CHAPTER 4

INVOKING THE LAW: THE MENTAL HEALTH ACT 1986

The last chapter identified how people in receipt of services are treated in acute public mental health services. The purpose of this chapter is to consider the conceptualisation of the subject utilised in mental health law which authorises the coercive treatment referred to in the last chapter. Although the law requires that all persons be considered equal before the law, the concept of mental illness undermines the concept of equality, as persons who are considered mentally ill are considered less than competent. This means that a patient's autonomy is denied. It is the coercive treatment legitimised by law that the consumer/survivor movement claims is problematic. The totality of this power, authorised in mental health law is the major source of conflict and helps to account for the emergence of the consumer/ survivor movement.

According to Habermas (1996) in *Between Facts and Norms*, the law regulates normative action through the institution of a system of knowledge and action. Individuals cannot maintain themselves as subjects if they do not find support and reciprocal recognition in cultural traditions: moreover, 'culture, society and personality presuppose each other' (Habermas, 1996: 80). Habermas (1996: 104) has identified citizenship rights as protecting the legal subject against State infringements: 'consociates under the law must be able to examine whether a contested norm meets with or could meet with the agreement of all those possibly affected'.

However, this is not the function of mental health law for those admitted to an acute public psychiatric ward. For instance, once a professional decides that all five of the section nine criteria of, for example, the *Mental Health Act 1986* (Victoria, 1998) are fulfilled, and schedule one and two are completed, the patient is admitted, and 'treatment' is authorised. The authority of the law deprives that person of autonomy and dignity by authorising and prescribing involuntary treatment (Okasha, 2000). Even those admitted 'voluntarily' are often coerced to do so. This institutional style of treatment requires that the psychiatrist accept a clinical responsibility for an individual, on the basis of a determination of 'mental illness'.

The determination of some one as 'mentally ill' also carries with it the power to authorise, administer and execute 'treatment'. The person appointed as a medical expert is at the same time endorsed with legal authority and administrator by the State, with the responsibility for the protection of the State. Responsibilities include those to the patient, the family, the institution, the State and the profession. Thus the psychiatrist is invested with a complex and contradictory set of responsibilities that are highly problematic in relation to mental health law. The example of th *Mental Health Act 1986* (Victoria, 1998) will be explored here in detail to examine the implications for the treatment of the patient as a person.

The Admission Procedure

The procedure for admission to an acute psychiatric service is determined by the *Mental Health Act 1986* (Victoria, 1998: 19) which authorises the use of ‘force as may be reasonably necessary’. This includes the authority to enter premises and to use restraint, and administer sedation for the purpose of transporting the person to a mental health service. Even without a formal recommendation for admission, a person can be taken to an approved mental health service if a registered medical practitioner is not available. This procedure greatly undermines a persons sense of wellbeing and safety, which has negative and lasting effects (Kroshel, 2000).

According to the *Mental Health Act 1986* (Victoria, 1998), a person can be admitted and involuntarily detained by a registered medical practitioner where a request and recommendation has been made ‘until the authorised psychiatrist examines the person’ (Victoria, 1998: 24), which must occur within 24 hours. The examination of the person by the authorised psychiatrist then confirms or discharges the patient from involuntary detention. If admitted as an involuntary patient under section 12 of the Act, he/she can be forced to accept any medical or psychiatric ‘treatment’ that the psychiatrist deems necessary.

Legal Requirements for Involuntary Admission

The ‘criteria for admission and detention as an involuntary patient’, in section 8(1) of the *Mental Health Act 1986* (Victoria, 1998) that must be adhered to are:

> (a) the person appears to be mentally ill; and
> (b) the person's mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved Mental Health Service; and
> (c) because of the person's mental illness, that person should be admitted and detained for treatment as an involuntary patient for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
> (d) the person has refused or is unable to consent to the necessary treatment for mental illness; and
> (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action (Victoria, 1998: 16-17).

The first criterion for admission and detention according to the *Mental Health Act 1986* (Victoria, 1998: 16) as an involuntary patient is 'if the person appears to be mentally ill'. But this is a cyclic argument, as Richardson and Machin (1999) argue: 'mental illness' relies on medicine for its definition and application. The statement: 'the person appears to be mentally ill' is the judgement of a psychiatrist. As pointed out in the last chapter, what is perceived as 'mental illness', is a subjective judgement without independent verification and requires legitimisation. This legitimisation is only provided by the authority in mental health law. As Eastman (1999) states, 'in short, definitional power under the Act rests on clinical judgement'.

The second requirement of admission is the need for 'treatment' that 'can be obtained by admission to and detention in an approved mental health service' (Victoria, 1998:16). However, the extent to which coercive 'treatment' is beneficial is under contention. The failure of patients to respond to treatment may be due to the inadequacies of the treatment on offer, such that: 'no alleviation or stabilisation can be achieved in the secure environment of a hospital' (Richardson & Machin, 1999: 7).

Richardson and Machin (Richardson & Machin, 1999: 7) suggest treating involuntary detention as medical treatment means that admission is justified while the concept of medical treatment is debased. Importantly, they argue that 'the law is using medicine as a shield, from a patient's point of view' (Richardson & Machin, 1999: 7). The third requirement for admission is a judgement of the danger the patient poses to oneself or others, a central issue for the implementation of Act. This prerequisite highlights the divided loyalties of the psychiatrist to the institution on whose behalf he acts, and to the family and the patient. However, the determination of danger is a subjective judgement, made on the basis of the registered practitioner's experience of the patient in question, this judgement is informed by their training. As was demonstrated in chapters two and three, there are no other reliable criteria whereby one can gauge 'mental illness' and the clinicians' ability to predict violence is limited (Norko, 1998; Rabinowitz & Garelik-Wyler, 1999). Yet, mental health legislation 'makes psychiatrists responsible for people perceived to be dangerous' (Fulford & Sadler, 2000: 679).

Even though a registrar responsible for the admission procedure may be certain of his/her predictions, this confidence is ill placed in ninety percent of cases (Rabinowitz & Garelik-Wyler, 1999). Rabinowitz's (1999: 105) study indicated 'less confidence in such predictions is warranted'. Though measures or tools to estimate dangerousness are available (Appelbaum, 1994) and used, they have limited value (Mullen, 1996). Appleby has conceded that his risk assessment tools are only able to establish a four percent chance that the person is a risk to others which means that there is a ninety-six percent chance they are not (American Psychiatric Association, 1983).

The problem with the prediction of dangerousness is that such predictions are so inadequate, that the official policy of the American Psychiatric Association (1983) is that psychiatrists are incapable of making them. Miller (1991) states that as such, the coercive treatment based on these predictions might even constitute a breach of ethical conduct. However, to avoid being blamed for the consequences of failure to respond to a perceived threat, there is pressure on professionals in mental health services to make such assessments and to intervene (coercively).

The clinician makes his/her assessment by consulting the family and considering the history. The more experienced psychiatrist, it is claimed, is more skilled in making these complex and difficult assessments. Although, as the last chapter identified, this may just mean the person is stereotyped. Moreover, the reliance on trainees in current acute mental health services means that the least experienced staff bears this significant responsibility. This role, increasingly imposed on psychiatrists through the limitations of alternative types of services and the increasing use of community treatment orders, is making ‘psychiatrists responsible for people perceived to be dangerous’, which ‘makes dangerousness a disease’ (Fulford & Sadler, 2000: 679).

The fourth requirement for admission is that 'the person has refused or is unable to consent to necessary treatment' (Victoria, 1998: 26). This prerequisite for involuntary admission is philosophically contentious as it makes a number of questionable presumptions. One presumption is that refusal is due to a lack of insight about one's own state. This lack of insight, as has already been established, is one of the criteria for a diagnosis of psychosis. But this assumption denies the very different perspective of the patient who considers the problem in terms of the events of their life, and not in terms of an illness. Added to this, is the disincentive as identified in chapter one, of the emotional burden and stigma associated with accepting a diagnosis of mental illness.

Another presumption is that the treatment is helpful, evidence for which has not been established. The consumer/survivor perspective even argues, supported with an array of evidence, such as the incidence of post-traumatic stress disorder associated with admission to an acute psychiatric ward (McGorry et al., 1991) to the contrary. Further, to deny a person the option to refuse treatment that has questionable, potentially traumatising and often damaging effects is a violation of the use of power, and precipitates a breach of trust in the one who authorises such.

Nonetheless, the fourth admission criteria presumes that if one were not 'mentally ill' or 'in their right mind', they would consent. The presumption of incompetence based upon 'refusal' to consent, is then used to endorse the fifth requirement for admission, 'the person cannot receive adequate treatment', 'in a less restrictive' manner (Victoria, 1998: 17). Fulfillment of these criteria to the satisfaction of the treating physician authorises him/her to detain the person involuntarily.

Community Treatment Orders

An alternative to or consequence of admission is that community treatment orders can be issued. This extends the power of psychiatrists to detain patients involuntarily in the community. Community treatment orders are another attempt to provide treatment with the least restriction to freedom, and 'least interference with rights and dignity (McIvor, 1998). The patient under a community treatment order is deemed to be an involuntary patient of an approved mental health service (Victoria, 1998: 33).

Under the terms of a community treatment order a person, as an involuntary patient, is detained in the community. This order may include where the person must live, and specifies the doctor whom they must report to and how often this must occur. The duration of such an order must not exceed 12 months but the Mental Health Review Board may extend the order endlessly upon approval. If the order is revoked due to non-compliance with medical treatment, the person can be returned to the mental health service as an involuntary inpatient.

McDonnell and Bartholomew (1997) showed that the main factor that predicts the use of community treatment orders is diagnosis, a history of poor compliance with medication, and the number of hospital admissions. But the recent review of one hundred and thirty cases heard by the Mental Health Review Board indicated that medication constitutes the sole form of treatment through the community treatment orders (McDonnell & Bartholomew, 1997). The consumer/survivor movement, dissatisfied with over reliance on medication, the side effects, and lack of negotiation, consider this unacceptable (McDonnell & Bartholomew, 1997).

Other problems identified by patients include 'a sense of disempowerment, and a loss of dignity, identity and self-determination'; those who asked to be discharged from the orders cited the 'invasive and stigmatic nature of the orders' (McDonnell & Bartholomew, 1997: 31). Though it is claimed that community treatment orders provide treatment in the 'least restrictive environment', there is no restriction to the number of times an order can be extended. This interferes with liberties over a prolonged period which is contrary to United Nation Principles (United Nations General Assembly, 1991). The use of community treatment orders, which erodes civil liberties, is apparently intended to compensate for inadequately resourced treatment services.

Studies have shown that there is no difference in readmission rates between those on community treatment orders and others (McDonnell & Bartholomew, 1997). This suggests community treatment orders do not achieve their intention of reducing readmission rates and that these rates depend upon factors not addressed in the order. The use of orders continues despite the lack of evidence to show that they have reduced readmission rates or increase compliance (McDonnell & Bartholomew, 1997; McIvor, 1998). Using community treatment orders does not address the problems of readmission as it still does not address the issues people identify as precipitating their crises, or how involuntary treatment works against the person's sense of autonomy (Holloway, Smukler & Sullivan, 2000).

Another problem with the implementing of community treatment orders is that there are no clinical guidelines as to which patients would benefit from them (McIvor, 1998). 'Well-designed studies comparing the efficacy of involuntary inpatient commitment to possible alternatives have never been performed' (Appelbaum, 2001). Thus, as involuntary treatment extends to the community, the boundaries between hospital and community blur.

The problem with the administration of involuntary 'treatment' and the use of coercion in acute public mental health services, and the use of community treatment orders, is a denial of a person's liberty and moreover their voice. Furthermore, the community treatment order, consistent with its coercive status as an involuntary admission, is considered counterproductive because it works against the interests of a therapeutic alliance (McIvor, 1998). Meanwhile, services that respond to a person's needs as the person him/herself experiences them are not provided.

The Mental Health Review Board, a statutory body constituted by the *Mental Health Act 1986* (Victoria, 1998) is responsible for monitoring the implementation of community treatment orders. But the monitoring approach of this statutory body is inadequate to deal with the failure of services to address the needs of patients. That is because it not only does not have the capacity for this type of evaluation but it authorises and extends the very practices that patients consider abusive: namely, enforced treatment. Furthermore, despite the necessity that all initial community treatment orders be reviewed in eight weeks, the Mental Health Review Board's annual report documents that often this does not happen until the 12-month review (Mental Health Review Board, 1999). And although patients can request a review, this does not relieve the statutory body of its responsibility to ensure a review occurs within the statutory review period.

Jaworowski and Guneva (1999) observed that the Mental Health Review Board's decision to extend community treatment orders:

> appears to be dictated more by the administrative demands of the mental health review board hearings rather than an active process of reviewing patient's management plan, including the role of CTO (Jaworowski & Guneva, 1999: 134).

This study showed that the number of community treatment order extensions had jumped forty-three percent in the twelve months prior to the study. In the three-month period of McDonnell and Bartholomew's (1997) study, only three percent of the community treatment order recipients were discharged. Ex-patients claim the lack of legal representation as the major factor in the Board's decision to uphold involuntary status and consequently express dissatisfaction with the Mental Health Review Board process.

Despite these problems, and amidst doubts about their efficacy, the use of community treatment orders is growing internationally. The current increasing reliance on community treatment orders raises 'the contemporary dangers of the political uses of psychiatry for purposes of social control rather than medical treatment' (Fulford & Sadler, 2000).

Psychiatric Law and the Legitimisation of Coercion

Denial of autonomy in the form of freedom, basic human rights and respect occurs in both formal and informal admissions (Cascardi & Poytheress, 1997; Hoge et al., 1997; Hoge et al., 1998; Nicholson, Ekenstam & Norwood, 1996). The use of the law to administer 'treatment' against a person's will and with coercion in Mental Health Services is claimed by professionals and community at large to be in a person's 'best interests' (Fennel, 1998; Freckelton, 1998; McCubbin & Weisstub, 1998; McLaclan & Mulder, 1999). But a growing body of mental health law research literature, indicates that coercion works against treatment benefits and is harmful (Cascardi & Poytheress, 1997; Hiday, Swartz, Swanson & Wagner, 1997; Hoge et al., 1997; Hoge et al., 1998; Kaltiala-Heino, Laippala & Salokangas, 1997; Kjellin & Westrin, 1998; Lidz et al., 1995; Nicholson et al., 1996).

This literature has also identified the experience of coercion not to be limited to involuntary legal status, but related to how a person is treated in public mental health services. Those people meaningfully involved in decision making, who felt they were respected and had an opportunity to tell their story, whether involuntarily admitted or not, experienced less coercion than those who had no such opportunity and were exposed to negative pressures such as threats and force (Hiday et al., 1997; Nicholson et al., 1996).

What has been found to be offensive to consumer/survivors is the use of violence and threats. In contrast, clinicians viewed coercion as necessary for carrying out their responsibilities. Coercive practices have many ongoing adverse affects for consumer/survivors, such as a reluctance to seek help. This aversion may explain the poor utilisation of psychiatric services as identified in the report: Mental Health and Wellbeing Profile of Adults: Australia 1997 (Australian Bureau of Statistics, 1998). It may also explain the unwillingness to continue with treatment once involuntary treatment regimes are lifted [Campbell, 1989]. Though psychiatrists agree that coercion needs to be minimised, how this is to be achieved is not agreed upon (Hoge et al., 1997; Hoge et al., 1998).

Psychiatrists defend themselves against patient complaints of the coercive nature of treatment by arguments such as the following:

> Many psychiatric patients are cognitively disordered at the time of admission and may have impaired ability to perceive coercive interactions to understand the significance of events or to recall interactions in an undistorted fashion… we cannot safely conclude that patients have accurately perceived the circumstances of their admission (Hoge et al., 1998: 132)

However, there is in the same article, an acknowledgement that clinician perceptions are also distorted in self-serving ways, as was identified in the last chapter. Nonetheless, the patient's perspective is discounted on the grounds that the patient is mentally ill: 'patient's perceptions may be affected by…cognitive disturbances associated with psychiatric symptoms' [Campbell, 1989: 133]. Yet, the discounting of the patient's perspective on the grounds of distorted thinking is to fail to consider that perspective. Blanch and Parish (1993) insist that there is no way to confirm patient's anecdotal reports of coercion. Yet, in an ongoing cycle of claim and counter claim, clinicians also acknowledge that coercive practices need to be reduced.

The literature on mental health law and coercion makes clear that what people want is to be involved in their treatment, as anything less is experienced as coercion. Hoge (1998) did a study that explored the 'Family Clinician and Patient Perceptions of Coercion in Mental Hospital Admission'. This research compared the different perspectives in mental health services and the determination of these differences. They found that families reported less coercion, threats and force had occurred compared with accounts by the involuntary patients or practitioners. Importantly, it was the involuntary patients who rated the lowest levels of procedural justice in comparison with either the family or professional, who rated procedural justice near the top of the scale.

Hoge offers two explanations. Firstly he argues defensively for clinicians, that the poor rates of procedural justice rated by patients could be blamed on unreasonable expectations or distress. But this denies the subjective nature of the experience of coercion on the person involuntarily admitted. And it would seem from the research questions Hoge asked that this was what he was attempting to identify in persons being admitted involuntarily: The research questions consisted of:

> How much of a chance did you have to say everything you wanted to about coming into hospital?
> How seriously did people consider what you had to say about coming to the hospital?
> How satisfied are you with the way people treated you when you were coming to the hospital
> How fair was the process of coming into the hospital (Hoge et al., 1998: 136).

The process of involuntary admission by definition involves actions against a person's will. Realistically, this would be experienced as lacking in procedural justice for the person involuntarily detained.

Hoge's (1998: 145) second explanation for the lack of procedural justice experienced by the patient is much more satisfying: that family members and clinicians over-estimated the amount of procedural justice accorded to the patient 'to justify their own behaviour in pursuing hospitalisation'. Hoge explores this idea further when he considers whether the determinants of family and clinician perceptions were the same as the patients'. The results of this analysis, supports the findings of another of Hoge's (1997) studies, that procedural justice plays an important role in determining family and professional perceptions of coercion.

Nevertheless, the three groups in Hoge's (1998: 145) study did not agree about how much procedural justice was provided. Their different perspective explained the differences between the three groups involved. Moreover, it was the family and professionals that received the procedural justice, rather than the patient: admitted against their will. When patients did not experience procedural justice, they felt coerced. The same divergent views were found between patients, carers and staff perspectives in a study in the United Kingdom (Round et al., 1995). This study found poor agreement between the different stakeholders in beliefs about a given patient's diagnosis and the purpose of his/her admission.

This is a similar finding to that of the review of consumer outcome measures conducted in Australia (Andrews et al., 1994). What was found to be important was the involvement of patients in the process of treatment. This notion of procedural justice is important in identifying what consumers want, which, if taken into account, involves the patient and eliminates their experience of coercion. It would be helpful to find ways to incorporate processes of procedural justice into current practice in public mental health services. This is attempted in chapters seven and eight.

Consumer/Survivor Rights

Despite the claim by mental health services that patient's rights are protected, examination of the *Mental Health Act 1986* (Victoria, 1998), indicates that patients have few rights. The first item of patient's right as stated by the *Mental Health Act 1986* (Victoria, 1998) includes the right to a printed statement, the right to obtain legal representation, the right to a second opinion and the right to information. The second item stipulates a printed copy of rights be administered to patients in their own language. The third item states that every person be given an oral explanation of these rights in terms they understand. The fourth item states it is the duty of the authorised psychiatrist to ensure these rights are complied with.

The *Mental Health Act 1986* (Victoria, 1998) states that 'information to be provided' to all patients include: copies of the Act, copies of the above statement, and addresses to which patients may write: the Review Board Tribunal, the Public Advocate, the Chief Psychiatrist, Community Visitors, Victorian Legal Aid, the Ombudsman and the Health Services Commissioner. The *Mental Health Act 1986* (Victoria, 1998) also states that (these) letters are to be forwarded without tampering.

However, according to Delaney (1999) of the Mental Health Legal Centre in Melbourne, the Act does not identify how to go about getting a second opinion. The failure of the State to provide for an independent hearing and legal representation and for a second opinion would appear to be a breech of responsibility on behalf of the State. There also appears to be a contradiction in the expectation that the same person, allegedly admitted as 'incompetent' is able to organise an independent hearing, legal representation and a second opinion for themselves. The provision of these 'rights' is not standard practice, they are only provided if patients contact the Mental Health Legal Service and appeal. The failure to provide for these rights is in effect, a denial of them.

As demonstrated, the legal rights of patients are few, and even then, not provided for. The legal requirement that patients admitted involuntarily are reviewed by an independent body, is not fulfilled in the State of Victoria for eight weeks. For this to be sooner an appeal is required. Neither is legal representation automatically provided for in this process. Zifcak (1997), a member of the Mental Health Review Board, acknowledges that the process of review is much more considered when legal representation is present. Even so, Delaney (1999) considers there is no way of effectively protecting the civil liberties of an involuntarily detained patient in Victoria, as the *Mental Health Act 1986* (Victoria, 1998) protects providers from legal action by legalising coercive treatment. She also states that this means there is no point in the person taking civil action. Thus, there is no recourse against practices patient’s experience as abusive.

The second part of the statement of peoples’ rights in the *Mental Health Act 1986* (Victoria, 1998) includes the right for information relating to hospitalisation. However, consumer/survivors claim they are often not told the side effects of drugs and treatments because doctors regard such knowledge as prejudicial to compliance (Okasha, 2000). The failure to provide for patient rights is highlighted in the consumer/survivor satisfaction survey results, where fifty-eight percent of respondents were not satisfied with the information received. Moreover, fifty percent of patients were also not satisfied that their rights were respected (Quadrant Research Services, 1997).

People considered ‘mentally ill’ may be subject to ‘invasion’ by a team of ‘service’ providers, the community assessment team (or CAT team). They may with the authority of the State in the form of the *Mental Health Act 1986* (Victoria, 1998) use whatever coercive measures they consider necessary, to enter, subdue, restrain, sedate chemically and/or physically and transport the person to hospital. The person may then be involuntarily admitted, secluded in a room and ‘treated’ with chemical and physical restraints. However, much of the treatment on offer is traumatic and may actually cause post-traumatic stress disorder (McGorry et al., 1991).

The recent response to these practices mentioned above and as raised by Burdekin (Human Rights and Equal Opportunity Commission, 1993; 1993; 1995), has been a reduction in accessible services, changes to the *Mental Health Act 1986* (Victoria, 1998) and a relocation of services from independent institutions to mainstream hospitals. Appelbaum (1994) even argues that the law has moved too far in the direction of human rights. But the way the law has embodied human rights claims is by attempting to restrict access to services to the most ‘serious’ cases. In contrast to Appelbaum’s claim, the law has been revised to restrict access to mental health services to emergency cases. Disappointingly, this has not addressed the problems people identify with the service itself. The service needs to be restructured so that those who are in need of support do not experience abuse of basic human rights.

There is a difference between the States in the application of the law in mental health services. An example of the discrepancy in the legislation is in regard to the administration of electroconvulsive therapy and consent. New South Wales uses the Mental Health Review Board to review the application for this procedure. In Victoria, no such process happens in relation to electroconvulsive therapy and consent although this is currently under review. In Victoria, a person can be given electroconvulsive therapy without consent on two grounds: if the person is considered ‘incapable of giving informed consent’ and if it is deemed ‘the performance of electroconvulsive therapy is considered urgently needed’ (Victoria, 1998: 91-92).

Another example of the differences in mental health law is from the United Kingdom. Recently, as stated in chapter three, Mind: The Mental Health Charity (Pedler, 2001) conducted a survey of 418 people who had experienced: electroconvulsive therapy and published the results in: *Shock Treatment: A Survey of People’s Experiences of Electro-Convulsive Therapy (ECT).* Mind found:

> 84% of respondents said that they had experienced unwanted side effects as a result of having ECT.
> 40.5% reported permanent loss of past memories and 36% permanent difficulty in concentrating.
> Among those receiving ECT within the last two years, 30% reported that it had resulted in permanent fear and anxiety.
> A third (32.5%) of recent recipients felt hopeful before having ECT but 29% felt terrified and 22% felt that they were being punished.
> In the short term, 36% of more recent recipients found the treatment helpful or very helpful and 27% unhelpful, damaging or severely damaging. However, in the long term, 43% of more recent recipients felt that it was unhelpful, damaging or severely damaging.
> 66.5% of the overall sample and 49% of those having ECT in the last 2 years would not agree to have it again.
> Respondents from black and minority ethnic communities were more likely to be detained under the Mental Health Act 1986 and to have

> received ECT without consent. They reported a more negative view of ECT than the overall sample with 50% finding it unhelpful, damaging or severely damaging in the short-term and 72% in the long-term (Pedler, 2001: 3).

They concluded:

> It seems impossible to predict who will be adversely affected, and given the seriousness and permanent nature of the potential side-effects recorded above, we believe that it should no longer be able to be imposed without consent (Pedler, 2001: 29).

The survey findings indicated that some people found electro-convulsive therapy helpful. However, the results indicated that it was impossible to predict who would be adversely affected. Given the serious and permanent nature of the potential side-effects recorded above, Mind recommended that electro-convulsive therapy should not be able to be imposed without consent (Pedler, 2001: 29). They also recommended a legal framework on decision making 'be developed as a matter of urgency' (Pedler, 2001: 30). They also suggest 'there should be a legal requirement for an independent advocate to be made available to any person for whom ECT is being considered' (Pedler, 2001: 29) and that ECT not be given if there is any indication of objecting (Pedler, 2001: 30). Mind also recommended that safeguards be established in mental health for all those receiving electro-convulsive therapy and not just involuntarily detained patients (Pedler, 2001).

Benchmarking Victoria by the United Nations Principles

The recent changes made in the *Mental Health Act 1986* (Victoria, 1998) have been a result of Resolutions on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United

Nations General Assembly, 1991). These United Nations Principles can be used as a benchmark against which the Victorian legislation can be judged in terms of its claims to support the rights of the patient.

Delaney (1992) discusses the adherence of the *Mental Health Act 1986* (Victoria, 1998) to the United Nations Principles (United Nations General Assembly, 1991). She argues that admission of a person to a mental health facility on the grounds that a person refuses to consent to treatment denies that person the right of choice and constitutes discrimination. This she claims, is a direct contradiction of the United Nations Principles.

> Discrimination on the grounds of mental illness is prohibited by the Principles, and it is certainly arguable that this denial of freedom of choice is discriminatory (Delaney, 1992: 576).

She goes on to argue that this is also a breech of the United Nations Declaration of Rights of Disabled Persons, and the International Covenant on Civil and Political Rights.

The justification for not allowing mental health patients to refuse treatment is on the basis that patients lack insight into their own condition and the capacity to assess their own 'best interests'. The Mental Health Review Board upholds this position. Delaney (1992: 577) attests 'this does not, however, negate the need to protect the right to refuse treatment however small the group of patients affected might be'. The United Nations Principles do not define the capacity to consent. This capacity seems to be more a function of who is doing the defining. This raises the question of 'insight'.

Delaney (1992) points out that there is a distinction between whether a person accepts that they have an 'illness' and whether they refuse the treatment offered in light of the side effects of that treatment. Also, the person may not consider what they are experiencing as an 'illness', due to the burden of stigma as identified in the first chapter. Health professionals identify a person's experience as symptoms of an 'illness', whereas illness is just one way of understanding or conceptualising those symptoms. There are other ways. From the consumer/survivor perspective, symptoms are related to their life circumstances. The demand by professionals that their patients view his/her symptoms in terms of the professional perspective (i.e. to attain insight) is a reversal of responsibility: it is the professionals' job to understand the patient's distress rather than the patient's to understand the professional perspective and expertise.

The United Nations Principles argue that restraint is to be used only to avoid 'immediate harm to the patient or others'. Whereas the *Mental Health Act 1986* (Victoria, 1998) also permits the use of physical restraint to prevent the destruction of property, but how this danger is to be established is a problem as discussed earlier. Such measures of restraint are inconsistent with the United Nations Principles. The consumer/survivor movement literature indicates that drugs and seclusion are used as a punishment, as has been demonstrated; indeed, Delaney (1992: 578) claims that this indicates 'just how open to abuse are the Act's broad criteria for such liberty denying practices'.

These coercive measures are experienced by people subject to such treatment as ‘intrusive and threatening to integrity’ (Delaney, 1992: 578). This highlights the need for recognition of patient autonomy through adherence to the United Nations Principles: ‘it also shows compellingly the desirability of the Principles’ stringency, and privileging of patient autonomy’ (Delaney, 1992: 578), which is not provided in the *Mental Health Act 1986* (Victoria, 1998).

In New South Wales the admission criteria prohibits prescription of drugs beyond professional recommendations. But professional standards are based on what psychiatrists are trained to do, which, as indicated by the reported experiences of ex-patients themselves, is problematic. This does not mean that changes to legislation would not be of benefit, as changes in legislation would have practical outcomes, which would in turn impact standards of the treatment of patients and therefore training experience.

Under the United Nations Principles, the lack of capacity to consent to treatment must be decided by an independent authority but this Principle is breached in the *Mental Health Act 1986* (Victoria, 1998). The United Nations document states: the decision to admit, is to be initially for a short period, pending review (United Nations General Assembly, 1991: 191). But the provision for review by the Mental Health Review Board does not routinely occur for eight weeks. By this time, few people are still under detention. So the decision for admission is entirely in the hands of the admitting psychiatrist.

The United Nations Principles also identify a person's right to appeal to an independent authority against treatment decisions. However the only provision for this is the Mental Health Review Board. Unless the patient makes an application for an appeal in writing to the executive officer; or the chief psychiatrist; or the authorised psychiatrist; or a community visitor; or the Ombudsman; or the Health Services Commissioner, this basic right is denied.

Furthermore, the Mental Health Review Board's independent authority is also open to question. The members include a legal professional, a psychiatrist and a community member, but no consumer/survivor representative. Delaney (1992: 580-581) states that this process denies the prerequisite to be impartial and becomes a 'rubber stamp' for inordinate psychiatric discretion', as the Board 'will always give great weight to the opinion of the treating doctors'. Indeed, the Mental Health Review Board, Delaney argues, is effectively meaningless (Delaney, 1992).

Review boards and tribunals favour social protection over patient autonomy: patient's complaints are seen as evidence of mental illness. 'Treatment' is given a very broad interpretation. What is considered to be in the patient's interests by the professionals is favoured over a person's need for autonomy. The claim by a person for autonomy is awarded little priority. The person as patient then has no effective recourse, as coercive treatment and detainment are protected under the *Mental Health Act 1986* (Victoria, 1998).

By contrast with Victoria, the procedures in New South Wales' mental health services draw heavily on formal legal process. The main criterion for admission in New South Wales is danger to self and others, which includes the risk of financial harm. In New South Wales, a patient's commitment decisions are reviewed within 48 hours of admission by a magistrate at a hearing, with legal assistance for the patient and periodic review before a Mental Health Review Tribunal. This means that the patient speaks to an independent authority within that time, which is more in line with the Principles than the Victorian system.

Even so, the New South Wales system has limitations. The New South Wales Mental Health Review Board is more formal and so in some ways counterproductive, though the convening of the Mental Health Review Board has the potential to provide a 'hearing' for patients, as its role allows for patients to voice their concerns and perspectives. An alternative model to the present system might combine the best of both approaches: the informality of the Victorian Board and the early sitting of the New South Wales Board, which has the potential to involve patients in a consensual approach to treatment. Including a consumer consultant and offering an independent hearing to validate patients' views would provide an opportunity for patients to define what they think they need.

Some International Comparisons

It is instructive and helpful to compare the Victorian and New South Wales Mental Health Acts with those of Europe, the United Kingdom and United States of America. Appelbaum's (1997: 136) review of the state of mental health law internationally is instructive. He states the radical change in every state in the law of civil commitment in America has essentially altered the status quo. Involuntary commitment has been limited to persons considered dangerous to self or others. The historic category of 'in need of treatment' was abandoned. In its place, there has been introduced a set of procedural rights drawn from criminal law whereby patients have the right to a hearing, representation by an attorney, to testify on one's own behalf and to have witnesses.

In England, commitment continues to be on the basis of health and safety of the patient or protection of others. Though patients can request post commitment reviews, only twenty-five percent do so. Reviews occur after six months and then every three years. Appelbaum reports, Europe has followed the trends in England and not those of the United States. Italy has explicitly rejected dangerousness as a basis for commitment because of the stigmatising effects. They also removed the legal provision for involuntary detention on the same grounds, although this is again under review (Tansella & Burti, 1999).

Nonetheless, despite the legal changes, Appelbaum notes there is little evidence to suggest that the commitment law reform in the United States has had an impact. 'Demographically and diagnostically, the groups look the same before and after reform' (Appelbaum, 1997: 141). Any fall in commitment he attributes to limitations faced by most professionals, including the shutdown of State facilities. This appears to apply to Australian mental health services also.

Appelbaum struggles with the reason law reform has not reformed practice. He claims it is due to the fact that laws are not self-enforced. That is to say, implementation of involuntary commitment is according to how it is applied. The law is applied not according to the criteria of whether they are considered dangerous or not, but according to what is considered a 'reasonable outcome'. Appelbaum identified the paternalistic behaviour of tribunals that Delaney also noted in the United States and England, to account for review tribunal's decisions on commitment. Decisions were not made on the basis of whether patients meet criteria, but whether they thought patients would conform to treatment.

Appelbaum identified that the recent changes in the United States mental health law reflect the contest over the presumption that people would be helped by treatment. This has meant that there is divergence between legal reform and moral sentiment in how the law is applied. The law is interpreted according to moral intuitions rather than according to the letter of the law. This has meant that the conflicting interests in mental health law, of providing treatment while protecting a patient's liberty to make decisions regarding their own care, despite legal reform, has been disregarded in the United States. This, according to Appelbaum, reflects a social consensus for the need for involuntary treatment.

Okasha (2000: 693) points out that the convention of the medical community is to attempt to protect a patient's interests by refraining from 'truth telling'. As has been demonstrated, the convention is that it is the opinion of the doctor that determines whether the patient is competent to give valid consent. But what, he asks, 'is the perceived harm when members of the medical community violate cultural conventions and insist on telling the truth to their patient' (Okasha, 2000: 693)? As Appelbaum (1997) and Okasha (2000) have indicated, public attitudes favour intervention, even if that intervention involves a violation of human rights and is coercive. But with the growing incidence of mental illness, this type of treatment is affecting more and more people. Recent research (Martin, Pescosolido & Tuch, 2000) indicates mental illness signals dangerousness to the community and it is this coupling that needs to be addressed in public policy and legal agendas.

This analysis of the *Mental Health Act 1986* (Victoria, 1998) and the New South Wales Act, together with some international comparisons has revealed that the admission criteria rely upon the concept of mental illness to justify coercive 'treatment'. But this does not take into account the negative impact on the wellbeing of the patient. This counterproductive situation for patients will be contemplated further in the following chapter through an analysis of the obligations of government, and how these currently are met. Considered in chapter eight is the governmental attempts to respond to the complaints made by ‘consumers’ of these involuntary received and coercively administered services.

From Mental Health to Legal Control

The Office of the Public Advocate is an independent statutory agency in Victoria that is responsible for dealing with complaints, regarding ‘treatment’ in mental health services. The Office of the Public Advocate also provides individual advocacy where it is required and not otherwise available. The office is also responsible for training community visitors, who constitute a monitoring system of mental health services. Community visitors are volunteers who visit psychiatric facilities and can make or respond to complaints according to strict and narrow guidelines. However, this is a limited means by which to monitor services, as coercion is authorised under the guise of ‘necessary force’ in the *Mental Health Act 1986* (Victoria, 1998).

Despite these patient complaint mechanisms, complaints are not taken seriously. Kelly (2000) remarks that not a single complaint has been upheld since the introduction of the *Mental Health Act 1986* (Victoria, 1998), reducing the complaint mechanisms to ‘paper tigers’. This leaves users of mental health services without effective advocates in the system. As patients’ complaints regarding their treatment are not considered legitimate, there is no effective accountability for poor or abusive practices. Further, the medical ‘treatment’ provided is defensively recorded in the person’s case history.

The chief psychiatrist's role is to evaluate mental health services in terms of their effectiveness for patient's welfare and wellbeing. The chief psychiatrist has the authority to visit a psychiatric service if she/he has reason to believe:

> (a) that a person with a mental disorder is not being provided, or was not provided with proper medical care by the service; or
> (b) that the welfare of a person with a mental disorder is being, or has been endangered by the service (Victoria, 1998: 131).

As raised in the introduction and in the discussion so far throughout the thesis, consumer/survivors claim these criteria are not adhered to in acute public mental health services. Consumer/survivors claim their experience of receiving services is that treatments are not helpful but harmful, and endangers welfare. Other sources that support the claim that services are damaging are the documented levels of post-traumatic stress, which occur as a result of treatment (McGorry et al., 1991).

The Burdekin report (Human Rights and Equal Opportunity Commission, 1993; 1995) also identified the on going and problematic issues in relation to receipt of mental health services. There is also growing evidence of an increase in suicide rates after contact with mental health services (Appleby et al., 1999; Whiteford, 2000). In the period 1993–97 there was a one hundred and thirty-five percent (135%) increase in calls to lifeline and crisis lines where the caller was seeing a psychiatrist. In the same period there has been an eighty percent increase in calls where there was specific mention of psychiatric disability (Hocking, 1998).

What these figures tell us is how dependent society is on psychiatric services and how inadequate these services are for meeting the needs of those diagnosed with a psychiatric illness. The coercion law literature discussed also makes clear that the coercive methods used in an attempt to fulfil a duty of care, work against consumer interests (Hoge et al., 1997; Lidz et al., 1995). Chris Burford (2000) suggests that the current monitoring of mental health services in Britain is so 'rudimentary as to be useless'. Statistics are limited as to how many people require a caseworker. This works as an incentive to discharge people because there are not enough caseworkers. He suggests:

> This failure to properly monitor creates a perverse incentive to leave vulnerable people with inadequate support, and perpetuates the revolving door, with well over half of admissions readmissions (Burford, 2000).

Burford complains, the British Mental Health Act does not use its power to find out what goes wrong and that the statistics that are taken are inadequate to identify the problems with the service itself. A similar situation is the case in Australian States where the gross statistics are limited to admission and follow up services (Victoria's Mental Health Services, 1996; Victoria's Mental Health Services, 1997).

The authorisation of the psychiatrist with State power informs every aspect of psychiatric practice in public mental health services, as medical interventions are delivered with the authority and protection of the State. Conversely, Szasz (2000) says that mental illness is a myth to substantiate 'ceremonial chemistry', that is, the substitution of medical control for legal and religious ones. He suggests responding to problems either as legal issues where the law is broken, or as psychiatric ones which should receive voluntary treatment. He suggests the myth of mental illness allows people to avoid personal responsibility and enable forced treatment in the interests of family or practitioners and not patients.

Szasz (1974) recommends the establishment of a support service for people to work out their own problems in living, rather than involuntary commitment. This is a tough line as there is little room for compassion or for the difficulties that exist between these two extremes for both families and people who are struggling with problems in living. However, the personal cost for involuntary medical treatment for the patient, though largely unconsidered in mental health, is substantial. The best solution would be to find a way somewhere between, that both empowers and supports people to be responsible.

Nonetheless, public attitudes favour coercion, and as Appelbaum's review identified, even legal reform does not necessarily change practice. Legislation is an articulation of both human rights and an attempt to protect infringement upon others' rights. Yet the use of the law to authorise coercive treatment is an abuse of justice and a contradiction in terms. So how are the conflicts of interests between the protection of the rights of the public and the rights of the 'patient' to be overcome?

What remains problematic is the way that patients in terms of their personhood are regarded. Szasz says that it is because of the threat of involuntary admission that it is not possible to say there is a genuine voluntary patient. He states that this accounts for the continued disregard of acute psychiatric patients as people. Likewise, the Understanding and Involvement Project referred to in chapter one, identified the powers of psychiatric professionals such as to detain, imprison, forcibly inject, and administer ECT as ‘a critical source of the stigma pervading the system and all who use and provide its services’ (Wadsworth & Epstein, 1996b: 157-8). Changes in mental health law have not gone far enough. Wadsworth suggests:

> the stigma will recede when the powers are only used and only able to be used in humane ways—that is, when they are used only as a very last resort by people who understand that their use reflects a society’s lack of alternative resources, they are used in the most minimal way possible, their use is accompanied with respect and kindness and not dislike and fear, there is aftercare to heal the trauma and their use is understood to be not the fault of the person on whom they are used (Wadsworth & Epstein, 1996b: 158).

It is the use of force, which is experienced by consumer/survivors as abusive. The use of force makes a mockery of the rights of men and women, and as Levinas (1993b: 123), whose work will be more fully discussed in chapter seven suggests, ‘the promise of an ultimate return to the rights of man is postponed indefinitely’. This highlights the need for the defence of human rights from outside the State. What is required is:

> a vigilance totally different from political intelligence, a lucidity not limited to yielding before the formalism of universality, but upholding justice itself in its limitations (Levinas, 1993b: 123).

Only then is the ‘conjunction of politics and ethics intrinsically possible’ (Levinas, 1993b). This is what is evidenced in the United Nations Principles and in the consumer/survivor movement in particular.