

No Force Advocacy

by Users and Survivors of Psychiatry

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No Force Advocacy
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Mental Health Commission of New Zealand

The Mental Health Commission of New Zealand is a statutory government agency established in 1998 with three key functions:

- * Monitor and report to Government on the performance of the Ministry of Health and District Health Boards in the implementation of the Government's National Mental Health Strategy.
- * Work with the sector to promote better understanding by the public of mental illness, and eliminate discrimination.
- * Strengthen the mental health workforce.

While it has a legislative mandate to monitor the performance of key sector agencies, the Commission believes the mental health sector needs to identify and promote effective practices, and recognise excellence and innovation.

The Commission works to promote recovery, and to ensure that meeting the needs of service users and their families is a priority in mental health services.

A wide range of the Commission's research and other information is available from www.mhc.govt.nz.

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Introduction

People with mental illness are regularly and in large numbers forced to take medication. They may be in a hospital or they may be in the community; they may find the drugs effective or they may not; they may find the side effects extremely unpleasant, disabling and even irreversible; but still, they are compelled under the Mental Health (Compulsory Assessment and Treatment) Act. Every year hundreds of people apply to be released from compulsory treatment, whether in hospital or the community: they want the same choices that all other New Zealanders have about whether to take medication for any actual or perceived illness.

The Mental Health Commission has come to the view that compulsory treatment in New Zealand, whether in the community or an in-patient unit, is used too much. It is used too frequently, for too long, and too often it is used for the wrong reasons - not those specified in the Mental Health Act.

Too often compulsion has been a mechanism for ensuring that better treatment is available: "If we put you under the (Mental Health) Act, we can ensure you get better treatment / access to treatment." That is a travesty, an argument which is not and could not be used in any other health services. In those extremely rare public health situations where force is used (detention and treatment of people with TB, for example), the argument is explicitly about public health, not about treatment quality.

The Mental Health Commission's agenda on this issue, and with this publication, is to:

- * Reduce the use of compulsory treatment.
- * Raise the fundamental issue of compulsory treatment, and human rights. Human rights are not just for people we like, or people we approve of: they are universal – they apply to all of us, or they are not human rights.
- * Put the views of service users at the centre of discussions.
- * Advocate against discrimination in legal processes, and the application of the law for service users.
- * Ensure that mental health services first do no harm.

The Commission recognises that discrimination against people with mental illness occurs within mental health services as well as among the wider public. The reasons are complex, and public opinion influences the practices of mental health services. So too do the practices of mental health clinicians affect public opinion. Widespread use of force reinforces the historic view that people with mental illness are dangerous, when in reality, service users are more likely to be themselves victims of violence.

Psychiatrists do not universally like compulsion. Growing unease about the harms of compulsion makes it less acceptable for many clinicians as the following clinical commentaries in this volume indicate.

From time to time a tragic incident involving a mental health service user will generate calls for stronger use of compulsion in mental health services. However good care and good treatment avert many problems. Force and quality should not be conflated: duty of care is not the same as quality of treatment.

The issue of compulsion is attracting increased international interest because a new United Nations Convention on rights and protections for people with disabilities is currently being developed. New Zealand has taken a leading role in the development of this Convention: New Zealand's proposal on a process for developing the Convention was adopted, and a New Zealand official chairs the Ad Hoc Committee. Several New Zealand government agencies have played substantial roles in negotiations for the Convention, particularly the Office for Disability Issues.

The Mental Health Commission has actively supported the Convention process, and has provided substantial support for a service user to attend meetings of the committee as an official member of the New Zealand delegation.

Forced medical intervention has been a critical issue throughout the development of the Convention, for people with a wide range of impairments. Forced treatment, all over the world, aimed at 'treating' actual or perceived impairments is harmful to people according to Minkowitz. While international comparisons are difficult because each country or state has a different regime, the most recent study shows that New Zealand has one of the highest rates of community compulsory treatment among the countries surveyed (Lawton-Smith, 2005).

In New Zealand community treatment orders were introduced in 1992 with the Mental Health (Compulsory Treatment and Assessment) Act. At that time some saw community treatment orders as a positive technology, enabling people to be liberated from institutions, but still treated. A leading researcher into community treatment orders in New Zealand has discussed them in terms of 'positive liberty', whereby forcing people to take drugs enables a better life – but judged by whose standards? At heart, this argument favours ends over means, and asserts that psychiatrists have better knowledge of what is in someone's best interests than that person does.

In exercising its statutory mandate to reduce discrimination against people with experience of mental illness, the Commission recognises that discrimination is a systemic issue as well as an individual one. Medical and legal systems which discriminate are the focus of the Commission's work to reduce compulsory treatment.

Too often, according to anecdotal evidence heard by the Commission, the balance of law and medicine favours medicine at the expense of the rights and legal protections all New Zealand citizens can and should expect. Although a number of protections were built into the 1992 Mental Health (Compulsory Treatment and Assessment) Act, there is a growing view that those protections are inadequate. There is growing anecdotal evidence of uneven legal representation for service users, and international research supports this (Peay, 1989; Perkins, 2003). Despite the existence of publicly funded legal representation, service users find it difficult to successfully challenge decisions to put them under the Act (MHRT, 2004; Diesfeld, 2005). Service user and mental health consumer networks deplore the lack of individual and peer advocacy to challenge forced treatment or to support decision-making.

Many service users view compulsion as an outrage and abuse of their liberty. Others find it oppressive to have doctors empowered by the state to force drugs on them. There are also those who are grateful (with varying degrees of ambivalence) for the treatment they received when their health was seriously compromised. Many service users find compulsory treatment inimical to recovery. It denies people the opportunity to learn from mistakes, and in doing so, treats adults as incompetent.

Data on compulsion is not recorded in a consistent manner, reliable statistics are not reported regularly, and there are major time lags in reporting, so that information is rarely up to date. As a consequence, it is difficult to monitor whether the constitutional imperatives which follow from locking people up and/or forcing them to take medication, are being observed.

The Commission recognises that there are rare occasions when compulsion is necessary to protect people from immediate danger to themselves or others. On the whole this should last only for the duration of an emergency. However, we believe those emergencies are far less frequent for people who have not committed a crime than New Zealand's compulsory treatment rates suggest.

The Mental Health Commission invited Tina Minkowitz, a self-described survivor of psychiatry, to write an advocacy paper on the use of force against people with mental illness, taking an international human rights perspective. The mandate was broad as the Commission's purpose

was to explore the growing dissatisfaction with the use of compulsion in modern mental health services.

This booklet comprises a paper by Minkowitz, advocating 'No Force' against people with mental illness, and four commentaries on that paper, two by lawyers and two by psychiatrists.

It is the first publication in a new series by the Mental Health Commission addressing issues of mental health, law and human rights. It is also the first publication on compulsion by a government agency which locates the service user view at the centre of discussions. More often, a legal or medical opinion is published and service user comment, when included, is appended. In this booklet, the views of the service user lead, and other experts were subsequently invited to comment. The contributors perspectives also raise questions about the use of compulsion, and reflect concerns which the Commission shares.

Traditionally, discussions about the role of force against people with mental illness were conducted without the involvement and voice of the people at the centre of the issue: the people who endure compulsory treatment. Service users are at the heart of the issue, and it is essential that their views be heard and recognised.

Minkowitz is an American human rights attorney, who has been active in asserting the rights of people with mental illness for more than a decade. She co-chairs of the World Network of Users and Survivors of Psychiatry (WNUSP) and chairs the International Disability Alliance. In those roles she has played a leading role in the development of the draft United Nations Convention on the rights of people with disabilities.

Minkowitz advocates for psychiatry without compulsion. Two principal grounds underlie her advocacy: force is a breach of human rights, and secondly that force is counter-productive, doing more harm than good. She examines a range of relevant human rights and human rights instruments, including the UN Convention Against Torture. Minkowitz recognises that all of us, at some times in our lives, need help to make important decisions. That should not become an opportunity for someone else to make decisions for us, but rather for us to be supported in our decisionmaking. She describes a supported decision-making model and discusses legal capacity in that context.

Peter Bartlett's expertise is in mental health law. He is currently Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law at the University of Nottingham, and he has a long-standing interest in patient rights and patient advocacy. While agreeing in principle with many of Minkowitz's points, Bartlett's examination of the issues leads him to identify the limits of a human rights approach, particularly when the courts are unwilling to uphold those rights: the judiciary is, at times, unwilling to make decisions which it believes would not be popular with society.

Tony Ellis specialises in human rights law and is a member of New Zealand's only human rights legal chambers. He provides a technical and international legal analysis of the Minkowitz arguments with particular focus on three key issues: torture, arbitrary detention and legal disqualification. Ellis argues that the threshold for torture is extremely high, and that alleging ill-treatment may provide a more effective route for challenging forced incarceration and compulsory treatment.

From Australia Ian Curtis provides a clinical response, seeking to moderate what he sees as the more extreme assertions in Minkowitz. Curtis agrees that psychiatry and allied mental health services have done harm in the past and he has some sympathy with Minkowitz's views with regard to involuntary treatment. However, he points out, under the Minkowitz model, more people may end up in the justice system or jail, and: "correctional institutions are not noted for promoting mental well-being".

David Codyre is an Auckland-based consultant psychiatrist, who has previously worked in Hawkes Bay. He examines the tensions between the use of force or compulsion and a recovery-approach to mental health treatment, recognising that force and healing are antithetical. He also highlights an inherent paradox in the current risk-management approach: a focus on risk-management may hinder recovery and therefore escalate risk.

With the publication of *No Force Advocacy by Users and Survivors of Psychiatry*, the Commission is pleased to launch a new series of publications, addressing mental health, law and human rights. Our goal is to promote the transformation of all medical and legal systems so they will better serve people who use mental health services.

Ruth Harrison
Chair

Mary O'Hagan
Commissioner
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No-Force Advocacy by Users & Survivors of Psychiatry

Tina Minkowitz, JD

Tina Minkowitz is a human rights lawyer who has survived psychiatric assault. She is currently a co-chair of the World Network of Users and Survivors of Psychiatry, and chair of the International Disability Alliance. Minkowitz was a member of the Working Group that produced the first official text of the United Nations Disability Convention, and had a leading role in NGO advocacy for the Convention.

What is force and what is no-force?

This paper looks at some of the issues related to the use of legal compulsory interventions by mental health services and related legal frameworks that restrict personal autonomy.

Emphasizing a human rights perspective throughout, this paper examines the arguments of users and survivors of psychiatry advocating that no force be used in mental health interventions. "No-force" is the campaign to eliminate all forms of coercive psychiatry and legal disqualification.

Outcry against injustice in mental health services is far from new. In documents from the 18th and 19th centuries there are protests against unjust confinement in asylums; one of the earliest, dated 1620 was a "Petition of the Poor Distracted People in the House of Bedlam".

Since the early days of the modern ex-mental patients' movement and the antipsychiatry movement, the systemic nature of abuse and violence in mental health has been exposed and challenged by organised advocacy. For instance, a 1982 Statement of Principles adopted by the International Conference for Human Rights and Against Psychiatric Oppression demanded an end to involuntary psychiatric interventions and condemned the psychiatric system in eloquent detail as a form of tyranny that "cannot be reformed but must be abolished".
Coercive psychiatry

It is difficult to talk about the details of coercion. There can be a voyeuristic quality to those discussions or a parading of pain. However psychiatric coercion and violence has included:

- * seclusion and detention
- * physical restraint via confinement in cage-beds, straitjackets and all kinds of mechanical restraints
 - * both sleep deprivation and enforced sleep
 - * forced surgery, including forced abortion and forced sterilization
 - * forced drugging and chemical poisoning, and
 - * forced psychosurgery and forced ECT.

Also, madpeople were specifically subjected to death during the Nazi Holocaust in the name of eugenics.

Legal disqualification

Legal disqualification methods include:

- * removing the right to marry
- * taking away the right to vote
- * guardianship, incapacity laws, and legal principles that put madpeople under the supervision and control of others
- * community treatment orders and outpatient commitment (which are mainly a vehicle for forced drugging)
- * mental health laws permitting forced interventions and incarceration in hospitals and institutions, and
- * legal immunities for psychiatrists amounting to the same permission.

These types of responses create madness as a social category which renders the individuals invisible.

Modern psychiatry perpetuates these responses in two ways. First, psychiatry claims a scientific expertise in the affairs of mad people, in understanding and classifying them and in changing their condition. Any change is viewed as evidence of the power of psychiatry over the state of madness, though it may not be a change that is desired or valued by the person acted upon. The medical model of madness has always enacted a power inequality, and this supports force.

Second, psychiatry is given authority as a matter of law to pass judgment on mad people and to select and separate them from everyone else. Modern mental health laws confer on psychiatry a portion of the powers of the state, particularly the power to confine and treat people against their will and the power to determine the standards by which people are selected for confinement. In this way, psychiatric violence is legally authorized and the victims are denied recourse to legal or full human rights protections.

From Human Rights to Legal Rights

One of the obvious starting points in seeking justice is the justice system. However, discrimination is in the justice system itself and the laws at its disposal must be uprooted in order for justice to be meaningfully served.

Much of the legal rights advocacy in the user/survivor movement begins with a due process perspective drawn from analogy with the criminal justice system. That perspective aims to give people detained in the psychiatric system parity with those arrested or convicted on criminal charges. Thus, psychiatric detention based on danger to self or other should require an overt act rather than a subjective judgment or prediction based on no clear criteria, and all elements of the need for commitment should be required to be proved beyond a reasonable doubt, which is the evidentiary standard for conviction of a crime.

Such advocacy was obviously limited because it did not challenge the legitimacy of psychiatric force per se.

The deficiency of this perspective led to the proposal of a “substantive due process” approach to eliminating psychiatric detention and forced treatment. “Substantive due process” is a doctrine developed in U.S. Constitutional law to address human rights violations that were not otherwise enumerated in the Constitution. While due process balances state interest against the interest of the individual, certain practices that lack any legitimate state interest can be prohibited entirely. A substantive due process approach would focus on the harmful nature of psychiatric force in absolute terms and prohibit it entirely.

The substantive due process approach was not heavily promoted and did not gain currency among users and survivors, and it is of limited use internationally since it is formulated in U.S.-specific terms. But it does represent an attempt to argue within a legal rights framework that force is always unlawful.

Human Rights for Madpeople

A human rights approach is based on the recognition that individuals have inherent rights independent of national laws. The basis of human rights is that they are universal and apply to everyone, regardless of their personal circumstance. Human rights are inherent, inalienable, universal and indivisible. They are inherent, because they belong to all humans, by virtue of our common humanity. They are inalienable, which means they cannot be given up, nor may they be taken away from people, regardless of national laws. Human rights are universal, and apply regardless of distinctions such as race, sex, language or religion. They are also indivisible, because human rights come as a total package – none is more important than any other.

A human rights approach allows us to invoke a wider perspective and hold governments accountable to fundamental principles of equality and justice. Human rights are enshrined in international treaties and declarations, but are continually evolving.

The human rights regime is based on the equal dignity and worth of all human beings, without discrimination. This principle is affirmed in the Charter of the United Nations and repeated in the Universal Declaration of Human Rights and core treaties. The UN Charter establishes human rights promotion as one of the purposes of the United Nations, alongside maintenance of peace and security and international co-operation for social economic purposes.

The human rights concept of equal worth and dignity is especially important for equality-seeking groups including the user/survivor movement. The user/survivor movement has begun to develop coherent theories of human rights that challenge exclusion and call on the world community to live up to its promises made to all human beings.

Equal worth and dignity of the individual is also important because it centres the individual as the holder of rights and as a figure in international law. For users and survivors whose dignity and

individuality have been assaulted, human rights advocacy represents a restoration of dignity and a form of reparation for the violations experienced.
Rights and Principles in No-Force Advocacy

An extensive range of international conventions, rights and principles support No- Force principles – however, states can and do disregard these conventions, rights and principles when it comes to madpeople.

Non-discrimination

Non-discrimination is both a right and a principle in international law. The International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) require governments to ensure equal enjoyment of the rights guaranteed in those treaties without discrimination, and ICCPR article 26 recognizes a right of individuals to equal protection of the law, without discrimination.

Discrimination is described broadly in both Covenants, including grounds of “race, colour, sex, language, political or other opinion, national or social origin, property, birth or other status”. The Committee on Economic, Social and Cultural Rights, which interprets the ICESCR, has recognized that disability is a prohibited ground of discrimination included in “or other status,” and it is widely accepted that this applies to the ICCPR as well.

One aspect of non-discrimination is the “right to be different” recognized in the UNESCO Declaration on Race and Racial Prejudice. This concept has resonated strongly among people with disabilities and users and survivors of psychiatry. It is related to the call for universalizing of standards to meet individual requirements on a basis of equality, rather than treating non-disabled people as a norm and accommodations for people with disabilities as a special case. Forced psychiatric interventions constitute torture

Protection against torture and other cruel, inhuman or degrading treatment or punishment is guaranteed to all human beings by the Universal Declaration of Human Rights (UDHR) and International Covenant on Civil and Political rights (ICCPR). The ICCPR also particularizes medical or scientific experimentation without free consent as a form of torture or other ill treatment. This protection is not subject to derogation, in keeping with the character of torture as a universal evil to be prohibited and criminalized at all times. A definition of torture is elaborated in the Convention Against Torture (CAT) and is useful in testing inherently harmful activities. Users and survivors of psychiatry have always claimed that forced drugging, electroshock, and psychosurgery, and seclusion and restraint, were torture and ill treatment, and now there is the ability to present the argument formally, to urge the acceptance of this application of human rights law.

Recognising forced interventions as a form of torture goes to the heart of the issue of free will versus coercion. Psychiatric violence breaks the will by destroying mental integrity, identity, and personality, through the involuntary use of methods that act on the mind through the brain.

The norm against torture and other ill treatment protects against harm to mental and bodily integrity, especially acts that are designed to break a person’s will or resistance. The definition of torture used most commonly in international law, from the UN Convention Against Torture (CAT) defines torture as:

- * an intentional act
- * inflicting severe mental or physical pain or suffering
- * for purposes such as obtaining information or a confession, intimidation or coercion, punishment, or for any reason based on discrimination of any kind
- * by or with the acquiescence of a public official.

Physicians who perform forced interventions are aware that severe pain and suffering is likely to result, and they proceed against the will of victims. Pain and suffering caused by these interventions may be severe, as documented both by the user/survivor movement and by organized psychiatry itself. In some instances, victims have been intended to experience pain and suffering as a desired “therapeutic” effect. Mental health laws or immunities provide state acquiescence to this.

Coercion, intimidation and punishment are often factors in the use of forced interventions like ECT, psychosurgery and forced drugging. Coercion occurs both in the use of these methods as a deterrent to undesired behaviour, and in the inherent nature of interventions that interfere with thought processes, emotion, consciousness, and self-perception.

Discrimination occurs first of all, by making an exception of actions against people with psychosocial disabilities, actions which would otherwise be considered torture. Discrimination also occurs in forced interventions where the purpose is to change a person from one state of being to another, against his or her will. This violates not only the right to informed consent and autonomy of mind and body, but also the right to be different – the right to not have our differences made the occasion for violence or coercion to change.

For users and survivors of psychiatry, application of the prohibition against torture to forced interventions would begin to redress the harm and allow for reparation to be pursued. More importantly, it would require the immediate abolition of all such forced interventions and assurances of their non-recurrence.

Self-determination

Another important principle is individual autonomy and self-determination. Selfdetermination of peoples is enshrined in the UN Charter and in the Covenants, but individual self-determination is implicit in the human rights regime centring on rights and freedoms of the individual and can be derived from a number of core rights, such as freedom from slavery, freedom from torture, freedom from experimentation without consent, right to informed consent in health care, right to liberty of movement and to choose one’s own residence. The disability movement has embraced the concept of a right to self-determination and the UN Special Rapporteur on Disability has also supported the concept of a right to selfdetermination that includes the right to accept or refuse treatment.

Recognition as a person

The right to recognition as a person before the law is recognized in the Universal Declaration of Human Rights (UDHR) and the ICCPR. This right is non-derogable, that is, it may not be limited even in states of public emergency.

The right to recognition as a person before the law can be interpreted narrowly or broadly. Narrowly, it may mean that every human being is entitled to be recognized as in fact having the status of personhood, with whatever implications that may have under the law. More broadly, recognition as a person before the law entails legal capacity – the capacity to assert, exercise and enjoy rights on one’s own behalf.

Freedom from arbitrary detention

The right to be free from arbitrary detention is significant for users and survivors but it requires some careful attention. Arbitrary arrest and detention are prohibited by the UDHR and ICCPR but the right is subject to limitation in times of public emergency. Much of the advocacy on user/survivor issues related to detention has focused on the “lawful” quality of the detention. This has limited potential because it results in establishing legal standards and procedures for detention, rather than challenging the basis of detention of users and survivors as discriminatory.

Liberty of movement

The right to liberty of movement and freedom to choose one's residence is also guaranteed by the UDHR and ICCPR. This right is potentially subject to restrictions in the interests of national security, public order, public health or morals, or the rights and freedoms of others. However, it is a significant source for the right to remain at liberty and choose one's residence on an equal basis with others, without discrimination.

Freedom of thought

Freedom of thought is guaranteed by the UDHR and ICCPR. The ICCPR further protects against coercion that would impair a person's ability to have or adopt a religion or belief of his or her choice. This protection is not subject to derogation or limitation. This provision somewhat duplicates the effect of the protection against torture, but it is broader and focuses on mental freedom rather than causation of harm.

Standards of health

The right to "the highest attainable standard of physical and mental health" (recognized in the ICESCR) is not the best theoretical basis for no-force advocacy. The user/survivor movement does not necessarily accept the premise that psychiatric interventions belong in the context of health, and many prefer to see social, cultural and community-based supports rather than illness-oriented treatment. However, there are aspects of the right to health that are relevant.

The first is the right to control one's own body and health, which includes the right to informed consent. This aspect of the right to health was recognized in General Comment No. 14 of the Committee on Economic, Social and Cultural Rights. It can be understood as a limitation on the powers of government, and also as an articulation of the role of individual autonomy in protecting bodily integrity and well-being.

Another important aspect of the right to health is that health services must be respectful of the cultures of "individuals, minorities, peoples and communities." This reflects a cultural dimension of our relationship to health and health services, which includes traditional or indigenous healing approaches as well as individual beliefs pertaining to the characterization of health needs and desirable services.

Economic, social and cultural rights

Article 22 of the Universal Declaration of Human Rights is a beautiful articulation of a concept that is central to disability movement human rights advocacy. "Everyone has the right to realization, through national effort and international cooperation... of the economic, social and cultural rights indispensable for his or her dignity and necessary for the free development of his or her personality." Users and survivors of psychiatry have struggled to find the balance between asserting the right to be left alone, and asserting a right to social support and disability-related accommodations. There is no contradiction between these rights, and article 22 helps us to articulate the interrelationship between them.

United Nations Convention on Disability Rights

In December 2001, the UN General Assembly passed a resolution to form an Ad Hoc Committee to "consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities." This represented a historic opportunity for the user/survivor movement to articulate basic elements of no-force advocacy as an application and interpretation of existing human rights from a disability perspective.

The World Network of Users and Survivors of Psychiatry (WNUSP) has played a leading role in mainstreaming user/survivor issues in the Convention, and enjoys the support of its allies in the International Disability Caucus (IDC) of disabled people's organizations and allied non-governmental organizations participating in the work of the Ad Hoc Committee.

The UN Working Group that drafted a text for negotiation comprised 27 governments, one national human rights institution and 12 NGOs including WNUSP.

Through participation in the Convention process, the user/survivor movement has succeeded in establishing a human rights discourse on rights and principles relevant to no-force advocacy. In particular, the principles of legal capacity, and the shift from substituted decision-making to supported decision-making, forced interventions as a form of torture, and prohibition of the deprivation of liberty based on disability, were addressed in the Working Group text.

Social model of disability

The social model of disability helps users and survivors of psychiatry to identify as an equality-seeking group of people, as a social minority subject to discrimination. Discrimination against madpeople is sufficiently similar to the discrimination faced by people with mobility impairments, sensory impairments (sight, hearing) and other groups of disabled people, that it makes sense to share a common identity.

Use of an explicit disability perspective provides access to a pre-existing theoretical framework that can be used or adapted as appropriate. Disability can be used as a lens to interpret and re-interpret specific human rights and eliminate bias in their application. This premise has been the foundation of user/survivor work on the Disability Convention, to be discussed further below. By identifying essential elements of no-force advocacy and correlating them with particular rights, we can develop arguments for the interpretation and application of these rights so as to require elimination of force as a matter of human rights obligations.

Even before the Disability Convention process, participation by users and survivors of psychiatry in a panel of experts advisors resulted in the historic proposal by the Special Rapporteur on Disability for adoption of guidelines that would recognize the right to self-determination, including the right to accept and refuse treatment, protection against unwanted medical or related interventions, and the right to refuse to comply with involuntary institutionalization.

Another value of the disability and human rights perspective is that it allows us to address discrimination experienced in all areas of life, and to examine the connections between force and other rights deprivations. An example of this is found in the report submitted by the Japan National Group of Mentally Disabled People (JNGMDP) to the UN Human Rights Committee, which monitors the ICCPR, in 1998. The Japanese group addressed violations of the right to life, inhuman treatments (including the absence of provisions for informed consent), the failure of a procedural mechanism to reduce involuntary hospitalizations, and social inequalities codified in law, among other issues. The JNGMDP did not explicitly argue for interpretations of the rights that would result in elimination of psychiatric coercion, but it remains a pioneering example of engagement with human rights mechanisms of the United Nations.

No More Deprivation of Liberty

A provision guaranteeing that no one shall be deprived of liberty based on disability faces opposition in the Ad Hoc Committee, despite its straightforward character as an obligation of non-discrimination.

Deprivation of physical liberty is a significant exercise of power over a person and a significant deprivation of rights for the individual. Loss of physical freedom entails obedience to those who hold the keys of confinement, and dependence on them for provision of food, shelter, health care and other basic needs. While people may learn to adapt to living in conditions of captivity, its involuntary nature conflicts with freedom as the natural human condition. Psychiatric detention, which claims to benefit both the detained person and society as a whole, runs counter to human aspirations and perpetuates segregation and subordination of people with disabilities.

Psychiatric detention is misconceived by some as the only mechanism of control that society has over people with psychosocial disabilities. By virtue of the insanity defence, it is said, criminal laws do not apply and for this reason, psychiatric civil commitment and commitment of people acquitted on insanity grounds is necessary. However, this fails to take account of the fact that

psychiatric detention does not only respond to offences against the law proven to have been committed beyond a reasonable doubt, but also to subjective predictions of behaviour. Psychiatric detention has no place in a democratic society, where people with psychosocial disabilities are guaranteed equal protection of the law.

Furthermore, users and survivors of psychiatry are coming to a consensus that the insanity defence is inconsistent with equal rights. Far from allowing most people acquitted of insanity to go free, the insanity defence can result in longer incarceration in psychiatric institutions, labelled as treatment rather than punishment. The intentional element in criminal acts should be applied equally to people with psychosocial disabilities as to others, so that failure to prove this element beyond a reasonable doubt would result in acquittal and freedom.

In keeping with disability rights principles, arrest and detention must adhere to the requirement of non-discrimination including reasonable accommodation, so as not to inflict harsher punishment on people with disabilities than on others in similar situations. In particular, reasonable accommodation in the context of arrest and detention should include access to support networks and to non-coercive support while in a present state of crisis. People accused or convicted of crimes are entitled to these measures as a matter of their right to be treated with humanity and with respect for the inherent dignity of the human person. However, special procedures and standards applicable to people with disabilities should be avoided since they perpetuate the psychiatric commitment system.

Supported Decision-Making & Legal Capacity

Supported decision-making can be understood, from a user/survivor point of view, as an application of the recovery perspective to the situation of decision-making. The recovery perspective is centred on individual strength and capability and the belief that madness is a temporary state of distress and disruption. It emphasizes hope and cultivation of the person's own abilities of self-reflection and development of skills particularly with experiences that might otherwise gain power over the individual.

Like recovery, supported decision-making is centred in respect for selfdetermination and for the inherent human capabilities of each individual.

The twin premises of supported decision-making are that everyone has legal capacity and that everyone is entitled to use support of their choosing when making and communicating their decisions. Support cannot be imposed over a person's objections, and a support person cannot act against the person's will or override his or her decisions. The supported decision-making model was developed as an alternative to guardianship, and it remains relevant in that respect to both users and survivors of psychiatry and other people with disabilities.

Legal capacity has emerged as a central issue in the convention, because it challenges the depth of society's lack of commitment to full equality for people with disabilities. What does it mean to say that disability is a social phenomenon that can be addressed through supportive accommodations? Legal frameworks are part of the social environment that must be re-examined and redesigned for accessibility. The disability movement has developed the concept of supported decision-making as a way of redesigning legal capacity so that it is accessible to all people with disabilities.

However, legal capacity also affects other areas of life where legal disqualification is imposed or a determination made about competence. The supported decisionmaking model would abolish all tests of legal capacity or determinations of incapacity, while ensuring that support is available as an entitlement to all who wish to use it.

Advance directives

Another important avenue of rights advocacy is the use of advance directives to preclude coercive psychiatric interventions, possibly including detention. Advance directives and enduring

powers of attorney use the existing framework of legal capacity, also allowing people to designate their preferred substitute decisionmaker, who can be a family member or trusted friend. If advance directives are respected, they can be a valuable tool for individuals and contribute to the move towards autonomy.

Imagine Beyond Force

The incorporation of no-force provisions in the draft text of the Disability Convention represents the possibility of freedom for users and survivors of psychiatry.

The Working Group draft, which guaranteed legal capacity without exception, prohibited deprivation of liberty based on disability, and prohibited forced interventions as torture, seems to have all the bases covered. If this were adopted and came into force as international law, imagine the difference it would make.

Users and survivors of psychiatry have begun on a wider scale than ever before to imagine a world without force and to bring it into being. Some work with peer advocacy and support, developing a new paradigm of self-determination in recovery. Some work on individual and systemic grass-roots advocacy. A growing number are becoming knowledgeable about human rights and linking local advocacy to national, regional and international human rights mechanisms.

Human rights provide us with scope for the imagination, as well as practical advocacy tools. If apartheid could be ended, why not forced psychiatry? As members of the human family, it is past time for users and survivors of psychiatry to have an equal chance at freedom from fear, freedom from want and freedom to live in dignity promised to all people.

- September, 2005

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World Network of Users and Survivors of Psychiatry. (2004). Resolution on the disability convention. Retrieved 3 Jan 2006 from <http://www.wnusp.org/congresses/vejle/resolution.pdf>. Human Rights? Of course... but what does that mean?

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Tina Minkowitz's paper, the occasion for this volume, is refreshingly frank. Since I'll be running a somewhat different argument – not entirely inconsistent with hers, I think - it is perhaps worth

identifying up front a set of views we share. Based on her article, I feel sure we agree on the following points.

- * People labelled as having mental disabilities have been systematically socially marginalised historically and in the present day. That is not acceptable, and must be addressed.

- * The views of those people don't count as much as those of 'professionals' – be they medical professionals, social care professionals or politicians – in determining what happens to them either as regards medical treatment or social care. That is unacceptable, and must be addressed.

- * Some forms of intervention are barbaric. Obvious examples include confinement in cage-beds, sleep deprivation and chemical-enforced sleep, aversion 'therapy' and eugenic interventions. In much of the world these treatments have disappeared; where they have not, they ought to be made illegal. We will each have our own list of what meets this threshold of barbarism. I once saw a ward where the occupants were not even given pyjamas, but wore only diapers. It deeply distressed me; it was less obvious that it so deeply distressed them.

- * Human rights, with its focus on things such as dignity, respect for the individual, freedom of thought, self-determination, and provision of procedural safeguards to protect against violations of those rights, represents a potential framework for addressing many of these issues.

Our views thus have much in common, and I hope we are headed in the same direction. Nonetheless, while I am a fan of human rights and have a healthy scepticism about psychiatric coercion, I also think we need to think in practical terms about how those principles and concerns get translated into law, and adopted into social practice. What positive changes do we want; what do we want to rule out entirely; what do we want to put controls on, and what would those controls look like? In short, human rights are wonderful; but what do they look like in practice? And a human rights approach, like any other legal or ethical structure, has pitfalls as well as benefits. What are the pitfalls of a human rights analysis, and how do we avoid them?

First a warning. I am a Canadian lawyer, living and working in England, with some knowledge of some other parts of Europe as well. I have little knowledge about the situation on the ground elsewhere. While I hope the experiences in the countries I know about are relevant, it is in the end up to local activists in their own countries to figure that out.

Contradictions of Empowerment

As noted above, there can be no doubt that the views of users have been marginalised in the development of mental health law, policy and practice, and that must be addressed. Such empowerment is at the foundation of a human rights approach. In policy terms, even this basic empowerment is problematic, however.

The first obvious problem is that users do not speak with one voice. Attitudes to medical interventions and the medical profession are an obvious example where attitudes differ. Tina Minkowitz's article associates psychiatric practice with coercion and the restriction of the liberty of those with which it comes in contact, referring to pharmaceutical treatments as 'chemical poisoning'. That certainly reflects the experience of some users, and those experiences are important and must not be ignored. Other users instead find psychiatric interventions liberating. Such users may consent to treatments that others find barbaric, such as ECT. User empowerment has to take account of choices made by these people as well. In legal and policy terms, this may restrict what and how we can regulate.

The second problem is that there are limits to how far some people can be involved in the decision-making process. Certainly, social institutions have been much too quick to marginalise the views of vulnerable people, and certainly legal, medical and care professionals have been much too quick to find people to lack capacity to be involved in decisions. When practised properly, supported decision-making can assist many of these people to reach an autonomous decision, and for this borderline group, supported decision-making makes considerable sense. It is difficult to see that it can apply to all people, however. For people with advanced Alzheimer's disease, for example, meaningful involvement in decision-making may be impossible. For them,

and indeed whenever supported decision-making is used, there is a question about the power relationship between the decision-maker and the person providing the 'support': the decision may become the will of the supporter, not the supported. In that case, the user is deprived of an autonomous decision just as much as if formal responsibility for the decision were given to another.

This is a reminder that coercion by legal systems is only one part of the coercion faced by people with psychiatric difficulties. As we remove formal legal coercion, it is always appropriate to ask what happens outside the legal realm. Historically, one of the reasons law got into the business of regulating the care of the insane had to do with inappropriate unregulated care – people chained to beds and so forth. While legal regulations certainly have their coercive elements, it is not obvious that we want to go back to a world devoid of legal safeguards.

Human Rights in Daily Life

In some areas, a human rights approach is theoretically unproblematic, and may offer real potential for practical gains. Daily life outside institutions, where discrimination is still rife, is an example. Employment statistics for people with psychiatric histories are, frankly, appalling. Accommodation in the community is often dire. Many users and former users of psychiatric services will have their own stories about how they have been denied services unfairly, often grotesquely unfairly.

This is an obvious area of consideration for a paper advocating a human rights approach, as it is the sort of area that human rights law is used to dealing with. The parallels will be clear to anyone with a background in the civil rights movements. Why is a refusal to hire people with psychiatric histories any more acceptable than a refusal to hire black people? Certainly, some people will require their particular situation to be taken into account in the workplace – time off may be required to visit therapists, for example – but human rights lawyers are used to dealing with that kind of problem in the context of physical disabilities. Mental disability may throw up some new fact situations, but there's not a lot that current legal theory and precedent shouldn't be able to handle.

This is therefore an area where a human rights approach is doctrinally unproblematic, but this in turn leads to a slightly different point about the limits of a human rights approach. Anti-discrimination legislation has been in place for black people for decades. In the United States, where much of this law was pioneered, no one would pretend that such discrimination has been eradicated. In parts of the world where we have seen real change, it flows not from human rights alone, but from broader social change and changes in attitude. Anti-discrimination laws help those changes along, but they do not bring the changes about on their own. Human rights must remain one part of a bigger strategy involving advocacy, visibility and political pressure if we are to see significant change. Winning rights, in itself, does not simply mean winning meaningful change.

The use of an anti-discrimination model also means that applicants need to identify themselves as people with mental disabilities, since anti-discrimination law is based on membership in an identifiable group. In this sense human rights law, not unlike medicine, forces people into specific labels. Indeed, under current practice, adopting such a label under human rights law will require a medical diagnosis. Users who already view themselves as having a medical disability will find this unproblematic, but users who are critical of the disability label or the medical model of disability will find it oppressive. Nonetheless, this categorisation is unlikely to change. Even if we were successful at raising questions about the link between mental disability and medical categories, human rights law would require a sufficiently robust non-medical model of mental disability to be able to determine who qualified for anti-discrimination protection and who did not. It is not obvious where such a model would come from, or what it would look like. As a result, antidiscrimination law by its nature entrenches distinctions that some will find offensive and oppressive. In this sense, human rights law, like any other legal or theoretical structure, can be a double-edged sword.

The Problem of Coercion

Tina Minkowitz's paper encourages us to imagine beyond 'force', and that is undoubtedly a desirable vision. It is not acceptable to use force without cogent and compelling reasons. It is manifestly unacceptable that enforced treatment or confinement be used as a matter of medical, social or political convenience.

But can we do without force completely? Our ideal is that medical treatment should not be provided absent the informed consent of the patient. What happens, however, if a person with severe Alzheimer's disease suffers a painful injury? Do we really not treat the injury because the individual is not capable of informed consent? I suspect that we all agree that to leave such a person in pain on that basis would be barbaric. As discussed above, it is not obvious that supported decision-making will allow this individual meaningful involvement in the decisionmaking process. At the same time, to treat the individual means moving away from a strict 'patient decides' model to someone else making the decision.

If we are prepared to make this sort of departure for physical treatments, is there a cogent argument not to make them for psychiatric treatments as well? Certainly, many psychiatric treatments have very intrusive adverse effects, but the same may be said of many physical treatments. As discussed above, whatever reservations many users have about psychiatric treatments, we cannot assume that all users have the same view regarding the desirability of 'cure'. For people who lack the capacity to consent, the provision of safeguards may be the way forward, be it for treatment for psychiatric or physical disorder. Such safeguards might require the decision-maker to take account of the values and views the user possessed while competent.

Such intervention based on incapacity appears to be non-discriminatory – we would do it equally for psychiatric and non-psychiatric conditions. For that reason, it has become increasingly significant in debates regarding the justification for compulsory treatment.² Indeed, in Ontario, it has been the law for more than a decade that any person with capacity has the right to consent to or refuse any treatment. That applies to both psychiatric and physical treatment, whether or not the individual is in a psychiatric facility, and whether or not they are formally confined in the facility.³

For decisions regarding medical treatment I support that approach, but not without reservations. The problem is that capacity is a notoriously slippery concept, and the evidence seems to be that courts and tribunals are quite happy to ratchet up the standard so that individuals are held to lack capacity and treatment occurs.⁴ The courts have no stomach for taking rights seriously in this area, particularly when the contest is between a psychiatric patient and doctors or other wellintentioned professionals. The precisely similar problem occurs, by the way, for advance directives: the experience is that the courts will bend over backwards to find reasons why they don't apply.⁵

This points to a serious problem with the human rights approach. It implies a central role for a robust court, and the indications are that courts may be anything but robust in protecting the rights of psychiatric users. One of the criticisms of the UN declarations of principles and other like documents is that they are lofty aspirations that never translate into change on the ground. If the courts are unprepared to enforce human rights standards, the human rights statutory achievements in the area of mental disability may too remain little more than tokenism. That in turn has positive and negative effects. On the plus side, even these relatively empty statements can assist in changing public opinion, and that can in turn lead eventually to real change. On the down side, such empty statements may nonetheless provide governments with political capital to which reference may be made, diverting attention from how little is happening in actual practice.

The Slippery Slope

If we allow that interventions without the agreement of the individual when that person lacks capacity to consent, the problem is how do we stop other justifications for involuntary

intervention? Are legislators permitted to consider other factors in the determination of when enforced measures are to be taken? As an obvious and politically relevant example, should the law be able to consider an individual's dangerousness to self or others as relevant to coercion?

There are numerous problems with this. On a practical level, how does one determine dangerousness? Actual violent behaviour would be one possibility, but few mental health acts go so far. More often, it is a matter of prediction. Traditionally, that has been based on the guesswork of admitting physicians, and has been notoriously unreliable.⁶ More recent and scientifically rigorous study has improved the predictive values, but it is a long way from exact. A study by John Monahan and his colleagues in America is the best available (2001). It placed people with mental disorders into five bands of dangerousness. The most dangerous band would have included only 27 per cent of the people who would be dangerous in the following year; but nonetheless 25 per cent of the people in that band would not in fact have committed a violent act in the following year. Note that this is the most accurate means of prediction available, and the authors acknowledge it is too complex to be used in clinical practice. There can be no doubt that using this sort of predictive mechanism will involve coercing a significant number of people who are not dangerous.

Statistical predictors of violence in more frequent use are problematic not merely because of their accuracy, but also their criteria for assessing dangerousness. These often include for example race and gender – better predictors of dangerousness than diagnosis, it would seem⁸. But do we really want a system that locks people up in part because they are male and black?

The use of a dangerousness standard of coercion in itself does not appear to violate human rights norms, at least as defined by leading human rights bodies and courts. The UN certainly takes the view that legislators may take other factors into account. In its Mental Illness Principles, a document that in its preamble defines itself as being for the protection of the civil and human rights of people with mental illness, allows civil confinement in psychiatric facilities and enforced psychiatric treatment for the safety of the patient or others⁹. The European Court of Human Rights seems similarly content to see compulsory admission based on an individual's perceived dangerousness¹⁰.

In terms of democratic theory, there is an obvious problem here, if the individual has not actually done anything dangerous prior to the compulsion. But is it really less defensible than quarantine, where people with a physical disorder may have their rights restricted not because they have actually infected people, but because they might? Certainly, the recent experience in the UK is that the politicians have no wish to stand up to tabloid newspaper editors who routinely play the fear card to sell newspapers. The argument appears as a 'balancing' of rights – the human right to liberty of the individual who will be coerced, and the 'human rights' of the remainder of society to go about their business free from danger. There is considerable slippage in the use of language here – it is not entirely clear that society in the abstract has 'rights'. Nonetheless, issues of social safety are used as interpretative guides to the scope of rights.

This is not necessarily a bad thing. We might think of the situation of an aggressive individual on a psychiatric ward. While the rights of that individual to be free of inappropriate coercion or control must be acknowledged, so must the rights of other persons on the ward to be in a safe and appropriate environment. At the same time, any acknowledgement of the curtailment of the aggressive individual's rights raises questions of the conditions in which segregation and physical and chemical restraint may be imposed. It is all very well to favour a no-force policy toward users; but it seems excessive to jeopardise the safety and well-being of other users to protect that principle. Yet again, if we begin to allow segregation and restraint, we are on another slippery slope: how is the range of such coercion to be controlled?

So What of Human Rights?

None of this is meant to undercut the basic propositions at the core of a human rights and empowerment agenda for people with psychiatric histories. The fact that we may not attain a

perfect solution is not an argument against a way forward that is an improvement on what we have now. It is instead a reminder that beneath the human rights slogans lies a nest of problems that are complex, and sometimes contradictory.

It is also a reminder that, however much we keep our eye on our ideals, laws are decided in the tussle of political negotiation. We must continue to strive for our ideals, lest we forget what we are fighting for; at the same time we must be aware of the sorts of issue that will arise in the negotiation so that we can prepare to respond to them. There is no such thing as a perfect deal. It is for people likely to engage with the psychiatric system to determine what is the right deal – or the best available deal. I would say that it is likely to involve creating both an appropriate system of regulation and the political culture in which such regulation can thrive.

- November 2005
Notes

1. See p.1 Minkowitz, T. (2005). *No-Force Advocacy by Users and Survivors of Psychiatry*. Wellington: Mental Health Commission.
2. See, e.g., Department of Health and Welsh Office, Expert Committee. (1999). *Review of the mental health act 1983 (The Richardson Report)*. London: Department of Health.
3. See Consent to Treatment Act, SO 1992, c. 31, superseded by Health Care Consent Act, SO 1996, c.2, sch. A.
4. See, e.g., *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762; *Re MB (Medical Treatment)* [1997] 2 FLR 426; *Norfolk v Norwich Healthcare (NHS) Trust v W* [1996] 2 FLR 613; *A Metropolitan Borough Council v DB* [1997] 1 FLR 767. For an argument against the use of capacity for decisions regarding civil confinement on this basis, see Bartlett, P. (2003). The test of compulsion in mental health law: capacity, therapeutic benefit and dangerousness as possible criteria. *Medical Law Review*, 11, 326.
5. Indeed, in *Re T* [1992] 4 All ER 649, the English Court of Appeal went so far as to say that treatment for the benefit of the patient in violation of such a refusal would attract only nominal damages: at pp 665 and 669. That probably can no longer be said to be an accurate statement of the law, but judges remain extremely hesitant to enforce advance refusals after the patient has lost capacity: see e.g., *HE v A Hospital NHS Trust* [2003] EWHC 1017 and cases cited therein.
6. See, e.g., Dershowitz, A. (1970). The law of dangerousness: Some fictions about predictions. *Journal of Legal Education*, 23, 24; Monahan, J. (1984). The prediction of violent behavior: Toward a second generation of theory and policy. *American Journal of Psychiatry*, 141(1), 10.
7. *Hutchison Reid v UK*, Application number 50272/99, judgment of 20 February 2003.
8. Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Clark Robbins, P., Mulvey, E., Roth, L., Grisso, T., & Banks, S. (2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence*. Oxford: Oxford University Press, table 6.7.
9. Wessely, S. (1997). The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry* 8, 11.
10. United Nations. (1991, 17 December). Principles for the protection of persons with mental illness. General Assembly Resolution 46/119, principles 11.6(b), 16.1.

Human Rights and Compulsory Medical Treatment

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Introduction

Four specific key aspects of Minkowitz's article are focused upon.

On the first, little need be said: the proposition that no force should be used in mental health interventions, and that the use of force should be viewed from a human rights perspective is one no human right lawyer could reasonably disagree with.

What I do fundamentally disagree with is the second proposition, that forced psychiatric interventions constitute Torture. That provocative proposition is worthy of far more considerable analysis that can be applied here. It is light years ahead of its time, particularly in New Zealand.

In the New Zealand context, the starting point is the New Zealand trilogy of rights, the prohibition against Torture and other Ill -Treatment¹, medical experimentation², and compulsory medical treatment³ contained in the New Zealand Bill of Rights Act (NZBORA). Unlike many nations the status of the local BORA is no greater than any other statute. The ability to depart from its protections if demonstrably justified in a free and democratic society⁴ together with the failure of the New Zealand to fully incorporate such international conventions as the International Covenant on Civil and Political Rights (ICCPR)⁵, and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)⁶, hardly bodes well for such a radical human rights theory postulated by Minkowitz.

The article fails to analyse why such behaviour is torture, rather than some lesser ill-treatment. At best a claim of ill-treatment might be arguable in Domestic Law. It might have more success before one or other or both the relevant United Nations Committees, The Human Rights Committee, or the Committee Against Torture, as breaches of articles under the respective conventions those Committees have jurisdiction over⁷. Again ill-treatment is a better prospect than torture.⁸

Third, given the article's approach as a generic international analysis, reference to the recent release by the UNESCO Report of the Working Group on Arbitrary Detention,⁹ is helpful as it lends support to the resolution passed by the Ad Hoc Committee pursuant to the 2001 General Assembly resolution to "consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities" discussed by Minkowitz.

Fourth and lastly, her article also canvassed various aspects of Legal Disqualification. Any interested reader would benefit from reading the 2005 Irish Law Commission Consultation Paper on Vulnerable Adults Laws,¹⁰ which has a useful current analysis.
Human Rights and Forced Psychiatric Intervention

At first sight the advancement of such a proposition that forced interventions are a form of torture, seems highly provocative. Using the standard definition of torture contained in the Convention Against Torture, the argument is superficially attractive, but soon sinks without a trace. In my opinion, the argument that it is something less than torture has a far better chance of success¹¹, as no Court or International Tribunal, easily makes a finding of "torture" because of the emotionally charged picture that is conjured up by say, mass rape, vicious beatings, and the more "standard" forms of torture such as genital electric shock usage. No Court or International Tribunal has yet made a finding on the type of argument put forward by the author that forced invention (and/or compulsory medical treatment) is torture.¹²

Article 1 of CAT defines torture.¹³ The three pillars of the definitions are¹⁴:

1. the relative intensity of pain or suffering inflicted: it must not only be severe, it must also be an aggravated form of already prohibited (albeit undefined) cruel, inhuman or degrading treatment or punishment;
2. the purposive element: obtaining information, confession, [or for any reason based on discrimination of any kind] etc;
3. the status of the perpetrator: a public official must inflict or instigate the infliction of the pain or suffering.

In my opinion, the test of an aggravated form of already prohibited treatment is unlikely to be met by forced incarceration, and compulsory treatment. Neither would it fit the proviso of not arising from or inherent from lawful sanctions. It could meet the second limb on the discrimination ground, and certainly meets the third limb inflicted by public officials, i.e. the psychiatric hospital staff.

A far better road to travel down than torture is the lesser evil of ill-treatment.¹⁵ In *R v Secretary of State Ex parte Adam & Ors*¹⁶ Lord Hope concludes it is impossible by a simple definition to embrace all human conditions subject to Article 3 of the European Convention on Human Rights.¹⁷ His Lordship continues quoting from *Pretty v United Kingdom*¹⁸ where the European Court of Human Rights said:

“As regards the types of ‘treatment’ which fall within the scope of article 3 of the Convention, the court’s case law refers to ‘ill-treatment’ that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering. Where treatment humiliates or debases an individual showing a lack of respect for, or diminishing, his or her human dignity or arouses feelings of fear, anguish or inferiority capable of or inferiority capable of breaking an individual’s moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of article 3’.

Given the difficulties of reaching the extremely high threshold of torture, alleging ill-treatment is a far better prospect.

UN Working Party on Arbitrary Detention

If a mental health detention is, or can be, an arbitrary detention (carrying with it at least in international terms a habeas corpus right), it is not hard to see it could not also be in some circumstances be cruel, degrading, or disproportionately severe treatment or punishment¹⁹.

The working party stated²⁰:

51. The handling of the phenomenon of mental illness is an age-old problem for humanity. Even though the treatment of the mentally ill has undergone considerable improvements, the need to isolate them from the rest of the society seems to remain a permanent element of the treatment. Whether isolation amounts to deprivation of liberty cannot and shall not be decided in the abstract. The Working Group is of the view that the holding against their will of mentally disabled persons in conditions preventing them from leaving may, in principle, amount to deprivation of liberty. Along the lines applied in its deliberation No. 1 on House Arrest, it will devolve upon the Working Group to assess, on a case-by-case basis, whether the deprivation of liberty in question constitutes a form of detention, and if so, whether it has an arbitrary character.

58. In the consideration of individual communications under its mandate the Working Group applies the following criteria:

(a) Psychiatric detention as an administrative measure may be regarded as deprivation of liberty when the person concerned is placed in a closed establishment which he may not leave freely. Whether the conditions of someone being held in a psychiatric institution amounts to deprivation of liberty, within the meaning of its mandate, will be assessed by the Working Group on a case-by-case basis;

(b) The same applies to the deprivation of liberty of suspected criminals pending medical check-up, observation and diagnosis of their presumed mental illness, which may have an impact on their criminal accountability;

We need to pay special attention to these areas as the New Zealand Human Rights Commission observes²¹ that prisoners who are physically or mentally unwell must be closely and specifically

monitored in recognition of the special rights and needs of these groups of detainees. They likewise observe that it appears that restraint, seclusion and other practices limiting freedoms are, at times, being used in ways that are inappropriate under human rights standards.²²

Given the moral, ethical and legal concerns surrounding all forms of compulsory assessment and treatment, we all need to be vigilant. This is particular so given the legal disqualification that follows such assessment and treatment.

Aspects of Legal Disqualification

Many rights of mental health consumers are removed as result of a compulsory invention. As the Irish Law Commission²³ states:

1.26 A finding that a person lacks capacity results in the restriction or removal of fundamental human rights. In this sense the issues of capacity and rights are inextricably linked. ...²⁴ Human dignity is at the core of the concept of human rights. Indeed, in a more general sense, if one accepts that the focus of human rights is generally about increasing autonomy then the connection between the two issues becomes even more apparent. There are a great many human rights instruments which apply directly or indirectly to persons with intellectual disability and mental illness.

They also observe that a fundamental shift has been taking place away from a medical model of disability towards a social and rights-based model, and that allied with that change from a medical to a social model of disability is a gradual, less discernible shift away from what may be termed "benign paternalism".²⁵

Conclusion

In so far as much as Minkowitz advocates the move from benign paternalism to an ability model rather than a disability model, she is to be applauded, but adoption of the torture argument should be positively discouraged within New Zealand in the present context of our human rights development.

- November 2005

Postscript: Given the depth of the topics touched on in the article it has been very difficult to only write 1500 words, and consequently only limited comment is possible. I would have liked to have engaged on the Freedom of Thought issue having discussed that issue recently in London with a top human rights QC. His view was interesting, but from a European perspective the right is not as absolute as it is in the ICCPR, and where the Europeans tread we (New Zealand) follows, as the European Court of Human Rights, unlike the Human Rights Committee, is full time and churns out jurisprudence.

Notes

1. Article 9. Right not to be subjected to torture or cruel treatment: Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

2. Article 10. Right not to be subjected to medical or scientific experimentation: Every person has the right not to be subjected to medical or scientific experimentation without that person's consent.

3. Article 11. Right to refuse to undergo medical treatment: Everyone has the right to refuse to undergo any medical treatment.

4. s5 New Zealand Bill of Rights Act.

5. International Covenant on Civil and Political Rights (ICCPR) ratified by New Zealand on 28 March 1979, and the right to make individual complaints granted on 28 August 1989, but the ICCPR is still not part of domestic law. It is an unincorporated treaty.

6. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) ratified by New Zealand on 9 January 1990, but only partially part of New Zealand Domestic law. See for instance Crimes of Torture Act 1989.

7. Articles 7 (partly) and 10(1) of the ICCPR, and Article 16 of CAT.

8. However, even that is problematic for example an US case would be met with the reservations entered to Article 7 of the ICCPR, and a similar one to CAT. The US Article 7 reservation reads;

“That the United States considers itself bound by Article 7 to the extent that “cruel, degrading treatment or punishment” means the cruel and unusual treatment or punishment prohibited by the Fifth, Eighth, and/or Fourteenth Amendments to the Constitution of the United States.

United Nations, Multilateral Treaties Deposited with The Secretary General 133 (1994) (status as of 1 December 1993). On 1 June 1992, President Bush signed the instrument of ratification. The instrument of ratification was deposited at the United Nations on 8 June 1992 and the Covenant entered into force for the United States on 8 September 1992. John Quigley, “The International Covenant on Civil and Political Rights and the Supremacy Clause” 42 *DePaul L Rev.* 1287, 1291 (1993).

9. Civil and Political Rights including the Question of Torture and Detention: Report of the Working Group on Arbitrary Detention, Chairperson-rapporteur Leila Zerrougi. E/CN.4/2005/6

10. Consultation paper on Vulnerable Adults and the Law: Capacity (LRC CP 37-2005)

11. Nigel S. Rodley, *The Treatment of Prisoners under International Law*, 2nd ed (OUP, 1999) p 96. The language of the Human Rights Committee has been especially inconsistent in its many cases dealing with violations of article 7. And at p 98 “To sum up on the issue of how severe or aggravated inhuman treatment has to be for it to amount to torture is virtually impossible.”

12. The argument advanced in *Jensen* could equally apply to seclusion in mental hospitals. See *Jensen v Denmark*, Communication No. 202/2002, U.N. Doc. CAT/C/32/D/202/2002 (2004). The complaint was that the State party violated articles 1, paragraph 1, and 16 of the Convention, by subjecting her to psychological torture and acts of cruel, inhuman or degrading treatment or punishment, treatment or punishment, by detaining her in solitary confinement from 29 April to 18 June 1998, it was rejected as inadmissible for failure to exhaust domestic remedies, but it looks like it might resurface after the formal step of seeking leave to Denmark’s highest court has been exhausted.

13. The term “torture” means any act by which severe pain or suffering whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.

14. Rodley, N. S. (2002). The definition(s) of torture in international law. *Current Legal Problems*, 55 (OUP, 2003) 467-93.

15. My abbreviation for the balance of s9 NZBORA leaving aside torture i.e. cruel, degrading, or disproportionately severe treatment or punishment.

16. [2005] UKHL 66. Para 54 (3 November 2005)

17. s9 NZBORA is a close match to a mixture of Articles 7 and 10(1) of the ICCPR, and both are in similar terms to Article 3 of the European Convention.

18. 35 EHRR 1,33, para 52

19. And thereby a breach of s9 NZBORA and /or Articles 7 and 10(1) of the ICCPR.

20. See note 9 above.

21. Human Rights Commission. (2004). *Human Rights in New Zealand today / Ngā Tika Tangata o Te Motu and New Zealand Action Plan for Human Rights — Mana Ki Te Tangata/ Priorities for Action 2005-2010*. Retrieved January 3, 2006, <http://www.hrc.co.nz/report/index.html>.

22. *ibid* Ch 11.

23. Consultation paper on Vulnerable Adults and the Law: Capacity (LRC CP 37-2005) Para 1.26

24. These human rights include the right to equality and non-discrimination; the right to bodily integrity; the right to protection of the person; the right to personal liberty; family rights; the right to personal and marital privacy; the right not to be subjected to inhuman and degrading treatment and property rights.

25. Ibid Paras 1.20 and 1.21

A Clinical Response

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The Minkowitz paper argues for people utilising mental health services (referred to in that paper as madpeople) to be auspiced by United Nations Conventions of disability and human rights. These "madpeople" are redefined as persons with disabilities ("Persons with Disabilities" UN 2004) and allied with an attack on medical psychiatry to secure success for a "No-Force" campaign eliminating "coercive psychiatry" and "legal disqualification". Minkowitz sees an historic opportunity for the "No-Force"/"user/survivor" movement to base psychological suffering in a disability perspective. The inclusion of needy people with mental health problems under disability provisions is practical and probably is already implicit in many treatment protocols.

In 1972, Dr Thomas Szasz proposed the view that mental illness was unlike any other illness. Psychiatric treatment, voluntary or not, was unlike any other treatment. Mental illness was a mythology and treatment was social action. It followed that involuntary psychiatric treatment was torture.

Szasz despaired for modern man that "skills acquired by diligent effort may prove to be inadequate for the task at hand almost as soon as one is ready to apply them". Many people find life disappointing and they seek the security of stability, even if that is purchased "only at the cost of personal enslavement". The healthy, adaptive alternative was a "learning life" committed to meeting challenges successfully.

Some people only learn one set of skills or at most a few. This leaves them solving the same old problems repeatedly and unsuccessfully. Human life was "a social enterprise" requiring greater flexibility in personal conduct. Szasz pointed out that some people require a personal instructor for this way of being and others do not.

Modern Psychiatric Practice

The idea of coercive psychiatry may have been more relevant earlier in history. There are still some elements of restraint, seclusion, and some treatments which obscure informed consent. However, generalisations in the Minkowitz paper confuse the historical past with contemporary practice.

Modern psychiatric practice is governed by principles of care, conduct, and ethical standards. Historically, one can sympathise with No-Force advocates. But coercive psychiatry in the extreme form implied by the Minkowitz summary resides in a past based in desperate ignorant attempts to help people. Those remaining areas of concern are monitored by official visitors and are subject to mandated consultative second opinions and sentinel event notices in many countries.

Eleven principles of psychiatry, as outlined by the Royal Australian and New Zealand College of Psychiatry (2004), are enshrined in that institution's Code of Ethics:

* Psychiatrists shall respect the essential humanity and dignity of every patient.

- * Psychiatrists shall not misuse the inherent power differential in their relationships with patients, either sexually or in any other way.
- * Psychiatrists shall provide the best possible psychiatric care for their patients.
- * Psychiatrists shall strive to maintain patient confidentiality.
- * Psychiatrists shall seek informed consent from their patients before undertaking any procedure or treatment.
- * Psychiatrists shall not misuse their professional knowledge and skills.
- * Psychiatrists shall continue to develop and share their professional knowledge and skills with medical colleagues and trainees in psychiatry.
- * Psychiatrists shall share the responsibility of upholding the integrity of the medical profession.
- * Psychiatrists have a duty of care to the health and well-being of their colleagues, including trainees in psychiatry.
- * Psychiatrists involved in clinical research shall adhere to ethical principles embodied in national and international guidelines.
- * Psychiatrists shall strive to improve the quality of, and access to, mental health services, promote the just allocation of health resources and contribute to community awareness of mental health and mental illness.

The Minkowitz paper, with its emphasis on users/survivors distorts the practical picture in the real world and the necessary systems evolving to ensure the minimising of suffering from mental health harms.

A repeated emphasis on madpeople suggests emphasis directed at functional psychoses such as schizophrenia, major depression, and bipolar affective disorder. Dismissal of these illnesses is not supported by the science base which provides data on predispositions, causation and natural history/course in line with other illnesses.

Serious mental illness can also present covertly. A depressive person can present with normal behaviour. Many people with mental illness hide their suffering or they use their intelligence to swap types of suffering. An example of this would be a person with severe generalised anxiety disorder who self-treats with alcohol. Similarly, many illicit drug addicts begin life anxious, severely depressed or mentally ill.

Many physical illnesses of the brain present with psychiatric symptomatology. There are practical needs for a trained helper disciplines such as psychiatry and psychology to make the correct diagnoses to minimise the harms from illness. A host of previously fatal illnesses have become practical problems for continuing management and containment because of advances in treatment.

The polemical sections on “coercive psychiatry” over-simplify the clinical situation. Forced surgery, sleep deprivation, and mechanical restraints are historical oddities except insofar as societies must continue to be alert to the abuse of power.

Modern practitioners of psychiatry are trained and aware so as to avoid generally coercive practices in psychiatry. However, there is still legislation for involuntary detention for psychiatric examination and treatments in urgently practical circumstances.

Certainly, not all involuntary examinations are necessary.

Criminal activity is no more likely to occur within the mentally ill population than in the general population. The presence of a mental illness in a person does not predispose to crimes against persons or property. Why then should people be deprived of liberty and rights because they manifest different mental content? But there are occasions when the abnormal mental content of an ill person will result in a causal relationship between the mental health status of that individual at the subject time and some unintentional unlawful act. These isolated cases are left to the fact-finders of the judicial process.

There are of course dangers, as Minkowitz points out, in providing some people with excuses for bad behaviour. Along with that goes the inherent risk that behaviours be repeated because society's response has been insufficient or ambiguous.

People who are sufferers in the true sense because of mental health harms must be directed towards help rather than being placed in situations of deprivation where further trauma and loss of trust in human nature occurs.

People will still present in mental pain and in trouble. People do develop health conditions which make them dysfunctional or deprive them of the necessary controls and discriminative judgment to function adequately in community. These people, as Minkowitz points out, become a problem to themselves and/or to other people.

It would require detailed negotiation amongst all the social, judicial, and other stakeholders to devise new systems for assisting those people. Minkowitz surely would not want vulnerable people to be dealt with solely by police in a necessarily robust manner.

The Australian National Mental Health Survey

The Australian Bureau of Statistics ascertained the prevalence of mental and substance-use disorders for Australia by way of a 1997 Australian national survey of mental health and well-being. This first Australian national household survey replicated the 1990 United States national comorbidity survey published in 1994 and the 1993 United Kingdom survey of psychiatric morbidity published in 1997. All surveys addressed three questions:

1. How many adults suffered from mental disorders?
2. How disabling was their psychiatric impairment?
3. What health services did they use and want?

Close to 23% of adult Australians reported having at least one psychiatric disorder in the previous 12 months. Some 14% suffered from a disorder when interviewed. About one-third of people with a mental disorder in the 12 months prior to the survey actually consulted about it as a problem. Most had seen a general practitioner, not a specialist.

About 1 in 6 people in the Australian community met criteria for a mental health disorder during that year. About 10% met criteria for active illness preceding the interview. Total prevalence was 22.7% using the International Classification of Diseases 10 (ICD-10) and 20.3% using the Diagnostic and Statistical Manual (DSMIV).

Women had higher rates of mood/anxiety disorders and lower rates of substance disorders. The elderly had lower rates for all disorders except cognitive impairment. The young had higher rates of substance use disorders. Currently married had lower rates for all disorders. Disorders were more frequent in those with less education. The employed had lower rates for all disorders. About 4% of people admitting to suffering from conditions suffered from 2 or 3 or more diagnoses at the one time (comorbidity).

Specialist psychiatry tends to deal with people suffering from the more complex problems. General practitioners deal with most sufferers. Without any form of protective legislation some people with complex problems and even their families will suffer badly.
Correctional Services

More people may end up in correctional custody under a Minkowitz model. Correctional institutions are not noted for promoting mental wellbeing. Suicide is the leading cause of death amongst adult offenders in custodial settings. Inmates are up to ten times more likely to die from suicide than their counterparts in the general population. Custody-related deaths may account for

up to three-quarters of all deaths amongst custodial clients who have not yet gone to trial and up to one-third of all deaths amongst sentenced prisoners.

In 2003 some English studies looked at non-fatal suicidal behaviour and found that over one-quarter of male prisoners on remand had attempted suicide. Half of the female prisoners on remand had attempted suicide in their lifetime. In the week prior to the interview, 23% of female prisoners had thought of suicide. Those who attempted suicide were in poorer general, physical, and mental health.

Mortality was examined in a twelve-year follow-up of 3000 young offenders undergoing their first custodial sentence in Victoria, Australia, in 1998-1999. Overall risk of death from any cause was nine times higher amongst male young offenders.

During the opening of a new prison in Scotland, a study examined the workload of the local hospital emergency department. During the first year of life of the new jail, 22% of 103 emergency transfers for treatment were for deliberate self-harm.
Utilisation of Psychiatric Services

It will be noted that the Mental Health Survey in Australia indicated that only about one-third of people with a so-called mental disorder in the twelve months prior to the survey had actually consulted medically about it. Most of these people had seen a general practitioner not a specialist psychiatrist. General practitioners are carrying the main burden of relieving the suffering of people with compromised mental health.

Most of the psychiatry being practiced, certainly in Australia, is being done by general practitioners. General practitioners are not so lacking in work that they go out and drag people in against their will in order to treat them with psychiatry. Most hospital admissions for psychiatric assistance are voluntary.

A majority of these people are approaching medical healers in an informed way within a voluntary treatment system about which they are increasingly wellinformed. Many people now access information sources including the internet before consulting medical doctors. The number of people consulting alternate healers ranging from psychological counselling to naturopathy through to acupuncture and so on probably exceeds that attending on medical practitioners. (The scientific data are not available to quote actual numbers).

Many people move from alternate therapies to more western-style medicine. Other people become disillusioned with westernised medicine and move to alternate therapists.
Involuntary detention for examination or treatment

With regard to involuntary initiatives, there can be some sympathy with the views of Tina Minkowitz. Most people with mental illnesses are not causing crimes. They are not hurting other people. Involuntary treatment orders may not be necessary very often.

The practical situation is that the people subject to involuntary treatment orders often have a long period of conflict with police and other social agencies together with multiple attempts by various people and agencies to treat them. Involuntary orders are often a belated, ineffective last resort.

However, we have had a real life examples of abuse in Australia. In some public sector organisations in Australia, whistle-blowers and other employees who become a thorn in the side of the bureaucratic powerbrokers can be compelled to have psychiatric examinations even in circumstances where their information provided to authorities about defects in the system was proven to be correct.

The nervous system and other bodily systems occupy the same physical spaces. It is inevitably required at some stage within the life cycle of every human being, that there be a diagnostic

approach to discern which bodily systems are breaking down. For example, an elderly person with a silent heart attack of myocardial infarct may well present with psychiatric symptoms because of blood clots migrating into the cerebral cortex. People with multiple sclerosis can present with psychiatric symptoms. Almost any physical illness may present psychological reactions and pains.

Presently, extremely powerful illicit drugs cause mental and behavioural suffering, particularly in young people. How are we to deal with drug-induced psychosis with phencyclidine, methylamphetamine, and benzodiazepines (among other drugs) where people generate great dangers for themselves?

We have had the tragedy in Australia where people with these disturbances go out in public armed with a knife or some such weapon and are dealt with most severely by police.

Suicidal people suffering from functional psychotic illness such as major depressive disorder can survive with a helpful intervention. When these people recover (as they do with modern treatment) they are usually grateful for the assistance received. If they have been well managed within a modern paradigm, they will also learn something about themselves and their biological predispositions so as to protect them during further illness episodes.

People who are consulting psychiatrists, psychologists, and other mental health workers usually do so on a voluntary basis. They only persist with that helping process if they decide that the process is of relevance.

In the public sector, the usual complaint is that the public sector people have done the compulsory examination too quickly and ceased the involuntary examination order and discharged the person too early. There are regular complaints that public sector voluntary treatments are truncated because of resource constraints.

There can be some sympathy with aspects of the Minkowitz paper and there are still areas which could be addressed by No-Force advocacy. But the old mental hospitals referred to by Erving Goffman in *Asylums* (1961) have been closed. There were abuses of the power imbalance between attendants and clients in those days. However, the old mental hospitals were not invented because supervisors, psychiatrists, and attendants wanted jobs. Like the mainstream medical psychiatric services now, mental health services existed because there was a market for them.

If all the mental health facilities were emptied and closed today, clients, relatives, police, and indeed the judiciary tomorrow "would raise a clamour for new ones" (Goffman 1961:334).

Conclusion

Combining legitimate criticism with over-generalisation is a problem in the Minkowitz paper. If the disability model assists people to learn mental healing, then we can all wholly support it. But we must provide adequately for people who have been deprived of mental health and who are in recovery. They require adequate resources with all of the agreed rights as part of our shared human condition including adequate housing and sustenance. Historical oddities and overgeneralisations jeopardise credibility.

Years ago I was fortunate enough to be the guest of indigenous New Zealanders of the Northlands of the North Island of New Zealand where I learned a terminology which I have never forgotten. The Maori health workers talked about "Voice, Choice, and Safe Prospect". I foresee a world where the constructive aspects of No-Force and other advocacy would require that people who have had their mental health compromised in some way should have, along with the rest of us, a voice in their destiny, an exercised right to choose their path, and a consistent experience of safe prospect where they can anticipate within the limits of the fates that tomorrow will be secured as was today.

If we want this for mental health, we must all work together to ensure that a fair share of the community's resources is devoted to people who are suffering or who are in recovery from mental health harms.

I agree that many people will be assisted more by social action focused by counselling psychologists, occupational therapists, and social workers. Along with non-government services and other agencies, we can work at demedicalising many of the conditions which currently are dealt with by general practitioners and specialist psychiatrists.

- November 2005

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A Person-Centred Psychiatric Perspective

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Introduction

While it is not pleasant for me, as a psychiatrist, to see the profession I have worked in for the past twenty-three years characterised as it is in this paper, the views expressed reflect those of many with the lived experience of serious mental illness and "forced treatment". They need to be

accepted as a valid and important perspective in shaping this debate; indeed as the most important perspective.

It needs to be said at the outset, that I agree with the basic proposal of this paper – which I take in somewhat modified form as being that “force” (the use of compulsion) needs to become the rare and temporary exception, rather than the rule, as a means of engaging people with serious mental illness in care and treatment. This approach is indeed being practiced very successfully in exceptional mental health services around the world (including within New Zealand), as elaborated on below.

However, there are also those with lived experience who feel that forced treatment, used thoughtfully for brief periods and in ways that maintain as much personal autonomy as possible, has been a useful and important part of supporting them towards recovery. Understanding the differences between these perspectives is key to understanding how use of compulsion in mental health services can be minimised.

Twenty years ago, to question the use of compulsion for people with serious mental illness who refused to engage in treatment and follow-up, even where there was clearly no risk of harm to anyone, was to be seen as being “unsuitable to train as a psychiatrist”.

In considering the No Force proposal, however, it is apposite to first remind ourselves that while the psychiatric theory and practice current in any era have played a role in shaping public attitudes and opinion regarding mental illness, the reverse influence is by far the stronger of the two. The prevailing cultural attitudes to, and myths about, “madness” have throughout history had a profound influence in shaping medical and psychiatric views regarding mental illness.

This influence is in fact indirectly highlighted in the Minkowitz paper. One example is the reference to euthanasia of psychiatric patients in Nazi Germany. This was a practice that foreshadowed the use of the gas chambers in the Holocaust, and came in the context of philosophy, thinking, and political rhetoric at the time, regarding racial purity and the place of eugenics in society. While this is the most negative influence of wider societal views on psychiatric practice in recent centuries, current mental health law and practice in general reflect the state of societal attitudes. Achieving the end of no-force psychiatry is thus going to require, among other things, active effort to shift attitudes in the wider community. New Zealand is somewhat unique in the world in having had several years of a media campaign which has demonstrated significant impact on community attitudes to serious mental illness (Yee & Lapsley, 2004), so clearly this end is possible over time.

What the reference to the Holocaust and other examples given by Minkowitz do is highlight the horror of what people with mental illness have been subject to over the ages, even though this may at the time have been seen as a benign or humane response. They also place in stark context the experience and views of people with mental illness in the 21st century, regarding abuse by psychiatry and mental health services in the name of what, according to current societal attitudes to mental illness, is seen as necessary and humane care and treatment.

Minkowitz has made a case for “no force” based primarily on a Human Rights perspective. To complement this I will briefly review a number of important lines of mental health theory, research, and practice, which are of relevance to the debate regarding the place of compulsion in providing mental health care.

Mental Illness: Disease, Disorder or Distress?

Central to the debate regarding use of compulsion is what we understand “mental illness” to be. If we can be sure that an individual’s “mind” has been “taken over” by a brain disease that is reversible, then that might justify the temporary taking over of the decisions about need for care and treatment. This is the implicit justification for compulsion in terms of both legislative intent, and psychiatric practice.

Mental illness is, however, extremely difficult to adequately define. Modern psychiatry has been profoundly influenced by the recent explosion of biomedical brain research, which has sought to find the basis of mental illness in “brain disease”. Thus far, this quest has increased our knowledge of the function of the brain and mind exponentially, and made more effective and tolerable treatments available. However, it has failed to demonstrate an underlying disease process for any of the mental health conditions other than those related to old age (dementias). We do know that most mental health conditions are associated with demonstrable differences in brain function. However we also, for example, know that brain function in an individual changes during such activities as sex and intense concentration, so what does the presence of changes in function really tell us?

What we are left with, in diagnostic terms, are so-called mental disorders. These are diagnoses based on clusters of symptoms that commonly co-occur, and result in problems functioning when they co-occur, for example the set of symptoms that represent the diagnosis of depression.

On the other hand, psychosocially focused research has demonstrated some other interesting associations. It has been known for some time that rates of childhood experiences of significant abuse are greatly elevated in people with mental illnesses compared to population rates (Wells, 2004). If this is so, then it is doubly tragic that people with serious mental illness experience treating services as further traumatizing them. A number of research studies have also found that the rate of “psychotic-like” experience in the community (e.g., religious experiences such as receiving messages from god, hearing god talk to one, etc) is 5% or more, yet less than 1% of people are diagnosed with psychotic illness. One study undertaken in France (Verdoux & Van Os, 2002) looked at what distinguished those diagnosed from those not. This study suggested that there was little in the nature of the experiences themselves that differed between those diagnosed and those not. However, the presence of positive meaning and a sense of control over the experience, and the absence of related distress, distinguished those who were not diagnosed.

These and other lines of research suggest that mental illness may be related as much to distress as disease. The corollary of this is that what may be required to help is support and healing, as much as treatment. Force and healing are obviously antithetical approaches.

Recovery

The past 20 years has seen many published accounts by people with serious mental illnesses, of what has facilitated their recovery (e.g., Deegan, 1996). There has also been an enormous volume of research – much of it qualitative – which has sought to answer this question. Common to both has been the understanding that recovery is not about the absence of ‘symptoms’ of ‘illness’, but is rather about stability of housing, adequate income, employment, meaningful relationships, and a sense of meaning and purpose in life – in the words of a well known New Zealand consumer advocate “a life worth living”. Recovery is thus defined as “living well in the absence or presence of symptoms of mental illness”. A key finding of this literature is also that recovery comes from within the person, not from any treatment. Sometimes treatment can facilitate this process, but equally sometimes it can delay or prevent it. (Banks, Burdett et al, 2004; O’Hagan, 2001). Thus a person who hears voices may have no interest in being treated for a mental illness they do not believe they have, but may be interested in getting help to reduce the intrusiveness of voices that interfere with their ability to succeed in work, where working is a key goal for them.

Mental health services personnel who actively listen to and take seriously the person’s concerns, wishes and needs, seek to support and empower them in getting these needs met, and “work with them rather than doing to them”, seem to help create the conditions within which recovery can occur. While I have never seen any research examining this, it is my impression that services which manage to support their staff in working in this way seem to have very few if any “critical incidents” such as serious violence against self or others.

Another key understanding to come from the recovery literature is that recovery is about being able to learn from experience, and being supported to do so; it is about trial and error and being able to learn from mistakes. One consequence of compulsion is that this becomes much more difficult to achieve; too often people with mental illness are deprived of the right to learn from their mistakes, in the name of treatment that is in their own best interests.

It is worth commenting on the fact that these key threads to what recovery is, really just reflect what wellbeing is about for any person. The final key understanding regarding recovery in the context of considering the place of compulsion in mental health services, is that the best form of risk management in mental health services is the facilitation of recovery – recovered people do not harm themselves or others as a result of symptoms of mental illness.

The implication of competence

At its heart, compulsion is about taking “required” action on behalf of a person with serious mental illness, who is seen to be incompetent to take that action themselves because of their “illness”. Thus, use of compulsion becomes the rule in engaging people who do not see themselves as ill, in care and treatment. However, this also creates the (mostly implicit) belief that people with serious mental illness are to greater or lesser degrees permanently incompetent. Thus they make bad choices, and need others to help them make decisions and/or make decisions for them. In my opinion this is the most insidious, but in many ways the greatest, harm created by the mandating of compulsion. By virtue of being deprived of the right to make mistakes even when not under compulsion, learning does not occur and thus incompetence is paradoxically created, reinforcing the belief that people with mental illness actually are incompetent. This is the heart of institutionalisation, and it is as prevalent now as in the days of the old institutions, even if in more moderate and benign form.

Tensions with “risk management”

At all levels of society, from the community, to Parliament, to the media, to the Ministry of Health, mental health services are expected to manage the risk that people with mental illness may harm themselves or others. The inherent problem for mental health services in ‘managing risk’ is that suicidal thoughts are very common, suicidal behaviour is fairly common, but completed suicide is very rare (Goldney & Spence, 1987). Likewise, psychosis is common in people referred to mental health services, the kinds of psychotic symptoms sometimes associated with risk to others are fairly common, but acts of violence by people with psychosis are rare (Resnick, 1993). Mental health services thus face a very simple statistical problem – identifying the few really at risk from the very many not at risk.

To put this in context, it has been amply demonstrated that being male and aged 18 to 25 is a better predictor of risk of violence than being mentally ill (e.g., Monahan, 1984). One of the best predictors of risk is past violent behaviour (e.g., Klassen and O’Connor, 1988). Yet we do not preventatively detain all people with a history of violent behaviour – they are presumed to be competent and thus self-responsible (admittedly a big assumption – yet we happily make it!). In contrast, our very poor predictors of risk in mental health services are the primary justification of mandated compulsion. We literally detain and forcibly treat hundreds to prevent one act of violence, and even then will miss someone who does commit violence reinforcing the need to detain more!

It is this more than anything that creates the rule of mandated compulsion. The expectation that mental health services will ‘manage risk’, with mandated compulsion as the ultimate tool in achieving this purpose, thus creates precedents, and reinforces attitudes/beliefs and practices, that are actively opposed to the conditions which we know will foster recovery. It could indeed be argued that just as compelling people to accept treatment will often hinder recovery; likewise compelling services to manage risk in this way will hinder recovery-based practices. Risk is best minimised by fostering recovery, rather than managing risk: managing risk” may paradoxically escalate risks, by hindering recovery.

management are the sound-bites du jour. The points made above support my belief that one cannot effectively practice one while practicing the other. Yet both are expected, even demanded. This dilemma has created what I believe is a seriously disabling tension for mental health services, and is the single biggest obstacle to progress in providing safer and more effective mental health care. More importantly, it is the single biggest driver of service provision that hinders recovery. Psychiatrists in particular, and most clinicians to lesser degrees, understandably respond to this dilemma by resorting to defensive practice – by ‘managing risk’ and often doing this via use of compulsion. To do so is to be able to defend one’s actions in the case of a tragedy – and even then there is a significant risk that one will still be subject to investigation and enquiry. To not do so in the interests of fostering learning and recovery in people with serious mental illness may be to expose oneself to even greater professional risk. The path most psychiatrists and other clinicians follow in this regard is sadly predictable.

Unfortunately the bottom line here is that the primary source of the problem is not psychiatry in general and the medical model in particular, but societal attitudes in general and the media in particular. Our views of reality are shaped more by the media than by dry boring facts. That most people associate psychosis with violence is but one of many examples of this – headlines about the unknown and therefore scary (“...psychiatric patient murders...”) appeal to basic emotions, statistics about the known (being male aged 18 to 25 is a greater predictor of risk than mental illness) do not.

Thus far this tension has remained implicit and has not been openly acknowledged let alone discussed/debated. Until there is informed debate about this issue, and a preparedness to support clinicians and services in both having the time to listen to and truly understand what will make a difference for the people with serious mental illness they work with, and then take clinically indicated ‘risks’ on this basis, it is going to be very difficult to progress the cause of recovery-based practice.

Lack of consumer-focused research on compulsion

Finally, it is obviously key to this discussion to examine the psychiatric literature regarding the evidence for any benefits from compulsion into treatment. For such an important intervention (in terms of both potential benefits and potential harms), there is surprisingly little research to help us in this debate. The results from the few studies conducted are equivocal, with some suggested improved outcome, some suggesting no benefits. Most of these studies have focused on service-focused outcome measures such as rates of re-hospitalisation, adherence to prescribed treatment, and length of time maintained in follow-up. Few have examined more consumer-focused outcomes such as quality of life, or consumer attitudes to care and treatment. And none have sought to quantify harms from compulsion as an intervention, despite this being so strongly stated as an issue within the consumer qualitative literature. In summary, it is not currently possible to state with any confidence what benefits and harms are associated with use of compulsion as an intervention (Salize & Dressing, 2005).

Exceptional Mental Health Services

All the above might sound fine, but what of mental health services which have sought to apply a truly recovery-focused approach. Internationally there are a number of well-known mental health services where use of compulsion is either extremely rare, or indeed is not mandated; these mental health services are renowned for their positive outcomes, and the lack of critical incidents of violence (against self or others) by their client group. Two of the many examples are the services in Trieste, Italy; and at The Village, Long Beach, California.

Recently I have had the privilege of working in Hawkes Bay with an innovative and sector-leading consumer-run service. Supported by a small group of dedicated ‘assertive outreach team’ clinicians and a small amount of psychiatrist time, this consumer operated service, called WIT (“Whatever It Takes” - which literally describes their modus operandi) has worked over the past three years with many people in Hawkes Bay with the most severe mental illness. Critical to the success of the service has been the ability to fund individualised, flexible, and often very intensive

(at least initially) packages of support and care, based on turning “whatever it will take” to make a difference for that person, into reality – starting with attention to the basics such as stability of housing and income.. Service delivery is based on fostering trusting relationships that extend over time, believing in the potential of the person, and a constant process of actively listening to understand what will make a difference for the person, translating that into action, and reviewing what is helping and building on success. Initially WIT worked with those who were in the “too hard basket” (many of whom had identified risk factors) - they were either permanently in hospital or constantly readmitted, and never able to be engaged in community treatment even under compulsion. Of this initial group, most are now living in their own homes, have a range of meaningful relationships, some are working part-time, and most are seldom if ever in hospital. The intensity of care provided has dropped dramatically, though can be increased for times of need when required. Many of the people using WIT have been taken off Compulsory Treatment Orders, some of which had been in force for 20 years. Use of compulsion is the very great exception rather than the rule, and is most often with consumer consent.

Conclusion

In finishing, I would affirm that the proposal made in the Minkowitz paper is not only one I believe in, but is also one that both the recovery literature and my own experience affirms is possible and indeed in the interests of best practice and good consumer outcomes. However, the one significant proviso is that this is only possible in mental health services where support and clinical staff:

1. work together in a highly skilled and complementary, recovery-focused way, and
2. orient clinical and support services around and behind a point of coordination with each individual consumer, which is based on relationship, active listening, and indeed healing, as the basis for service delivery.

This is unfortunately a set of characteristics which are rare in modern mental health services, though could be much more common if examples of “best practice” such as that described were supported and promulgated, and if the use of compulsion shifted from being the rule to being an intervention of rare and strongly justified exception. We are fortunate in New Zealand to be in the position of having (by international standards) well-resourced mental health services, so if it is possible anywhere, it is possible here. Perhaps one day it will be possible to dispense with compulsion entirely; I hope this ideal is possible.

- November 2005

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