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AN INTRODUCTION TO PSYCHIATRIC ETHICS

2nd Edition

Edited by **Dr Michael Robertson**

THE PSYCHIATRIC PROFESSION, CONTEXT AND HUMAN RIGHTS

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CONTENTS

Introduction to the second edition 2

SECTION 1. NORMATIVE ETHICAL THEORIES AND PSYCHIATRY 5

Utilitarianism 7
Deontic Ethics 11
Principles Based Ethics 14
Casuistry 16
Common Morality Theory 19
Virtue Ethics 20
The Ethics of Care 22
The Ethics of "the Other" 23
Professional Ethics and Psychiatry 25
Post Modern Professional Ethics 27

SECTION 2. CONTEXT 29

SECTION 3. PSYCHIATRY AND HUMAN RIGHTS 35

What are Human Rights? 36
Current Conceptualisations of Human Rights and Mental Illness 37
Psychiatrists and Human Rights Violations Pre-Twentieth Century 38
Psychiatric Human Rights Abuses in the Twentieth Century 39
Human Rights Abuses and Australian Psychiatry 41
Recent History 41
Indigenous Mental Health and human rights 44
Asylum Seekers 46
Social Justice and Severe Mental Illness in 21st Century Australia 47
Coercion and Involuntary Treatment 49

SECTION 4. SELECTED THEMES IN PSYCHIATRIC ETHICS 53

Forensic Patients 54
LGBTIQ People 57
People Living with Intellectual Disabilities 58
Children and Adolescents 59
The Elderly 60
Women 62
Psychiatrists and the Media 63

EPILOGUE 65

REFERENCES 66

APPENDICES 84

INTRODUCTION TO THE SECOND EDITION

Socrates once posed the question 'how should I live?' The essence of this challenge was the question of a 'good life'. By 'good', one does not mean 'not bad', but rather some overriding sense of value to a life. Many religious texts provide a workable foundation of such an ethical life. For others, the concept of being a responsible member of a community or a society provides such foundations.

Psychiatry is a specialty of the profession of medicine. Professions possess their own codes of ethics, often formulated by learned members of the group. Such codes of ethics are recognised as standards of professional conduct by which acts are judged. Whilst this may work from a public perception, these do not necessarily provide a comprehensive or even substantive account of what it is to be an ethical psychiatrist. Many have argued that ethical physicians are possessed of virtue and therefore perform virtuous acts, whereas others regard the caring aspect of medicine as the value providing the foundation of medical ethics.

The word 'ethical' has many connotations. Many confound the description of an act or a person as 'ethical' as meaning 'right' or 'lawful'. As such, to describe something as 'unethical' does not mean it to be illegal or even necessarily incorrect. To best understand ethics one must understand the values from which they emerge. Put simply, Socrates' question is best answered in the notion that living a good life is to live in accordance with a set of values. Such values may be handed down by Divine command, may emerge as part of broader social values or may be simply constructed by individuals during their lives.

Is there a distinct discourse in psychiatric ethics?

Bioethics emerged in the 1980's as a separate discourse in moral philosophy. Medical ethics has been subsumed under the umbrella of bioethics, although the Hippocratic tradition of *primum non nocere* (first do no harm) still enjoys some status in the moral deliberations of medical practitioners. The field of biomedical ethics became more formal with the publication of the authoritative text *The Principles of Biomedical Ethics* (now in its 6th Edition[1]) by two American philosophers, Tom Beauchamp and James Childress. Much of the focus of biomedical ethics has been upon the implications of technological advancement in medicine, such as therapeutic cloning, reproductive assistance and the use of embryonic stem cells. Psychiatric ethics, by contrast, has tended to languish in obscurity and has been referred to as the 'bioethical ugly duckling'.[2]

Campbell and collaborators[3] see psychiatric ethics as having a special status in biomedical ethics, given the effect of mental illness on autonomy. They argue that psychiatric ethics should adhere to three basic tenets of beneficence and non-maleficence: using validated methods to return a patient to proper functioning as a responsible and self-directed individual; refraining from any treatments which are harmful and preserving distance between acting within an 'emotional entanglement'. They appear to have little time for academic debates about the relative merits of one ethical theory over another, arguing that "patients should not be adversely affected by such Olympian struggles among the demigods of the medical pantheon (p.163)".

Radden offered a more comprehensive case for the uniqueness of psychiatric ethics.[4,5] She argued that psychiatry differentiates itself from other medical specialties in the unique role of the therapeutic relationship in therapeutic outcome; the vulnerability of psychiatric patients; and the

features of the psychiatric therapeutic project – defined as "re-forming the patient's whole self or character...akin to the responsibilities of raising children". As such, she argued that virtue ethics are profound to psychiatry. Other writers have defined the uniqueness of ethical issues in psychiatry, particularly regarding treatment, as arising from the stigma of mental illness and issues surrounding autonomy.[6] Radden thus argued that special virtues required of the psychiatrist are compassion, humility, fidelity, trustworthiness, respect for confidentiality, veracity, prudence, warmth, sensitivity, humility and perseverance.

Dyer[7] argued that psychiatry's status as a part of the profession of medicine needs to be reconsidered. Dyer claims that a physician is currently characterised more by his or her technological skills or expertise rather than their ethics or values. Medicine, along the so-called "learned professions" such as the law, teachers or clergy, were originally defined by the knowledge held by their members and by the beneficent application of that knowledge to the needs of fellow citizens. Dyer contends that medicine has become largely a commodity and that market forces have interceded in the doctor patient relationship. As such a professional relationship in medicine has become more an issue of technical services traded in the marketplace, rendering the Hippocratic tradition in medicine little more than an historical footnote. In Dyer's view this places psychiatrists in the middle of social tension – on the one hand to be a professional means to place the psychiatrist in an attitude of service to one's fellow man, yet on the other, market forces require the psychiatrist to earn his or her living by the knowledge and skill they have acquired. Whether one shares Dyer's concerns in full, it is reasonable to assume that much has changed in medicine in the last few decades.

Psychiatry, Context and Human Rights

The first edition of this monograph was completed in 2008. Since that time, society has polarised further along economic and cultural lines. Economic inequality, geopolitical instability and the horrifying consequences of environmental degradation and climate change have become more apparent as have their potential psychopathological consequences. The democratic process in many liberal societies have produced results (or 'near misses') that are as disturbing as those seen in Europe in the 1930's.

While Australia has enjoyed a relative degree of stability in this period, social and economic inequality have become more pronounced and our politics have become more partisan, petty and combative to the point where a generation of young people have little faith in democracy to provide a stable or fair society. Populism has become the default position in Federal politics, with the return of racist tinged rhetoric on the fringes of the political right that dictates much of the tone of political discourse. Transformative public policy such as the National Broadband Network, education funding reforms and the National Disability Insurance Schemes have become "political footballs" and floundered through bureaucracies that are inadequate to the task. Australia's human rights record has been traduced by political expedience in the case of asylum seekers and policy inertia or confusion on questions of equality and equity applied to Aboriginal people, people living with disabilities and/or severe and persistent mental illness and LGBTIQ people. Younger Australians, ostensibly living in a situation of greater privilege that these groups, face significant challenges including the consequences of intergenerational theft arising from public policy failures in the domains of the housing market, wage stagnation and environmental degradation. Beyond

this, anomie and professional isolation arising from the 'casualisation' of the workforce undermines the mental health benefits of engagement in meaningful employment.

The psychiatric profession has entered a phase of reappraisal. Both the apparent failure of decades of investment in biological psychiatry to provide any meaningful improvement in the lives of people living with mental illness and the innovation in psychiatric training introduced by the RANZCP has prompted a new generation of psychiatrists to enter their professional lives questioning the "social" as well as the "biological" aspects of their discipline.

My intention in this review of the original 2008 monograph is to acquaint the practitioner new to psychiatry (or the established colleague amidst a process of "reappraisal") with the important contextual influences in their professional lives and to help them frame their thinking in a human rights discourse applied to their discipline. There are several excellent textbooks of psychiatric ethics that I recommend to readers for a more comprehensive review of the field and to further their engagement with the topic.

In Section 1 of the monograph I provide a detailed review of different normative ethical theories and their application to psychiatry. In section 2, I provide a brief account of different contextual influences on the profession of psychiatry. In section 3, I introduce the concept of human rights and apply this to several themes in psychiatric practice that will be critically important in the professional lives of new psychiatrists in the next decade. In the final section, I provide a selective survey of psychiatric ethics applied to situations or groups where the human rights perspective is vital.

This monograph does not provide any answers, only questions for consideration and, hopefully, stimulus for deeper engagement.

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1 NORMATIVE ETHICAL THEORIES AND PSYCHIATRY

1. NORMATIVE ETHICAL THEORIES AND PSYCHIATRY

INTRODUCTION TO SECTION 1

In this section, I will outline ethical theories and discuss their relevance to psychiatry. Many theories of ethics have emerged throughout history, however (except for virtue ethics) the main ideas in moral philosophy relevant to psychiatry have only appeared since the Enlightenment. This reflects the intellectual theme of liberal humanism, which places human reason, unconstrained by political or social tyranny, at the centre of moral philosophy.

Theories of ethics are either "descriptive" or "normative". Descriptive ethical theories aim to define "what is", whereas normative theories aim to define "what should be". While descriptive ethics are problematic in that they may lack solid theoretical foundation, normative ethics suffer the problem of justifying "should" and "ought" statements.

The Scottish philosopher David Hume argued that that most humans act ethically in response to their emotions, proclaiming that "reason is the slave of the passions".[8] Normative ethics try to define "shoulds" based upon various methods of reasoning, an approach that the utilitarian philosopher RM Hare described as "prescriptivism".[9]

Robertson and Walter[10] have constructed a taxonomy of normative theories in psychiatric ethics, categorising them into three domains – instrumental, reflective and integrative (Table 1).

INSTRUMENTAL APPROACHES

1. Utilitarian ethics;
2. The ethics of duty (deontic ethics);
3. The four principles;
4. Casuistry;
5. Common morality theory

Reflective approaches

6. Virtue ethics;
7. The ethics of care;
8. The ethics of the "Other";

Integrative approaches

9. "Professional" ethics
10. "Post-modern" ethics or "Anti-modern" ethics;

Table 1. A taxonomy of normative theories in psychiatric ethics

Instrumental approaches apply a method of reasoning to generate a workable or applicable "output" or answer to an ethical quandary. The "answers" may be reliable, but can jar with the sensibilities of the moral agent and not integrate well with a person's value system – the coherence between values, ethics and the individual psychology of a moral agent is what philosopher John Rawls described as "reflective equilibrium".[11] Reflective approaches to psychiatric ethics prompt the moral agent to apply a process of reflection to arrive at a position regarding an ethical dilemma

that accords with a value system or consistent approach to moral action. Integrative approaches are applications of various theoretical ideas to specific aspects of clinical practice or social action. Each of these approaches have strengths and limitations in their application to ethical dilemmas in psychiatry.

UTILITARIANISM

Introduction

Simply defined, "utility" is a measure of the relative happiness or satisfaction of a group, with regards to access to resources. The provision of such resources, such as goods or liberties, is instrumental to pleasure – the absence of pain. As the basis of moral philosophy, 'ethical hedonism' seeks to maximise pleasure. This approach dates from antiquity and the writings of Epicurus.[12] Utilitarianism has been so dominant in moral philosophy, that it is argued that it is the starting point for all ethical considerations.[13] It may be that there is a survival advantage for species which practice utilitarian approaches in that elevating group over individual needs may help primitive communities thrive.[14]

With the advent of political liberalism of the Enlightenment and the French and American revolutions of the late Eighteenth Century, the concept of utility emerged as a credible basis for political and moral philosophy. The method of utilitarianism was first articulated by Bentham,[15] who argued that all humans were beholden to a form of hedonism, and as such a moral and political philosophy should aim to maximise pleasure. Bentham's utilitarianism was base, arguing it was "better to be a contented pig than an unhappy human". The evolution of utilitarianism as a credible ethical theory derives from post-Bentham writers, particularly the work of Mill[16,17] and Sidgwick,[18] who articulated a method of moral reasoning based on the concept of utility. The key ideas underlying the evolution of utilitarianism are summarised in Table 2 (see page 8).

The Philosophical Basis of Utilitarianism

One of the initial problems with the concept of hedonistic utilitarianism is how to quantify the level of pleasure achieved by an action. This "quantification problem"[29] diminishes the value of Bentham's and Mill's utilitarianism as it invites relative considerations of the merits of different pleasures. If we provided a ticket to the World Wrestling Foundation championships to every member of society, why would this be any less valid than a ticket to a Mozart concert? The way around this problem is to consider preferences rather than hedonism. Preference utilitarianism, advanced by Peter Singer,[27] advocates that individual's preferences, rather than indulging pleasures, are the consideration of a moral deliberation.

The first problem with considering preferences as the basis of utilitarianism is the issue of adaptive preferences, whereby people accept less because of low expectations (such as the "contented slave").[30] The second problem is of the issue of unexperienced preferences (i.e. ones we will never know existed) and preferences that may be harmful.[13] The third problem is of 'external preferences' in which the individual's desires regarding the distribution of preferences to others is considered. A recent example of this is the idea that a population can express preferences for how the law deals with same sex marriage. This moves beyond what someone wants for themselves, but also what they desire for others. Like any "uninformed" preferences, there is a nihilistic expectation that the rights of others will be invariably violated and therefore all external preferences should be disregarded in any utilitarian calculation.[13,3] Because of this, some have argued that preference utilitarianism be limited to goods which are universally desired or provide basic necessity.[32]

Author	Key Concepts	Other issues
Bentham (1748-1832)	Maximising utility was to maximise the total amount of pleasure in society.[15]	Preferable to be 'a contented pig' than 'unhappy human'. Higher pleasures not preferable to base ones 'pushpin is as good as poetry'. Runs into the 'quantification problem' i.e. how to measure pleasure.
Mill (1806-1873)	Cultural, intellectual, and spiritual pleasures are of greater value than physical pleasures in the eyes of a 'competent judge'.[16,17]	Provides foundation for later formulations of 'preference' utilitarianism i.e. the good relates to satisfaction of greatest number of preferences. "Act" and "Rule" utilitarianism distinction later outlined by JJC Smart.[19]
Sidgwick (1838-1900)	Outlines a method of moral philosphy based on "Universal Hedonism" (utlilitarianism).[18]	Sidgwick's Ideas provide the foundation of current conception of utilitarianism and highlights some conflicts between personal and collective pleasure. Rejects motivations as a basis of morality, rather sees 'common sense' as the basis of ethical choice.
G.E Moore (1837-1958)	No true conception of the ethical good could be formulated. Maximising "ideals", like aestheticism, or love preferred to mere pleasure.[20]	Advances the notion of what is later dubbed 'informed preferences' and economic views of personal preferences.
RM Hare (1919-2002)	Levels of moral thinking – "practical" is utilitarian and "analytic" is more complex.[9,21]	Sees Kant's 'Kingdom of ends as utilitarian in spirit.[21,22] Advances a form of utilitarianism as a method of psychiatric ethics.[23]
Popper (1902-1994)	"Negative Utilitarianism" as the responsibility to prevent the greatest amount of harm or evil.[24]	Argument *reductio ad absurdum*, against negative utilitarianism is the so-called 'pin-prick argument', which states it would be better to painlessly destroy humanity than allow one person to experience a pin-prick.[25] Also criticised by JJC Smart.[26]
Singer (1942-)	Utilitarianism requires equal consideration of those interests, whatever the species.[27] Utilitarian ideas a form of naturalism – suppressing individual need for that of the collective has survival advantage.[14]	Concept of 'diminishing marginal utility' argued. Adopts a 'journey' model of life, which sees validity of claim to consideration of preferences based in sentience and the stage or capacity to meet life goals. Singer's views are polemic and have led to heated debate, over the way his philosophy appears to validate euthanasia and abortion.[28]

Table 2. Key Concepts in the evolution of utilitarianism

As I noted previously, one of the challenges in moral philosophy relates to the epistemology of moral assertions. In other words, what is the nature of moral truths as against factual truths? RM Hare, a prominent writer in utilitarianism identified the problem of "prescriptivism" in moral reasoning.[9,33] Put simply, prescriptive moral statements containing "should" or "ought" to have a different status, and verifiability, than those referring to fact. "You should do A" is a different proposition from "this is an A". Hare sought to define conditions in which prescriptive statements, "should" and "oughts" could be valid. In his vast oeuvre, Hare identified two conditions for prescriptive truths – "universalizability" and the so-called "golden-rule". Hare's utilitarianism extended from this approach.[9] Hare distinguished between two levels of utilitarian deliberation – a critical level of thinking applied the Golden-Rule Argument. An intuitive level of thinking utilised simple consequentialist principles.[34] In confronting an ethical dilemma, one deliberates *prima facie* using a simple consequentialist approach i.e. which approach has the best outcome for the most. In Hare's method, one then deliberates at the critical level, considering issues of virtue, justice and so on. The conclusions of the intuitive level must be acceptable at the critical level.

The distinction between intuitive and critical levels has evolved into "Act" and "Rule" utilitarianism.[19] Act utilitarianism is where the moral agent decides to act based on what is most likely to maximise utility in an instance. Rule utilitarianism is more prescriptive and has the moral agent acting relative to the notion of maximising preferences generally, rather than regarding the specific instance.

Evaluation of Utilitarianism

The advantages of utilitarianism as an ethical theory lie in its intuitive appeal, particularly in the case of act utilitarianism, and its apparent scientific approach to ethical reasoning.[19] Beauchamp and Childress see utilitarianism's strengths are its output power, practicality and clarity.[35] They argue that utilitarianism approximates their principle of "beneficence" and fits well with approaches to public policy.

There have been several challenges to utilitarianism. Among these are the so-called "replaceability problem",[36] based upon a thought experiment involving the utilitarian justification of one healthy person being killed to provide transplant organs for a half a dozen others in need – a utilitarian calculation. Another scenario is whether we would kill one man to save dozens of others.[29] In medical ethics, this potentially maleficent aspect of harming some to benefit the maximum is considered in the light of the intentions of the moral agent, and the proportionality of the harm to utility – the "doctrine of double effect".[37] Many have argued that these challenges are "straw man" in nature and that utilitarian approaches to ethics work extremely well in common or mundane situations, rather than the elaborate or unrealistic scenarios devised by the critics of utilitarianism.[38] Those who are concerned about the potentially maleficent conclusions from utilitarian calculations have called for a degree of "deontic constraint" rather than indulging the completely impersonal considerations of the positive and negative effects of decisions based on utilitarian grounds.[39] In other words, rather than be purely beholden to the principle of utility in a vacuum, the moral agent should also reflect upon duties to other persons. The alternative is the unrealistic prospect of the "U-Agent",[40] totally devoid of any personal morality and wedded to the utilitarian abacus. In reality, physicians incorporate "agent relative values" in considering a utilitarian calculation morally wrong if its consequences affront the basic tenets of a healing profession.[41] Workable forms of utilitarianism based professional ethics require adherence to a process of moral reflection to promote the welfare of others.[42]

The other main criticism of utilitarianism is the notion that moral agents are responsible for all the consequences of their choices, including the failure to prevent negative consequences and the consequences of consequences, placing an unreasonable burden on the utilitarian moral agent.[29] The more balanced view appears to be that the responsibility for ongoing consequences of utilitarian choice actually diminishes over time.[43]

Utilitarianism and Psychiatry

The suitability of utilitarianism as a basis of psychiatric ethics has been discussed elsewhere.[44] Hare advanced a version of utilitarianism as a workable basis for psychiatric ethics,[23] based upon his previous work in moral theory.[21] Hare argued that utilitarian accounts of psychiatric ethics are often abandoned unnecessarily because of the conflict between agent relevant duties of psychiatrists towards their patients. Hare suggested that psychiatrists:

> ***"need not think like utilitarians; they can cleave to principles expressed in terms of rights and duties and may, if they do this, achieve better the aims that an omniscient utilitarian would than if they themselves did any utilitarian calculation." (Hare, 1993, p.30)***

Peter Singer's writings of utilitarianism introduce a controversial "principle of equality" encompassing all beings (including other species) with interests and, therefore, preferences.[27] While all species prefer to avoid pain, only sentient humans maintain an interest in cultivating their unique individual abilities. Singer considers this distinction as the justification of differential consideration of different preferences. Singer then articulates a concept of "diminishing marginal utility" in which the utilitarian consideration of preferences considers both the need as well as the desire for the preference. This elaborates into a "journey model" of life, which measures the merits of how preferences fit within a life journey's goals. A personal interest in continuing to live and not suffer to fulfil an individual life journey is the highest order of preference in utilitarian calculation. Singer's utilitarianism justifies both euthanasia and termination of pregnancies carrying fetuses with profound deformations.[28]

Extending Singer's views to psychiatry may lead to some unpalatable conclusions. Mental illness, by its very nature, thwarts a life journey's goals compared to other forms of physical illness. Many severe forms of schizophrenia engender profound levels of impairment of individual life projects, particularly where the clinical picture is dominated by negative symptoms or disorganisation. Comparing the different prognostic implications of psychiatric diagnoses leads to distinctions made on the value-laden concept of quality of life. Applying Singer's variation of utilitarianism to psychiatry, the preference of a person with severe, intractable schizophrenia to avoid suffering are placed second to the desire of the patient with phobic anxiety to return to university and continue a fulfilling life journey. Moreover, in the utilitarian based public policy decisions about the allocation of limited health resources, the diminishing marginal utility doctrine takes on even more significance, as the preferences of many in society are gratified by the mildly disabled returning to employment and contributing to society through individual fulfilment, rather than the preferences of those patients with severe psychiatric disability to avoid or reduce suffering. This also introduces a variant of the quantification problem. It is part of a psychiatrist's responsibilities to attend to the economic aspects of treatment decisions.[45] The international standard measure of utility in this regard is the Disability Adjusted Life Year (DALY)[46] and the Quality Adjusted Life Year (QALY).[47] Singer argues that the use of QALY justifies the favouring of the preferences of those not severely disabled by mental illness,[48] even though these are insensitive measures applied to psychiatric disorders.[49]

In recent times two factors extraneous to psychiatry, may have promoted utilitarianism's position in psychiatric ethics. First, legislated responsibilities of psychiatrists, particularly in relation to issues of public safety, have effectively trumped any ethical code of conduct intrinsic to the psychiatric profession.[50] Such legal imperatives are invariably utilitarian in nature and have usually emerged in the context of social and political responses to issues such as public safety.[51,52]

The other factor promoting utilitarian thinking in psychiatric ethics has been the changes to healthcare systems in the face of globalisation and financial pressures, particularly in the US and Australia. Indeed, as Dyer has stated, medicine has become a three-way relationship between doctor, patient and third-party provider.[7] This issue was given close consideration by Green and Bloch (2001), who identified that when applied to mental health care decisions in a managed care setting in the US, there emerged the problem that "maximizing the common good encompasses a central limitation—the indifference to the uniqueness of the person".[53] Green and Bloch go as far as to suggest that the psychiatrist may be ethically compromised submitting to a market driven approach in the management of mental illness. Robertson and Walter (2007) have applied these critiques to utilitarianism applied in psychiatric ethics, arguing that that actions necessitated by utilitarian calculations are in violation of the "do no harm" principle of medical ethics and do not serve as a credible basis of psychiatric ethics.[44]

DEONTIC ETHICS

> ***"Two things fill the mind with ever new and increasing wonder and awe...the starry heavens above me and the moral law within me."***
>
> **- Kant *Critique of Practical Reason***

Introduction

The ethics of duty, or deontic ethics, are usually attributed to Kant and his later followers.

Kant's moral philosophy is outlined in three main works: *Groundwork for the Metaphysics of Morals* (1785) *('Groundwork')*,[54] *Critique of Practical Reason* (1787),[55] *Metaphysics of Morals* (1797).[56] To Kant, the central ethical question was prescriptive – 'what ought I do?' Kant's valorisation of human reason dictated that the answer to this question had no reference to a conception of what was good or the concept of virtue. Kant sought principles of action, which could be adopted by anyone without any specificity about desires, circumstances or social relations. In developing a prescription for duties, Kant differentiated between so-called "perfect" duties, which are required of all moral agents always, and "imperfect duties". The latter refers to somewhat of a double negative – not neglecting our duties to others in need.

Kant's Ethics

A central concept to Kant's ethics is the notion of individual autonomy. Kant defined "autonomy" as the capacity for free, rational moral choice. This is a form of "practical reason" which exists in the spirit of the Enlightenment. Man is not beholden to divine command of superstition, but rather a notion of secular, rational morality. In a similar vein, Kant rejects other forms of moral sensibility such as the emotions or filial bonds. The sign of a good moral agent is the possession of "good will". The moral worth of an act is its relationship to a good will – not intentions or consequences. In other words, deontic ethics can be reduced to the notion of doing the right thing for the right reasons.

Kant's conception of autonomy is therefore profoundly different from the more modern conception of autonomy as the right to the liberty to pursue one's own ends, to satisfy one's desires and to exercise freedom of choice, without the undue interference of others or of the state. In

Kant's "Kingdom of Ends" each moral agent is both self-legislator but beholden to a common law. The key issue of any morality in Kant's eyes is that of universalisability.

The other recognisable aspect of Kant's ethics is the notion of the "Categorical Imperative", articulated in the *Groundwork*. Kant argued that, in day-to-day dilemmas, we develop maxims that guide decision. The injunctions found in many codes of ethics for psychiatrists are redolent of Kant's maxims. The universalisability of moral maxims is tested against the Categorical Imperative.

The Categorical Imperative has multiple formulations. The First Formulation articulates the principle of universalisability by directing:

> ***"Act only according that maxim whereby you can at the same time will that it should become a universal law."*** **(421)**

The Second Formulation is the injunction:

> ***"Act as if the maxim of your action were to become through your will a universal law of nature."*** **(421)**

Arguable, this formulation seeks to define a relationship between the laws of nature and the moral law.

Kant's Third formulation is often dubbed the "formula of humanity":

> ***"Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means."*** **(429)**

If ethics is a guide to relations between persons, then this is the most important of Kant's ethics. The purpose of good actions is respect for persons as beings who are intrinsically valuable. The formula of humanity is Kant's main argument against suicide. He argues that destroying oneself to avoid pain or achieve another end violates the formula of humanity. He argues in the *Groundwork*:

> ***"To annihilate the subject of morality in one's person is to root out the existence of morality itself from the world as far as one can, even though morality is an end in itself. Consequently, disposing of oneself as a mere means to some discretionary end is debasing humanity in one's person."*** **(423)**

The intrinsic value of persons, core to the practice of psychiatry, is justified in the fourth formulation of the Categorical Imperative. This defines "the idea of the will of every rational being as a will that legislates universal law" (431). To Kant, persons are intrinsically valuable because they are free, rational (or autonomous) agents. This is somewhat Aristotelian in nature, given that Kant places reason highest among human capacities. It is also significant in the context of psychiatric ethics, given the impairment of reason that is a fundamental part of mental illness. Much of psychiatric ethics is focused upon situations where self-legislation and reason are impaired, and so Kant's formula of autonomy is arguably vitiated in the context of mental illness.

'Kantian' Ethics

Contemporary deontic ethics are not specific applications of Kant's writings. O'Neill[57] distinguishes between Kant's ethics, "Kant's ethics" and "Kantian ethics". The distinction lies within the neo-Kantian ideas of writers like Rawls, whose liberal autonomy is Kantian in spirit. Moreover, there has been some revisionism in the interpretation of some of "Kant's Ethics", particularly his use of the phrase *"Menscheit"*, interpreted as either "humanity" or "man".[58] It has been argued that the phrase "Humanity in a person" in the *Groundwork* refers to the characteristics of personhood. Humanity is distinct from animality by the capacity to define ends of intelligent behaviour. As such, humanity must be respected even though the most foolish or impaired may "throw away" one's humanity.[58] This latter interpretation appears to

factor in the limitations to the formula of humanity posed by mental illness.

Problems with Kantian Ethics

Kant's ethics have numerous limitations. O'Neil lists common criticisms of Kant's ethics:[57]

i. **"Formalism"** – the Categorical Imperative is empty or vacuous

ii. **"Rigorism"** – Deontic ethics are rigid and insensitve sets of rules with no nuance or subtlety.

iii. **"Abstraction"** – The Categorical Imperative is too abstract to guide action

iv. **"Conflicting Grounds of Observation"** – there is no guide as to what to do when duties come into conflict

v. **"Place of the Inclinations"** – Deontic ethics do not account for moral impulses

vi. **"No Account of Wrong doing"** – Deontic ethics provide no guide as to wrong actions

Many find acting purely from duty morally repugnant. Acting from duty does not really countenance compassion for others, but is merely fulfilling a responsibility. This would seem anathema to a psychiatrist dedicated to the relief of human suffering. Moreover, acting merely from duty, and denying human impulses such as care, empathy or compassion, may nurture attitudes of objectification towards others. If we have mere obligations towards the psychiatric patients, rather than care or compassion for people who suffer from mental illness, we run the risk of objectifying our patients.

Kantian Ethics and Psychiatry

Despite the prominence of Kantian ethics in moral philosophy, very little has been written about their specific application to psychiatry. The Kantian concept of autonomy is qualitatively different from the conception usually applied in biomedical ethics, however the notion of reason as the mark of human function is a useful construct in psychiatry. The Aristotelian idea that human *telos* is one of excellence in reason has been argued as a critical issue in understanding mental health and illness.[59,60] The core of mental illness is a harmful dysfunction of that rational capacity, and this has been recently debated as a key ethical issue in the provisions of mental health legislation in NSW.[61,62]

Kant's *Menscheit* concept may help us approach patient autonomy in psychiatry in a different way. The *Code of Ethics* for the RANZCP[50] directs its Fellows to "respect the essential humanity" of their patients. The Kantian construct of the human person as a rational being, able to construct maxims of rational moral action, helps us to conceptualise what is involved in this principle. The essence of the humanity of our patients is not in their suffering, their circumstances or their rights as citizens, but in their capacity to legislate moral action. Kant's formula of humanity highlights that any action we take with our patients must be beholden to their reason, no matter how deviant it may seem relative to our own. This then guides us as to what the essence of mental illness may be. Wakefield argued, convincingly, that a theory of mental illness must entail "harmful dysfunction"[63,64] and saw the dysfunction in evolutionary, non-relativist terms. In the Kantian perspective, the dysfunction is in that of rational Kantian autonomy. The rational capacity that facilitates moral action is the function that must be impaired for the patient to be subject to coercive or involuntary treatment. Moreover, the restoration of that reason is the goal of psychiatric intervention. The *Menscheit* concept is not focussed upon actions or choices, but rather the capacity to make such choices.

In terms of duties, one might take the view that codes of ethics are prescriptive duties and, as such, are Kantian in spirit. The proscription of the exploitation of patients, whether it be sexual, financial or in research settings, is clearly relevant to the 3rd formulation of the Categorical Imperative. The principles of the RANZCP Code of Ethics are arguably maxims of action formulated in

the light of the first and third formulations of the Categorical Imperative. Such duties guide action in all circumstances, without regard to contextual factors. The devil is in the detail of the notion of what is a "universal law". For a law to be truly universal is to assert that any psychiatrist at any time would accept such a fact. Prescriptive duties such as RANZCP Code of ethics Principle # 2 – "Psychiatrists shall not misuse the inherent power differential in their relationships with patients, either sexually or in any other way" or # 6 "Psychiatrists shall not *misuse* their professional knowledge and skills" rely on a question begging argument as to what the term *"misuse"* means. These are surely the most relativistic of all injunctions, relying on value judgments as to what the core concept of "misuse" means.

PRINCIPLES BASED ETHICS

Overview

Principle based ethics has become dominant paradigm in Western medical ethics.[35,65,66] It is a method of ethical reasoning first developed for biomedical ethics by the US philosophers Tom Beauchamp and James Childress. The method owes much to the work of WD Ross, who argued that ethical duties were related to *prima facie* responsibilities to irreducible ethical principles.[67] It is also influenced by a form of common morality governing public behaviour[68] advocating that when approaching moral dilemmas, physicians deliberate a conflict[67] between four core principles:

i. **Respect for autonomy:** respecting the decision-making capacities of people and enabling individuals to make reasoned informed choices.

ii. **Beneficence**: considering the balance of benefits of treatment against the risks and costs to act in a way that benefits the patient.

iii. **Non-maleficence**: avoiding causing harm to the patient, or at least harm disproportionate to the benefits of treatment.

iv. **Justice**: distributing benefits, risks and costs fairly and treating patients in similar positions in a similar manner.

These four principles, often referred to as the four "4P's", are the cornerstones of Beauchamp and Childress' principles based ethics. Other authors have advocated the addition of other "P's" such as "mutuality"[69], "confidentiality" or "veracity".[69]

Psychiatrists commonly face ethical dilemmas around the issue of involuntary treatment. Within a principles approach, these dilemmas can be easily couched in terms of a *prima facie* conflict of the patient's autonomous choice to refuse treatment and the need for beneficence to relieve suffering. In many circumstances, the conflict is vitiated by the effects of mental illness, such as psychosis, on the patient's capacity for autonomy and the scales are therefore tipped towards the beneficent obligation to relieve the patient's suffering. When the patient's autonomy is not so clearly diminished, such as cases involving the involuntary treatment of personality disordered patients, or those who abuse alcohol, the deliberations required become more complex. In those circumstances, a more detailed consideration of the effects of the patient's psychopathology upon autonomy, and the anticipated benefits of treatment, is required.

Autonomy in the '4P's'

Many of the conflicts mediated by the four principles involve clashes with the principal of autonomy. As noted in the previous section, autonomy is the principle of individual self-rule or self-governance. It is now enshrined in the liberties and rights of modern liberal states. One author has defined autonomy in terms of mental state utilitarianism,[70] or a state of self-regulation, based upon reason and self-interest. Feinberg[71] sees at least four aspects to autonomy: - the capacity to govern oneself, the actual condition of self-government, a personal ideal, and a set of rights expressive of one's sovereignty over oneself.

Autonomy also relates closely to the concept of personhood and individual responsibility and agency.

Autonomy is the foundational concept in liberal philosophies, and is therefore at the core of ethical theories such as Kant's deontology[72] and Mill's version of utilitarianism.[17] In Kant's theory, autonomy is central to practical reason, and hence our obligation to duty and to regard others as equals. It is therefore the foundation of his "Categorical Imperative". This idea had been expanded by neo-Kantians, such as Korsgaard[73] who sees autonomy as the source of all personal obligations, since it relates to our capacity to impose these upon on ourselves. Beauchamp and Childress[35] see that all theories of autonomy accord with the issues of liberty, and agency.

The principle of autonomy is critical in psychiatric ethics. Reason and self-interest are faculties that can be profoundly affected by mental illness and its treatment.[74] The concept of autonomy in principles based ethics is focused more on 'autonomous choice' rather than issues of self-governance. "Autonomy" as one of the '4P's' focuses upon "normal choosers" who act intentionally, with self-control and understanding of their actions.

While autonomy is ostensibly on a par with the other principles, it tends to prevail in prima facie conflicts.[75] Moreover, autonomy is argued to be conceptually prior to the other principles,[76] valorising it over the others. As Veatch has argued:

> ***"my own observation is that autonomy has had far and away a pride of place in practice. Justice has given it some competition, but most contemporary theories of justice (for example, Rawls) have an individualistic point of departure anyway; and most renderings of beneficence have had about them the flavour of religion or goody-goodiness, sure losers in the secular world of public policy."*** [77]

The centrality of autonomy in moral philosophy is predominantly a phenomenon of the liberal West. Given much of the discourse in bioethics has been Anglo-American, it is clear how autonomy has emerged as a 'first among equals' of principles.

Criticisms of the principles approach

The undoubted strengths of the 4P's approach are its clarity and simplicity. In an Anglo-American ethical context at least, it has almost taken over the field. The approach is not, however, free of significant problems.

Many of the advocates of the four principles approach have claimed it carries a universality.[78] It has been advocated as a credible method of medical ethics in cultural settings, including Islam,[79] some African cultures[80] and in Judaism,[81] but others question its application outside the English-speaking world.

Indeed, patient autonomy, the very centre of the 4P's approach, has been described, by Pellegrino, as a cultural artefact.[82] This position is apparently supported by a series of studies[83-85] that have provided a cross cultural comparison of autonomy in medical ethics between American and Japanese physicians. In Japanese patients, prioritising individual autonomy may isolate patients from their families and ultimately compromise patient care.[84] In Japanese culture, diagnostic and prognostic information is often withheld from patients at the request of family members.[83] In the vexed issue of suicide in Japanese culture, issues of autonomy are quite peripheral to the ethical considerations around the area.[85] In African cultures, autonomy is subjugated by communal bonds and responsibilities and is of peripheral relevance in ethical deliberation.[80] In post-communist Russia, physicians are still primarily beholden to the state, despite attempts to legislate on behalf of patient autonomy.[86] In China, bioethical discourse is revisiting traditional morality as a reaction to "a naïve acceptance of North American and Western

European moral philosophical approaches and the bioethical perspectives they produced".[87]

Taking other lines of criticism, Clouser dubbed the 4P's approach "principlism" and criticised its vacuity and incoherence.[88] Along with Gert, Clouser has also criticised "principlism" as doing little more than providing a checklist of obligations with no specific guidance in mediating a prima facie conflict. It is often not clear for example where the limits of an ethical deliberation are to be drawn. Gert and Clouser also regard Beauchamp and Childress' assertion that beneficence or non-maleficence are substantive principles of obligation as being superficial.[89] In response, Beauchamp and Childress have acknowledged Clouser and Gert's critique as being based on a fallacy of relevance – "correct but irrelevant" (p.390). They responded that the 4P's had never purported to place their theory on the same footing as other grand ethical theories.[35]

Engelhardt defines the 4P's as a form of procedural morality, merely providing a 'non-foundational approach' to bioethics.[90] Engelhardt prefers the principle of "permission", rather than autonomy, as permission is constitutive and is philosophically prior to the principle of beneficence. Engelhardt considers beneficence is a negotiated, or contractarian arrangement not a universal, foundation principle. He describes both autonomy and beneficence as "chapter headings" functioning merely to "indicate the sources of certain moral rights and obligations (p103)". If permission is constitutive and beneficence negotiated, then the former is the only substantive component of morality. In Engelhardt's view, moral authority derives from mutual consent. Moreover, Englehardt does not see justice or non-maleficence as substantive, seeing the former as a redundant and defining the latter as applied beneficence.

Engelhardt thus distinguishes between "moral friends" sharing a substantive ethics and "moral strangers" who consent to a mutually agreed set of rules of behaviour. As such, he sees that the 4P's approach is only "feasible when individuals with the same or very similar moral visions or thin theories of the good and justice have reconstructed their moral sentiments within divergent theoretical approaches (p.56)". To Engelhardt the method of the 4P's is a helpful device:

1. to resolve moral controversies between individuals with similar moral sentiments but different approaches;
2. to explore the ways different theories, reconstruct the same set of moral sentiments or intuitions;
3. to elaborate differences between moral views and their implications for bioethics and;
4. to resolve controversies between those who do not share the same moral vision or sense.

Like many other moral theories, the lack of contextualisation in the method of the 4P's has been an additional source of criticism. Some have argued that virtue ethics and care ethics can inform the 4P's approach as a means of achieving a more comprehensive framework in psychiatric ethics[91] and bioethics generally.[78]

CASUISTRY

Background

Casuistry is a method of ethical reasoning based upon cases. It is analogous to the common law based in precedents, which guide subsequent legal judgments. The best account of the historical background of the method of casuistry is provided by Jonsen and Toulmin (1988).[92] They argue that the first account of case based reasoning can be found in the orations of the ancient Roman figure Cicero. In the early Christian church, the idea of case based or precedent based dispensation of penance in the confessional is documented in the *Penetentials*. In medieval times, clerics utilised the method of

'Casus Conscientiae' (or "cases of conscience"), which would study and discuss difficult or troubling cases. The method of "High casuistry" reached its apotheosis in the hands of the Jesuits in the Sixteenth Century a period of significant political change in Europe. The profound influence of the Jesuits, as well as their reputation for sophistry placed the method of casuistry in a controversial light.

The methods of casuistry

The modern incarnation of casuistry appears to start with Albert Jonsen and Stephen Toulmin's *The Abuse of Casuistry* (1988).[92] Jonsen and Toulmin argue that moral reasoning had to be based upon emphasising general theoretical moral principles, which generate algorithms which are applicable to difficult moral choices. As such, they argue that there are clear sets of moral paradigms (*prima facie* duties) and that precedent or test cases exist, allowing comparison between the matter at hand and the historical case. As such, casuistic reasoning avoids the perils of moral absolutism and ethical relativism.

Jonsen subsequently articulated a more specific methodology for casuistry.[93-95] Jonsen defines a case as an event or "a happening".[94] He emphasises that a case is a manifestation of a set of circumstances surrounding a set of maxims the centre of the case. In psychiatry, a case may involve the central maxim of "respect for autonomy" and the circumstances relate to the notion of placing a patient's financial affairs under the control of a third party. The test case, or "paradigm" may be that of a patient with a severe, chronic psychotic illness, whose incompetence results in financial exploitation and disadvantage such as homelessness or profound self-neglect. The case at hand may involve a patient whose alcohol abuse is problematic and the imposition of financial restrictions upon the patient in primarily aimed at restricting their access to alcohol.

The method of casuistry seeks to order the circumstances of the case relative to the central maxims involved. The first task of the casuist is to "parse" or deconstruct it.[94]

Jonsen's method of analysis nominates four 'special topics' of significance in clinical applications of ethics: [95]

i. **Medical Indications** – assessment of the objective clinical issues in relation to the case;
ii. **Patient Preferences** – acknowledgement of the individual values and expectations of the patient;
iii. **Quality of Life** – consideration of the overarching goal of the physician is the alleviation of suffering and the enhancement of quality of life; and
iv. **Contextual Features** – the broad socio-cultural, historical and psychological circumstances in which the case occurs.

Jonsen argues that in the method of evaluating the case in question, the casuist proceeds in the order specified. This does not indicate that any one topic is given priority over another,but rather to ensure consistency in the method.

Jonsen's method then applies a taxonomic procedure to the cases of relevance to the case at hand. This taxonomy of cases involves "lining up" cases in rank order from the paradigmatic case to the case at hand. The order of these cases is determined by their similarities to the paradigm case. As the features of the case are identified, and the similarities to the paradigm established, the case is ordered along the line. The further down the order of similarity to the paradigm case, the less kinesis the case possesses. Jonsen proffers the metaphor of a billiard ball losing kinetic energy, the further it rolls from the source of movement. As such, the more distant a case appears to be from the paradigm case in the order cases, the less applicable are the conclusions of the paradigm case to the case at hand. To Jonsen, the ability

to establish the 'kinetic' aspects of case based moral reasoning is akin to the practical wisdom, or phronesis, discussed in a previous article.

This method is identical to the critical approach of normative analogy, whereby the merits of a proposition (the subject) is compared to that of a precedent proposition (the analogue). The subject and analogue of the normative analogy are first compared in terms of the presence of similarities. The more similarities between the subject and the analogue which are relevant to the conclusion in relation to the analogue, the stronger the normative analogy. The second phase of this method is to identify negatively relevant differences between the subject and the analogue, which may vitiate the strength of the conclusion of the similarities between the cases.

Other writers have provided slightly different methodology to that of Jonsen. Miller's method of casuistry[96] also suggests the use of paradigm cases and moral frameworks, as well as the establishment of "presumptions", which enshrine moral rules and maxims as forms prima facie obligations to a case.[67] Miller's method of casuistry involves firstly establishing the relevant paradigm and clarifying the presumptions which define the case's ethical aspects. The context of the case is then defined and the opinions of authorities are considered in the light of the case. This brings about a synthesis of the ethical aspects of the case in question. Tallmon's methodology of casuistry[97] simply involves articulating Jonsen's topics relevant to the case, refining these until the critical topics are identified and then constructing the argument accordingly.

Criticisms of Casuistry

The most famous critique of casuistry was articulated by Pascal in his *"Provincial Letters"* (1656).[96] Pascal argued that casuistry promoted a laxity in moral reasoning firstly because it had no solid moral base. Secondly, casuists tended to seek probable opinions on every side of a difficult case and created a series of possible solutions to moral problems which could be arbitrarily picked by the whim of the chooser. To Pascal, the method of casuistry had come to represent a form "Jesuitical excuse-making". With the decline in scholasticism which followed the advent of the Enlightenment, casuistry was abandoned, until its recent resurrection in biomedical ethical circles.

Despite the intuitive appeal of the methods of casuistry, it still suffers from the problems articulated in Pascal's critique, the potential for conclusions to be spun through nimble arguments. Such sophistry is made possible because casuistry lacks a substantive ethical foundation. This is the core of Engelhardt's critique.[90] In other words, casuistry is little more than a form of vapid procedural morality in the eyes of some.

Arras argued that the casuist's position cannot be truly theory-free.[98] Moreover, there are significant power structures affecting bioethical discourse which will profoundly affect the selection of paradigm cases and how these are defined and the ethical texture they are seen to present. This segues into the notion of ethics as a form of moral discourse, which will be considered in a separate paper in this series. Casuistry is therefore argued by Arras to be unlikely to achieve moral consensus outside of particular forms of moral discourse.

Casuistry and Psychiatric Ethics

Likeprinciple based ethics, casuistry presents an ethical procedure, which lacks a substantive foundation. To apply casuistry to psychiatric ethics, we would need to derive a series of paradigm cases upon which to base our casuistic taxonomies. The lack of undisputed paradigm cases leads to a reliance on famous cases for paradigms, rather than those which have been carefully reasoned. At present, the only recognizable paradigm case is the "Tarasoff case",[99,100] a precedent which was largely articulated by lawyers and academic psychiatrists.

To use such legalistic cases is to operate under a suppressed premise that there is coherence ("integralism") between the law and ethics, a notion many would not readily accept.

In attempting to define what constitute paradigm cases, particularly in the light of Arras' critique, they would need to be derived from a broad consensus of multiple views of psychiatry, and mental health generally. This resides on the idea of moral discourse, and ethical truths, relying upon a free, democratic consensus approach to such knowledge. This then leads to problems relating to discourse as a form of knowledge in general, and the type of relationship between power and knowledge described by Foucault.[101] The composition of the discursive formation that attempts to define ethical norms instrumental to the development of paradigm cases is a complex undertaking. Any form of moral discourse would need to be based upon preconditions of equality of access, viewpoints and communication capacities within the discursive formation.

COMMON MORALITY THEORY

Introduction

In complex post-industrial societies, the composition of the population is shaped and determined by complex patterns of immigration, integration of different cultures and economic factors. This makes for a plurality of moral and ethical positions on many questions of public policy the expectations of professions. Yet despite divergence of views on many questions, there exists a common ground among all citizens on fundamental questions of rights, promise keeping, liberty and mutual safety.

The philosopher Bernard Gert coined the term "common morality theory", reflecting the commonly held values of citizens living in a stable democratic society.[68,102] Such a model of values is a form of descriptive ethics, in that they reflect what people actually do in different situations. According to Gert, a descriptive common morality system of values is based upon five basic harms – death, pain, disability, loss of freedom, and loss of pleasure. From these five harms, Gert derived ten ethical maxims that define norms of conduct in pluralist society (Table 3).

GERT'S MAXIMS

1. Do not kill
2. Do not cause pain
3. Do not disable
4. Do not deprive of freedom
5. Do not deprive of pleasure
6. Do not deceive
7. Keep your promises
8. Do not cheat
9. Obey the law
10. Do your duty

Table 3 – Gert's 10 maxims from the common morality

The first five rules directly prohibit direct infliction of the five basic harms whereas the second five prohibit actions that may cause those same harms indirectly.

Gert described a two-step method for justification of acts that appear to violate these injunctions. The first step is to establish all the relevant facts to give an account of the action, posing questions such as – What moral rule would be violated? What harms would be avoided, prevented, and caused by the rule violation? And what benefits would be caused by the rule violation?

The second step in Gert's method requires the estimation of the community response to the kind of violation proposed or prohibited. The likely harmful and beneficial consequences of the two estimates are then compared. If the general knowledge that such violations are allowed leads

to a better outcome for the community (as against a general knowledge that they are not allowed), then the violation is justified. The approach to moral deliberation is a quasi-consequentialist to this approach. Two recent issues put indirectly or indirectly to parts of the Australian community was the proposed legislation of physician assisted suicide (do not kill) and the legalisation of same-sex marriage (do not deprive of freedom). In some jurisdictions, the physician assisted suicide question was resolved (at least for the time being) by accepting that the sum of welfare in the community was increased by the rejection of the proposed violation. The issue of marriage equality involved the rejection of the proposed violation (do not deprive of freedom) by allowing existing marriage legislation to remain in place.

Gert's philosophy represents a form of social contract. The basic harms universalisable in that all rational people would agree that these are the basic values of stable societies. Gert describes the independence of these rules of religious, nationalistic or scientific beliefs as the "the blindfold of justice". Arguably an innate approach to psychiatric ethics is little more than an application of common morality to specific quandaries in psychiatric practice.[88,103-105]

VIRTUE ETHICS

Virtue in Antiquity

Most people understand virtue as a quality of moral excellence. The concept of virtue, or αρετη (arête), is clearly articulated in Aristotle's *Nicomachean Ethics*[106] as "a settled disposition of the mind determining the choice of actions and emotions, consisting essentially in the observance of the mean relative to us...as the prudent man would determine it". (Book II, Ch. 6). Aristotle had made a study of "great men" and attempted to define what it was that made them so. He had averred that the definitive character of mankind was the capacity for reason, and so the "ratiocentric thesis" of the good life was central in Aristotle's thought. Happiness, or εμδαιμονία (eudemonia), was found in the life of rational excellence. The four cardinal virtues in antiquity were: courage, prudence, temperance and justice. The Aristotelian concept of virtue is a habit of choosing the golden mean between the extremes. In the case of justice, for example, the mean lies between being excessively generous or forgiving and being excessively harsh or austere. As such, the habit of choosing the golden mean is a form of dialectic reasoning in that the synthesis of an action or thought arises from the tension between two alternate views.

Phronesis as a substantive ethical model

The habit of finding the mean requires prudence or 'phronesis' (practical wisdom) prior to the other virtues. In other words, the virtuous individual possesses the judgment to find the mean and the practical ability to apply it. Phronesis can be seen as having a number of components.[97]

i. the citation or acknowledgement of specific ethical principles where appropriate;

ii. the integration of past experience on the present situation;

iii. the capacity to argue by analogy from paradigm cases to particular ones;

iv. the capacity to 'paralell process' other issues to guide moral inquiry by egg psychodynamic implications; and

v. the capacity to combine all four aspects to formulate a mode of praxis.

Applied to the craft of psychiatry, virtue involves an integration of its *telos* (goal) and the use of skills (*techne*), to achieve it. The virtuous psychiatrist possesses practical wisdom to find the right actions in the specific role of alleviating suffering of the ill. Munson had highlighted this distinction,

to some degree, in the separation of science and medicine: science and the knowledge it created was instrumentally, rather than intrinsic to, the telos of medicine.[107]

Recent Conceptions of Virtue Ethics

More recent incarnations of virtue theory have provided useful points of reflection. Arendt observed the trial of Adolf Eichmann, the architect of the Holocaust, and realised the 'banality' of his evil related purely to the failure to reflect upon the nature of his actions and his mindlessly servile attitudes to duty.[108]

> ***"Except for an extraordinary diligence in looking out for his personal advancement, (Eichmann) had no motives at all...He merely, to put the matter colloquially, never realized what he was doing." (p.114)***

Arendt's later development of the concept of virtue distinguished the virtues of individual life and that of the world of action *('viva activa')*.[109] For Arendt, the public and private spheres were distinct, the former moving beyond pure self-interest.[110] This revision of virtue ethics clearly occurs in the context of the totalitarian excesses of the Twentieth Century and raises an issue that is pertinent to contemporary psychiatric ethics – can the psychiatrist be truly virtuous without taking part in the public or political sphere?

The virtue ethics of MacIntyre[111-113] further develops the concept of the socially situated, contextualized virtue. In Athenian society, the concept of "the good" – αγαθσζ (agathos) – related to how a man discharged his allotted social functions within the community, or polis. As such, the measure of the virtue of a man was his functioning as a successful citizen. In ancient Athens, this involved political action. To hold on to this as the archetype of virtue risks anachronistic versions of the moral philosophies, which are "overwhelmingly the creation of dead-white-male heads of household, including some slaveholders and misogynists".[114] This has been a focus of MacIntyre's arguments about the limits of all moral philosophies; they are situated within a particular culture at a particular point in history. MacIntyre's solution is emphasis upon parts of human existence which are universal, such as birth and death, and the establishment of community, or what Nussbaum refers to as "non-relative virtues".[115] MacIntyre argues it inconceivable that friendliness, courage and truthfulness would not be valued in any society at any historical point.

MacIntyre's concept of practical wisdom integrates virtue, *telos, techne* and *arete*. He considers 'practices', which are the exercise of human excellence in the pursuit of a collectively defined good. MacIntyre holds that in Greek ethics we begin with society where evaluative language is tied to the concept of a socially established role. He argues that ethical questions "about ourselves and our actions depend(s) on the kind of social structure of which we are a part (p.91)".[116] In MacIntyre's view, "bricklaying is not a practice; architecture is. Planting turnips is not a practice; farming is (p.188)".[111] Applied to psychiatry, the practice of the virtuous psychiatrist is the pursuit of expert knowledge, sound judgment and the other components of clinical skill and the application to the conception of a collective good.

The virtuous physician; the virtuous psychiatrist

Applied to biomedical ethics, various authors and professional groups have provided a checklist of desirable virtues in physicians, often extrapolated from the four classical virtues. Beauchamp and Childress[35] list compassion, discernment, trustworthiness, integrity and conscientiousness. Engelhardt[90] lists tolerance, liberality and prudence as virtues required of a physician. Pellegrino provides a hierarchy of physician virtues, some necessitating such selfless superogatory acts that they could not be sustained by even the most devoted physician.[91] Indeed, the main critique of

virtue ethics as a moral philosophy in psychiatry, is that it seems to have impractical expectations of individuals and places the individual amid a potentially disabling "psychodynamic process of identification with the idealised ethical superman".[7] Radden outlined the virtues necessary of a psychiatrist, including compassion, humility, fidelity, trustworthiness, respect for confidentiality, veracity, prudence, warmth, sensitivity, humility and perseverance.[4] Virtue ethics have been proposed as a foundation of psychiatric ethics,[117] with some argument that the sole virtue of phronesis can provide a comprehensive account of ethics in psychiatry[118] or at the very least, inform more prescriptive codes of ethics in psychiatry.[119]

Robertson and Walter have argued that, while virtue ethics are of great importance, there are significant limits to their instrumental value in psychiatric practice.[120] The virtuous psychiatrist reflects upon his or her motivations and the "big picture" aspects of their actions, usually based upon a balance of utility and duty. The habit of incorporating this process and finding the "golden mean" is the pathway to phronesis, or practical wisdom and this, in itself, may provide the psychiatrist with a substantive moral philosophy. Virtue ethics can provide a means of informing more practical deliberations, such as those based on consequences, or abiding a social contract.

THE ETHICS OF CARE

Background

A more recent development in moral philosophy has been the recognition of the place of caring or emotional bonds between persons as the basis of ethical action. The status of the "ethics of care" remains indeterminate. Some have argued it to be a substantive moral theory,[121] whereas other views describe an ethics of care as a virtue, a cluster of virtues, or a version of virtue ethics.[122]

The notion of an ethics of care arose as a reaction to the work of Kohlberg,[123] whose study of latency age and adolescent boys delineated levels of moral thinking. Kohlberg argued that at an early developmental stage, individuals behave according to socially acceptable norms because they are compelled by the threat of punishment. The next level is a form of psychological egoism or self-interest morality, giving way to a "post conventional" level of moral development characterised by the acknowledgment of a social contract and the development of a principled conscience.

Gilligan[124,125] argued against Kohlberg's finding, stating his sample was entirely male and that studies of females reveal that they are more focused on caring for others and maintaining social relationships, rather than defining a rational good. Gilligan highlighted girls' refusal to make moral decisions out of context, their desire to avoid conflict and their emphasis on relationships in their thinking. Gilligan was not dismissive of the male impartial voice of justice and argued that the two options are complementary. In some circumstances, abstract ethics of justice are a more appropriate, whereas in other situations the ethics of care are more appropriate. Gilligan argued that morality is better defined as occurring within a network of caring relationships and not a preoccupation with abstract notions of individual autonomy.

Blum[126] distinguishes between care ethics and the notion of justice. He describes this in terms of the conceptual differences between "impartialism" and the ethics of care. Blum argues firstly that care ethics has a "particularist" aspect in that it does not abstract from the situation. Second, care ethics is involved in a certain context and does not delimit an autonomous, self-legislating individual as against a contextualized agent in a network of relationships. Third, care ethics involves the integration of emotion, cognition and action,

which Blum argues makes it work in the tradition of David Hume's emotivism.

Later views of the ethics of care, like those of Baier[127,128] and Noddings[129] focus upon the limits of abstract moral theories such as Kant's, and how the ethics of care may add to the perspective of the moral agent. Noddings provides a compelling argument in describing that any mother would violate the Categorical Imperative to lie to save her child.[129] Such actions are motivated by care and not by abstract notions of what is right.

The ethics of care and psychiatry

This area has been considered in some depth elsewhere.[120] Like the ethics of virtue, the ethics of care has limited instrumental value in clinical settings. It can certainly inform the ethical standpoint,[91] and Adshead has argued that the ethics of care and the other abstract ethical theories offer "two voices in psychiatric ethics".[130]

Apart from its limited output value, the ethics of care suffers from an inadequate analysis of the concept of "care", which has been argued to be "hopelessly vague".[131] In lacking a normative or descriptive account of morality, care-related language defines the concept of "care" as being constitutive of a moral good. This stumbles into a form of prescriptivism, which argues that actions are good if they are caring. The argument suffers from a suppressed premise that care is constitutive of an ethical good. Moreover, the prescriptive argument that "one ought care" is weakened by a fallacy of ambiguity – caring about how your football team fares is not the same as care of your family or patients.[132]

In suggesting the ethics of care is a substantive moral philosophy, Held[121] argues that it has five defining features. First, "the focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility (p.10)". Second, the ethics of care values emotions, and appreciates emotions and relational capabilities that enable morally concerned persons in actual interpersonal contexts to understand what would be best. Third, the ethics of care rejects the view that the more abstract the reasoning about a moral problem, the better. Fourth, the ethics of care proposes a novel conceptualisation of the distinction between private and public moralities and of their respective importance. Finally, the ethics of care adopts a relational conception of persons, which is in stark contrast to the rights based approaches of modern liberal individualism.

THE ETHICS OF "THE OTHER"

Introduction

Since the Enlightenment, Western philosophy has been based upon the Cartesian notion of the "cogito" – the thinking, knowing being, engaged with the phenomenal experience of the universe.[133] The privileging of the "subject" (the knowing self) over "the object" of the subject's experience has led to a form of solipsism that has been argued as being the basis of many egregious moments in human history. The implication of this Cartesian tradition is that Western philosophy prioritises the existence of the individual self over the existence of the other. In extreme circumstances, this leads to objectification or dehumanisation of the other person.

The "Other"

The notion of "the Other" has a complex philosophical history. German philosopher Fichte originally emphasised the necessity of interaction with other rational beings in order to achieve consciousness,[134] an idea later evident in Hegel's "Master-Slave" dialectic.[135] Hegel asserts that a solipsistic "I" is self-conscious when confronted by an encounter with another "I" – the individual acknowledges, ultimately, the equal status of the other individual.[136]

The interplay between the philosophical subject and object is evident in the work of Lacan[137] and Sartre, in that through the "gaze" of the Other, the philosophical subject becomes object. In other words, the subject becomes object (or Other) through being seen by another. Sartre refers to this as a sense of "shame". In *Being and Nothingness*[138] Sartre used the metaphor of "the eavesdropper" to illustrate this point. A person is peering at others through a keyhole; Sartre shows how the subject listening to others behind a door, becomes the Other or object when another person sees him eavesdropping:

> ***"But all of a sudden I hear footsteps in the hall. Someone is looking at me... I shudder as a wave of shame sweeps over me."* (p260)**

This new concept of himself as an object or image in the mind of the Other, is called 'being-for-others', or *pour-autrui.* This new experience of the self is not known by the subject but rather lived – the eavesdropper is that object captured in the Other's mind. The "shame" is revealed in the Other's look.[139]

The concept of "the Other" is most readily associated with the French existentialist De Beauvoir in *The Second Sex.*[140] De Beauvoir described the Other as embodied in the "radical alterity" of women. De Beauvoir observed that woman is consistently defined as "the Other" by man, who takes on the role of "the Self" – a process that obtains through extant power structures in society. De Beauvoir believes that one is not born a woman but rather "becomes woman" through ascribed, socially constructed roles. De Beauvoir's *The Coming of Age* later applied this process to the elderly.[141]

In the aftermath of the Holocaust, Levinas saw that human values reside within the otherness of persons. Levinas became critical of Western philosophy's preoccupation with the self-other distinction. Levinas' philosophy rejected the approach to other people as merely phenomena to be known – a process he describes as "totalisation".[142] Applied to others, totalisation removes any form of difference between persons to a sameness. A "person" therefore becomes merely one of a genus "people". In *Totality and Infinity*, Levinas argued for equivalence in the relationship between the Self, or "the Same" *(la Même)* and the Other *(l'Autre)*. Levinas' work was, ultimately, characterized by the "one big idea", namely the notion that ethics was the first philosophy in being "a relation of infinite responsibility to the other person".[143] (p.6) Levinas "ethics" refers to the responsibility to the Other and the rejection of the Self-Other distinction established in Western philosophy.

The Other and psychiatry

Scottish anti-psychiatrist Laing argued that "ontology" (existence) of "madness" is defined by "models" in the consciousness of others.[144] The nature of experience of the person deemed "mentally ill" derives from knowledge of the patient's experience constructed by others, creating for the person a loss of "radical freedom". The Otherness of the psychiatric patient, is manifest in the analytic clinical gaze of the psychiatrist, who categorises and objectifies the patient's experiences as an illness through the act of diagnosis. The enforced "otherness" in the psychiatrist-patient interaction, is mediated through diagnostic labels that totalise the patient as a psychiatric "other". "Mary" becomes "the borderline PD" or "John" becomes the "bipolar I". It is not a long bow to draw to link this form of enforced otherness with human rights abuses perpetrated against people with mental illness (see below).

PROFESSIONAL ETHICS AND PSYCHIATRY

The Oxford English Dictionary[145] defines a "profession" as:

> ***"An occupation whose core element is work, based on the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning, or the practice of an art founded on it, is used in the service of others. Its members profess a commitment to competence, integrity, morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society."*** **(my underlines)**

The key elements of this definition are the existence of a social contract between a professional group or individual and society, the promotion of public good and several desirable virtues. In exchange, the group is accorded autonomy and the capacity to self-regulate.

The original Hippocratic tradition in medicine has arguably swept aside[146] by the commercialisation of the health system[147] and the technological progress in medicine.[7,147] In the face of such profound changes in society and the practice of medicine, institutional bodies in medicine have reaffirmed the concept of medicine as a profession:

> ***"In developed countries, it (medicine) has changed in one or two generations from a cottage industry to one consuming a significant portion of each country's gross domestic product."*** [147]

Professional ethics, arguably, have three core components – specialised training and the acquisition of specialised skills; the provision of expert assistance to those in need and vulnerable; and the virtues of trustworthiness, efficacy and knowledge which ultimately enhance the common good and aggregate well-being.[148]

Several physician's organisations have jointly outlined a series of principles and responsibilities for the medical profession, which integrate the recent evolutions in medical practice.[149] In this new code, the principles of patient welfare, patient autonomy and social justice are juxtaposed with the responsibilities of commitment to professional competence; honesty with patients; confidentiality; appropriate relations; improving quality of care; improving access to care; ensuring a fair distribution of finite resources; pursuit of scientific knowledge and; maintenance of trust by managing conflicts of interest and professional responsibilities.

Any medical practitioner, whether psychiatrist or physician, abides a social contract[149] as both a healer and professional. Professional ethical autonomy is given on the understanding that professionals will devote themselves to serving the best interests of society and will self-regulate to maintain high quality service,[150] with licensing boards confining themselves to the monitoring of the discharge of contractual obligations by individual physicians. Contractarian theories have been criticized as historically inaccurate ("not worth the paper they were never written on"),[151] but perhaps the most disquieting critique of contractarian ethics for psychiatrists is their implicit moral nihilism. They are, in essence, self-interest theories of morality in which members abide by a covenant out of pure self-regard. Contractarian theories deny psychiatrists their moral agency, highlighting the limitation of many Enlightenment moral philosophies, in their failure to account for

the emotional bonds in moral agency[124,152] and their impoverished view of human morality.[153]

Rawls, crafted a conception of distributive justice over his career.[11,154,155] The elements of Rawls' approach to justice related to a hypothetical notion of having moral agents conceptualise an "original position" in a future society, which the participant is blinded as to who they were going to be. This was a "veil of ignorance" that was "pre-social" and "pre-historical". Based on these constraints, the moral agent would then define a just distribution of goods in this future "well-ordered society". Such resources were not merely wealth, but also freedom, mobility of labour and equal access to opportunity to achieve fulfilment in life. Rawls assumed that all would operate on the assumption that they would end up the least advantaged person in the society and through a process of "constrained maximisation" allocate resources accordingly. In Rawls' philosophy, the most just distribution of social goods was one which ultimately benefitted the most disadvantaged.

Whilst Rawls' social contract method was ingenious, there are problems with what he defined as "social goods". Rawls saw that all members of a "well ordered society" had equal entitlement to access social goods to have the opportunity to live fulfilling lives. Rawls took the Kantian view that individual fulfilment is a product of autonomy, or rational self-governance. As such, social goods are instrumental in achieving this, and the just distribution of these social goods assists members of society to achieve this autonomous existence. As Nussbaum points out, such an approach falters when we consider the situation of those whose capacity for autonomy is impaired life-long. A person with disabling chronic schizophrenia may never be truly capable of autonomy and so their needs are poorly met in Rawls' philosophy. Nussbaum builds on the so-called "capabilities approach" to justice[156] to provide a more workable account of the primary social goods at the centre of Rawls' distributive justice.[157]

Rawls' theories, these have been extended to the specific area of health care by American philosopher Daniels.[158] Daniels defines healthcare broadly, as encompassing individual medical services, preventative interventions, public health initiatives, workplace safety and social resources for chronically ill and disabled. Daniels argues that the right to healthcare carries the implicit assumption that access to healthcare is on par with other civil rights, which equates healthcare with other social goods.

The rationale of providing healthcare paid for by third parties, such as government, is, therefore, to help restore normal function by decreasing the effect of disease or disability. This compensates for the "natural lottery" in which liability for disease is considered an accident of birth, rather than the individual failings of the sufferer. A guarantee of access to healthcare does not have the goal to enhance well-being or general capability, but merely correcting for the natural lottery. This would address the vulnerability aspect of our conception of dignity.

Daniels and Sabin have applied these concepts specifically to mental health.[159] They advance a "normal function model" in the light of how mental illness may affect that function. They propose that the goal of mental health care is to obviate the disadvantage arising from mental illness, thus making everyone equal competitors for social resources. Their model of justice, achieved through mental health care, has three dimensions:

i. A **"normal function model"** of mental health care seeking to create 'normal' competitors for social resources;

ii. A **"capability model"** seeking to create equal competitors for resources;

iii. A **"welfare model"** addressing the fact that people suffer because of attitudes or behaviours they did not choose and cannot choose to overcome, which should justify access to mental health care.

The normal function model allows a society to draw a plausible boundary around the scope for insurance coverage. Sabin and Daniels argue that the capability and the welfare models are the most morally substantive, but are the most problematic in implementation.

POST MODERN PROFESSIONAL ETHICS

Overview

Postmodernism is a term variably used to describe any intellectual activity, from art to architecture, which appears to break with the rationalist traditions of the Enlightenment.

Lyotard[160] summarised the core of postmodernism as being "incredulity to metanarratives", or the rejection of grand, unified conceptual schemes. Psychiatry is argued to be "a quintessentially modernist project" because of its embrace of scientific paradigms.[161] The postmodern approach to knowledge has been applied to psychiatry,[162] averring that things are far more complex than argued by one over-arching theory, such as biological psychiatry.

Applied to ethics, Hugman argues that the postmodern approach seeks to move away from overarching theoretical structures into individualising relationships against the background of desired virtues.[163] Hugman nominates the work of MacIntyre,[111-113] Foucault[164] and Bauman[165] as being the key works in postmodern ethics applied to the helping professions.

Bauman's Post-Modern Ethics

Bauman, a Polish philosopher working in the shadow of Holocaust. Bauman sees ethics as "a moral party of two (p.82)". Bauman's post-modern approach to morality are his response to the failings of post-Enlightenment European moral philosophy.[166] Bauman insists that our moral responsibility cannot be reduced to the fulfilment of a limited set of socially constructed, arbitrary rules. He takes the view that human morality can only be grounded in the moral impulse.

Bauman's postmodernism is:

> ***"modernity without illusions... (t)he illusions in question boil down to the belief that the "messiness" of the human world is but a temporary and repairable state, sooner or later to be replaced by the orderly and systematic rule of reason."* (p.32)** [165]

Bauman describes the "aporetic" nature of human relations and in the face of this, he rejects socially constructed morality. Bauman is critical of bureaucracy and systems. Bauman views procedural or contractual morality as alienating to the moral agent.

Foucault's Post-modern Ethics

Michel Foucault's writings covered many aspects of knowledge and power. His *oeuvre* made frequent reference to psychiatry. In the tradition of post-modernism, Foucault's ethical project rejects the notions of religious, scientific or conventional moral codes as being the basis of any moral philosophy. Foucault took the view, akin to that of the Ancient

Greeks, that traditional morality must be replaced by an ethics based upon the "aesthetics of existence". Foucault's ethics is primarily concerned with how we decide what kind of person to be and how we seek to be that person.[164] Foucault argued that we have to create ourselves as "works of art",[167] arguing "couldn't everyone's life become a work of art? Why should the lamp or the house be an art object, but not our life?" (p. 261).[164] Foucault contends that ethics is the practice:

> ***"In which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral goal. And this requires him to act upon himself, to monitor, test, improve, and transform himself (p. 28)."*** [168]

Foucault sees that this process is constrained by the fact that many of the practices available to us for such aesthetic realisation have been appropriated by the culture in which we live. This process of self-creation involves us firstly rejecting those forms of identity imposed upon us by society and its institutions. Thus, "Foucault's ethics is the practice of an intellectual freedom that is transgressive of modern knowledge-power-subjectivity relations".[169]

This constitutes a form of secular humanism, in which mankind, not God or other conventional practices, determine what is good or right. In this view, we see that Foucault is extending the humanism of Nietzsche, who rejected religion, in particular Christianity, as a form of "slave mentality" and called for the ethical superman, or *'übermensch'*, to rid himself of mundane constraints and take command of his own destiny – what he defined as the "will to power".[170,171]

CONTEXTS

2

2. CONTEXTS

INTRODUCTION TO SECTION 2

Mental health and mental illness are determined by the complex interaction of multiple factors – this is the assumption underlying the commonly cited "bio-psycho-social" model of Engel,[172] the conceptual framework most commonly used by psychiatrists in their discipline. Psychiatrists practice within a socio-cultural context and the history of different psychiatric professions often influences clinical practice, the operation of institutions and the regulation of the psychiatric profession.

In this section, I propose to outline several contextual influences on psychiatry in Australia to assist the reader's engagement with the latter parts of the text.

Alienism

From the mid-1800s until the mid-twentieth century, Australian psychiatry existed primarily as an extension of British psychiatry.[173] Until the 1950s, psychiatry in Australia (and elsewhere) was based on a principle of "alienism". The essence of alienism is attributing an extreme form of "otherness" to people with mental illness, leading to social exclusion and institutional incarceration. Alienism takes the position that the mentally ill "other" is also a conduit of other undesirable traits such as criminality, chemical dependency, intellectual disability and "social undesirability". Like many other medical disciplines at the time, psychiatry in Australia focused on the hygiene of white European settlement.[174] In 1843, the *Dangerous Lunatics Act* was passed in NSW, and similar laws followed in different Australian colonies. Asylums functioned much like gaols[175] – sites of incarceration, seclusion and physical restraint. The discipline of psychiatry, eugenics and racial hygiene all reached a confluence in public policy towards immigrants and Aboriginal people. The main anxiety within white Australia was the influx of Chinese migrant labourers into Australia in the Nineteenth Century[176] and the civil unrest that followed including several deadly race riots. Mental illness was (and in some instances, remains) grounds for exclusion from immigration to Australia, the US and other British protectorates or dominions. Australian psychiatrists feared importing madness and "mental deficiency" into the colonies.[177] This anxiety yoked immigration and public policy with discourses of eugenics and mental hygiene. Following Federation, the 1901 *Immigration Restriction Act* referred specifically to "insanity" and "mental defect"[178] as grounds for exclusion alongside non-Anglo-Celtic race.

Sexism

This, now ubiquitous term refers to the privileging of one gender over another. Invariably this involves male domination over women but the reverse can occur occasionally. Extreme forms of sexism involve sexual objectification, sexual violence and overt discrimination against women. Sexism is frequently structural in nature i.e. obtains negative assumptions about women that underlie public or institutional policy, societal attitudes or practices.

Psychiatry has a problematic history with sexism, particularly in the medicalisation of the female experience and the assumption of deviant states evident in behaviour that is equally explicable in terms of social disadvantage, marginalisation or other persisting states of exclusion or victimhood.

Racism

Racism assumes the natural superiority and desirability of one race over others. A uniform phenomenon in human history, racism permeates social attitudes, customs, culture and public policy. Racism can vary in scope from structural to individual. Racism frequently leads to exclusion, stigmatisation, marginalisation and social disadvantage. In its more extreme forms, racism leads to large scale violence perpetrated against racial "others" reaching its apotheosis in genocidal violence and ethnic cleansing. There is no accepted international definition of racism, although the United Nations 1965 *UN International Convention on the Elimination of All Forms of Racial Discrimination* defined the term "racial discrimination" as meaning

> ***"any distinction, exclusion, restriction, or preference based on race, colour, descent, or national or ethnic origin that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."***

Racism in psychiatry can be subtle or overt. Subtle forms of racism manifest as ignorance of a person's race or culture in their experience of mental health or illness, the medicalisation of cultural difference and the assumption of differential risk posed by different groups leading to higher levels of coercion in psychiatric care.[179,180]

Ableism

Ableism takes the position that abled bodied persons are superior to people living with disabilities. Abelism characterises people as defined by their disabilities and incapacities.[181] The ableist view of disability assumes that the totality of a person is their disability and that their defects or faults require mitigation to participate more "normally" in society. Institutionalised ableism is reflected in the failure to accommodate the needs of people living with disabilities e.g. suitable access to buildings or accommodation for learning difficulty or sensory impairment in education. Ableist language can be the pejorative use of outdated terms such as "retarded" or "spastic" but can also include subtle manifestations such as referring to a person by their disability e.g. "a schizophrenic" or "an autistic". Ableism may be well intentioned such as solicitousness, misplaced pity, demeaning and unwelcome efforts to support or assist a person with a disability or a patronising or infantalising tone of speech. Abelism in mental health systems manifests in the failure to provide appropriate services, the automatic assumption of diminished autonomy or capacity or a lesser quality of life and by extension "invisibility" in decision making about health care choices affecting the person.

Ageism

Ageism is the assumption of old age as a negative or devalued state of being and is characterised by the stereotyping of and discrimination against individuals or groups based on older age. Ageism comprises prejudicial attitudes towards old age and the ageing process; discriminatory practices against older people; and institutional practices and policies that perpetuate stereotypes about elderly people.[182]

Biopower/Biopolitics

The term *"biopouvoir"* (biopower) appeared initially in Foucault's work *History of Sexuality*[183] and was later developed in a series of lectures he gave at the *College de France*.[184] The central idea in Foucault's construction of biopower is the integration of power of the sovereign with biological science,

reforming political power as, ultimately, control over life. Foucault described a contemporary shift from the power of the "sovereign" or ruling class to the power of governments influenced by "discursive" power – power exists in specific discourse (evident in a "discursive formation"). This is a manifestation of Foucault's formulation of the indistinguishability of "power" from "knowledge". Foucault considers knowledge is always an exercise of power and power always a function of knowledge.[185] Foucault considered a "discourse" as an institutionalised way of speaking or writing about reality that defines what can be intelligibly thought and said about the world and what cannot. A discourse *creates* a form of truth, rather than discovering it as it is.

Within modern societies, bureaucracies create contexts that are particularly ripe for the exercise of biopower, because a critical component of modernity is the control of biology, inevitably co-opted into a bureaucratised medical profession. According to Foucault, biopolitical power emerges within the modern capitalist nation state where it is exercised in, for example, interventions to effect control over fertility, compulsion to vaccination, screening and treatment of disease, dietary control or pharmaceutical manipulation. Biopolitical power is exercised at both the level of the individual and the population (what he terms the "massification" of individuals into a population). Applied to psychiatry, biopower provides a compelling framework to understand coercive psychiatric treatments, biomedical models of health and illness and the privileging of certain forms of knowledge (such as evidence based medicine).

Heteronormativity

Heteronormativity defines the assumption that heterosexuality is the norm for humans and that traditional gender identity and roles are the most desirable state of being. Heteronormativity assumes that deviations from this position to be abnormal, aberrant and unhealthy. The term emerged from the line of inquiry in Critical Theory termed as "Queer theory".[186] Now normalised in academic discourse, "Queer Theory" is the analysis of non-heteronormative sexual identity and behaviour including same sex relationships, gender fluidity, intersexual states and transgender people. Queer theory also tasks itself with "intersectionality" – understanding the intersection between different forms of otherness including race, gender, and disability.

Neoliberalism

As an economic philosophy, neoliberalism encompasses a program of public policies which impose "the rule of the market", through the removal of trade barriers; deunionisation and casualisation of the workforce, leading to myriad of contracts between employers and employees; the removal of price controls and barriers to trade and; the reduction of public expenditure on social goods, such as health and welfare. Neoliberals seek the removal of all forms of regulation in the economy and see the government as providing little more than a means of intervention in breaches of trade, such as in cases of corruption or fraud. Citizens in a neoliberal state are recast as "consumers" and consumption leading to economic growth the only true good of the market.

As a moral philosophy, the most significant in neoliberalism, is the assumption of personal responsibility for life choices and their consequences. Healthcare had been traditionally been considered by many as a unique form of social good,[158] however with the exponential growth and complexity in health system in recent decades, healthcare has become as much a commodity as telecommunications or education. The concept of "medical neoliberalism" is built on the commodification of health and wellness in the market and the transformation of physicians from carers to service providers and patients to consumers. Health systems are now run by complex

bureaucracies, clinical governance structures and information systems. This has necessitated a management culture in a large, multibillion dollar "industry". Managerialism has led the focus of healthcare to move from a moral, values based enterprise to one focused on "outcomes".

The second component of the neoliberal health system is the emergence of "consumerism" in mental health. The laudable trend towards empowerment and a greater contribution by those living with mental illness towards decisions about their care is characteristic of several reforms in mental health, although in the neoliberalism influenced health system, the notion of the consumer-provider interaction has completely changed the nature of the therapeutic relationship.

Medicalisation

The philosopher of medicine Illich defined medicalization or "iatrogenesis" as occurring in both clinical and social/structural domains.[187] Within the clinical domain, medicalisation is manifest as iatrogenic harm caused by excess medical intervention increasing the level of pathology. The social/structural domain of medicalisation, perhaps most akin to the current neoliberal paradigm, sees biomedical discourses and instrumental approaches to life's problems as being accepted within a society as the best approach to their resolution.

By contrast "disease mongering" is considered as the process by which the manufacturers of various pharmaceuticals promote awareness of a particular disorder in order to pique the curiosity of the potential sufferer, or physician who may be susceptible to such marketing.[188]

Pluralism

The most recognised approach to the construction of understanding in psychiatry is the is the bio-psycho-social model of American psychiatrist George Engel.[172,189] Engel argued that psychiatric distress and disorder arises from the interaction of biological, psychological and social factors.

Despite its widespread application, Engel's biopsychosocial model is not without its critics. Engel's model is seen to merely force several themes into co-existence, rather than attempt theoretical integration.[190] Ghaemi defines Engel's theory as "eclectic" and not intellectually rigorous. By contrast, Ghaemi urges psychiatrists to accept an approach of pluralism,[191] building on the earlier work of psychiatrist Karl Jaspers, who sought to "understand" and not "explain" his patient's experiences.[192] Pluralism in this context is the assumption that phenomena observed empirically require multiple co-existing explanations to account for their nature rather than one comprehensive explanation. There is no single defining factor in any form of human experience – the origin of the US Civil War or the motivation of Pol Pot in perpetrating the genocide in Cambodia cannot (or should not) be explained by one theoretical assumption. In the same way, a psychiatrist's understanding of the patient demands the indulgence of multiple concepts of framing their experience.

Advocacy

Advocacy is the process of collective or individual action in attempting to influence or stimulate change. Advocacy is invariably performed on behalf of an individual or group and varies widely in scope and focus. As people living with mental illness frequently experience marginalisation or disempowerment, psychiatrists often need to advocate on behalf of the best interests of the patient. Advocacy is the usual response to an injustice suffered by an individual or group. Empirical ethics research highlights psychiatrists see "advocacy" as one of their core values.[193]

Given the divergence of views within the psychiatric profession on several questions of public policy, there is frequent tension about the extent of advocacy appropriate for psychiatrists *qua*

members of a professional group versus *qua* private citizens. To resolve this, Robertson and Walter proposed an "onion skin model" of advocacy by psychiatrists[194] (Figure 1). In this model, there is a core of expertise possessed by psychiatrists and therefore actions in this regard are incontrovertibly psychiatric. As one moves to the outer layers of the model, where questions of community attitudes and public policy are situated, the discourse is less psychiatric and more socio-political. In such instances, the uncontested role of a psychiatrist as a member of a professional group lies in informing the public debate over matters of policy and community attitudes and less direct political action. The importance of this model is that the further away one gets from the core business of psychiatry – defined as assessment and treatment of symptoms and impairment – the less substantive is the role of the psychiatrist in advocacy. The true value of this model is that it avoids the "either-or" approach to advocacy and, more significantly, provides a coherent basis for levels of advocacy, proportionate to a psychiatrist's expertise.

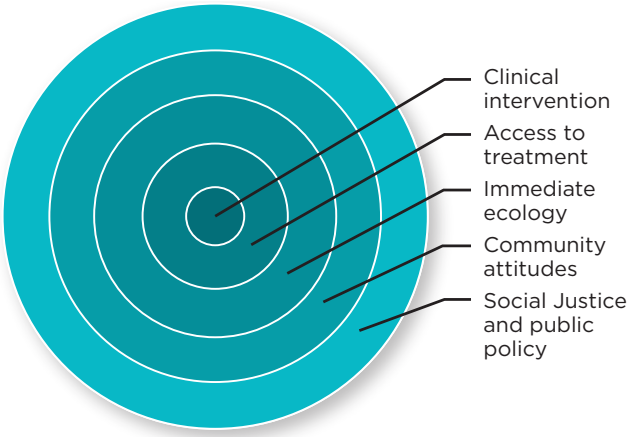

Figure 1 – The "Onion Skin" model of advocacy and justice (After Robertson and Walter 2013)

At the core of the model is the advocacy for best treatment for the patient in a clinical setting. This may include peer review or the advocacy amongst medical colleagues. The next level describes the capacity of patients to access treatment, whether it is medication, inpatient care, or appropriate psychological management. This may involve representations to third parties or institutional bureaucracies. The next layer describes the scope of advocacy for an individual patient in areas such as access to housing, welfare benefits, access to employment or other social goods. This advocacy is often achieved through advising government or non-government agencies of the clinical aspects of a patient's circumstances. This may also involve providing clinical information to civil or criminal courts. Beyond these is the role of advocacy in attempting to influence unhelpful community attitudes, particularly those which involve stigmatising patients. Increasingly, dedicated non-government agencies have been tasked with this responsibility, resulting in psychiatrists participating in a clinical advisory rather than public advocacy role. The final level sees psychiatrists informing legislatures of the potential psychiatric consequences of specific public policy positions.

PSYCHIATRY AND HUMAN RIGHTS

3

3. PSYCHIATRY AND HUMAN RIGHTS

INTRODUCTION TO SECTION 3

In this section, I provide the reader with an introduction to the concept of human rights and discuss the history of psychiatry in Australia and internationally from the perspective of human rights. While human rights are, ultimately, the responsibility of the state, the psychiatric profession has demonstrated a historical propensity to collude in human rights abuses. More contemporaneously, psychiatrists frequently work with patients, whose human rights are either violated or compromised.

WHAT ARE HUMAN RIGHTS?

According to the Australian Human Rights Commission:

> ***"Human rights recognise the inherent value of each person, regardless of background, where we live, what we look like, what we think or what we believe. They are based on principles of dignity, equality and mutual respect, which are shared across cultures, religions and philosophies. They are about being treated fairly, treating others fairly and having the ability to make genuine choices in our daily lives."*** [195]

On 10 December 1948, the United Nations General Assembly adopted the "Universal Declaration of Human Rights". The priority placed upon human rights in this setting emerged from the experience of totalitarianism in Europe and extreme Japanese militarism in the Asia-Pacific region. This was not the first attempt at enshrining human rights – in 622 BC the prophet Mohammed imposed a series of what can be argued as human rights or obligations in the Constitution of Medina. In the history of the West, efforts at establishing human rights included the *Magna Carta* (1215), the *Declaration of the Rights of Man* that followed the French Revolution (1789) and the *Bill of Rights* contained in the Constitution of the United States. In these assertions, human rights are considered "natural" in that they are not dependent on the laws or customs of any culture or government, and therefore universal and inalienable i.e. they cannot be repealed or restrained by laws imposed by any government or other law maker. Unlike rights that are entitlements or privileges that reside in statutes or foundational documents like constitutions, human rights are considered to exist as an intrinsic part of human experience. Implicit in this is that they are "inalienable" – they cannot be altered in any circumstance or context.

In recent history, human rights discourse has become more the focus of juridical process and has been politicised at national and international levels. The troubled tenure of former Australian Human Rights Commissioner Professor Gillian Triggs from 2012-2017 is a clear illustration of the highly-politicised nature of asserting human rights in a political environment, where populism erodes a nation's international obligations to human rights.

The core assumption in any discourse of human rights is the unconditional possession

of entitlements that are forms of liberty. The philosopher Isaiah Berlin elaborated concepts of "positive" and "negative" liberties, which have become the foundation of modern legal constructs of human rights.[196] "Positive" liberties are entitlements to freedoms such as where to live, who to have children with or access to social goods such as education or health care. "Negative" liberty posits freedom from constraints, restrictions or other forms of imposed disadvantage such as exclusion, deprivation or persecution.

CURRENT CONCEPTUALISATIONS OF HUMAN RIGHTS AND MENTAL ILLNESS

In December 1991, the United Nations General Assembly passed a Resolution adopting the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* put forward by the United Nations Human Rights Commission (see Appendix 1). The document covered multiple aspects of the experience of people with mental illness and the provision of mental health care including – the right to live and work, as far as possible, in the community; standardised diagnostic practices; acknowledging a patient's culture in mental health assessment and care; the provision of involuntary treatment in the least restrictive setting appropriate to the patient's needs; the use of medication only for the benefit of the patient; appropriate standards for consent to treatment; judicial oversight of involuntary psychiatric treatment; standards for design, maintenance and improvement of mental health facilities and; appropriate mechanisms for review of involuntary treatment.

In 1992, the then Human Rights and Equal Opportunity Commission reviewed mental health laws across the Commonwealth, noting "The legislation in every Australian jurisdiction breaches the standards prescribed in the UN Principles in a number of ways. In some jurisdictions, these breaches constitute fundamental violations of basic human rights".

In 2006, The United Nations adopted the Convention on the Rights of Persons with Disabilities (UNCRPD), which has now become the international standard for judging international adherence to human rights for people living with disabilities, including mental illness. The UNCRPD advocates, inter alia, that:

> ***"countries must guarantee that "persons with disabilities enjoy their inherent right to life on an equal basis with others (Article 10), ensure the equal rights and advancement of women and girls with disabilities (Article 6) and protect children with disabilities (Article 7). Children with disabilities shall have equal rights, shall not be separated from their parents against their will, except when the authorities determine that this is in the child's best interests, and in no case shall be separated from their parents on the basis of a disability of either the child or the parents (Article 23). Countries are to recognize that all persons are equal before the law, to prohibit discrimination on the basis of disability and guarantee equal legal protection (Article 5). Countries are to ensure the equal right to own and inherit property, to control financial affairs and to have equal access to bank loans, credit and mortgages (Article 12). They are to ensure access to justice on an equal basis with others (Article 13), and make sure that persons with disabilities enjoy the right to liberty and security and are not deprived of their liberty unlawfully or arbitrarily (Article 14). Countries must protect the physical and mental integrity of persons with disabilities, just as for everyone else (Article 17), guarantee freedom from torture and from cruel, inhuman or degrading treatment or punishment, and prohibit medical or scientific experiments without the consent of the person concerned (Article 15). Laws and administrative measures***

must guarantee freedom from exploitation, violence and abuse. In case of abuse, States shall promote the recovery, rehabilitation and reintegration of the victim and investigate the abuse (Article 16). Persons with disabilities are not to be subjected to arbitrary or illegal interference with their privacy, family, home, correspondence or communication. The privacy of their personal, health and rehabilitation information is to be protected like that of others (Article 22). On the fundamental issue of accessibility (Article 9), the Convention requires countries to identify and eliminate obstacles and barriers and ensure that persons with disabilities can access their environment, transportation, public facilities and services, and information and communications technologies." [197]

Article 12 of the UNCRPD focuses upon "equal recognition before the law" and this has emerged as a specific focus of enquiry in mental health care and the application of coercion as a form of substituted decision making under mental health laws in Australian and New Zealand. Concerns about limited judicial oversight of involuntary psychiatric treatment and the, at times, lax preconditions to enforcing psychiatric treatment are commonly cited as criticisms of Australia's compliance with the Charter.[198]

In June 2017, The United Nations Special Rapporteur (UNSR) on the "right to health" reported to the UN General Assembly on the state of mental health services globally.[199] The UNSR described a global system in crisis, due in large measure to the psychiatric profession's adherence to a limited view of mental health and mental illness. The UNSR was critical of the ongoing segregation of mental health services from other parts of the health system and their inherent power imbalances through excessive coercion in detention and enforced treatment, as against a "rights based" approach to mental health care that empowered the patient.

In seeking to explain the origin of the problems, the UNSR noted the primary problem was the hegemonic influence of the biomedical model of mental health and mental illness. This led to biases in the construction of evidence based practice; over-emphasis on the use of psychotropic medication in mental health care; the concentration of power in the mental health system in the hands of "biomedical gatekeepers", often in problematic collaboration with the pharmaceutical industry. The UNSR observed that the biological psychiatrists who influenced mental health systems adhered to outdated orthodoxies that mental disorders were inherently dangerous, invariably necessitating biomedical interventions. This perpetuates stigma and discrimination against people living with severe mental illness and explains disturbingly high levels of coercion in mental health care. These observations were in clear violation of the UNCRPD and earlier declaration of the rights of people living with mental illness.

In August 2017, the RANZCP conducted a broad review of the empowerment of psychiatrists in mental health legislation, considering the 1991 and 2006 UN declarations.[200] It concluded that "*despite convergence in many areas dealing with involuntary commitment, capacity and regulated treatments, as well as seclusion and restraint, the legislated tests still vary a great deal, as do the results that flow from them".*

PSYCHIATRISTS AND HUMAN RIGHTS VIOLATIONS PRE-TWENTIETH CENTURY

In the period prior to the European Enlightenment, the treatment of people with mental illness was akin to imprisonment and torture. Involuntary psychiatric commitment was arbitrary and often involved collusion between physicians and families.

The insane were the object of fear and ridicule – in Bedlam hospital in London, one could pay to visit the inmates of Bedlam hospital, rather like animals in the zoo.[201]

The best-known analysis of the history of madness is Foucault's *Madness and Civilisation*.[202] Foucault argued that in the Renaissance the "insane" were possessed of a kind of maniacal wisdom. In the period of the "age of reason" of the European Enlightenment, madness was reformulated as an extreme form of "unreason" and placed people with mental illness in the same category of criminals. This led to a process of mass incarceration of mentally ill people in institutions akin to prisons, in a process Foucault termed "the great confinement". Apart from containment and exclusion, these psychiatric institutions sought to impose reason on the irrational patient – this dovetailed with the evolution of medical science as a form of natural science in the Eighteenth Century, thus facilitating physicians to categorise mental illness as akin to other forms of illness.

The history of psychiatry is argued to have taken a more humane turn with the work of Phillippe Pinel at Bicêtre and later Salpêtrière hospitals in Paris, where he abolished seclusion and restraint as well as restricting more barbaric treatments such as bleeding, purging, and blistering in favour of a "moral" therapy that involved interpersonal engagement with patients. This turn to psychological therapy put Pinel at odds with his more biologically minded colleagues.

PSYCHIATRIC HUMAN RIGHTS ABUSES IN THE TWENTIETH CENTURY

The two totemic events in the history of human rights abuses by psychiatrists are the mass murder of more than 300,000 people with psychiatric, intellectual and physical disabilities under the National Socialist (Nazi) regime in Germany and its occupied territories and the mass persecution of political dissidents in the former Soviet Union (USSR). Yet beyond these landmark moments in the history of psychiatry, the mentally ill have suffered gross deprivation and depredations at the hands of societies that were not totalitarian or politically repressive. In asylums in the United States, Australia and Europe, patients were subject to neglect, malnutrition, abuse and exploitation. These people were subject to treatments that are now considered barbaric such as malaria therapy,[203] deliberate sepsis or rudimentary leucotomies performed by the now infamous "lobotomist" Walter Freeman.[204]

In Wilhelmine and Weimar Germany, prior to the rise of Adolf Hitler, psychiatric inpatients languishing in asylums suffered and died in enormous numbers. From 1880 to 1920 the number of asylum "inmates" in Germany increased nearly five-fold with no increase in funding or provisions.[205] Nearly 70,000 German psychiatric patients died of starvation and hypothermia during World War I.[206] Prior to the Nazi's assumption of power in January 1933, German psychiatrists were overly influenced by the biological psychiatry of Emile Kraepelin[207] and adopted eugenics as a core assumption in their discipline. First described by English polymath Francis Galton,[208] "eugenics" argues for the improvement of the human species through encouragement of desirable probands to breed (what is now considered "positive eugenics") and preventing inferior genetic stock from propagating ("negative eugenics"). Far from being an exclusively German preoccupation, eugenic societies were influential in numerous other countries, most conspicuously the USA. The world's first law for compulsory sterilization was passed in the US state of Indiana in 1907 and until the 1960s, almost 60% US states had similar laws in operation. The "euthanasia" of people considered genetically inferior (particularly the "feeble minded" (people living with intellectual disabilities) was

publicly debated in the US – prominent professor of neurology Charles Foster Kennedy[209] argued for the active non-voluntary euthanasia of "feeble minded".[210]

In July 1933, the German parliament (Reichstag) passed the *Law for Prevention of Hereditary Diseased Offspring* and established a series of "Hereditary Health Courts" that issued compulsory sterilisation orders. Within five or so years, children with disabilities living in institutions were murdered by medical and nursing staff by deliberate overdoses of barbiturates, or combinations of morphine and scopolamine. Mass killing of disabled adults and children using carbon monoxide gas chambers began in early 1940 in six dedicated killing centres in Germany and Austria (in Brandenburg, Grafeneck, Hartheim, Bernberg, Hadamar and Pirna). This was a centralised process of mass murder organised from an address in Berlin – Tiergartenstraße 4. This highly secretive operation was given the code name *Aktion T4*.[211] At the same time patients in asylums in Nazi occupied Poland and later the USSR were murdered by shooting or mobile gas vans by special killing squads of the SS *(Einsatzgruppen)* or occasionally by the regular German army *(Wehrmacht)*. Many of these killings were performed at the direct request of asylum directors seeking to free up beds or remove troublesome patients.[212] By late summer 1941, growing community awareness of the T4 program in Germany led to public protest, prompting Hitler to order the program of gassing to cease. Regardless, many German psychiatrists and asylum nurses continued the mass murder of patients in special hospitals, mostly by deliberate overdose or starvation. This phase was later termed by historians as "decentralised" euthanasia.[211] To dispense with continued indulgence of the euphemism "euthanasia", historians in Germany now refer to this crime as the *"Krankenmorde"* (the murder of the sick).

Many of the psychiatrists, physicians and nurses who participated in the T4 program had developed skills in mass murder by poison gas and were later deployed by the Nazi regime to kill scores of prisoners in the concentration camp system too sick to work in a program called *Aktion14f13*. In 1942, most of these medical and nursing staff skilled in mass murder by gas were deployed to effect the genocide of Poland's Jewish population in three extermination camps established in Poland (Belzec, Sobibor and Treblinka) as part of the Nazi's "Final Solution".[211] Most of the perpetrators of the Krankenmorde escaped prosecution after the war and many returned to their pre-war professorial chairs or practices. It was only in 2010 that the German Society for Psychiatry, Psychotherapy and Neurology (DGPPN) made an official apology for the complicity of the German psychiatric profession in the *Krankenmorde*.

A decade later, psychiatrists in the USSR were co-opted by the regime to assist in a process of medicalised persecution of dissidents or those deemed a threat by the regime. In the 1960's Major-General Pyotr Grigorenko, a decorated veteran of the Great Patriotic war against the Nazi's become openly critical of the regime of General Secretary Nikita Kruschev. Rather than having Grigorenko murdered or sent to a Siberia, Kruschev preferred him declared "insane" and therefore his views would be discredited. Grigorenko was arrested by the KGB and later diagnosed as suffering from "paranoid development of the personality associated to reformist ideals".[213] He was committed to the Serbsky Institute, a secure forensic psychiatric hospital in Moscow.

Subsequent psychiatric based persecutions of dissidents offered a "gentler" face to dealing with troublesome citizens political and had the added advantage of discrediting opposition views.[214] Moscow became the epicentre of this crime against humanity and the central villain of

the story was Professor Anrdrei Snezhnevsky, the director of the Institute of Psychiatry of the USSR Academy of Medical Sciences. Snezhnevsky and his collaborators were convinced of their rectitude.[215,216] Numerous diagnoses such as "Schizophrenia forme fruste" and "Paranoia with delusions of reform" emerged in Soviet psychiatric discourse.[217] The most infamous diagnosis used by Soviet psychiatrists in this program of persecution was "sluggish schizophrenia". The core of Snezhnevsky paradigm of schizophrenia in the USSR was that there was no plausible explanation for rejection of the Soviet model of society other than insanity.[218]

The Soviet Union had two networks of psychiatric hospitals. One was an ostensibly mainstream network administered by the Ministry of Health, another comprised a network of *psikushka* ("forensic" hospitals), administered by the Ministry of the Interior under the auspices of the KGB. Patients were sent to forensic hospitals following orders by Soviet courts and psychiatric tribunals. Many were admitted to the Serbsky Institute in Moscow, a facility that continues to operate as a secure psychiatric hospital. In the early 1960's, psychiatric prisoners were subject to insulin coma therapy, high doses of neuroleptic drugs and un-anaesthetised Electro-Convulsive Therapy. This practice often fractured vertebrae, long bones or caused abdominal viscera to rupture. 'Orderlies' in these facilities were often criminals who had been patients there.[219]

The World Psychiatric Association (WPA) became aware of the malfeasance of psychiatrists in the USSR in 1971, after being notified by a document written by Vladimir Bukovsky, a dissident who faced imprisonment in labour camps, prisons and *psikushka* for a total of 12 years. It took six years to respond formally, although a WPA committee investigating the political abuse of psychiatry, the "Geneva Initiative on Psychiatry", was founded in 1974. In 1977, the WPA held its triennial congress in Honolulu. By that time, the British Royal College of Psychiatrists and the American Psychiatric Association had agitated for action in the case of Soviet psychiatric abuses. The WPA made a formal condemnation of the practice in the Soviet Union and other Eastern Bloc countries, and similar abuses in South African Apartheid.

The 1977 *"Declaration of Hawaii"* called for the psychiatric profession to respect patient's autonomy and maintenance of beneficence and non-malfeasance. It also addressed issues of informed consent, confidentiality, and provided guidelines for forensic evaluation of psychiatric patients and involuntary treatment. There was also an obligation for psychiatrists not to 'misuse' their professional skills. Specific reference was made to the use of involuntary treatment in the absence of psychiatric disorder.

By 1982, the Soviets faced expulsion from the WPA, and voluntarily withdrew to save face. After much posturing on both sides throughout the 1980's, Soviet psychiatric practices were abandoned in the face of Gorbachev's *glasnost* and *perestroika.* They were readmitted to the WPA in 1989.

HUMAN RIGHTS ABUSES AND AUSTRALIAN PSYCHIATRY

RECENT HISTORY

In the latter part of the Twentieth Century, Australian psychiatry drifted away from its asylum origins and absorbed the tenets of the social psychiatry movement, which emphasised the significance of social environment and inequality in determining mental health and illness.[220] By the 1970's, the accumulating evidence of the effectiveness of antipsychotic drugs such as chlorpromazine marked a shift to an era of biological psychiatry that dominated the next

40 years.[221] The prospect of effective treatment for mental illness and potential recovery spurred attempts at a shift away from institutional based treatment to community mental health care.[222,223]

This process of deinstitutionalisation in Australia was, ultimately, deemed a failure by several independent and government inquiries, which revealed significant flaws in the implementation of deinstitutionalisation and community mental health. Patients were ejected from large psychiatric hospitals into substandard accommodation or homelessness and circumstances of gross social deprivation. In 1993, the *Burdekin Report*[224] estimated that around one in five adults in Australia suffered from some form of mental disorder, but that only about 3% accessed mental health services. The *Burdekin Report* concluded that this was a function of ignorance and stigma in the community. In 1993, the Australian Health Ministers' Conference (AHMC) endorsed a *National Mental Health Strategy* (NMHS), facilitating the decommissioning of an institutionally focussed mental health system to one that was consumer and community focused.[225] The RANZCP was heavily involved in informing this policy, although the strategy seems to have been far less successful than anticipated.[226] Rather than see the blossoming of community psychiatry, the phenomenon of "transinstitutionalisation" saw people living with severe and persistent mental illness forced into de facto psychiatric institutions such as boarding houses, nursing homes or prisons. In Australia, much like the rest of the developed world, the prevalence of psychiatric disorder is significantly higher in the prison population than the community,[227] inviting the critique that prisons have become the de facto psychiatric institutions.[228]

Beyond this failure of the government to discharge its obligations were well documented instances of abuse and neglect of people living with mental illness. The Human Rights and Equal Opportunity Commission's (HREOC) "National Inquiry into Human Rights of People with a Mental Illness" (1990-1993) concluded that services for people living with mental illness were "disgraceful".[229] Despite the commencement of NMHS,[230] the HREOC found persisting failures in the mental health system and ample evidence of mistreatment and neglect of people living with mental illnesses.[230-232]

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Two scandals loom large in the psyche of Australian psychiatrists – the death of numerous patients at Chelmsford Private Hospital in Sydney and the abuse of patients in Ward 10B of Townsville Hospital in Queensland.

The Chelmsford Hospital scandal came to light in the late 1980's and involved the criminally reckless use of the discredited practice of continuous narcosis or "Deep Sleep Therapy" (DST). Under the direction of a psychiatrist, Dr Harry Bailey, and a local general practitioner, Dr Ian Herron, DST was performed at Chelmsford from 1963 until the mid-late 1980s. Patients were induced into continuous profound sedation with barbiturates, fed through nasogastric tube and administered ECT. Those who did not respond to Bailey's satisfaction were referred to a local teaching hospital for cingulotractotomy. Apart from severe medical negligence, Chelmsford Hospital was also culpable in its use of inexperienced nurses in the care of such patients. Moreover, when the hospital's medical board prohibited the use of DST, Bailey subverted the process by admitting patients under Herron's name. After a series of complaints, a Royal Commission was conducted in 1988/9[233] and concluded that, at the very least, 24 patients had died as a result of DST at Chelmsford. Another 19 patients who had undergone DST had suicided within a year of their admissions to Chelmsford. The Church of Scientology's "Citizen's Commission of Human Rights" had been the main agitator

about Bailey's conduct. Bailey committed suicide in 1985. Unrepentant, his suicide note stated, "Let it be known that the Scientologists and the forces of madness have won".[234] The persisting impact of Chelmsford on the Australian psychiatric profession appears to be diminution of professional autonomy – subsequent mental health legislation in NSW prohibits private psychiatric hospitals admitting patients on an involuntary basis; "psychosurgery" has been outlawed and the administration of Electroconvulsive Therapy is now closely regulated by independent tribunals.

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Just as the Chelmsford scandal was resolving, another emerged in Queensland. Dr John Lindsay, the director of the psychiatric ward of Townsville Base Hospital (Ward 10B) had run the inpatient unit along the lines of a "therapeutic community" – therapeutic community treatment of mental illness sees patients and clinicians living together and taking group based approaches to treatment, including in Ward 10B's case, decisions about medication. By 1986, 123 complaints had been made to the Townsville Hospital's Board about Lindsay and Ward 10B,[235] including allegations of sexual and physical abuse and gross medical negligence. In 1991, the Queensland government established a Commission of Inquiry.[236] The commission received testimony that patients in Ward 10B were subjected to "cruel and inhumane" treatment and identified sixty-five deaths attributable to either suicide or iatrogenic causes. Like Chelmsford, 10B affected psychiatry in Australia in that:

> ***"Although (Townsville Ward 10B) suggests that problems at Townsville can be attributed to Lindsay's desire for innovation, and refusal to recognise mistakes, further investigation reveals that this is not an unusual problem within psychiatric practice in Australia."*** [235]

The decades that followed Chelmsford and Ward 10B seemed free of such scandal for psychiatry until June 2014, when Miriam Merten, a patient in the mental health unit at Lismore Base Hospital, died after she sustained multiple head injuries. The coroner's inquest in to Miriam Merten's death heard evidence that she had been locked in a seclusion room for hours at a time, and when the two nurses supervising her unlocked the door they allowed her to wander around naked with little supervision. The CCTV footage of Miriam Merten, staggering around the ward naked and delirious caused outrage within the community. A review conducted subsequently by then NSW chief psychiatrist, Dr Murray Wright and colleagues, found that patients in mental health units in NSW were placed in seclusion for periods of more than 5 hours almost 3,700 times in the 12 months prior.[237] The enquiry found seclusion rooms were often "unhygienic", inadequately cleaned and patients lacked access to natural light, fresh air or bathrooms. Dr Wright's review found "cultural problems" – specifically prejudicial attitudes to patients with mental health problems who were cared for in hospital Emergency Departments. While not recommending the total banning of seclusion or restraint, the report concluded with 19 recommendations for mitigating the problems identified in the enquiries.

The imagery of Miriam Merten in Lismore Baes Hospital is disturbingly redolent of psychiatric hospitals of the past. In 1948 a journalist, Albert Deutsch, made a study of psychiatric hospitals in the United States. In his book, *The Shame of the States*,[238] Deutsch found evidence of widespread human rights abuses arising from the kind of hostility and neglect later described in Dr Wright's report, noting "the most serious defects arise from the deadly monotony of asylum life, the regimentation, the depersonalization and dehumanization of the patient…the contempt for human dignity"[195] (p.28).

INDIGENOUS MENTAL HEALTH AND HUMAN RIGHTS

As noted previously, psychiatrists in the Australian colonies functioned as extensions of British psychiatry and were focused on the mental hygiene of European settlement. Racist attitudes towards Indigenous Australians were evident in early writings of Australian psychiatry. Aborigines were characterised as "crude and simple, childish and devoid of reasoning, and often sexual and animal in nature" and as such "Aboriginal insanity was interpreted as the most exaggerated expression of their innate primitiveness and savagery".[239] Psychiatrists were little interested in the mental health of Aboriginal people, until the arrival of Norton Manning in Sydney in the late Nineteenth Century. Among many aspects of Manning's project in modernising psychiatry in the NSW colony, he became interested in the mental health of Aboriginal people in the asylum system. Manning observed that the dominant theme in the clinical presentation of male Aboriginal patients incarcerated in asylums in NSW, was cultural alienation or estrangement.[177] Through contemporary eyes, this was an extension of the catastrophic consequences for Aboriginal civilisation of white European inhabitation of traditional lands.[240] This forced dispossession was, ultimately, the initial phase of an attempted genocide of Aboriginal Australia – there later followed sporadic murders of groups of Aboriginal people, sexual violence, enslavement and a state administered program of ethnic cleansing (the forced removal of mixed race Aboriginal children – the "Stolen Generations"), the traumatic legacy of which remains within the Aboriginal community.[241]

By any measure, Aboriginal civilisation was subject to a genocide perpetrated by European colonisers.[242] In 1948, the United Nations adopted its "Convention on the Prevention and Punishment of the Crime of Genocide" and outlined a construct of the crime of genocide based on the work of Polish lawyer Raphael Lemkin.[243] Article 2 of the Convention defines genocide as:

"...any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:

(a) Killing members of the group;

(b) Causing serious bodily or mental harm to members of the group;

(c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;

(d) Imposing measures intended to prevent births within the group;

(e) Forcibly transferring children of the group to another group.

Any reading of the history of white settlement in Australia and its impact on the Aboriginal population meets the criteria of genocide. In December 1992, then Prime Minister Paul Keating delivered a speech in a park in Redfern that acknowledged the harms brought to Aboriginal people by European Settlement. It was not until the formal apology delivered in 2008 by then Prime Minister Kevin Rudd, in 2008, to the victims and families of the "Stolen Generation", that there has been any formal recognition of genocide or "ethnic cleansing" inflicted against Aboriginal Australia.

The ongoing situation of injustice faced by Indigenous people in Australia manifests as physical and mental illness and social discord.[244] Arguably, disrespect and a sense of inferiority become physically manifest as immune suppression, inflammation, and acute and chronic illness. Externally, these social processes emerge as substance misuse, risk-taking, "lateral violence" and violations of the social contract leading to higher

rates of imprisonment.[244,245] Trauma is transmitted through generations of Aboriginal people through disrupted patterns of interpersonal attachment, collective narrative identity of victimhood and familial and community violence. Like all people, physical health, mental health and social injustice are inseparable for Aboriginal people. Aboriginal people suffer common DSM psychiatric disorders,[246] however the critical element in understanding Aboriginal mental health is that these disorders are often experienced in the context of factors such as guilt or self-reproach arising from the experience of such injustice and social failure. This profoundly influences help seeking amongst Aboriginal people, whose relationship with health care professionals from non-Aboriginal society is often characterised by problematic power relationships.[247] There are frequent breakdowns of order in Aboriginal communities, leading to demoralisation and anomie.[248] As representatives of a more powerful group in society, non-Aboriginal health care workers find themselves in a difficult situation. This has created a discourse in Aboriginal mental health which has realised the need for culturally respectful and sensitive mental health services.[249] Credible approaches to Aboriginal mental health require empowerment of the Aboriginal community and, in particular, their health care workers in a process of what is describe as "deep listening" to the community[250] and collaborative consultation with different Aboriginal communities and their leadership.[251]

Interest in the mental health of Aboriginal Australia remained limited until the 1960s, when psychiatrist John Cawte began his project in Aboriginal mental health.[252,253] Like Manning, Cawte observed that Aboriginal patients in asylums diagnosed as suffering severe mental illness, demonstrated the consequences of the anomie arising from social isolation, displacement from traditional lands, forced integration with white Australia and loss of connection with their culture.[252,254]

Manning's and Cawte's observations of the psychiatric consequences of colonisation on Aboriginal people are echoed in the context of French colonisation in Algeria by psychiatrist Frantz Fanon. Fanon saw psychiatry and psychiatric institutions as being extensions of the power of the coloniser. To Fanon, the process of colonisation requires the negation of the indigenous population's relationship to traditional lands, identity and culture.[255] Fanon's *The Wretched of the Earth*[256] described European psychiatry as "alienating" the colonised population from their traditional civilisation by forcing their individual experience into a psychiatric category through the lens of European psychiatry. Fanon considered French psychiatry exerted a hegemonic cultural influence upon the colonised, creating a sense of "otherness" in the colonised population. This caused fragmentation of identity. Fanon formulated an application of Jacques Lacan's notion of *meconnaissance*[137] to the coloniser-colonised dynamic. In the coloniser-colonised dyad, diagnostic categorisation, detention in asylums and enforced psychiatric treatment effect alienation of the colonised from their cultural origins and in the process causes internalisation of the violent repression of colonisation.[257]

Since the 1990s there has been considerable progress in the field of indigenous mental health. The area is now a substantive component of psychiatric training in Australia and New Zealand and the RANZCP has been vocal in a sophisticated and non-partisan way in attempting to promote the field, disseminate the necessary skills and knowledge among its members[258] and influence public policy.[259]

ASYLUM SEEKERS

While boasting its multiculturalism and a highly successful immigration program, Australia has a troubling history in meetings its obligations to refugees. One of the first acts of the new Australian Federal parliament was to pass the *Immigration Restriction Act* 1901 that sought to privilege white European (read "British") immigration over other races. In justifying this openly racist policy, then prime minster Edmund Barton argued in parliament:

> ***"I do not think either that the doctrine of the equality of man was really ever intended to include racial equality. There is no racial equality. There is basic inequality. These races are, in comparison with white races—I think no one wants convincing of this fact—unequal and inferior. The doctrine of the equality of man was never intended to apply to the equality of the Englishman and the Chinaman. There is deep-set difference, and we see no prospect and no promise of its ever being effaced. Nothing in this world can put these two races upon an equality. Nothing we can do by cultivation, by refinement, or by anything else will make some races equal to others."***

Australian racism was not confined to anti-Asian immigration or genocidal policies against Aboriginal Australians. In 1938, the Intergovernmental Committee on Refugees convened in the French spa town of Evian to address the international response to the migration crisis posed by Jewish people fleeing Nazi persecution in Germany and Austria. Australia's delegate to the Evian conference, Federal Minister for Trade and Customs Thomas White, argued that Australia would refuse to accept Jewish refugees from Europe on a large-scale because of concern about importing "foreigners" and "racial problems".[260] White's remarks are depicted at the Yad Vashem Holocaust memorial as the symbol of the world's indifference to the unfolding disaster facing Europe's Jews. Australia was one of 145 countries to later sign the UN Refugee Convention in 1951, which committed to not penalise refugees for the manner of their entry into the country; to no "refoul" refugees (return to circumstances of persecution or danger) and to guarantee them basic civil rights.

Small numbers of skilled migrants from southern Europe were allowed to immigrate to Australia to work on the Snowy Mountains Hydro-electric Scheme in the 1950s, however racist and xenophobic sentiments persisted within Australian government until the mid-1960s. The White Australia policy was formally abandoned by the Whitlam government in 1973. A steady stream of refugees from Vietnam, Cambodia, East Timor and other sites of geo-political turmoil in the region began to arrive in Australia, often by unauthorised means, from the mid-1970s onwards. This pattern of migration from South East Asia to Australia is, in general, considered a beneficial experience for all and has become the foundation narrative of what many argue is a generally well-structured Australian immigration policy.[261]

The collapse of world order in the late Twentieth and early Twenty First Centuries, particularly in the Middle East, has created a large scale global refugee problem and has challenged Australia's recent found belief in its tolerance as a society. While much blame for Australia's current human rights problems is laid at the feet of the populist race baiting of the Liberal government of John Howard (1996-2007),[262] it was the Keating Labor government that in 1994 introduced the draconian modification of *Australian Migration Act* that both began the policy of mandatory detention and disallowed judicial review of detention of asylum seekers. In 2001, the Howard government introduced legislation that excised Australian migration zones (such as Christmas Island) and introduced indefinite mandatory detention, through

the designation of several offshore detention sites in the Pacific – the so-called "Pacific Solution". These policies have proven popular with parts of the Australian electorate whose votes are necessary for securing a parliamentary majority.[263] The United Nations Special Rapporteur on Torture has found that various aspects of Australia's asylum seeker policies – specifically indefinite detention of asylum seekers on Manus Island; the harsh conditions of the camp; the frequent unrest and violence (including sexual violence) inside the centre and; the failure to protect vulnerable individuals, all amount to breaches of the UN Convention "Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment". Then Prime Minister Tony Abbott's response to the criticism was to complain that "Australians were sick of being lectured to by the United Nations".

This vexed mixture of problems has proven one of the defining questions in psychiatric ethics in Australia. Australian psychiatrists face the quandary of working within a policy and legal framework that is arguably racist and without question, profoundly injurious to the mental health of people seeking asylum.

Dealing with the consequences of forced migration, political persecution and racial violence have been critical themes in the history of psychiatry.[264] Australian psychiatrists are well aware that Australia's policies of indefinite or open ended detention and uncertainty over current and future statelessness are profoundly injurious to the mental health of asylum seekers.[265-267] In February 2012, the RANZCP provided a series of recommendations that asserted that the detention of children was a human rights violation; that detention should not be conducted off-shore; that asylum claims should be processed promptly and; that specialised mental health services should be provided for asylum seekers.[268] Four years later, the RANZCP released guidelines for clinicians working in the detention centres, advocating principles of "proper use of professional knowledge and skills", responsibility to the patient, clinical independence, advocacy, and confidentiality.[269]

The conduct of the RANZCP over the public policy dilemmas of contemporary immigration policy has placed it, in some respects, in direct conflict with the state.[270]

Australian psychiatrists have direct clinical involvement with asylum seekers in detention centres and make regular constructive contributions to public discourse on the issue. There has emerged an extensive literature in this space, offering arguments in direct opposition on clinical grounds to such policies.[271] Psychiatrists have also advocated on behalf of asylum seekers[272] and have argued for the need for public reporting of health data of asylum seekers in detention to inform public debate.[270,273] In some circumstances, this has necessitated the conduct of unsanctioned or "subversive research" identifying the psychopathological consequences of these immigration policies.[274] *The Border Force Act* (2015) prohibited initially the distribution of information acquired working within the "border force system", even health information. In the face of pressure from medical refugee advocacy groups, in September 2016 the government amended the law to exempt health workers.

SOCIAL JUSTICE AND SEVERE MENTAL ILLNESS IN 21ST CENTURY AUSTRALIA

People living with severe and persistent mental illnesses continue to face significant challenges. They are often isolated by the symptoms of their illness,[275] confront stigma and discrimination,[275,276] homelessness, neglect, isolation, poverty, unemployment or underemployment, and violent victimisation.[275,277-279] Only a third of this group access the mental health care they need.[280] In the

homeless population in Australia, around 75% have a mental illness.[281]

Around half of the prison population have mental health problems – one in five prisoners taken into custody are taking prescribed psychotropic medication[282] and prisons have become the epicentre of transinsitutionalization.[283] Due to co-morbid physical illness, the life expectancy of people with severe and persistent mental illness is shorter compared to the general population.[284,285] Around 80% of men and women living with serious mental illness have shorter longevity of between 10 and 36 years,[286] creating a situation of what one advocate described as a form of "creeping euthanasia".[287] The RANZCP has tasked itself with advocacy for appropriate physical and mental health services and continued engagement in questions of ethical practice and human rights.[288]

In public health discourse, the concept of "equity" describes and seeks to explain differences in the quality of health outcomes and access to healthcare across different populations. "Horizontal equity" is the equal treatment of individuals or groups in the same set of circumstances, whereas "vertical equity" interrogates the idea that people who face forms of social inequality e.g. people living with severe mental illness, should be treated differently according to their level of need. By contrast, "inequality" in health refers to those instances in which the health of two demographic groups differs, despite comparable access to health care services. "Equity" describes access whereas "equality" describes health status.

Ethical dilemmas posed by questions of distribution of and access to limited mental health treatment resources have come into focus in the last decade, particularly given the stark contrast between the apparent benefits of universal health coverage and the commodification of health care resources in a market model. Original theories of distributive justice tended to polarise along either liberal egalitarian models, such as that of Rawls,[11,155] and libertarian ideas, such as those described by Nozick.[289] As noted earlier, Rawl's *Theory of Justice*[11] has been extended to the specific areas of health care by Daniels.[158]

The model of social justice proposed by Rawls provides a useful framework for understanding "social justice" in the setting of mental health. In this approach, social justice exists within the successful operation of the social contract, which involves rational choosers abdicating certain natural rights in exchange for a just pattern of distribution of social goods benefitting the least well off. Rachels has posed three circumstances where the social contract process appears to fail:[151]

i. What of those citizens, like the mentally ill, who may be incapable of rational agreement to the social contract process, yet need the protection of the sovereign or the benefits of the social contract?

ii. What of those members of society who are second class citizens and do not benefit from the social contract, yet are expected to abide by it?

iii. What if the sovereign fails in its responsibilities in enforcing the social contract?

These three scenarios represent specific instances of social "injustice" and arguably provide a framework for psychiatrists to conceptualise social justice regarding their patients. In the first category of social "injustice" many people living with severe mental illness cannot, by virtue of their disability, abide all expectations of the social contract. In circumstances where there is potential for improved engagement in the social contract e.g. economic participation or social service, these should be a critical part of mental health care. Second, psychiatrists frequently provide care and advocacy for people whose status is "second class

citizen", such as asylum seekers and other groups whose human rights are under threat. Third, as we have seen, there has been consistent failure of the sovereign to adequately fund mental health services or effect a form of persecution against some groups within the population. In each of these categories of social injustice, the critical response from psychiatrists is advocacy.

COERCION AND INVOLUNTARY TREATMENT

The most frequent ethical dilemma faced by psychiatrists and mental health systems involving potential violation of human rights, arises from the prospect of coercion, detention and enforced psychiatric treatment.[2,290-293] In many jurisdictions, psychiatrists are empowered to restrict liberty and enforce psychiatric treatment in institutions and in the community. Many therapeutic relationships in psychiatry exist under a profound power asymmetry brought about by coercive treatments and many people living with severe and persistent mental illness experience little or no sense of agency or autonomy in their healthcare.

The asserted right of the state to enforce psychiatric treatment emerge from the rubric of *parens patriae* literally translated as "parent of the nation". This construct appeared in the 16th Century within the "King's Bench" (the predecessor of modern day Supreme or High courts) and defined the power of the sovereign to intervene against an abusive or negligent parent, legal guardian or informal caretaker. The original intention of *parens patriae* was for the sovereign to act as the parent of any child or individual in need of protection. The *parens patriae* doctrine should be distinguished from the *in loco parentis* doctrine, in that the latter involves care that is "temporary in character and not to be likened to [the permanent situation of] adoption".[294]

The emergence of political liberalism in the Eighteenth Century and the establishment of societies based upon the assumption of liberal autonomy and liberty, rendered the prospect of the encroachment of the state on a citizen's liberty anathema, although psychiatric coercion persisted without challenge. Psychiatric asylums, restriction of liberty and coercive treatment only became the foci of protest by advocates of civil liberties during the wave of social change that emerged from the 1960's.

In the modern liberal democratic state, the two broad moral justifications for enforcing psychiatric treatment – against the assumption that the patient is not competent to refuse such treatment – are the "risk" argument" and the "capacity argument". Both justifications feature to varying degrees in mental health laws across the Commonwealth – Tasmanian mental health laws rest more on questions of incapacity and substituted decision making, whereas the *NSW Mental Health Act* is almost exclusively focused on the issue of risk.

The "risk argument" for involuntary psychiatric treatment

The "risk" justification for coercion in psychiatric care arises from the "harm principle" of Mill. Mill's *On Liberty*[17] argued:

> ***"That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others."***

This is otherwise known as the "harm principle". The state is justified in its intervention in the lives of its citizens if their actions, whatever their origin, are likely to be harmful to others. This would justify incarceration in the prison system, quarantine in the case of contagion or involuntary psychiatric or medical treatment of an "incompetent" adult.

The assumptions underlying the harm principle applied to coercion in psychiatric treatment[295] are:

I. That the individual in question is not responsible for their actions;

II. The individual's incompetence is about to cause harm;

III. The treatment will ultimately enhance the individual's competence, and/or prevent further deterioration and;

IV. The treatment takes place in the least restrictive manner.

Mental health legislation usually defines the "harm principle" in terms of the construct of "risk". "Risk" is a term that has multiple meanings in different disciplinary contexts, although all approaches to "risk" attempt to apply knowledge to an area of uncertainty.[296] The act of "risk assessment" is an evaluative process that estimates the probability of a negative event in clinical settings – it is the process of attempting an estimate the likelihood of dangerousness, such as completed suicide or harm to others. In risk based mental health laws, risk is usually defined in terms of "risk of harm" to self or others. This is an extremely limited view of risk in this context, as much of the disadvantage arising from persisting and untreated mental illness exists in the realm of interpersonal, social, educational and occupational disadvantage.[297] In the insurance industry, actuarial assessment is a mathematical discipline aimed at computing a probability of adversity, based upon a broad consideration of variables. Applying actuarial approaches to risk in mental health is a process of passively predicting the likelihood of harmful or dangerous behaviour,[298] which is a profoundly inaccurate process, with only a quarter of all dangerous acts being predictable by psychiatrists.[299] Psychiatrists are frequently inaccurate in overestimating the risk posed by mental illness.[300]

The problem of prediction of risk and the tendency to overestimate risk leads both to overuse of coercive psychiatric treatment and, paradoxically, delays in treatment until the patient's illness is so severe that risk of harm meets the legal test.[301] Risk then becomes the focus of clinical attention[302] rather than recovery or engagement in collaborative treatment. In addition to the consequences of self-neglect, damage to reputation, finances, career and relationships, delays in treatment lead to poorer prognosis after treatment. Mental health laws based on the risk of dangerousness also tend to promote stigma[303] – the reality is that people living with severe mental illness are far more likely to be victims of violence than perpetrators.[304] In truth, of the less than 5% of the population who commit any offence, the vast majority of these are non-violent acquisitive crime,[305] arguably arising from the social inequality faced by people with severe and persisting mental illness.

Risk based mental health legislation promotes unrealistic expectations within the community about a psychiatrist's capacity to mitigate risk. In cases of severe mental illness such as schizophrenia, dangerousness posed by the illness can be mitigated by treatment in almost 70% of cases.[299] In circumstances of violent or dangerous behaviour occurring in the setting of personality disorders or drug abuse, the ability of psychiatric treatment to mitigate dangerousness is much lower.[306]

The Capacity argument

The "capacity argument" for involuntary psychiatric treatment is based upon the notion that mental illness impairs the sufferer from seeking treatment through the effects of the disorder. Impairment of reason, insight or judgement are the presumed impairments to be compensated for by such legislation. This is a form of "substituted decision making".

The assumption underlying this argument is accepting the premise that the fundamental impairment of mental illness is the impairment of autonomy. Accepting that the definition of autonomy is the capacity for rational self-governance, this presupposes the capacity to understand and decide on questions affecting the person's "best interests".

Radden defined the impairment in autonomy of mental illness in terms of "dispositional autonomy" i.e. the long-term approach taken by a person to life choices.[74] Radden has argued that mental illness disrupts the synchronic (or cross sectional) component of dispositional autonomy. This presents the basis of a complex argument about the moral justification of involuntary treatment, residing in the notion of identity or self-hood. Put simply, the assumption in this situation is that the acute psychiatric disturbance imparts a "temporary" disruption to a consistent pattern of life choices that may adversely affect the patient. Mental health laws based on incapacity or incompetence take the position of either "substituted" or "assisted" decision making. The use of such mental health laws intervenes on behalf of the patient considering their established pattern of life choices. The process of substituted or assisted decision making remains in place for the duration of the disturbance with the aim of returning autonomous choice to the patient.

If one abides the "capacity" justification for coercion in psychiatric treatment, the question is begged as to the need for specific mental health laws, as against other legislative constructs of substituted or assisted decision making such as guardianship or enduring power of attorney.

NOTES

SELECTED THEMES IN PSYCHIATRIC ETHICS

4

4. SELECTED THEMES IN PSYCHIATRIC ETHICS

INTRODUCTION TO SECTION 4

In this section, I will discuss the specific challenges psychiatrists face in working with different clinical populations or settings. This is not a comprehensive survey of applied psychiatric ethics. The elderly, women, people living with intellectual disabilities, LGBTI people, children and adolescents and mentally disordered offenders all have complex needs that present specific challenges for psychiatrists, many of which fall under the rubric of human rights. Recall that "human rights" refers to the possession of naturalistic entitlements that ultimately pertain to equality. It is also arguable that these groups of people present specific types of "otherness". Writing specifically about gender, *The Lancet* noted "Mental health is above all about how a person thinks and feels. That reflects their biological health but also their sense of self, how they think that others perceive and treat them, and how they see their role in society".[307] These comments readily apply to all forms of the "other" in culture.

Given the significant influence of media (both mainstream media and Web 2.0) in the culture, this has implications for psychiatric practice and in particular advocacy. I have included a substantive discussion of this area for completeness.

While I have suggested key contextual influences for the reader to reflect upon as they engage with the material, I have not framed the discussion in specific "shoulds" and "oughts". Rather I have sought to pose more questions than answers.

FORENSIC PATIENTS

Key contextual factors: Dual Role dilemma; Biopolitics

Forensic psychiatry has been the most fertile areas of ethical discourse. This is hardly surprising, given the distinct status of forensic psychiatry, situated between medicine and the law. A significant dilemma faced by forensic psychiatrists is the manner in which it appears to move away from the Hippocratic principle of *primum non nocere*.[308] This concept, defined as the "dual role"[309-313] posits that there is a *prima facie* conflict between the role of "treater" and the role of "evaluator". This is most vexed in the issue of the role of psychiatrists in the administration of the death penalty. On the one hand, it has been argued that psychiatrists, simply, should not participate in assessments which may lead to execution.[314] On the other hand, some do not distinguish between the morality of psychiatric examinations made of prisoners on death row, as against those made at any other point of the criminal justice process.[315]

Robertson and Walter have reconceptualised the dual role dilemma as a means of framing ethical quandaries in psychiatry.[316] Many ethical dilemmas in psychiatry pose a challenge a psychiatrist faces in conflicting expectations or responsibilities between the therapeutic relationship on the one hand and the interests of third parties, such as government or private institutions on the other.

Stone argues that the role of "evaluator" moves the forensic psychiatrist away from the role of physician

and the fundamental notion of non-maleficence.[317] Taking a contrary view, Appelbaum argues in his "parable of the forensic psychiatrist"[318] that beneficence and non-maleficence are not central in forensic psychiatry, which therefore has a distinct set of ethics. Appelbaum sought to distinguish forensic psychiatry, arguing for the concept of "forensicist"[319] whose responsibility was to justice or the courts, and not the patient.[320]

In the UK, the issues are arguably quite different. Gunn does not see the dual-role dilemma as relevant in British forensic psychiatry.[321] For Gunn, the ethical dilemmas faced by UK psychiatrists emerge from their role in the clinical care of mentally disordered offenders.[322] British forensic psychiatrists appear to be more troubled by political pressures impacting upon the welfare of their patients.[52] An additional dilemma in the UK, is the prospect of pre-emptive detention facilitated by "Dangerous Severe Personality Disorder legislation".[51,52,323] Similar dilemmas emerged in the context of the participation of mental health professionals in interrogations of "unlawful combatants" in Guantanamo Bay and Afghanistan,[324] highlighting disparities between civilian and military codes of ethics for medical practitioners.[325]

Ethical quandaries in Australian forensic psychiatry

The NSW M*ental Health Act* (2007) *(Act)* includes provision for the detention in mental health facilities of patients who are "mentally disordered" rather than "mentally ill". The justification for coercive psychiatric treatment in this subgroup of patients is the presence of impaired reason. Per the wording of the legislation, temporary coercive treatment may be utilised *"if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary: for the person's own protection from serious physical harm, or for the protection of others from serious physical harm".*

This empowers psychiatrists to both deprive a patient of liberty and administer, under duress, psychotropic treatment to a person who may not be mentally ill. Patfield has argued persuasively that under the NSW law psychiatrists might be acting in violation of the Declarations of Hawaii and Madrid.[61]

The perception of the "dangerousness" of psychiatric patients is a canard born of stigmatic portrayal of people living with mental illness.[326] As noted previously, while one in twenty people with a mental illness may criminally offend in their lifetime the vast majority of such offences are non-violent or minor[305] and the fact remains that a person suffering from mental illness is 14 times more likely to be the victim of crime than the perpetrator.[304] In the circumstance of a person living with a mental illness perpetrating a serious or violent offence (0.5% percent of males and 0.05 percent of females)[327] there are specific ethical quandaries that arise when these patients deal with the criminal justice system in NSW.

The status of the so-called "insanity plea", particularly in the case of homicide, has been fertile ground for debate in psychiatric ethics. One position in the debate is that a more compassionate approach to mentally disordered offenders through a specific legal pathway is integral to the moral basis of a society.[328] The alternate view sees diminished responsibility for criminal offending in the context of mental illness as an unworkable and arbitrary distinction made in the already muddied waters of the philosophy of personal responsibility.[329]

The commission of a criminal offence requires both the *mens rea* ("guilty mind") and *actus rea* ("guilty act"). The attribution of criminal responsibility requires the person to be aware that their actions are unlawful at or around the time of the actual criminal act. In jurisdictions in the United States, this is usually defined as a "not guilty by reason of insanity" (NGRI) plea. Australian criminal law in this regard resides the tradition of the so-called

"M'Naghten rules". Daniel M'Naghten was a Scottish wood turner, who possessed a highly systematized delusional system involving persecutory ideas relating to the English government and the Catholic Pope. M'Naghten shot and killed Edward Drummond, parliamentary secretary to Prime Minister Peel, presumably amidst a psychotic episode. At this criminal trial, M'Naghten was found by the jury to be not responsible for his crimes. M'Naghten was then detained for the rest of his life "at Her Majesty's pleasure" at Broadmoor Hospital. The English House of Lords later determined the so-called "M'Naghten rules" holding that prisoners suffering "defective reasoning" could not be held criminally responsible for their actions.

In NSW, if a person argues successfully to a magistrate that at the time of an offence they were suffering from a mental illness the charges may be dismissed under s.32 of the *Act* and the person required to "observe" a mental health treatment plan. In cases of more serious or violent offending, the matter proceeds to the District or Supreme Court and if the person is determined unfit to plead or found "not guilty by reason of mental illness" (NGMI) they are referred under s.33 to the Mental Health Review Tribunal. They may become a "forensic patient" in the community, referred to a prison hospital or a secure declared mental health facility. People within the correctional system who are found to be mentally ill and in need of treatment become "correctional patients".

Provisions under s.32 raise obvious ethical quandaries for the psychiatrist, such as what to do in the case of a patient defaulting or refusing to comply with a treatment plan – particularly if this may necessitate a breach of confidence. Section 32 defines a "breach" as *"a failure of the defendant to comply with mental health or disability service support conditions".* Unless under a mandatory reporting scheme, such breaches of the *Commonwealth Privacy Act* 1988, may lead to heavy financial penalties and sanction. To date, there is no clear precedent of a "public interest" justification of a privacy breach. If a psychiatrist is concerned about the risk posed by a patient, regardless of a s.32 treatment plan, they can only do so by "good faith" use of the *Act*.

There has been debate about whether there exists a breach of duty of care in circumstances where a psychiatrist fails to use the Act to detain a person who later commits a serious criminal offence. This was brought into sharp focus in the case of Kevin Presland, who in July 1995 killed his brother's fiancée after he was discharged after a brief voluntary admission from James Fletcher Hospital in Newcastle NSW. At the time of his initial presentation, Presland was drug affected and had acted in an aggressive manner – factors later considered by the courts to be predictive of his potential future dangerousness. Presland was later found not guilty by reason of mental illness and became a forensic patient in a prison hospital until his release into the community in 1999. In 2003, Presland brought a civil claim in the NSW Supreme Court against Hunter Area Health Service. Justice Adams found in Presland's favour and awarded him $370,000 damages to compensate for pain and suffering and the loss of earnings while he was incarcerated as a forensic patient. The matter was appealed in 2005 (*Hunter Area Health Service & v Presland* [2005] NSWCA 33 (21 April 2005).[330] Of relevance here is that the three judges in the NSW Court of Appeal agreed unanimously that the Area Health Service and the clinicians involved had breached their duty of care at common law and the *Act* in failing to assess adequately Presland's mental state and their failure to use the *Act* appropriately. Justice Sheller noted that the Area Health Service and the clinicians involved owed Presland a duty of care that should have extended to foreseeing the risk of Presland's mental state disturbance and his being detained under the *Act* for the protection of others against serious harm. On the question of

damages, citing the legal maxim *"ex turpi causa-non-actio* ('...from a base cause, an action does not arise'), the three NSWCA judges ruled that Presland's criminal offending and subsequent lawful detention as a forensic disentitled him to compensation.

An area of increasing focus in the ethics of forensic psychiatry are ethical questions arising in civil matters, such as assessments of psychological injury in the case of worker's compensation or motor accident claims. In these circumstances, jurisdictions have codes of conduct for expert witnesses mandating, inter alia, impartiality. The issues of the psychiatrist facing a dual role dilemma arise here, particularly in situations where information uncovered in a psychiatric assessment of injury may be prejudicial for the claimant (particularly when the author of the report is a treating clinician).

LGBTIQ PEOPLE

Key contextual factors: Heteronormativity; Alienism; Advocacy

Psychiatry and the LGBTIQ community have a troubled history. Despite recent progress on marriage equality in Australia and other countries, the human rights of LGBTIQ people are still under threat globally. "Homosexuality" remains a criminal offence in many countries punishable by execution in Iran and Saudi Arabia. LGBTIQ people face persecution, exclusion and imprisonment in many other countries. Tasmania was the last Australian state to decriminalise "homosexuality" in 1997.

The first medicalised accounts of "sexual deviance" are found in the work of English physician Havelock Ellis.[331] In the Nineteenth Century, psychiatrists sought to understand "homosexual deviance" in terms of developmental anomalies, genetics and neurohumoral models. All of these approaches sought to define LGBTI people as deviant "other", either in terms of "moral degeneracy", biological inferiority or abnormal development of character.[332] In 1973, the American Psychiatric Association voted by a narrow margin to remove "homosexuality" from psychiatric nosology. Numerous attempts to disabuse homosexual patients of their "orientation" culminated in the development of an applied form of aversive therapy termed "Sexual Orientation Change Efforts" (SOCE). Men seeking SOCE often did so because of the distress their sexuality caused in relation to others' expectations of them.[333] As Neil McConaghy (a previous SOCE advocate) noted it was *society* that needed treatment.[334]

Despite ongoing efforts at SOCE in socially conservative jurisdictions in the United States, in 2015 the RANZCP formally repudiated "Sexual Orientation Change Efforts" and asserted its position on the equality of rights of LGBTI community members.[335] The RANZCP has, on occasion, also distanced itself from organisations with an arguably homophobic agenda, such as "Doctors for the Family", despite some RANZCP Fellows being members.[336] Despite these efforts on the part of the RANZCP, it is evident that both homophobic and transphobic attitudes persist in contemporary mental health professions[337,338] and excess psychiatric morbidity within the LGBTI community remains a major concern.[339]

The situation facing transgender (trans) people is more alarming. According to the "The First Australian National Trans Mental Health Study",[340] the health of trans people in Australia "is in a state of crisis". Trans people experience very high levels of mental health problems, particularly depression and anxiety syndromes. Trans people are four-times more likely to have been diagnosed with depression than the general population, and approximately 1.5 times more likely to have been diagnosed with an anxiety disorder. Trans people commonly experience discrimination and harassment, ranging from social exclusion to violence and assault. Trans people experience discrimination when accessing

health care, and the health care system generally fails to meet their needs. Some people report good relationships with medical practitioners, but this was often a matter of luck in finding a supportive doctor and knowing where to go for help.

PEOPLE LIVING WITH INTELLECTUAL DISABILITIES

Key contextual factors: Ableism; Biopolitics; Neoliberalism; Advocacy

"Intelligence" is as much a social construct as a medical one. Intellectual functioning assumes, inter alia, a person's capacity to process information, apply learned or remembered information to new environmental or cognitive challenges and adapt to new circumstances. Intellectual "ability" utilises many cognitive capacities in different ways and presupposes their normative functioning.

The standardized measurement of intelligence is the intelligence quotient (IQ) developed in 1905 by French psychologists Binet, Henri and Simon. They had sought to develop a means of quantifying intelligence by focusing on verbal abilities based on chronological age. The original intention of Binet and colleagues was to identify children with learning disabilities in French schools and then refine teaching methods to assist them. Binet was critical of attempts to quantify intelligence, believing it to be a much broader construct than his assessments implied.[341] Despite Binet's misgivings about the validity of his assessments in measuring "intelligence" the American eugenicist, Henry Goddard, appropriated Binet's work in 1908, later publishing his own version of the psychometric instrument measuring "Intelligence Quotient" (IQ), which was introduced into American public schools in 1911. Goddard proposed an IQ-based taxonomy of intellectual disability – "morons" (IQ of 51-70), "imbeciles" (26-50), and "idiots" (0-25). Goddard considered "morons" or those of lesser intellectual capability socially unfit necessitating either their exclusion from society, their compulsory sterilisation or both. Goddard also championed the use of IQ testing as part of a racist immigration policy to the US.[342]

Despite the disturbing history of the mean-spiritedness of IQ testing, it remains the medical standard in defining "intellectual disability". Beyond its origins in racism and eugenics, the caveat in defining "intellectual disability" are the flaws in the construct of "intelligence". Many people who do poorly on IQ testing are capable of normative psychosocial function and exhibit resilience and adaptability in other domains of their lives. The "medical model" of intellectual disability defines these people in terms of their sup-par performance on IQ testing, which would seem to miss the point of the challenges they face in life, particularly in the education system and in various work settings that do not cater to their needs.

Over a lifetime this translates to significant unmet need among people living with disabilities. People living with disabilities are the largest disadvantaged group in the world.[343] Only a third of people with intellectual disabilities access the mental health care they need.[344] In addition, people with intellectual and psychiatric disability are among the most vulnerable to physical and sexual abuse in the community.[345] Children living with intellectual disabilities are almost four times more likely to experience physical violence or bullying than non-disabled children – the risk faced by these children of sexual abuse is also much higher than their peers.[346] A 2015 Australian Senate inquiry found that violence, abuse and neglect of people with psychiatric disability "is both widespread and takes many forms", reporting that a root cause begins with the de-valuing of people with disability.[347] This devaluing, it was argued, "permeates the attitudes of individual disability workers, service delivery organisations and, most disturbingly, government systems designed to protect the rights

of individuals" (page xxvi).[347] Due to physical illness co-occurring with mental illness or intellectual disability, the life expectancy of people with mental illness and disability is considerably shorter than the general population.[284]

Like any group of people with complex needs, the ethical dilemmas posed to psychiatrists providing care for people living with intellectual disabilities vary throughout different stages in life and often present the same quandaries as seen in other clinical settings. Children and adolescents living with intellectual disabilities often require advocacy for educational support, respite and social support for families. Adults living with intellectual disabilities face additional challenges navigating complex social and public institutions (including the bureaucracy that accompanied the introduction of the National Disability Insurance Scheme – NDIS) and face problems with exclusion in employment and accommodation.

The World Health Organization (WHO) considers reproductive rights to rest on the recognition of the basic entitlement of all couples and individuals to "decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health".[348] They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence. Despite UN demands for legislative protection of the reproductive rights of people living with intellectual disability, legally sanctioned forced sterilisation of women living with intellectual disabilities continues to occur in Australia. These procedures are often based upon paternalistic "best interests" arguments including "eugenic" justifications; the best interests of the community; menstrual management; incapacity for parenthood and "prevention of sexual abuse".[349]

CHILDREN AND ADOLESCENTS

Key contextual factors: Medicalisation; Neoliberalism; Biopolitics; Pluralism

Childhood is argued as being a "social construction" with a "brief history".[350] As such, the conceptualisation of childhood within the context of psychiatric ethics appears to relate to the differentiation between children as beings and autonomous, self-legislating adults. Given the rubric that "children are not small adults", the evolving or future autonomy of the child[351] and its significance in clinical decision making have been a focus for discussion in the psychiatric ethics literature.[352] The complexity of the construct of "informed consent" in childhood and how this should reflect the wishes of the child often challenges the psychiatrist working with children and adolescents.[353,354] Psychiatrists often have to juggle a complex mix of concerns about a child's confidentiality, their capacity to consent or refuse treatment and advocating for the child's interests.[355] This is often most problematic caring for children in institutional settings. As the Royal Commission into child sexual abuse (2013-17) recommended, children in institutional care need to be provided with opportunities to participate in important decisions in their care as well as promoting awareness of the scope and effects of sexual abuse and emotional neglect of children. The advocacy component of the therapeutic relationship in child psychiatry frequently castes the therapist in the role of pseudo parent.[356]

Psychopharmacology and children

Psychopharmacological treatment of children is subject to, at times, impassioned debate, yet it has received little substantive consideration in the psychiatric ethics literature. The use of stimulant medication in Attention Deficit Hyperactivity Disorder (ADHD) has received much attention and has been hitherto the main battleground in this area. Many of the ethical arguments against

stimulant use in children with putative ADHD are deeply controversial in nature. Among the most recognised of the polemics are those of Peter Breggin,[357,358] who disputes the validity of the diagnosis of ADHD and the evidence that pharmacotherapy actually helps. Other authors have asserted that commercial pressures brought to bear by pharmaceutical companies have influenced the evidence based supporting the use of psychopharmacology – particularly stimulant medication – in children diagnosed with ADHD.[359,360] This speculation is given oxygen by the controversy in the lay press over increased sales of methylphenidate for use in children in the USA[360] and recent, albeit unsuccessful, class-litigation against the American Psychiatric Association and the pharmaceutical company marketing methylphenidate as "Ritalin", Novartis.[361] A balanced review of the situation concludes that the supposed ethically-based arguments against stimulant use in ADHD rely on the assumption of inevitable iatrogenic harm, an observation disputed by longitudinal follow up studies.[362]

More trenchant ethical critiques of child psychiatric disorders such as ADHD and Oppositional Defiant Disorder (ODD)[363] are based on the theory of "medicalisation".[364,365] ADHD in particular, has been the focus of an argument that neoliberalism and globalisation has seen the "migration" of the diagnosis, mediated by the transnational pharmaceutical industry; the influence of western psychiatry transmitted by the commercial success of the DSM diagnostic criteria; the role of the internet and easily accessible online screening checklists (the "Doctor Google" phenomenon); and the activity of various advocacy groups in promoting the diagnosis.[366]

A similar process has characterised discourses around the use of antidepressants in children. The issue of newer antidepressants and the over-diagnosis of depression has been the subject of critics of the "Antidepressant era" such as that of Healy,[367] who has championed the argument that the serotonin reuptake inhibitor class of antidepressants has led to increased suicidal behaviour in patients.[368] The pooled data indicates an overall trend of newer antidepressants to be of benefit in childhood depression, particularly fluoxetine,[369] despite some legitimate concerns about slight increase in risk of suicidal behaviour in children.[370] Most balanced reviews of this issue indicate that antidepressants should continue, with some caveats in childhood depression.[371] Like the ethical debate around ADHD, the safety of these drugs has been the main focus of discussion.

THE ELDERLY

Key contextual factors: Ageism; Pluralism; Medicalisation; Neoliberalism;Biopolitics

Like childhood, old age is a social construct, subject to similar assumptions about capacity, competence and the relative quality of life. The key themes in the clinical ethics literature in psychiatry of old age have focused on the dilemmas arising from permanent cognitive impairment caused by dementing illness; questions of competence and testamentary capacity, (particularly in regard to financial estates) and; decisions about the health care,[372] including surrogate decision making in the face of cognitive impairment.[373] The increasing popularity of advanced directives or "Ulysses contracts" by older patients has necessitated psychiatrists to develop models of this kind of decision making[374,375] using the construct of "precedent autonomy" – the extrapolation of a life philosophy to a critical personal choice in late life.[376]

Questions of equity in health care for older patients are also important considerations in the ethics of psychiatry of old age. Utilitarian based arguments posit that access to psychiatric services should

be limited on the grounds of age,[377] akin to the views of Daniels about healthcare in the elderly in general.[158] In the US, 30% of the health budget is spent on 5% of patients who die within 12 months,[378] with a third of this spent in the last month of life.[379]

The vexed debate over end of life decision making is often situated in discourses over ethics in the psychiatry of old age. The frequently used and emotive term "euthanasia" is usually defined as the intentional ending of another person's life, directly by intervention of a physician through the lethal administration of drugs, at that person's competent and voluntary request.[380] This is Voluntary Active Euthanasia (VAE) – the patient submits to a process that ends life. Passive forms of euthanasia involve the withholding of life saving or life prolonging intervention. This is either voluntary passive euthanasia (VPE), such as indicated in the consent of a competent patient or through advance directive, or non-voluntary passive euthanasia (non-VPE), where a decision is made without the patient's consent to withhold such treatment.

By contrast, Physician-assisted suicide (PAS) is defined as a physician intentionally assisting a person to end their life by the provision of drugs for self-administration, at that person's competent and voluntary request.

Emanuel[381] has summarized the tenets of the pro- and anti-euthanasia positions. Advocates of euthanasia argue:

i. That competent adults have a right to autonomy or self-determination and should be allowed to choose the manner and timing of their death.

ii. The provision of an option of a better timed or controlled death to a person suffering without apparent alternative options provides better choice than prolonged suffering.

iii. The distinction between PVE (passive voluntary euthanasia), PIE (passive involuntary euthanasia) AVE is not significant.

iv. Permitting euthanasia will not inevitably lead to unacceptable consequences, citing the experience of jurisdictions where AVE has been legislated.

Arguments against legislated euthanasia include:

i. Not all deaths are painful or associated with severe suffering;

ii. Appropriate palliative care can, in many circumstances, effectively relieve suffering at the end of life.

iii. The distinction between AVE and PVE is morally significant in that the former involves a physician intervening to end life, rather than not intervening to prolong life.

iv. Legalising euthanasia will place society on a "slippery slope".

The "slippery slope" argument posits that if we allow position "A" to come about, then it is inevitable that, through some direct or indirect connection, position "Z" will eventually also come about. The "slippery slope" argument assumes an inevitability to the progression to a morally reprehensible outcome through the gradual progression of seemingly innocuous steps. "A to Z" (not "A to B") is a deliberate device to highlight that there are numerous intermediary steps and not an inevitable progression from a well-intentioned act to a situation of calamity or malevolence.

International experience to date with assisted dying laws has been mixed with regard to the "slippery slope" argument correct. In 2002 the Netherlands introduced the *"Termination of Life on Request and Assisted Suicide (Review Procedures) Act".* Under the Dutch law AVE is permissible if the patient is suffering unbearable pain, their illness is incurable, and the request made in "full consciousness" by

the patient. Additionally, the involuntary euthanasia of severely disabled infants is allowed under the "Groningen Protocol" (2004), if the diagnosis and prognosis is certain, "hopeless and unbearable suffering is present" and "both parents give consent".[382] Similar laws have appeared in Belgium, Luxembourg, the United States (Oregon, Vermont, Washington, Montana and California) and in 2017 in Australia (Victoria).

The Dutch euthanasia statistics indicate a steady increase in the number of euthanasia deaths – 1923 in 2006, 3136 in 2010 to 5516 in 2015 (3.9% of all deaths in the Netherlands). Most AVE cases involved cancer, the Netherlands' leading cause of death, other medical conditions as a pretext to AVE is uncommon – cardiac disease was the pretext to AVE in around 8% of cases, neurodegenerative disease around 6% of cases. Multiple serious health problems in old-age underlies around 3-4% of cases. Untreatable mental illness is a rare health factor in Dutch euthanasia cases, with dementia present in 1 in 50 assisted deaths (2%) and other mental illness found in 1 in 100 reported euthanasia deaths. In most cases, assisted dying usually occurred at the patient's own home or hospice and has decreased in hospitals. There is no evidence of any divestment in palliative care in legislatures where assisted dying laws have been introduced.

The Netherlands, Belgium and Luxembourg also allow assisted dying for people who are not terminally ill, such as those suffering from psychiatric illness or early stage dementia and a small percentage of Dutch and of Belgian assisted deaths since 2002 were provided due to "intractable psychiatric disorders". The original intention of this provision of assisted dying laws in Benelux countries considered "intractable suffering" (presumably the result of severe treatment refractory depression) as being reasonable grounds for assisted dying. Yet the available data indicates that depression was the main clinical problem in just over half of those patients who proceeded to AVE. At the time of writing, Dutch law makers were considering a modification of their euthanasia law to allow older people to seek assisted dying on the grounds of "being tired of life". This may, arguably, being vague endorsement for the existence of a "slippery slope" – the World Psychiatric Association and other international groups remain opposed to AVE or PAS in the context of psychiatric disorder.

WOMEN

Key contextual factors: Sexism, Pluralism, Medicalisation

Throughout 2017, a series of high profile scandals involving sexual harassment within the entertainment industry in the US and Australia brought about a cultural "moment" that highlighted many aspects of the female experience. Beyond the sexually predatory behaviour of empowered males in workplaces, structural inequality, manifesting as disparities in wages or career prospects between men and women are one of many defining aspects of the challenges women face in an ostensibly "post-gender equality" society.

The number of women who are homeless or sought housing assistance has doubled in the 3 years from 2012-15, with around half of these women being forced out of home due to domestic violence.[383] In questions of healthcare equity, research and treatment services for debilitating conditions affecting women, such as endometriosis, have been ignored or chronically underfunded.[384] These social disadvantages have significant implications for the mental health of women. The World Health Organisation noted:[385]

> ***"Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks."***

While subject to much debate, the frequent observation that depression is more common in women appears to be a true observation that has multiple explanations beyond simple questions of biology.[386]

As noted earlier, throughout history women have been defined as the quintessential "other". Simone De Beauvoir's *The Second Sex*[140] outlined the "radical alterity" of women, consistently defined as "the Other" in a constructed social role. As part of this otherness, women have until recently had their problems medicalised and psychiatry has been a central influence in this process.

The concept of "hysteria" dates to Plato's dialogue *Timaeus*, where rogue wandering uterine activity was argued to account for much of women's problems. This misogyny remained a dominant paradigm in medicine until the social liberation movements of the 1960's and 70's.[387]

Psychiatry's complicity in medical misogyny was spectacularly evident with the 1964 publication of a controversial paper in *Archives of General Psychiatry* – "The wife beater's wife: a study of family interaction".[388] The authors of this paper, three white males from Framingham Massachusetts, observed that domestic violence perpetrators were "hard-working and outwardly respectable", but were "shy, sexually ineffectual mother's boys". The female victims of their violence were "aggressive, efficient, masculine and sexually frigid". Jarring to the contemporary reader, this kind of misogynistic blaming the victim attitude persists. Judith Hermann, wrote of the piece "while this unabashed, open sexism is rarely found in psychiatric literature today, the same conceptual errors, with their implicit bias and contempt, still predominate" (p.117).[389]

Sexual abuse and sexual violence towards women accumulates by a factor of 10% every year[383] and occurs in the context of male empowerment.

Like the victims of workplace sexual abuse and harassment, the sexual abuse of women in therapeutic relationships occurs in the context of power differentials.[390] While there is ample evidence of serious psychiatric consequences to sexual violence and its associated disadvantage,[391-393] women's mental health is still defined through the prism of predominantly male centred diagnostic constructs[394] and the existential consequences of complex and accumulative trauma[395] being framed as "borderline personality disorder", arguably revisiting the medicalised otherness of the discredited construct of hysteria.

PSYCHIATRISTS AND THE MEDIA

Key contextual factors: Advocacy, Neoliberalism

Media, particularly electronic and print media, have been the main vehicles for advocacy by psychiatrists on behalf of vulnerable groups such as people living with chronic mental illness and asylum seekers. The RANZCP has a regular media presence, seeking to inform public debate and has established its own ethical position on this conduct. Several annotations of the 11th Principle of the RANZCP Code of Ethics comment specifically on the use of media by Fellows.[396] Very occasionally, psychiatrists have used media to advance fringe political views, arguably abusing power by citing their status as psychiatrists rather than identifying their opinions as those of private citizens. On several occasions, an Australian psychiatrist was found to have been a serial plagiarist.[397]

Following the election of Donald Trump as President of the United States, the quandary of psychiatrists participating in the media has re-emerged in another emotive debate.[398]

After losing the 1964 general election to Lyndon Johnson, the Republican Nominee, Senator Barry Goldwater, sued the magazine *Fact*[399] after it had published articles questioning his psychological

suitability for the Presidency, based in part on the responses to a questionnaire sent to over 12,000 American psychiatrists.[400] The case prompted a critical discussion within the American psychiatric profession, prompting the American Psychiatric Association (APA) to modify Rule 7.3 to its *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry:*

> ***"On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement."*** [401]

This restriction is now referred to as the "Goldwater Rule".

The dramatic and highly polarising circumstances of the Trump presidency has both reignited and reframed debate on the Goldwater Rule in the American psychiatric profession. Some American psychiatrists believe that the new circumstances legitimate the right to highlight in the public sphere, concerns about the mental state of holders of high office, rebalancing competing agendas of personal and professional views. Others have argued specifically that psychiatrists developing opinions on such matters based on sources other than direct psychiatric examination is accepted practice in other spheres such as advising third party payers or the court system.[402]

In formulating an approach to how Australians might use the media in line with the RANZCPs Code of Ethics, Robertson et al formulate a series of Socratic questions for psychiatrists in preparing such contributions:[403]

(a) Who does the contribution serve – the psychiatrist who made it, the patient, the psychiatric profession or the community?

(b) Do my actions diminish or enhance the status of the psychiatric profession?

(c) Am I speaking as a member of the psychiatric profession or as a private citizen?

(d) Am I using my status and knowledge as a psychiatrist to good purpose?

Psychiatry and Social Media

The advent of Web 2.0 allowing user-generated content,[404] rather than passive browsing, has changed the nature of social interaction irrevocably. Vehicles such as "Twitter", "Myspace", "Instagram", "Tumblr" "Facebook", "YouTube" and web logs (Blogs) account for a sizeable proportion of online activity[405] and have redrawn interpersonal interactions and interpersonal boundaries. Self-photography ("selfies") have become a dominant means of self-expression, leading to breakdown in interpersonal boundaries. Despite arguments that excessive use of social media correlates with pathological narcissism,[406] the excess use of the internet and social media has led to the proliferation of a variety of putative internet and social media addictive disorders.[407] There is accumulating evidence that excess internet use corresponds with worsening depression,[408] with a specific "Facebook depression" described in circumstances psychological distress correlates with a paucity of "Facebook friends" and the experience of rejection in social media or being subject to online abuse "trolling".[409]

Despite the profound cultural changes brought about by Web 2.0, psychiatrists are proving late-adopters of social media in their professional lives. Some more adventurous psychiatrists or their professional organisations make use of "Facebook", "Twitter" and "LinkedIn" to inform and advocate.

Email or other forms of cyber communication are by no means uniform in clinical practice[410] – this likely arises from concerns about diluting clinical boundaries, confusing the doctor-patient relationship with other forms of online relationship, and creating unrealistic expectations of rapid or out of hours contact.[411]

Some general ethical principles surrounding the interaction between psychiatrists and patients using social media or the internet generally include the principles of confidentiality and consent, addressing problems surrounding professional boundaries and the possibility of a dual relationship in addition to avoiding soliciting favourable testimonials from patients in such a public forum.[412]

EPILOGUE

In this monograph, I have tried to provide a survey of some themes in psychiatric ethics, contextualised to important questions in the discourse of human rights. As psychiatrists are, ultimately, empowered social actors in a complex post-industrial and cyber-intense setting in a time of geopolitical chaos, economic uncertainty and the manifestations of environmental degradations, these issues become more influential in practice.

Goethe's character Faust denounced intellectual traditions that are merely inherited and not recreated anew by each new generation – in this spirit this monograph has not sought to hand you answers but rather I have sought to stimulate and inspire your capacity to ask questions of your profession and its complex relationships.

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APPENDICES

APPENDIX 1 – THE UNITED NATIONS PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS AND FOR THE IMPROVEMENT OF MENTAL HEALTH CARE

Principle 1 – Fundamental freedoms and basic rights

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.

3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.

4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.

5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.

Principle 2 – Protection of minors

Special care should be given within the purposes of the Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

Principle 3 – Life in the community

Every person with a mental illness shall have the right to live and work, to the extent possible, in the community.

Principle 4 – Determination of mental illness

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.

2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status.

3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in the diagnosis of mental illness.

4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.

5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

Principle 5 – Medical examination

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

Principle 6 – Confidentiality

The right of confidentiality of information concerning all persons to whom the present Principles apply shall be respected.

Principle 7 – Role of community and culture

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.

2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.

3. Every patient shall have the right to treatment suited to his or her cultural background.

Principle 8 – Standards of care

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.

2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

Principle 9 – Treatment

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection

of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Principle 10 – Medication

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of principle 11 below, mental health practitioners shall only administer medication of known or demonstrated efficacy.

2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

Principle 11 – Consent to treatment

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.

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

(a) The diagnostic assessment;

(b) The purpose, method, likely duration and expected benefit of the proposed treatment;

(c) Alternative modes of treatment, including those less intrusive;

(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

(a) The patient is, at the relevant time, held as an involuntary patient;

(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent;

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 of the present principle, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 of the present principle, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

Principle 12 – Notice of rights

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the present Principles and under domestic law, and the information shall include an explanation of those rights and how to exercise them.

2. If and for so long as a patient is unable to understand such information, the rights of the

patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

Principle 13 – Rights and conditions in mental health facilities

1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:

(a) Recognition everywhere as a person before the law;

(b) Privacy;

(c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;

(d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

(a) Facilities for recreational and leisure activities;

(b) Facilities for education;

(c) Facilities to purchase or receive items for daily living, recreation and communication;

(d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.

4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

Principle 14 – Resources for mental health facilities

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:

(a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;

(b) Diagnostic and therapeutic equipment for the patient;

(c) Appropriate professional care;

(d) Adequate, regular and comprehensive treatment, including supplies of medication.

2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of

patients comply with the present Principles.

Principle 15 – Admission principles

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.

3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in principle 16 below, apply, and he or she shall be informed of that right.

Principle 16 – Involuntary admission

1. A person may be admitted involuntarily to a mental health facility as a patient or,) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 above, that that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

Principle 17 – Review body

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.

2. The initial review of the review body, as required by paragraph 2 of principle 16 above, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.

4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable

intervals as specified by domestic law.

5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of principle 16 above are stillsatisfied, and, if not, the patient shall be discharged as an involuntary patient.

6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.

7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

Principle 18 – Procedural safeguards

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.

4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.

6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.

7. Any decision on whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

Principle 19 – Access to information

1. A patient (which term in the present Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

Principle 20 – Criminal offenders

1. The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

2. All such persons should receive the best available mental health care as provided in principle 1 above. The present Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of principle 1 above.

3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.

4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with principle 11 above.

Principle 21 - Complaints

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

Principle 22 - Monitoring and remedies

States shall ensure that appropriate mechanisms are in force to promote compliance with the present Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

Principle 23 - Implementation

1. States should implement the present Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.

2. States shall make the present Principles widely known by appropriate and active means.

Principle 24 - Scope of principles relating to mental health facilities

The present Principles apply to all persons who are admitted to a mental health facility.

Principle 25 - Saving of existing rights

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that the present Principles do not recognize such rights or that they recognize them to a lesser extent.

NOTES

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