on Mortality Risk”, in *Psychiatric Services* (ps.psychiatryonline.org), Vol. 57 No. 11, November 2006, pp 1607-1613

¹⁰ Criterion (d) in Section 8 of the Mental Health Act is not specifically addressed in the paper because it is so absurd that it would be comical if it were not also so tragic. It is a Catch-22 that Joseph Heller would be proud of. It basically says that denying you have a mental illness (or refusing treatment) is proof that you have one.

¹¹ Peter Lehmann and Peter Stastny, *Alternatives Beyond Psychiatry*, Peter Lehmann Publishing 2007