

Informed Consent for Schizophrenic Patients

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BJS Hons

A thesis submitted for the degree

Master of Arts

Department of Philosophy

School of Humanities

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Flinders University of South Australia

October 2011

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Summary

In Western society, it is generally considered that those capable of enacting an autonomous choice should have that right respected. In relation to this, this thesis discusses the problems involved with obtaining a valid informed consent to medical treatment from schizophrenic patients. Schizophrenia often impacts on the individual's ability to consent or participate in their treatment, and can affect their ability to deliberate and make decisions which are not self-defeating. When this occurs, coercive treatment methods are generally applied.

In this thesis I assume that the patient's personal autonomy is the primary issue regarding paternalistic medical interference, and any other coercive intervention. A *tension* exists between liberal values, emphasising the individual's right to freedom, and the general justifications used to justify coercive intervention. The argument in this thesis poses the following question: What criteria correctly determine when a schizophrenic's autonomy is reduced sufficiently to justify the instigation of coercive treatments?

Why is the patient's participation in their treatment so important? Obtaining consent to medical treatment, even whilst treatments involve some restriction of liberty, results in decisions which are conducive to a schizophrenic's own particular values, desires and motivations. This holds especial importance because of the specific nature of the illness. Schizophrenia can significantly affect an individual's personal identity. This happens because the individual changes and adapts to accommodate the illness. This then impacts upon their ability to make decisions which are representative of their true self. Although this occurs, it is still important that when treatment decisions are made they take into account the patient's values and specific goals.

Society's conception of mental illness, and the mentally ill, greatly influences the success of the treatments provided to them - particularly those provided within the community. Mental health services need to be constructed in a manner which recognises the influence of society on consumer recovery and their sustained mental stability. This, at times, proves difficult due to the problems of marrying a clinical approach to treatment, with the social aspects and nature of schizophrenia. Schizophrenics are not individual units, but exist within a complex social structure, requiring that they function adequately in this environment. Acknowledging this and putting appropriate measures in place, thereby protects them against undue discrimination and social oppression.

The provision of an adequate level of mental health care is dependant upon the government constructing legislation which involves treatments that are fair to all.

Currently, the legislation in South Australia lacks the ability to sufficiently address values in treatment, as well as provide an array of treatments which are flexible and diverse. A lack of sufficient funding constrains and limits the provision of treatments. Including schizophrenics in their treatment and providing them with more options would enable their care to be personalised and could greatly improve treatment outcomes. These issues form the basis of my argument within this thesis.

Declaration

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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October 2011

Acknowledgements

Firstly, I express my sincere thanks to my supervisors Dr. Craig Taylor and Ms. Cheryl Simpson. They have encouraged and challenged me. I am indebted to them for their advice and guidance. They have provided me with the confidence and motivation to complete this thesis.

Secondly, I would like to thank my family, friends and colleagues for their encouragement, advice and continued support.

Finally, I would like to give especial thanks to Dr. Paul Gresham for his patience, support, and invaluable and unstinting practical and technical assistance throughout the duration of this undertaking. Of especial importance, and most deserved of recognition, has been his rigorous proof reading.

Introduction

Treatment for mental illness that is undertaken without the consent of the patient is known as involuntary treatment. There are many reasons for, at times, not respecting a schizophrenic's autonomous informed choice concerning their treatment. This may occur due to the nature of their symptoms, or because particular legal procedures have been put in place, and is justified as being the best way in which to provide appropriate care and treatment to the individual.¹ This thesis is concerned with the importance and relevance of the reasons most commonly used to justify coercive mental health treatment, together with the possible effects, which may occur, due to the use of coercion.

When involuntary hospitalisation occurs, respect for the individual's civil liberties conflict with concern for their welfare.² Currently society, mental health professionals and the government agree with the use of involuntary treatment for schizophrenia in certain situations. This is because it is believed that schizophrenics, and others deemed seriously mentally ill, should be involuntarily hospitalised when, due to their illness, they may pose a *serious* threat to their own welfare or to others.³ Importantly, for the topic of this thesis, their confinement often occurs in conjunction with their not being considered mentally competent to make a rational decision regarding their own medical treatment.

The principle of personal autonomy will play a major role in this thesis. It will be argued that personal autonomy is considered valuable, not only for its own sake, but for the benefits it makes possible. However, there are, for all of us, occasions where autonomous choice may be properly restricted to prevent us from suffering harm. Thus, respecting an individual's right to autonomous choice when it may pose a *serious* risk of ill effect is questionable. Instead it may be better to restrict their autonomy. This occurs quite commonly within the treatment of schizophrenic patients and there are many ethical and legal problems which can ensue because of this.

In the past, in health care, patients were often passive recipients of both care and treatment.⁴ This was because it was believed that doctors knew best. The move away from paternalistic treatment and towards patient autonomy occurred due to judicial and legislative activism - which embedded the rights of patients in their treatment.⁵ Of significance, one of the rights which evolved was the giving of informed consent to medical treatment, which is the focus of this thesis.

This thesis will show that a variety of key aspects play a role in the procurement of an appropriate informed consent from schizophrenic patients. Certain key elements will be analysed - such as rationality, competency, personal identity and personal autonomy. It will be argued that the experience of schizophrenia can have profound implications on an individual's person. This makes their participation in their

medical treatment of vital importance and shows how important informed consent is in psychiatry.

The treatments provided for schizophrenia are critical. If the illness is left untreated it can result in suicide, or even homicide. Its symptoms can impair an individual's thoughts and actions, resulting in the necessity for coercive treatment. Therefore, coercive treatments, over-riding a patient's right to informed consent, are given because of the serious nature of the illness, and to protect the welfare of the patient and others. This highlights the need for a viable legal framework to be erected for those who require coercive mental health care. When coercive treatment occurs, mental health legislation needs to protect the rights of the small minority of individuals who are unwilling to accept treatment.

This thesis is written out of concern for the vulnerability that is a part of every schizophrenic's life. Their condition means that sometimes their ability to defend themselves against exploitation is undermined, necessitating special constraints to be imposed on those who treat them.⁶ Ethical and human rights principles need to be applied to the protocols and methods utilised in treating schizophrenics. They play a more critical role in psychiatry than in other forms of health care.

It must be acknowledged that respecting patient's right to give informed consent has significant advantages both during their treatments and in their future lives. A treatment will be more effective if the patient supports it. Therefore, the patient needs to be involved in the treatment process. Both in life and in the treatment of schizophrenia it must be recognised that a "goal is only a goal if it is set by those who want to adhere to it"⁷ Therefore, if successful treatment is the desired goal then it is only appropriate that consumers play a role in achieving that goal.

The importance of individuals, and their rights, is one of Western society's most common ideals, and we place a high value on the securing of consent. This is because of the significance we give to respecting one's personal autonomy and to the right of individuals to their own personal sovereignty.⁸ Arguments in favour of informed consent by schizophrenics are based upon this individualistic argument.

The basic moral principle underlying informed consent is the principle of personal autonomy (self-determination). Questions regarding a schizophrenic's autonomy are raised because it can be subverted by the illness.⁹ In this thesis I am assuming that the primary issue with regard to paternalistic interference, and other forms of coercive intervention in the treatment of the mentally ill, is the patient's personal autonomy. Precise criteria, defined in mental health legislation, need to determine when a schizophrenic's autonomy is sufficiently diminished to justify coercive action. In respecting the autonomous choice of a schizophrenic there is a requirement to assess the capacity of the individual's ability to decide in an autonomous fashion. Therefore, much of this thesis will revolve around the competence required for schizophrenics to make autonomous decisions.

However, respect for informed consent is not solely dependant on patient autonomy. Within the procedure of informed consent there are other principles involved. Of especial significance, is the principle of beneficence (health or well-being).

The presence of other values in the informed consent process can cause problems, and informed consent often involves the balancing of different values. As this thesis will demonstrate, this can be complicated and may, at times, be difficult to achieve.

Western society provides a framework not only for the understandings we hold about schizophrenia, but also for the rationales behind social, clinical and legal aspects of its treatment.¹⁰ Unfortunately, the issue of stigma still affects our current conception of mental illness, making psychiatry different from other fields of medicine. An added concern is that schizophrenics are often believed to be more dangerous than the rest of society. This conception is destructive in relation to schizophrenic individuals finding a place within society; which is vitally important because of the impact it has on the treatments currently provided and on the autonomous existence of schizophrenics residing within the community.

This reveals that there is risk involved in treating schizophrenics outside mental health institutions. They face special challenges in life, which have to be considered when placing and treating them in the community. In utilising community care, we are attempting to treat schizophrenics in the same manner as the rest of society. However, being treated in this manner will not result in equality being achieved for them. Without recognition of this, individuals suffering schizophrenia lack the ability to behave autonomously within society, and their existence is seriously compromised.

Chapter 1 will be an introductory chapter and present the mental illness, schizophrenia, and some of the issues affecting the illnesses sufferers. The social factors influencing schizophrenics are recognised. More attention, and consideration, is required in mental health treatment, to an individual's values, social situation, and individual difference – all of which need to be considered prior to instigating treatment and throughout treatment. The role that psychiatrists, the government and society play in the existence of schizophrenics will be discussed, and the importance of respecting an individual's human rights in their medical treatment will be highlighted.

In Chapter 2 the concept of personal autonomy is defined. To be considered suitably autonomous, and to be making authentic and autonomous choices, the individual concerned needs to identify with themselves. The illness schizophrenia can prevent this.

Chapter 3 reveals that coercive treatment can rightfully be applied when an individual's decision-making is deemed irrational or self-defeating. However, in

deciding for the individual, respect must always be given to the patient's own particular set of values even if they are deemed incompetent to decide at that specific time.

Chapter 4 introduces 'informed consent' and the many different elements that must combine to achieve an adequate informed consent from schizophrenic patients.

In Chapter 5 the specific problems which are caused by the illness schizophrenia and which impact on the individual's ability to make competent decisions will be discussed. This chapter includes responses to the specific problems identified.

Lastly, Chapter 6 discusses the intricacies involved with mental health law. The implications of the manner in which mental health law is constructed upon the types of schizophrenic treatments made available and the care provided to those with schizophrenia will be analysed. Problems which can occur in mental health legislation will be discussed. The role of legislation (in particular the new South Australian *Mental Health Act 2009*) in upholding and controlling treatment for schizophrenics will be analysed.

Chapter 1: Schizophrenia – How does it affect the sufferer?

1.1 Schizophrenia and informed consent

The term 'mental illness' covers a spectrum of different conditions, ranging from psychosis to addiction and less severe conditions such as neurosis. Although all conditions are important, this thesis concentrates on schizophrenia. The effects of schizophrenia often affect the autonomy of its sufferers, but an important factor in respecting an individual's autonomy involves the right to make informed choices about one's own medical treatment.

Consent to medical treatment is important in law because every person has a right to determine what is done to their own person. Therefore, for a doctor to treat a patient without appropriate consent is a trespass;¹ so obtaining consent is a legal requirement prior to medical interventions. However, there are some limited exceptions to this – for example, in emergencies, and under mental health legislation.

Much of the discussion in this thesis revolves around coercive treatments. To implement coercive treatment involves a balancing act. This is because while it is undesirable for practitioners to treat an individual without their consent because this infringes the right to bodily integrity, neither is it acceptable if necessary and appropriate treatment does not occur because an individual is not able to provide consent.² It is this specific aspect of medical treatment upon which the argument in this thesis is based. At what point is it permissible to enforce treatment on a patient, without consent, due to considerations that it is necessary to do so?

In South Australia, a patient's consent must be both effective and informed. Legally, for consent to be considered informed, patients must be given all the information relevant to the procedure and their situation.³ Legally, this means that schizophrenics who can capably understand the nature of their illness and the effects of the proposed treatment can give consent to their treatment. Consent can be obtained either verbally or in writing.

For consent to be considered effective, individuals should be able to demonstrate in their own words their understanding of the proposed treatment.⁴ Merely responding with a 'yes' or 'no' is insufficient.

Individuals suffering from schizophrenia often have their right to select the medical treatment that they would prefer refused, instead being compelled to follow a treatment plan against their will. When this occurs it means that certain restrictive measures are forced upon the individual - this will have effects, some of which may be of serious concern. Thus discussion related to informed consent is of great importance.

1.2 Schizophrenia is a 'mental' illness

When looking at the concept of mental illness, one finds various arguments about whether illnesses classed as mental are in fact physical illnesses. How we can distinguish between a physical illness and a mental illness is a matter of some debate. However, the fact that individuals lose their ability to form intentions and utilise their judgment shows that schizophrenia, as an illness, definitely has a strong 'mental' component.⁵

Sadler identifies an important contrast between psychiatrists and those who practice other forms of medicine. A psychiatrist will usually consider "the self, the psyche, or the 'whole person' in their ministrations."⁶ In contrast, although also accommodating the self to a degree in treatment, the other medical fields will most often focus more upon something physical - such as an organ or a specific disease. Thus a distinct difference is that in psychiatry one's sense of self plays an important role in both diagnosis and treatment.

The treatments provided for mental illness have features distinguishing them from other fields of medicine. A major difference relates to addressing a patient's personal identity in treatment. This may be complex, for just as all people evolve and adapt throughout their lives, so do schizophrenics throughout their experiences. Throughout their illness schizophrenics are subject to constant reflexivity and self-modification. This makes diagnosis difficult because the psychiatrist must treat a patient who is engaged in a kind of continual modification and reinvention.⁷

An important part of behaving autonomously centres upon the ability to make decisions from the true perspective of oneself. If schizophrenia forces patients to continually adapt and change their values and ideals, it must have a vast influence on their ability to make decisions which truly reflect their beliefs. This is of concern not only in the short-term, such as when giving informed consent to medical treatment, but also in long term planning and life direction. The affects of schizophrenia, as well as its treatments, on the individual will feature heavily throughout the discussion in this thesis.

A significant difference between psychiatric treatment and other fields of medicine is that diagnosis in psychiatry often involves subjective thinking; a psychiatrist's values and life experience come into play. Although subjective thinking does play a role in other fields of medicine, they clearly differ from psychiatric treatment in this area.

There is much debate regarding the importance of values in psychiatric care. Arguments supporting the role that values play claim that the diagnostic judgment by a psychiatrist of a schizophrenic is based on evaluations; it involves values and not just a simple description of facts.⁸ Therefore, diagnosis in mental illness cannot

be separated from one's personal perspective and values. This reveals, as Fulford claims, that the "values involved in diagnosis come close to being fully visible in psychiatry".⁹

As will be revealed in this thesis, the key problem with the role that values play, is that their inclusion is often at odds with the current medical approach taken to treating and dealing with the illness schizophrenia. A medical approach means that psychiatrists must behave like other scientists and rely on fact, which tends to divorce them from considerations regarding values. However, nobody can be completely value-neutral.

Additionally, even if psychiatrists could logically eliminate all the ethical and value considerations involved in their decisions and practice, this would be considered 'morally outrageous'.¹⁰ A specific example is when a psychiatrist must consider the importance of respecting an individual's right to liberty when selecting treatment. To ignore such an important value in treatment decisions would indeed be morally outrageous, emphasising the importance of respecting values within psychiatric treatment.

The role of values often leads to an assumption that psychiatry is a primitive science, whereas it is actually a sign that its evaluative (and scientific) procedures are more complex in nature.¹¹ This is because psychiatry involves the behaviour and experience of human beings, in which values play an integral, inseparable part. It is consequently important to recognise the wide and legitimate variations that can occur in human values.

The acknowledgement that psychiatry is different means that our current conceptions of schizophrenia have to be considered. For instance: Can schizophrenia be reduced to scientific terms, or does it require a different kind of intelligibility?¹² This chapter will consider this question and some inadequacies that occur in psychiatric treatment due to our current medical conceptions. However, *many* aspects of the current approach are extremely beneficial for schizophrenic patients, this is important and must be remembered throughout this discussion.

1.3 The power of psychiatry

As our society has developed, the sphere of influence held by the field of psychiatry has also developed. According to Foucault, this has occurred since the seventeenth century. As the power of the state increased it became necessary to develop techniques to control society and regulate citizens.¹³ As a consequence, psychiatry began to be seen as a medical speciality which dictated "the socially operative concepts of normality and abnormality".¹⁴ One result of this was the exclusion of the abnormal or insane from the rest of society.

In Western society today, psychiatry is shaped by both political and economic forces.¹⁵ Economic forces, for example, impose limitations on the time that

psychiatrists spend with their patients, while political pressures limit and dictate the treatments available.

Australian mental health law has traditionally followed the path of English law.¹⁶ In the past, both here and in England, mental health law revolved around the prevention of harm. Much regulation focused on the public's safety, and the public's concerns and ideals relating to the management and control of schizophrenics. Currently, here in Australia, in the enforced hospitalisation of a schizophrenic, concerns revolve around both protection of the patient's rights to their individual autonomy *and* respect for the public's right to their own safety.

We are in an era where community care is being upheld as the most humane way of dealing with the mentally ill in our society. This has involved legislative reform, which has been specifically designed to protect the rights of those deemed seriously mentally unwell. Encompassed within these legal reforms is respect for both the dignity and liberty of, schizophrenic individuals. However, in the protection of these rights, it may be necessary to utilise coercive measures.

Basically, what this reveals is that the changes which have occurred in mental health policy over time have been caused by a combination of societal, political, legal and economic demands. Throughout history there has been a continual requirement for mental health policy to deliver those outcomes considered to be appropriate within the dominant social climate.¹⁷

Any discussion of psychiatry, and its place in society, needs to address the consideration that it involves social control. In Western society, psychiatrists have emerged in a unique place; they not only provide therapeutic benefits but also wield an immense amount of interpersonal and social power. They are acceded to in advice regarding raising children, marriage and divorce, employment, which person is right or wrong, and what kind of person one should be.¹⁸

In the area of mental health, psychiatrists can legally detain their patients for an indefinite amount of time. Community treatment orders (CTOs) are utilised, under which an individual must comply with certain conditions whereby they are allowed to reside in the community. In addition, anti-psychotic medication can be forcibly administered to an individual. Such restrictive measures raise important ethical questions about the treatment of schizophrenics, a vulnerable group of people, and the role that psychiatrists play in that treatment.

The most restrictive measure to be applied is involuntary hospitalisation. Although stringent relevant procedures are applied,¹⁹ there are valid grounds for considering the issue of justice for this particular group of individuals. Schizophrenia makes one extremely vulnerable - more so than others within society. The psychiatric patient has far fewer safeguards against unjust treatment than other groups within society.²⁰ Therefore, it is essential to focus on the current social policies which have

been adopted to accommodate schizophrenics whose autonomy is diminished due to internal factors, since these policies determine the role played by the psychiatrist. Chapter 6 will analyse mental health law and will address these issues further.

1.4 Anti-psychiatry and social constructivism

Social constructivism is a theory which claims that

*knowledge is not something we acquire but something we produce; that the objects in an area of inquiry are not there to be discovered, but are invented or constructed.*²¹

Therefore social constructivists may claim that there is nothing wrong with the mentally ill, and “that madness is nothing more (and nothing less) than what we make of it.”²² This section will consider the social constructivist argument, as well as the implications it has towards the condition schizophrenia.

To begin, although the social constructivist position certainly has relevance for the less-serious mental impairments such as forms of neurosis, the reality of conditions such as schizophrenia cannot be ignored and so society must have mechanisms in place to deal adequately with this illness and those suffering from it. In the labelling of individuals as schizophrenic, we are describing their condition and their particular forms of behaviour.

Currently, some groups within society consider the manner in which we view mental illness to be flawed. The Church of Scientology is one such influential group, basing its beliefs on the teachings of Thomas Szasz (1961).

Szasz is considered to be an anti-psychiatric writer, although, he rejected the term. The anti-psychiatry movement emerged in the 1960s, and its focus was to question the fundamental assumptions and practices of psychiatry.²³ Thomas Szasz wrote ‘the myth of mental illness’ in which he argued that mental illness was merely a deviance from societal norms, or moral conduct, instead of a medical condition.²⁴

Although the argument presented in this thesis does not concur with Szasz’s position, the anti-psychiatric arguments have certain elements that are important in discussions related to the current position held by schizophrenics in Western society. A particular strength of the anti-psychiatric argument is that it questions the concept of what mental illness is. The concept of *what mental illness is* lies at the core of psychiatry. Questioning it permits us to view critically the place of mental illness in society, the role that psychiatrist’s play and the validity of the current treatments utilised. It also permits us to query the current procedures in place to deal with the issue of informed consent.

As mentioned in Section 1.2 there is often disputation about what mental illness actually is; with some theorists claiming that psychiatric disorders are, to a degree,

body disorders.²⁵ Alternatively, Szasz argues that mental illness is *not* analogous with physical disease, and by disputing the scientific basis of psychiatry claims that the current medical approach taken towards mental illness is incorrect.²⁶

In response to Szasz, Michael Moore presents valid arguments about the importance of accepting and recognising the reality of conditions such as schizophrenia. He disputes the anti-psychiatric movement's claim that schizophrenia is merely a socially constructed concept, arguing that schizophrenia is not a "palpable falsehood propagated amongst the populace by power-mad psychiatrists, but a cruel and bitter reality."²⁷

The diagnosis of individuals as schizophrenic often occurs because it is considered that they are failing to act rationally. Therefore, anti-psychiatrists need to prove that schizophrenics are genuinely capable of being as rational as everyone else, if they are to dispute the current mechanisms in place to treat such individuals.²⁸ In response to this, Szasz claims that the behaviour of schizophrenics, if assessed, can be described as rational.

Moore's objects to Szasz's claim, because he sees it as 'notoriously easy' to ascribe a consequence to *any* action, desire, belief or form of behaviour which can then explain it to be rational. Moore uses the example of the shedding of leaves by a tree. A tree in shedding its leaves can be considered

*rational if we suppose that it desires to survive the coming winter, and believes that the only way to do this is to lower its sap level thereby killing of its leaves.*²⁹

This example is meant to highlight the problem with Szasz's argument; which is that anything can easily be described as rational if we have that intention.

Consequently, for a schizophrenic to be considered as rational as the rest of society, they must be promoting desires we can relate to, and holding beliefs we consider rational. In utilising Moore's argument, it can be argued that there is insufficient proof that the illness schizophrenia does not cause irrational behaviour, which provides support for the utilisation of coercive measures when individual's rationality has been affected by their illness. This includes the processes involved with obtaining a valid informed consent from those with schizophrenia.

1.5 The Current Conception of mental illness

Jennifer Radden (1995) relates her perspective of madness, being that of 'unreason', to Foucault's work (1961, 1963). Foucault claims that between the Renaissance and the Age of Reason (in the late sixteenth and early seventeenth centuries) there was a shift in public perception of insanity, involving a shift from considering insanity as unreason (*deraison*) to madness (*folie*).³⁰

When mental illness was viewed as a failure to reason, it was contrasted with the

everyday imperfect rational thought of others. During The Age of Reason, this perspective dominated and shaped the manner in which society understood mental illness. The change to viewing mental illness as ‘madness’ meant that it began to be seen as a medical condition, making it seem more remote or removed.³¹ This greatly affected the manner in which schizophrenia was treated.

With the advent of the medical model, and the resultant management of those considered mentally unwell, there has been an increase in the view that the insane and the sane are dissimilar.³² This is one of the key reasons for Radden to argue that the ‘unreason’ perspective of insanity should be resurrected – albeit in a slightly different form, by rejoining the links connecting an individuals’ ‘saner’ weaknesses with the unreason exhibited by the insane.³³ This would emphasise the ordinariness that is a part of mental illness, which the current medical model fails to do.

Society’s members would relate to schizophrenics more easily if they were viewed as being more connected to normal life and its experiences. Many benefits could be gained by changing society’s outlook on mental illness, both socially and professionally. Reducing the stigma and prejudice, together with increased acceptance, would promote and enhance the autonomy of schizophrenics within the community. The mentally ill’s existence in the community would be vastly improved, if society’s members were more accepting.

The value of Radden’s argument, for this thesis, is that it highlights some aspects of ordinariness and familiarity in mental illness that the medical model, due to its clinical nature, has problems in accommodating.

If we understand that there can be different ways of viewing schizophrenia, as well as its symptoms and treatments, we then enable ourselves to assess the social factors involved with this condition and the alternatives which arise from this analysis. For instance, although anti-psychotic drugs are a valid part of treatment, other important viable alternatives can be utilised. If a patient’s condition does not improve, then alternatives to anti-psychotic medications should be considered. Such analysis renders us *less passive* as a society in our dealings with disorders like schizophrenia.

One result could be that we become less likely to rely *solely* on psychiatrists, and more likely to consider and apply other viable alternatives in treatment. The great variations between patients means that the use of more diverse treatments may enable patient heterogeneity to be handled better, which may provide more success in treatments. The value of this will be discussed further in Chapter 6.10.

Nevertheless, changes in the conception of, and treatment of, schizophrenics may not always be positive. For example, change may cause significant disagreements which could cause patients to suffer, and, alterations in coercive treatment methods may result in negative repercussions for an already vulnerable group of

individuals. Therefore, it could be vastly counter-productive to completely abandon the current medical approach taken towards mental illness.

Therefore, although part of the focus in this chapter is on the inadequacies of the medical model in psychiatry, the traditional categorical model has benefited both research and clinical diagnosis, so complete abandonment of this system of psychiatric diagnosis and treatment would not be beneficial. However, the influence of the current medical system utilised to diagnose mental illness must be assessed.

1.6 The Diagnostic and Statistical Manual of Mental Disorders (DSM).

An important manual which lists and categorises mental illnesses is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM has impacted heavily upon the area of psychiatric analysis since its first publication in 1952. The DSM is currently in its fifth edition, which is due to be published in May 2013. Its purpose historically has been to enhance communication between psychiatrists and to collect statistics.³⁴ The DSM plays a significant role in the current day diagnosis of the mentally ill.

The American Psychiatry Association controls the construction of the DSM. To qualify for inclusion in the DSM, a condition needs to be voted in by the Association. Significantly, the DSM is often utilised in court and in mental health tribunals to corroborate psychiatric diagnosis. Obviously at times this may present problems, so this warrants further discussion.

In the past, the categorisation of various conditions included in the DSM has featured what would now be considered to be abuse towards certain groups of people. One example was the categorisation of homosexuality as a mental illness, which was finally removed from the list of mental illnesses by the American Psychiatry Association in 1986.³⁵ This highlights the flaws which can occur in psychiatric diagnosis, revealing that the categorisation of mental illnesses can be subjective, being heavily influenced by cultural and historical ideals. Therefore, the symptoms of 'schizophrenia' as described in the DSM are fluid and may alter over time, as society changes and scientific knowledge grows, causing its categorisation to be altered.

The history of diagnosis reveals much about the evolution of psychiatry. Before World War II, in the era when asylums were prevalent, there were far fewer categories of mental disorders. Since the DSM was published in 1952, when it contained 112 entries, it has tripled in size to a (still growing) 374 in 1994.³⁶ This has occurred within 50 years. Currently, many of the categories include outpatients who are less impaired, which raises the question of where psychiatry actually begins and ends.³⁷

Questions can be raised about the over-inclusion of particular character states, which are milder and less destructive in nature than conditions such as

schizophrenia, but are now being diagnosed as mental illness. This has fuelled the anti-psychiatric claims of social constructivism, which asserts that ethically any deviation from the norm in society should not be used as a justification to diagnose mental illness.

Although schizophrenia is a reality, it is heavily impacted by the categorisation process used to construct the DSM. With the diagnosis of mental illness, there is reliance upon behaviour which is considered to be abnormal. This means that any diagnosis is perceptually-based,³⁸ and enhances the validity of the argument that mental illnesses are in many ways socially constructed.

Such issues reveal that although the DSM does have important scientific credentials, psychiatry presents difficult problems for scientific classification. Scientific investigation is important. However, this commitment to science means that only certain questions and evidence are considered,³⁹ resulting in a restriction in the areas of inquiry and only certain fields of research (deemed important) being included in the manual. It can, therefore, be argued that a more focused rational discussion and debate about the value commitments implicit in the manual, and those which apply to psychiatry in general, could greatly advance the construction of the DSM.

The discussion in this thesis concerns the importance of values in psychiatric care and the necessity to recognise the social stressors which can heavily impact upon the success of the treatments provided to the mentally ill. The DSM has a valid scientific base but more effort needs to be made to meld scientific classification and psychiatric diagnosis with the realities of treatment and care of the mentally ill.

The important point (with regard to the topic of this thesis) is that the requirements of scientific classification often conflict with the practical demands of psychiatric classification;⁴⁰ this means that the human element of conditions such as schizophrenia may not be properly addressed, due to the DSM's commitment to scientific credibility. Less scientific approaches could greatly benefit schizophrenics. Adherence to a clinically-based approach detracts from the many benefits which could accrue in the fields of both diagnosis and treatment by heeding the impact of society and its related constraints on those individual's labelled 'mentally ill' or 'schizophrenic'. More will be said on this issue later in this chapter.

1.7 The history of schizophrenic treatment

The last two sections have revealed that throughout history, various conceptions of schizophrenia have come and gone. These conceptions have influenced the provision of mental health treatments. During the age of 'unreason', as discussed in Section 1.5, and before the middle of the 18th Century, the services provided for the mentally ill reflected the dominant perception of sufferers held at the time.⁴¹ The development of modern day approaches began after this time.

Before antipsychotic medications became available, the treatments available were both limited and generally ineffective.⁴² However, there was a significant change in the 1950's, when a range of drugs became available which could enable the schizophrenic's condition to improve, thereby allowing them and the psychiatrist more options for treatment.

Deinstitutionalisation came to the fore in the 1960s. The public no longer supported the idea of permanent confinement in asylums for those suffering schizophrenia. With the advent of community care came the age of treatment mostly through anti-psychotic medication and often (when deemed necessary) combined with involuntary hospitalisation. Consequently, informed consent became a serious issue in psychiatric treatment.

With the advent of community care, the significant role that families and others play in the care of schizophrenics has also become increasingly apparent, and psychiatrists may request assistance from this group to ensure adequate treatment. Families and friends may also be required to give consent to treatment, when it is deemed that the schizophrenic cannot do so adequately. Although this is most commonly a role assumed by the psychiatrist in charge of treating the patient, at times, friends and family will be relied upon to make decisions regarding care.

Problems with deinstitutionalisation have arisen due to the conception that *all* schizophrenic patients benefit from being treated in the community, which means that *where* schizophrenics are being treated is now considered to be of more importance than *how* they are treated.⁴³ In reality, care in both the community and in hospitals can be lacking.

Within the community, a comprehensive system to cater for the large number of schizophrenics now living in its midst has been developed. Importantly, as Lamb argues, for this to be effective the services provided must involve recognition of the heterogeneity of patients.⁴⁴ This means that the mental health system must accommodate personal difference amongst schizophrenic patients and meet their individual needs.

Studies have revealed a great variation between individuals,⁴⁵ so what works for one may not work for another. For some patients, gaining employment and living independently are attainable goals. For others the maintenance of a certain level of functioning, such as the ability to live in the community when under a suitable level of supervision, is the highest attainable goal. Thus, it is important to cater for the needs of each schizophrenic, and to acknowledge that each have their own particular strengths, weaknesses, and requirements.

One of the reasons that people with mental illness are often ostracised (in contrast with patients in other fields of medicine) is because it is viewed by the public as being vastly different from physical illness. Further, because the majority of

schizophrenics now reside within the community, the public's perception impinges heavily upon the capacity of mentally ill people to be autonomous within society. When I refer to the capacity of schizophrenics to be autonomous in everyday life, I am referring to certain key aspects of their existence such as their level of self-esteem, their confidence, or their ability to fit in and associate with other people. These are important factors in life, and are significant for the autonomous life of schizophrenics and will be further discussed in Chapter 5.

These issues highlight the importance of patient autonomy in schizophrenic treatment. In this thesis, personal autonomy is considered to relate to one's *capacity* for utilising self-determination. Differences between individual patients will form a major part of the argument, because an individual's values, principles and ideals matter when we refer to respect for the principle of autonomy. This thesis argues that in the treatment of schizophrenia, the psychiatrist must accommodate each person's individuality, which means recognising their specific social situation, as well as their beliefs and values.

Mental health policy must recognise the need for both hospitalisation *and* community care. Funding must also be provided to accomplish this. A failure to recognise this has resulted in disillusionment of all concerned in the treatment of schizophrenics. Chapter 6 will analyse this in more depth.

The provision of appropriate therapeutic care can provide opportunities for a better quality of life. This quality of life can at times be outside a schizophrenic's control, highlighting the importance of treating them appropriately and with respect.

1.8 Involuntary treatment

In our society we have certain rights as individuals with which the government or its representatives have no right to interfere. There is, therefore, an onus on the government or psychiatrist to ascertain whether an individual's rights are legitimately being restricted. This must occur when an adequate informed consent is not obtained from patients in the area of schizophrenic treatment.

Thomas Szasz in his book *Ideology and Insanity*, disputes the current justifications used to confine individuals. He argues against involuntary hospitalisation and claims it to be a crime against humanity which should be abolished.⁴⁶ He asserts that one's liberty should be more highly valued than one's mental health, and that "no individual should be deprived of their freedom for the sake of [their] mental health".⁴⁷

The anti-psychiatric movement does not oppose treatment agreed to by the patient. However, they do not agree with utilising coercive force where informed consent is not given, believing that social, legal, or community sanctions should be left to deal with the situation.⁴⁸ In contrast, some writers claim that involuntary hospitalisation is justifiable in certain circumstances, such as when required to

avoid harm – especially in relevance to harm to others. Chapter 3 will discuss the significance of ‘harm’ in mental health policy, within which it plays a major role.

Although there are alternative views about the suitability of current treatments related to schizophrenia, at times such purely theoretical arguments need to be put to one side. For example, it is imperative that at certain times involuntary hospitalisation be made available for those suffering from a serious episode of schizophrenia. This is because of the specific effects of this mental illness - there are times when schizophrenics do require special attention and care. This may occur when a schizophrenic’s rational capacities have been affected by their illness and they are making choices which are self-defeating. The relevance and applicability of coercive treatment for schizophrenics will also be discussed in Chapter 3.

1.9 Community care

Across the western world there have been debates about community care and its effectiveness. Reports from the U.S.A claim that sufferers in the community face poverty and hostility from their neighbours, one result of this being that a large number of mentally ill people are homeless.⁴⁹

Reports from the U.K. reinforce these points, with the additional concern that adequate community services are not being provided. A large percentage of consumers do not receive the services required for their needs, or have lost contact with service providers altogether,⁵⁰ just disappearing within society.

Here in South Australia, community confidence in government-run services provided to the mentally ill residing in the community is low.⁵¹ This suggests that there are current inadequacies in our present day mental health system. These will be further discussed in the final chapter of this thesis where South Australian mental health law and its significance is analysed.

With the provision of psychiatric treatment, there has been the basic concern of attempting to “balance social control with care and treatment under conditions of expenditure restraint”.⁵² The expenditure required to treat schizophrenic patients adequately seems unreachable, as mental illness grows within society and the costs of the various treatments available increase. Further problems within community care have occurred because a large number of the mentally ill return periodically to hospitalisation. This has resulted in the number of beds required being grossly underestimated. These issues need to be fully addressed; extra funding is required for the entire mental health system.

In response to these and other problems associated with deinstitutionalisation, the U.K. government introduced more restrictive measures for those with a mental illness that reside in the community under the Mental Health (Patients in the Community) Act 1995. That Act required patients released into the community to abide by the terms of a specified care plan - in other words to be under a form of

supervised discharge, under which an individual must adhere to a number of restrictions. Any non-compliance with the directives means that the schizophrenic may be re-admitted and formally detained in a mental health institution against their will.

Although they legally have this power, U.K. health care workers are reluctant to utilise the powers of the Act as it may threaten both their relationship with the patient and any therapeutic gains.⁵³ Application of the restrictive powers of the Act could alienate patients from their treatment team, resulting in them no longer wishing to participate in their mental health care. Yet, that participation is vitally important to their recovery. Therefore, any responses that may threaten therapeutic benefits must be seriously re-considered. The implications of non-participation in treatment will be further analysed in Chapter 6.

In South Australia, restrictive measures such as CTOs have been put in place to attempt to stop the 'revolving door' of admission to hospital followed by release which often results in the individual falling unwell again and being readmitted to hospital. CTOs are intended to provide treatment which is effective and prompt, in response to patients refraining from taking their medication or if their condition begins to deteriorate whilst residing in the community. They assist in keeping individuals in the community and out of hospital, and are a valuable tool for psychiatrists. The elements of CTO's are similar to the powers discussed in the above U.K. Act. CTOs will be discussed in more depth in the final chapter of this thesis.

These changes are intended to balance the schizophrenics' freedom with elements of control for the sake of both patient and public. The most important question is: How much control should occur? Whereas the old asylums had humanitarian shortcomings they had a large amount of control over the patients, and were often of benefit.⁵⁴ Community treatment must find the necessary balance to obtain the correct amount of control.

Coombes states that the underlying philosophy behind community care may differ depending on whether it is care *in* the community which is envisaged or care *by* the community.⁵⁵ This is because if an individual cannot exist autonomously in the community without support, there *must* be the interrelated provision of support services in place to provide assistance. Although residing in the community may permit patients to be more involved in their own care, and to have more freedom and liberty, they may still be heavily reliant on others. These could include family, friends, support groups, charity organisations, hostels, drop-in clinics and many other necessary services.

Therefore, providing care in the community for a schizophrenic patient, involves many more individuals than just a psychiatrist and patient. Communitarian ethics embrace this fact, because they focus upon the patient being situated in a network

of different relationships.⁵⁶ The Communitarian approach to mental health accommodates the necessity to consider others in treatment, not just the patient. Since the development of community care the participation of 'others' in mental health treatment has been recognised in policy. Their role has been acknowledged as well as appreciated.

1.10 The 'disabled'

It is important to distinguish between impairment and disability. People are impaired if they differ from the population in some way that confers a disadvantage on them. Their resultant disability depends on the interaction between the impaired person and the society in which they live. In practice therefore, disability represents the amount by which society and an impaired person fail (knowingly or unknowingly, willingly or unwillingly) to interact in such a way that the impaired person can lead an autonomous life. The extent to which impairment becomes a disability is greatly affected by prejudice, ignorance and discrimination. This is particularly true for schizophrenics because they are often ostracised whilst living within the community.

The U.K. civil rights movement for disabled people has learnt that at the core of prejudice is a refusal to acknowledge a common humanity shared between those who are oppressed and the oppressor.⁵⁷ The treatment of schizophrenics may deny them both human and civil rights, because the procedures currently instigated for their care may not provide them with the same type of existence as the rest of society. It needs to be recognised that being treated in the same way as others does not mean they will be able to utilise their full set of rights.⁵⁸ They may have difficulty in finding suitable housing or utilising other government services. Accordingly assistance may be required to deal with a variety of 'normal' situations which can appear insurmountably difficult to a schizophrenic, such as paying a bill or catching a bus.

It can be argued that the common humanity we share should enable us to recognise each other's right to equality. Community care must involve assistance in *more* areas to enable individuals to exercise their right to achieve as much autonomy as can be afforded them within society.

One social factor which constricts schizophrenic's autonomy is poverty. This is because it restricts so many of their opportunities. Mental illness often means that one's hope of staying employed is significantly affected, which means that family members are frequently relied upon to help out when things become difficult.

The forms of care provided by the government and charity organisations to assist schizophrenics need to be examined to determine precisely what their form of 'care' (which could be in cash payments or other services) involves. Currently, much of the assistance provided does not enable one to state one's opinion, make one's

own decisions regarding one's life, or share in the community life that others enjoy.⁵⁹ An adequate ethics of care would recognise the importance of autonomy in individuals' lives and the importance of allowing them to form their own preferences. The care provided needs to fulfil the aims of permitting both individuals' participation in decisions which will affect them, and more involvement in community life.

1.11 Human rights

People's rights are inextricably coupled not only with their responsibilities and constraints, but also with the rights, responsibilities and constraints of others. For example, while psychiatrists have a responsibility to respect a patient's rights, and also a duty of care towards them, they also have to provide care within constraints such as a lack of funding, suitably qualified staff, and time. The patient therefore has a responsibility to recognise both the duties and constraints of psychiatrists. Similarly, society has a responsibility to recognise and respond to the needs of a schizophrenic, who in return has to recognise society's constraints such as lack of funds.

Human rights are often described as those rights held by all humans, which are unconditional and inalienable. Possession of human rights should be for everyone, not only those with certain merit. In attributing human rights to people, we express an attitude of respect towards the humanity of each individual. Importantly, health professionals have learnt that respecting human rights may be an essential part of promoting and protecting an individual's health.⁶⁰

Rights are described as being powerful assertions that demand both status and respect.⁶¹ Mental health care is considered by many to be a human right, not just the privilege of a certain few. Yet a satisfactory level of mental health care for schizophrenics has yet to be reached in our society, even though it is a critical element for the well-being of schizophrenics. If we have this moral claim, because of our humanity, which includes our dignity, freedom and individuality,⁶² then individuals' appeals to their rights must be fairly considered.

This involves the mentally ill being recognised as subjects with rights, as opposed to objects of welfare.⁶³ Thus, society's aim should be to facilitate conditions for the mentally ill which respect their human dignity and enable them greater enjoyment of their human rights.

In life we each have a variety of rights. Recently, it has been recognised that the highest attainable standard of mental health and access to services involves recognition of *all* of the various rights a person holds. The United Nations *Convention on the Rights of Persons with Disabilities* (the CRPD) acknowledges this, by including not only civil and political rights, but economic, social and cultural rights.⁶⁴ This highlights their inter-relatedness and interdependence. The CRPD

claims that the appropriate treatment and care of schizophrenic patients involves the recognition of all of these rights. To accommodate this, the social model of disability, rather than the medical model of disability will need to be adopted.

What is the medical model of disability? The medical model of disability

tends to believe that 'curing' or at least 'managing' illness or disability mostly or completely revolves around identifying the illness or disability from an in-depth clinical perspective [and involves] understanding it, and learning to 'control' and/or alter its course.⁶⁵

Mental illness, today, is generally viewed in a medical sense where mental illness is seen as an inhibitor of an individual's equality. Thus the medical model requires the mentally ill to overcome their condition to participate fully within society.⁶⁶ This model provides a structure for the patient's care and protection, and the provision of rehabilitation services.

Disability, viewed in the social sense, focuses on the physical and social environment as the causes of exclusion. This requires that society should recognise its need to adapt so that the mentally ill can participate and enjoy their full set of rights, which relates directly to the discussion in the previous section. The social model of disability promotes the social inclusion of those who are mentally ill.

Recognising the value of the social model of disability is important, due to community care being considered a valuable mode of treatment. Community care highlights the importance of social inclusion and the need to protect schizophrenics against stigma.⁶⁷ This requires the acknowledgement that there are certain risks involved with treating individuals in the community which must, therefore, be recognised.

In the treatment of schizophrenia, the impact of society should be considered. Society affects schizophrenics in many ways. How schizophrenia is viewed affects schizophrenic's view of themselves, their place within society, and their illness. Therefore, society has a vitally important effect on the life and treatment of schizophrenics.

1.12 Social oppression

The cultural or social oppression faced by schizophrenics is important, and requires recognition, because community care is currently the preferred form of treatment. Oppression can originate in various ways, such as via the prejudice engendered by the media's focus on the violent behaviour of schizophrenics. This means schizophrenics tend to face judgment in their lives in the community, which can affect their recovery and re-initiation into the community after hospitalisation.

The treatment and diagnosis of schizophrenics involves their inner compulsions (self-oppressions) as well as oppressions which originate externally. It is therefore

vital that treatments *empower* individuals to deal with the opinions and constraints they face whilst living in the community. In Chapter 5 the importance of self-esteem and self-respect will be discussed. Protection of self-esteem during treatment is vitally important to empower the patient to succeed at life in the community. This can be accomplished by respecting the values and ideals of the patient, as opposed to ignoring them, which can cause serious inner pain and may ultimately lead to failure.

External constraints which affect one's empowerment are not only physical, but include other constraints faced in society such as economic, social, legal and cultural.⁶⁸ The problems involved in achieving empowerment require the relationship between inner (psychic) and the outer (cultural) oppression to be examined.

Greater recognition of the role played by external forces in the lives of schizophrenics could reduce the number of serious relapses, and even prevent murder or suicide. It is therefore necessary to acknowledge such pressures within the community, since accommodating these pressures will empower them to cope better with life. Such an approach would also reduce the practice of blaming them, thus assisting the mentally ill to resist any oppression and ultimately to change.⁶⁹

As discussed in Section 1.10 the social oppression and prejudice faced by schizophrenics can be described as a type of dehumanisation, which is the "denial of the humanity of a group of persons who are different in ways that are held to be 'inferior' – that is, nonhuman".⁷⁰ This becomes highly apparent when they are treated in the community.

Those who reside in the community are socially dependent upon each other in various ways. For schizophrenics the effects of this dependency can be harsh, and at times crippling. Marginalisation, ostracism, stigma and misunderstanding by society's members all affect how they are treated – both clinically and socially. These problems need recognition, because failure to do so is a denial of the fact that the prejudice and oppression found in society contributes to the effects of schizophrenia on a person.

Much good comes from the medical-models approach to schizophrenia, but one criticism is that it sees mental illness as a disease and does not recognise the relevance of socially-constructed stressors,⁷¹ thereby failing to accommodate the influence of society in the formation of mental illness. The medical approach fails to give sufficient consideration to the individual as a person, with a culture and past history as well as values and desires. This means that cultural and individual differences, together with their effects upon schizophrenic diagnosis and treatment, tend to be discounted.

As will be argued in Chapter 3.8 both psychological and social constraints can impair

a patient's autonomy. This means that psychiatrists must assess these constraints in their treatment, thereby assisting patients to restore control over their lives. The psychiatrist needs to have knowledge of the patient's social situation to help them to become fully autonomous individuals in the community. Schizophrenia in many ways makes individuals different from others in society, and this needs to be acknowledged, instead of just placing them in the community and expecting them to be as functional as the rest of society without the provision of appropriate levels of assistance. Chapter 6 will address this issue further.

1.13 Conclusion

Schizophrenia is a mental illness, with characteristic symptoms, effects and treatments that differentiate it from physical illnesses. It can influence patients' ability to function rationally and reasonably.

Psychiatrists in particular, but also the government and society, have important roles to play related to the treatment and care of schizophrenic patients. A diagnosis of schizophrenia seriously affects one's rights, such as to give informed consent, claims to moral standing and quality of life. Many individuals become isolated socially once diagnosed with schizophrenia and pressures arise from various forms of social oppression - including prejudice, lack of respect, being treated as inferior, and the denial of humanity. These pressures can decrease an individual's self-trust and self-respect, making them more dependent on psychiatric care.

The important point is that treatments must accommodate schizophrenics' current position within society, otherwise the future of those suffering schizophrenia in the community will be unsuccessful in a variety of ways.

The next chapter will focus on personal autonomy, its characteristics and its value, and its central importance in the treatment of those with schizophrenia.

Chapter 2: Personal Autonomy

2.1 What is personal autonomy?

This chapter will identify the concept of personal autonomy which forms the basis of the argument in this thesis. The term 'autonomy' derives from two Greek words: one meaning 'self', the other meaning 'reason' or 'principle' or 'law', thus, the term means 'self-law' or 'self-rule'. The Ancient Greeks used autonomy in the political sense, with autonomous states in mind. However, this thesis focuses on personal autonomy.

Political and personal autonomy have both similarities and differences. An important similarity is that neither the autonomous state nor the autonomous person should be subjected to control or external interference, but instead must be free to govern and direct the course of their own existence.¹ This is an important aspect of autonomy, and provides the reason for respecting autonomy.

In life, it is important that we have beliefs and values that can be identified as integral to ourselves, and from which, by utilising our own capacities, our actions can ensue.² This involves an important concept: that as autonomous individuals we do not just act in a reactive manner, but utilise our basic capabilities for thought and action to plan.³ This means, that as individuals, we should be able to chart our own lives, utilising our own thoughts and actions. It goes beyond liberty, freedom or independence, into something deeper - autonomy. It is more accurate to understand autonomy as self-determination or self-governance rather than merely 'freedom' from the authority of others,⁴ because freedom is only one of the conditions implicit to autonomous decision-making. Aspects of freedom and autonomy will be discussed further in Section 2.7 of this chapter.

Autonomy can be considered as a character ideal. Those who depend overly on the advice of others are often seen as too compliant or gullible. It could therefore be argued that autonomous people do not accept things without a certain amount of reason.⁵ Although this may be true, it is sometimes best to draw upon information provided by others, particularly when they can be considered a reliable source of information. This implies, of course, that one has the ability to recognise when a source of information may be unreliable. This suggests that autonomous individuals should be capable of deciding the best course of action by utilising the evidence and information around them.

Autonomous existence, within the coercive factors of Western society, requires that we maintain a certain amount of power and authority over our social roles and within our general way of life. This requires us to utilise our capacities to be self-determining, rather than being constrained on a different path by forces which feel irresistible.⁶ It is, therefore, important to recognise that schizophrenics may encounter irresistible forces due to the pervasive nature of their illness.

Additionally, as Mele argues, to be considered autonomous an individual needs to be capable of reliable deliberation, and to possess a degree of mental stability and self-control.⁷ It is therefore evident, that the specific effects of their illness may at times cause schizophrenics to be judged to be non-autonomous, and therefore deemed incapable of making informed decisions. This occurs because of the specific effects the illness can have on an individual's deliberation.

It is a fact that the more severe afflictions of mental illness – such as psychosis - can severely undermine an individual's autonomy so that the sufferer is no longer fully autonomous. Schizophrenic patients often suffer from a form of psychosis which is pervasive in the effect it has on one's mind, personality or behaviour.⁸ These particular elements are critical for one's ability to make informed choices. Although my focus is predominately on schizophrenia, there is a relevance to psychosis and the effects of psychosis in all mental illnesses, due to the similarity in the symptoms which often occur.

Both clinical and ethical grounds underlie the treatments for schizophrenia and related symptoms of the disorder. However, some symptoms require a degree of care because of the effects they have upon a patient's autonomy. Where external or internal forces may affect a schizophrenic's autonomy, it is important that there is a practical, ethically-justified framework which can be relied upon when making treatment decisions. It is this particular element of psychiatric care which is the focus of this thesis.

It is extremely important to recognise the distinction between dispositional autonomy and occurrent autonomy. This distinction plays an important role in mental health treatment. Robert Young defines *occurrent* autonomy as: "when we talk of people acting autonomously in *particular* situations".⁹ He distinguishes this from *dispositional* autonomy which refers to one's autonomy over the course of one's life. This difference is important because schizophrenia is often episodic. Consequently there is usually sufficient reason to restrict an individual's occurrent autonomy when they are considered unwell, whilst leaving their dispositional autonomy as unaffected as possible. The worth of respecting our dispositional autonomy should be obvious.

Importantly, the moral protections which apply when one is autonomous may not be granted to an individual who is considered to be non-autonomous.¹⁰ In relation to informed consent, this reveals that disrespecting an individual's informed consent to treatment is not an action to be taken lightly, because autonomous choice gives protection against the intrusion of others, brings moral entitlement and shows respect to the individual.¹¹

In Western society, the personal sovereignty, which each individual possesses, should always be respected. It can only be rightfully over-ridden when there are strong justifications provided. Thus restricting an individual's autonomous choice

must *only* occur in circumstances where there are stringent opposing demands presented by a competing moral principle.¹²

It is important to recognise that when schizophrenics suffer serious psychotic episodes, and are incapable of enacting decisions necessary for their own well-being, then coercion does not ignore the ability to be autonomous - since the conditions implicit in autonomous action are absent.¹³ Therefore, the individual's autonomy has not been limited or infringed by the medical intervention. However, this is always a matter of degree.

A relevant factor in considering the capacity to be autonomous is that individuals who are deemed incapable of making autonomous choices can still manage to do so,¹⁴ even though it may only be in a limited sense. Beauchamp uses the example of mental patients confined permanently in an institution; although deemed incapable of existing autonomously in the community they still make autonomous choices. Examples include: selecting the food they prefer, the people they like, the clothing they wish to wear. They are still acting autonomously even though they fail to meet the critical conditions deemed necessary for autonomy.¹⁵ Having said this, they may still be incapable of making certain serious decisions, such as taking medication which may be vital to their health.

The effects of schizophrenia on an individual's ability to reason and judge are considered one of the predominant reasons for questioning an individual's ability to give autonomous choice. However, means of enhancing autonomy should *always* be considered, since autonomous choice is an extremely important component of *any* individual's life. Taking responsibility for one's treatment has especial significance, because the advantages gained from that participation are significant for the patient involved, as will be discussed later.

Consequently, the principle of autonomy has had a huge impact on medicine over the last few decades. Its relevance to this thesis is significant, because any discussion on 'informed consent' *must* include consideration of personal autonomy and its value. Respecting the autonomous choice of schizophrenic patients involves a requirement to assess the capacity of their ability to decide in an autonomous fashion. Therefore, much of this thesis will revolve around the competence required for a schizophrenic to make an autonomous decision.

2.2 Autonomy and life

As humans we often fall short of complete autonomy, due to the nature of our existence. In addition, we may be autonomous but not always act that way, and there are many factors in life that can influence our ability to be autonomous. A claim could therefore be made that a person acts autonomously if they exercise *a certain degree of control* over the actions and choices they make in their own life.¹⁶

This is illustrated in Aristotle's *Politics*, where he likens citizens of a state to sailors

on a ship guided by a helmsman. In this analogy we are the helmsman. The helmsman is vital for autonomy because he steers the ship amidst many external considerations – such as the desired direction, weather, currents and guidance from his crew. External influences with which the helmsman deals are not a threat to his ability to rule, as long as he continues to make his decisions utilising practical wisdom.¹⁷ The helmsman exhibits his wisdom (and autonomy) by choosing and following what he deems the most appropriate path. This illustrates that “external influences do not *determine* behaviour, but merely affect *how* one rules”.¹⁸ Therefore, external constraints do not necessarily pose any threat to our ability to rule our own lives. Within society, individuals face external influences from rules, laws and social norms, so like the helmsman we steer ourselves towards and away from different issues in life. Therefore, although we may not be totally self-sufficient, we are still the rulers of our own lives.¹⁹

It is sometimes difficult to assess where particular influences begin and end, and how much they influence a person. The influence of society is important to my argument in this thesis, because those involved in the informed consent process are not independent units, but exist amidst a vast structure of interpersonal relationships.²⁰ Because of this, personal autonomy must be comprehended not against, but within, our social existence.

As was outlined by Aristotle’s argument, although societal factors on individuals can be influential, they are not ultimately controlling. We are able to behave autonomously within the various influences of our society. However, it is also unavoidable that some influences will interfere with, or deprive us of, the ability to enact autonomous choice.²¹

For issues of informed consent there is a necessity to distinguish between those influences which are compatible with autonomous action and decision-making, and those which compromise autonomy. In Section 2.9 the coercive factors in society which can influence one’s ability to perform actions autonomously will be assessed.

To summarise the discussion in this chapter thus far, having autonomy within society means that we, as individuals, are not overly affected by other people, by society and its institutions, or by natural circumstances, in such a way that we are not in control of or self-directed in our lives.²²

This shows that two basic conditions are required for autonomy: the first being *liberty* (independence from controlling influences), and the second being *agency* (capacity for intentional action).²³ Autonomy requires one to be free (to a certain degree) from controlling influences, but also to have the ability to act intentionally. This means we understand autonomy in two different ways. Firstly, in relation to an individual being a validly autonomous *person*, and secondly relating to one’s ability *to act* autonomously. Both aspects are important when considering the informed consent of schizophrenics.

2.3 Autonomous actions

The fact that there are numerous constraints which can prevent an individual from acting autonomously suggests that whereas some actions may be clearly autonomous, there will also be those that are *questionably* autonomous. The most important constraint pertinent to this thesis is schizophrenia. Since schizophrenics whilst unwell are often not considered to be fully autonomous, they are often considered to be incapable of performing *any* autonomous action. Consent to medical treatment is consequently not obtained.

In dealing with informed consent, people's acts qualify as autonomous *precisely* because the people are autonomous. In other words, an act is deemed autonomous because the person is deemed autonomous. However, the issue of whether or not a particular individual is sufficiently autonomous to make a specific decision may be debatable.

Historically Kant's view of autonomy was the most prevalent in philosophical discussions of personal autonomy. The Kantian position claims an individual is a model of autonomy if:

*capable of acting on the basis of effective deliberation, guided by reason, and neither driven by emotions or compulsions nor manipulated or coerced by others.*²⁴

However, more recent conceptions of personal autonomy deem persons autonomous when they act according to their own character, or desires, which originate from their own particular set of motivations.²⁵

Consequently, the concept of an *authentic person* is utilised in philosophical discussion when discussing a person's capacity to be autonomous. The *authentic person* refers to an individual behaving autonomously because they are in touch with their true self. On this basis, one's action is considered *authentic* if undertaken on the basis of one's own desires, values, and plans.²⁶ Noggle argues that the key ideal behind such concepts of autonomy is that any psychological element is considered to be authentic if its history is free from any influences which may undermine its authenticity.²⁷

This would mean that to behave autonomously, one must make decisions that relate directly to one's own specific individuality. Such an approach to personal autonomy accommodates both individual difference and an individual's specific desires. This accommodation of the diverse individuality which each of us as humans possess is valuable because it captures a truth - that we are capable of reflecting on our desires and either endorsing or repudiating them,²⁸ thereby reflecting what we as individuals most value. Thus, reflection, utilising our own specific evaluative system, results in decisions which reflect our specific standpoint on different issues.

Using this concept of autonomous behaviour, it does not matter just how as individuals we come to form our desires and values, either through socialisation or other means, but whether we have by reflecting upon them made them our own.²⁹ In other words, actions and attitudes most honestly reflect an individual if they demonstrate not only our desires, but also judgments which reflect what we as individuals deem worthwhile.

In making our choices, decisions are made with reference to the beliefs and desires which reflect our immediate environment, but also include those beliefs and desires which are a longstanding and integral part of each of us as an individual. These long-range goals and values are of vast importance to one's decision-making; they are uniquely personal attributes which are "complicated products of personal history and social environment".³⁰ Our goals, beliefs and values form the core of whom we are. They shape the rest of our psychological elements,³¹ which ultimately determine not only how we decide to live our lives, but what holds the most importance to us.

This raises a question: How may the common symptoms of schizophrenia interfere with an individual's deliberation? In life each individual is altered by the specific life experiences faced. With the condition schizophrenia, a hurdle that arises is that certain facets of a schizophrenic's self or identity begin to feel alien or foreign. Symptoms such as 'command' hallucinations (which will be discussed in Chapter 5.2) pressure individuals to behave in a manner unlike their usual selves. This exposes them to foreign ideals and desires, and to situations in which they would not normally find themselves, which ultimately affects their decision-making. Typical schizophrenic symptoms, therefore, have a severe and detrimental effect, often resulting in decisions that do not adequately reflect that person.

This reveals that a concept of autonomous action which relies on decisions being based on an individual's own particular motivational set may lead to difficulties when considering mental illness. The symptoms of schizophrenia often have serious implications on the giving of informed consent by schizophrenic patients, because of the specific effects the illness has upon a patient's deliberation.

So what happens in a situation where personal autonomy is threatened because an individual has conflicting desires? Harry Frankfurt (1971) and Gary Watson (1975) claim that the autonomy of an action can decrease, or even be nullified, when it springs from an attitude which is in conflict with other parts of the individual's psychology.³² This implies that to be considered autonomous a schizophrenic's decision needs to be founded objectively, and be justified by reasons which have strong foundations, or are coherent with their other principles, values, etc. This is an important element in considering the validity of a schizophrenic's decision-making.

Beauchamp states that one of the key problems involved with the above theories is

the issue of reflective identification. If reflective identification with an individual's desires, values, etc, is deemed necessary for an action to be autonomous, then many of our actions usually considered autonomous would be considered to be *non-autonomous*.³³ For example some of our snap decisions, if they had been reflected upon, may have been decided differently. This would pose a problem in deciding which actions can validly be considered autonomous. A rigorous application of reflective identification to considerations of autonomous decision-making will significantly narrow the number of actions that are protected by the principle of autonomy.³⁴ Such a severe restriction of those actions considered to be autonomous could be detrimental in many situations.

Moral and policy considerations demand that a line must be drawn to distinguish which actions should be considered autonomous and which should not. The accepted line will *heavily* influence the number of individuals considered sufficiently autonomous to give informed consent. For example, to require a high level of mental capacity, combined with a high capacity for in-depth reflective identification with one's values, could result in many patients who would normally be considered autonomous being considered non-autonomous.³⁵ However, the opposite will also apply, allowing a low threshold (in these areas) has the reverse effect, so that many people who are normally classed as non-autonomous would be deemed as being autonomous. One example would be children.

It is a basic fact that decisions about competence sort individuals into two separate groups. Those who fall below the threshold will be treated as incompetent, whilst those above will be treated as competent - this occurs even though a patient's capabilities can vary greatly depending on the circumstances.³⁶ This is one of the failings of rights-based mental health law, and will be further discussed in the final chapter of this thesis.

In summation: one of the most important aspects of being autonomous is to relate in certain ways to some element or other which precedes your actions. This may be your desires, judgments, evaluations, etc, which you act on because they represent your own beliefs and standpoints. In many ways when we as individuals decide to act in a certain way it is because it suits us to do so, for example, by being satisfied with the course of action we are undertaking. This highlights the importance and significance of one's individuality, and of individual analysis in any process involving informed consent from a schizophrenic patient.

2.4 Personal autonomy and informed consent

Why should informed consent and personal autonomy be respected in the treatment of schizophrenics?

Respect for the autonomy of individuals, in the process of obtaining informed consent, means recognition and appreciation of their specific capacities and

perspectives. This means that (in general) individuals should not be interfered with when making medical decisions, thus enabling them to act as they choose. Respect for autonomy involves the acknowledgement of another's right to their own decisions, whereas disrespect for autonomy "involves attitudes and actions that ignore, insult, or demean others".³⁷ This implies, from a moral point of view, that we should respect not only actions we consider to be correct, but also actions with which we may not agree.

In mental health treatment there are actually many other additional benefits to be gained by respecting a patient's autonomy. Firstly, there is a strong connection between the possession of autonomy and the ability to lead a fulfilled life. Secondly, one's self-image fluctuates in accordance with the degree which we believe ourselves to be autonomous.³⁸ The importance of self-esteem will be discussed in Chapter 5.5.

Importantly, the utilisation of our capacity to make autonomous choices means we will develop in a manner aligned with our own interests, values and tastes.³⁹ We are more fulfilled if we are able to nurture and embrace the areas we prefer in life. So the more self-directed we are, the more satisfying our life will be.⁴⁰ However, it must also be acknowledged that respect for a patient's autonomy could result in actions being undertaken that are self-defeating for the individual concerned. Chapter 3 analyses when and where coercive methods can be employed to restrict the actions of an individual, due to the consideration that their actions are self-defeating.

2.5 Personal autonomy and mental health

The boundaries of our social interactions in life are constrained by the fundamental political boundaries of our society.⁴¹ Any discussion of bioethics in regard to the place of psychiatry and mental health within society must take this into account, and encompass not only the ethical rights of individuals, but also their political rights. The current role that personal autonomy has in all areas of health care is based on our respect for a liberal form of government; and this requires a respect for persons that is inseparable from respect for autonomy. It is a fact that some other cultures do not value the principle of autonomy as highly.

Any philosophical discussion which arises from a focus on autonomy also encompasses the pluralism which is inherent in Western society.⁴² The onus on personal autonomy emerged from the recognition that psychiatrists may not have the same value systems as their patients in the area of mental health care. Respect for autonomy is intended to ensure that individuals are able to receive types of medical treatment with which they agree. The right to informed consent allows those patients who are adult and competent to make choices which relate to the values which they hold,⁴³ and thus acknowledges their specific values.

The reason that problems relevant to autonomy are so evident in mental health is due to the schizophrenic's dependent condition and the psychiatrist's authoritative position. Ethical issues arise because conflict occurs. Consequently autonomy plays a prominent role in mental health care, and this has led to frequent conflicting arguments on the subject.

In addressing this situation, arguments challenging the supremacy of personal autonomy in medical care claim that patient welfare would be improved by a return to a more paternalistic approach,⁴⁴ and examples can be found which indicate that in the restriction of an individual's autonomy their happiness can be increased. Consideration of the fact that restricting the autonomy of schizophrenics may actually promote their happiness rather than cause undue unhappiness, leads into discussion regarding coercive mental health treatment and its relevance.

2.6 Coercion and personal autonomy

Coercion is a deliberate, enforced interference in the life of an individual by another person or organisation. Coercion occurs when a patient is forced to do something that they otherwise would not do.⁴⁵ It is often used to prevent bad things from occurring to the relevant person, and is justified on this basis. It occurs in mental health, for example, when individuals are hospitalised under constraint because of their mental condition.

Although coercion can often be well justified, as Feinberg says it *always* carries a price.⁴⁶ Therefore it is essential in mental health to recognise the value of an individual's freedom and liberty. This recognition should apply even if the individual's right to freedom can justifiably be "overridden by more powerful reasons on the other side."⁴⁷ Why is this point so important?

Writers such as Von Humboldt, Mill and Hobhouse agree with the concept that the highest good for man is a dynamic process of growth and self-realisation rather than enjoyment of passive contentment.⁴⁸ Self-realisation involves the utilisation of certain unique human potentialities, which are developed through the involvement of certain specific abilities, so the development of self-realisation requires practice. Such development comes from making choices, especially those that are difficult, and from choosing amongst a variety of alternatives. Having freedom to make one's decisions is actually of great good to the individual, even if the individual sometimes makes decisions which are foolish.

This emphasises the value of allowing individuals to decide for them-selves in life. As choosing for one-self holds great merit, and this is especially relevant for future decision-making; the fact that one has previously made decisions related to medical treatment can be of great value in the future. This is specifically true for schizophrenic patients due to the episodic nature of the illness.

A further consideration is that, in making their own choices, patients promote their

own psychological well-being,⁴⁹ which has great value in mental health treatments and significantly impacts upon an individual's ability to cope with their illness. Thus, the freedom to choose holds merit in psychiatric treatment. So what elements of freedom are important to this discussion? The next section will consider which aspects of 'freedom' apply when respecting personal autonomy in psychiatric care.

2.7 Freedom and personal autonomy

A lack of freedom occurs when one's opportunities are restricted by the narrowing of available alternatives. The inability to act freely because of constraints placed on us can cause frustration, which is a form of unhappiness.⁵⁰ This is obviously not good for the individual concerned.

The influence of political autonomy has given rise to the common conception that personal autonomy means merely that one is independent from the authority of other people.⁵¹ This aspect of autonomy relates directly to freedom. In this context, it is important to recognise the difference between *negative freedom* and *positive freedom*; these were distinguished by Kant in *Foundations of the Metaphysics of Morals* 1785. *Negative freedom* is independence from external forces, while *positive freedom* means having self-determination (i.e. autonomy).⁵²

Thus, those who advocate the *negative* ideal of *freedom* take a narrow view of what may be considered as interference with an individual's options. The only restriction upon liberty they recognise is interference by other people. In contrast, those who advocate the view of *positive freedom* understand liberty as possession of the psychological resources required for self-governance.⁵³ Under this view individuals need to maintain control over their own cognitive states, and also over their social roles and relationships.

Although both negative and positive freedom relate directly to the topic of this thesis, autonomy incorporates more aspects and is much broader. To have autonomy one must operate in the presence of economic, political and social arrangements.⁵⁴ Therefore, although autonomy calls for the presence of both positive and negative freedoms, it is a much larger concept.

2.8 Psychiatry, informed consent and personal autonomy

Considerations of informed consent and personal autonomy in psychiatry differ from other medical professions, for a variety of reasons. Chadwick and Aindow present two possible reasons. The first is the fact that mental illness carries a stigma, and the second - which is important for this thesis - is that there is often "a presumption of an association between mental illness and impairment of autonomy".⁵⁵ In many ways these two reasons are related.

Firstly, even though mental health and the community have come a long way since the days of the asylum, stigma remains a large problem. Society, as a whole, still

does not comprehend mental illness and how it affects individuals. More education would be useful, but unfortunately the media is one reason that the stigma still exists; they often present stories about violent episodes enacted by the mentally ill – most prominently by those suffering schizophrenia. Thus, there is still a lack of understanding within the general public regarding the mentally ill.

Secondly, a restrictive version of the capacity for autonomy entails the presumption that the capacity for autonomy is *lacking* in *all* schizophrenics. Advocates of such a view might claim that schizophrenia gravely affects an individual's ability to be autonomous by interfering with their thought processes and thus with their rational decision-making. However, the affliction of being irrational and making poor decisions can hardly be considered as a trait of every schizophrenic. Also, irrational decision-making is usually not an unrelenting continual theme, it varies with time. Therefore, this view requires further discussion.

In relation to this the Nuffield Council on Bioethics states that:

*Even at its worst ... mental disorder is rarely a matter of comprehensive incapacity; it is commonly a matter of impaired or intermittently impaired capacities. Most people can continue, throughout the duration of their disorder, to take all decisions for themselves with no more assistance than a person without mental disorder. Accordingly, no general case can be made for those suffering mental disorders to be exceptions to the usual requirements for informed consent, or to other aspects of respect for persons.*⁵⁶

On the basis of this argument, it *cannot* be claimed that *all* individual's suffering schizophrenia are incapable of giving informed consent. This capability varies with individuals and over time. Some patients will still retain the capacity to make decisions while others will not. It is vital in schizophrenic treatment to recognise that patients are heterogeneous. The fact that patients vary so greatly in personality, values and ideals will play a significant role in the arguments presented in this thesis in relation to their treatment. Considerations of personal difference *must* be incorporated in mental health policy.

One could argue, with respect to all areas of medicine, that *any* individual suffering *any* illness can suffer a diminished capacity for making autonomous decisions.⁵⁷ Having said this, there is still a valid case for arguing that schizophrenia can affect individuals' autonomy, making them far more vulnerable than may occur with other illnesses. This reinforces the fact that 'informed consent' is particularly important in the area of psychiatry and in the treatment of schizophrenia.

2.9 Making autonomous decisions

When one talks about an individual acting in-authentically, one usually is referring to the fact that certain constraints are affecting their autonomous action. As has

already been considered in this chapter, schizophrenia may be one such constraint, due to the effects of many of its common symptoms upon an individual. Often, however, the constraints affecting actions occur via one's social existence, since external forces can also usurp an individual's power. This point is particularly important because the current treatment of schizophrenics occurs mainly within the community.

In reference to autonomous action, and to balance external pressures, the concept of the *authentic self* is applied to autonomous action. As explained, in Section 2.3 of this chapter, the "authenticity of a psychological element depends on its relationship to the self".⁵⁸ This highlights that although we are influenced by the society we exist in; personal autonomy requires us to make decisions which reflect our own personal identities.

In the course of our lives, it is not possible for a rational and sane individual to have no internal structure of aims and desires, or to lack any conception of their real self. Persons lacking these attributes, and having no internal order, would have difficulty existing within society, as they would lack direction in all of their endeavours. To initiate any form of autonomous decision-making, individuals require self identity so that they can reflect what they value in the decisions they make. Chapter 1.2 introduced the importance of personal identity in the treatment of schizophrenics. Considerations relating to one's personal identity are of vital concern in schizophrenic treatment.

2.10 Challenges to traditional Western liberal views of autonomy

Various arguments claim that none of us as individuals choose our convictions and desires in a manner which is completely autonomous.⁵⁹ Instead, our convictions and desires are formed without our consent and this is due to the influence of society.

This means that any notion of autonomy must be compatible with the fact that we are shaped by certain influences which are unchosen.⁶⁰ Consequently, upon reflection, each one of us may concede that we are not as autonomous as we like to imagine, because of the vast number of issues in our lives over which we have no control. Thus we must concede that we can only be autonomous to a certain degree, and this has implications for the mentally ill that reside within our community.

The vision of autonomous individuals as self-directed creatures is attractive to liberal society, because we valorise the ideal of personal freedom and self-definition.⁶¹ However, this ideal is problematic to some, such as Oshana, who believe the type of self-determination that comes from independent self-creation is impossible. The result would be that the term 'autonomous agent' then refers to an entity which bears little resemblance to a real human being.

Thus, critics claim that the current conceptions of autonomy focus too narrowly

upon individuals as being either controlled or independent. They criticise the current model of the autonomous person as being inattentive to such things as emotions, community life and our natural development.⁶²

Other challenges to traditional views are presented by feminist writers who argue against the current perception of autonomy, claiming that it revolves on an unrealistic ideal of personhood.⁶³ They too argue that it ignores the part of our personal identity which is influenced by our society.⁶⁴ Communitarians, on the other hand, argue against what they conceive to be an excessive amount of respect accorded to the autonomous individual within Western society.⁶⁵

In recognition of the relevance of these arguments, problems can be identified when focusing overly on patient autonomy in treatments provided to schizophrenics. If patient autonomy is overly focused upon it may actually demote the values of the community at large.⁶⁶ This is obviously detrimental to all members of society, and all individuals involved in an individual's care.

Communitarian, feminists and other critics deserve to have their views acknowledged, and each of these views will play a role in this thesis. This is because the position which schizophrenics commonly hold in society has an immense impact upon their psychological wellbeing and the values they uphold. It also has a huge influence upon the treatments they prefer, and the success of treatments chosen for them. Thus, if the influences of society are deemed to be overly restrictive this needs to be addressed when considering the provision of community care.

In connection with the making of autonomous decisions, this thesis (predominantly in Chapter 6) will consider whether the welfare of schizophrenic patients would be enhanced by involving more people, in addition to the psychiatrist, in treatment. We should not ignore the social dimensions involved in mental health care, particularly the immense impact that any course of treatment has on community and family.⁶⁷ Since we are in the era of community treatment for schizophrenia, the inclusion of others in treatment deserves more consideration. For example, considerations of personal autonomy could include some emphasis on the mutual dependency of individuals within society.⁶⁸ Having stated this, it is still vitally important to emphasise that the patient's ideals and values should always be given their due respect in the treatment instigated for their care.

The challenges to the traditional view of autonomy presented by feminist and communitarian writers all emphasise the social nature of people. This is important for this thesis because who we are, how we define ourselves, and the content of our desires, values and principles, are essentially fashioned by our connections to other people, and to society and its traditions. Since they are so integral to whom we are, we may lack the ability to separate these external elements from our own selves.

Psychological determinism is a “view of human psychology that holds that one’s interests and beliefs and values, and consequently one’s decisions for action, are wholly a product of one’s heredity and environment”.⁶⁹ This is an extreme statement of the view expressed above. Although I do not agree with this concept, the influence of society on the individual is vastly important when it comes to schizophrenia. The viewpoints discussed above represent challenges to the more traditional concepts of autonomy, but perhaps modest variations of the traditional concepts can accommodate these challenges.

2.11 Conclusion

A primary focus of this thesis is on the right of schizophrenic patients to be involved and participate in their treatment, and the important role that this plays in their welfare.

The obligation to obtain informed consent in clinical situations is related to the principle of respect for personal autonomy. The maintenance of patients’ autonomy is extremely important. It can affect not only the progress and success of treatments, but is also important for their future lives. The situation is made even more complex by the fact that schizophrenia itself affects one’s autonomy.

Thus autonomy is a central feature to be considered in the treatment of schizophrenics, particularly in situations where that autonomy may be limited by the nature of the treatment proposed.

This chapter has considered several viewpoints which can be used to define autonomy, and also how we might decide whether to consider a person as autonomous or non-autonomous. The question then becomes: how do these specific views *relate* to the obtaining of an autonomous choice from schizophrenic patients? Do they reveal why those suffering schizophrenia are often deemed incapable to give an autonomous choice to their medical treatment?

Thus, the next chapter will discuss the common reasons utilised when justifying coercive medical intervention in a schizophrenic’s life, due to the consideration that they are considered incapable of giving an adequate informed consent to treatment.

Chapter 3: Harm, Offence and Paternalism

3.1 Introduction

In this chapter the issues of involuntary hospitalisation and other coercive medical interventions that may occur as part of mental health treatment will be discussed. The question to be raised is: What are legitimate grounds for instigating such treatments?

When the condition of schizophrenics becomes serious, medical treatment is usually given without their consent. Three principles commonly used to justify intervention are:

- *The harm principle* – to keep the individual from harming others.
- *The offense principle* – to prevent the individual offending others.
- *The principle of paternalism* – to prevent the individual from harming themselves or to otherwise benefit them.

The acceptability and applicability of these principles in coercive mental health treatment will now be considered.

In this chapter I am assuming that the primary issue with regard to paternalistic interference - and any other form of coercive intervention, in the treatment of the mentally ill is the patient's personal autonomy. Precise criteria, defined in mental health legislation, are required to determine when a schizophrenic's autonomy is sufficiently diminished to justify coercive action. Within such legislation is a *tension* between on the one hand, the liberal values emphasising individual freedom, and on the other hand, the justifications used to justify coercive intervention.

3.2 The 'harm principle'

The 'harm principle' is the basis for intervening to restrict a schizophrenic's liberty with the sole purpose of protecting others. Involuntarily hospitalisation utilising this principle involves a prediction concerning the propensity of the person concerned to commit harm to other individuals.

The 'harm principle' is often applied when not respecting an autonomous choice from schizophrenics, because it is argued that restrictions on an individual's liberty should apply when harm is threatened to others.¹ The principle is advocated by many who support the value and dignity of each individual, because of the specific restrictions it places upon medical intervention; the schizophrenic's autonomy is considered to be important unless others are threatened by the exercise of it.

This raises the question of whether schizophrenics are (in general) so harmful. Certain cases are clear-cut, such as when there are threats of committing murder, but other cases are more difficult to determine. When commitment occurs on the basis of the deemed possibility of dangerous behaviour, it is based on the

psychiatrist's predictions of future 'harm'. But no actual evidence needs to be provided, only subjective predictions which are not always reliable. This could possibly result in the detention of more, or less, individuals than necessary. Thus, a dilemma is involved; one must accept that predictions may be inaccurate, which could lead to innocent people being detained, or alternatively, to other people being harmed.

In situations involving issues of danger, it is particularly important to act fairly *both* to the individual concerned and to the public, because as Feinberg claims we (as a society) are inclined to *overestimate* threats to our safety and to *underestimate* the social value of individual liberty.²

The release of certain individuals into the community will always involve an element of risk. If psychiatrists do not accurately assess an individual's need for treatment, then patient and public may both be put at risk.³ It is therefore important to recognise that although implementing specific procedures for risk assessment may minimise or reduce risks, no system can *ensure* an absence of risk.⁴ If, in the future, the area of risk prediction improves then considerations may alter regarding the appropriateness of detaining 'dangerous' patients.⁵

Recently the pressure on psychiatrists to ensure that they commit the correct people for the correct reasons has increased. This is partly due to the media publicising violent incidents involving individuals with a mental illness. There has been a mind-shift from reliance on community care to an awareness and acceptance of the fact that certain individuals sometimes require involuntary hospitalisation because of the danger they present. It is through treatment that the risk of an individual behaving dangerously due to psychosis decreases. Therefore, it is important that an ethically viable system to provide such care is put in place.

Propensity for dangerous behaviour

Many arguments which focus on the hospitalisation of schizophrenics (without their consent) revolve around the actual potential for harm that the majority of schizophrenics present.⁶ If the majority of schizophrenic patients are not dangerous, then this raises questions about the utilisation of the harm principle. Some philosophers argue that if there is no *serious* threat of harm to others, then intervention on the basis of this principle is incorrect and commitment cannot be justified on such grounds as an individual's liberty is considered to be far too important.

Many studies have been conducted seeking to establish whether there is a relationship between violence and mental disorder. These studies reveal that violent behaviour does sometimes occur due to psychosis, usually in an individual's first episode.⁷ However, the data shows that the *majority* of those who suffer mental illness are not violent.⁸ This differs significantly from the common

perception held by the public, who for a long time have perceived those who suffer from mental illness to be 'dangerous'.⁹ This perception still remains even though many studies have disputed this fact.

Amongst the general public in Australia, males of a low socio-economic background are typically more violent than other groups.¹⁰ And amongst the mentally ill, this group is also the most likely to be violent. Therefore, although violent behaviour does occasionally occur with the mentally ill it is usually associated with other factors. This means that in assessing an individual's propensity for violence, the psychiatrist must consider these *other* factors. According to Monahan, they include: sex and age; race and socioeconomic status; past violent behaviour; and whether there is addiction to alcohol or heroin.¹¹

This raises two questions. Firstly, are psychiatrists qualified to assess these non-medical forms of risk? Secondly, what is the moral basis for this form of assessment of the mentally ill?

For instance, authorities would not be permitted to detain those who are not suffering a mental illness, merely because they are young, male and poor; quite simply it would be unjust to impose restrictions due to these considerations. So does mental illness raise the level of risk proposed by schizophrenics to a level where these factors then need to be considered?

As can be seen, there are problems involved with predicting dangerousness. However, the above factors give some indication of the level of risk, and may be more important than the psychological factors in determining the level of risk to be taken into account when considering the release of an individual into the community.

Prediction

In mental health care, psychiatrists apply their subjective analysis to a patient's treatment, thereby, utilising their own particular values, which play a significant role in diagnosis and treatment. Their assessment of patients will to some extent reflect their own past history, their training, the role they play in society, the rules applying to psychiatric practice, and inevitably their attitudes, values and belief systems.¹²

Thus, the psychiatrist's ideals will inevitably play a major part in the assessment of potentially dangerous patients - what they deem to represent safety or liberty will inevitably influence their decision-making. Political and social influences will also affect decision-making - these influences apply pressure upon the psychiatrist to get decisions 'right'.

When utilising the 'harm principle', a schizophrenic's past behaviour may justify the psychiatrist's treatment decision. If an individual has previously behaved

dangerously when psychotic, it may be inferred that such behaviour could reoccur if they become unwell again. Detention justified in this manner would be preventative – to prevent a harmful event occurring. Situations such as these *often* arise in the treatment of schizophrenics.

An important factor to be considered by the psychiatrist, according to Hamilton and Bullard, is the *relationship* between the dangerous behaviour threatened and that of the individual's illness.¹³ Can the individual be treated, and therefore become less likely to behave violently, or are they naturally of a violent disposition? Another important consideration is whether or not upon release the patient will have appropriate supervision within the community, since appropriate supervision would diminish the likelihood of future violent behaviour.

An important parallel exists between an individual imprisoned by the criminal justice system and one involuntarily hospitalised due to a prediction of dangerousness. People can be imprisoned when proof is 'beyond a reasonable doubt'. The courts are often not 100% certain that the individual committed the crime, but the criminal justice system operates under a system that accepts this. This means that innocent people are sometimes jailed; similar reasoning could be applied to involuntary hospitalisation.

An important distinction, however, is that in the criminal justice system, detention only occurs *after* a crime. This is not the case for those suffering schizophrenia, since a psychiatrist is justified in detaining an individual when they believe it is *likely* that individual may cause harm. This would be legally impossible (in most cases) and morally unacceptable for those who are classed as dangerous but are considered to be sane.

A study conducted by Bartlett and Sandland on the level of predictive accuracy indicates that "between a half and three-quarters of those identified as dangerous by psychiatric professionals do not, in the end, turn out to be violent."¹⁴ When evidence like this is presented it raises the question: Should this type of detention continue to be permitted? Statistics like these support the argument that because there are no scientific measures to predict dangerousness accurately, no patient labelled as dangerous can ethically be detained.

However, the public has a right not to be subjected to harm, so this protection from harm must form an integral part of mental health legislation, and sometimes requires the application of the 'harm principle' in the involuntary treatment of schizophrenics.

3.3 Offense

The 'offense principle' is concerned with behaviour deemed as overly offensive to members of the public. In the area of mental health, there are valid questions to be asked about the use of this specific principle because of the gravity of infringing

upon an individual's liberty. Loss of liberty is so important that less invasive measures should be used where at all possible as a response to offensive behaviour.

So what are offensive behaviours? They are behaviours which cause shame, embarrassment, or discomfort to others.¹⁵ However, there is a wide variation in what may be deemed offensive behaviour, ranging from the mildly offensive to that which would offend virtually everyone. In addition there is a distinction between what can be termed harmless offensive behaviour, and behaviour which causes harm and thus satisfies the 'harm principle'.

If we apply the 'offense principle' as a liberty-limiting principle, it must meet the requirement that we do not repress alternative, but harmless, behaviour. As a society we may take genuine offense at activities which are actually harmless; however, the offensive behaviour displayed must be of a serious nature if liberty is to be restricted.

Therefore, it is important to distinguish between behaviours which are merely offensive and those that are genuinely harmful.¹⁶ The latter occurs when the offense is so great as to cause such extreme emotional distress as to constitute an actual harm.

Feinberg suggests two standards that could be applied to ascertain when intervention due to offense is appropriate. The first, the *standard of universality*, refers to the type of offense that causes a reaction which "could be expected from almost any person chosen at random from the nation as a whole, regardless of sect, faction, race, age, or sex".¹⁷ The second is the *standard of reasonable avoidability*, which means that any member of the public should only claim the right to protection by authorities from offensive behaviour if they cannot effectively avoid it without inconvenience to themselves. Feinberg considers the regulation of behaviours which meet the above standards as legitimate - an example of which could be swearing loudly and continuously in public.

Anti-psychiatrists insist that the current mechanisms utilised to involuntarily hospitalise individuals are jointly accepted by the state and psychiatrists as a device to exert social control over those who are unconventional or annoying.¹⁸ To some degree we must accept that schizophrenics may behave in ways that are abnormal or different. However, an individual's liberty is far too important to warrant involuntary detention for this reason alone.

At times the general public may become concerned by schizophrenics' behaviour, which may appear unusual or give offence, and consider it to be a threat requiring action from the authorities. This could result in detention. Unfortunately, this may occur prior to a detailed consideration of the patient's condition, which may have indicated that any potential for harm being enacted was limited. This is of concern since 'harm' would be the primary justification for such enforced hospitalisation. As

a consequence, “individuals who behave offensively in public are sometimes involuntarily committed to mental institutions, even though their behaviour poses no serious threat of harm to themselves or others”.¹⁹ In such circumstances, the interests of others are placed above those of the individual.²⁰ Additionally, it has placed the psychiatrist in a position of social control rather than what is traditionally a therapeutic role.

Since it is generally agreed that exhibiting offensive behaviour is not necessarily a sufficient justification to deprive individuals of their liberty, the ‘offence principle’ is not generally utilised. Mappes and Zembaty claim that authorities instead provide the ‘harm principle’ as the justification for treatment, as opposed to the ‘offense principle’. This is because the ‘harm principle’s’ usage is so widely accepted. Thus, it is not uncommon for individuals to be hospitalised “simply because their behaviour is offensive; but the attempt to justify their commitment is made on other inapplicable grounds, such as their supposed dangerousness”.²¹

3.4 Paternalism and issues of ‘harm’ to oneself

In mental health legislation, the term ‘harm’ is commonly utilised in connection with an individual causing harm either to others or themselves. The *Mental Health Act 2009 SA*, in the defining criteria, which must be met to coercively treat an individual, states:

*because of the mental illness, the person requires treatment for the person’s own protection from harm (including harm involved in the continuation or deterioration of the person’s condition) or for the protection of others from harm.*²²

Therefore, the term ‘harm’ is currently utilised to detain individuals due to predictions of harm – either to oneself or others.

In constructing such legislation there will always be a problem in providing a precise guide for psychiatrists. There are difficult cases, where different elements have to be balanced against each other, for example, the question of harm to the patients themselves has to be considered. This section is concerned with that particular aspect of harm.

In mental health legislation coercive legal criteria have to address the issue of a patient’s mental distress, clarifying when intervention is justifiable. Although this is difficult it is important. The justification will generally include the harm that may occur to the schizophrenic if their illness is left untreated – for example, the deterioration of their condition.

Also, the nature of a specific harm is important, as there are various degrees of harm. Harms classified as serious would include a future loss of liberty, and the erosion of mental powers.²³ These harms are direct obstacles to an individual’s

future personal autonomy, and are therefore relevant to the topic of this thesis and its focus on autonomy.

A psychiatrist, when medically intervening on the basis of harm, should present strict justifications before initiating coercive treatment. Any detention must rest on the fact that the harm predicted is extreme and is therefore manifestly unreasonable.²⁴ When involuntary treatment is utilised psychiatrists need to demonstrate the “exact nature of the harmful effects (or beneficial consequences) to be avoided (or achieved) and the probability of their occurrence.”²⁵ This is important due to the worth of respecting an individual’s liberty.

When an intervention does occur on the basis of harm, the type of intervention utilised must be linked directly to the behaviour that is threatening harm.²⁶ This is particularly relevant to the involuntary hospitalisation of schizophrenics, which is often instigated to prevent them from harm to themselves or to others.

The fact that current mental health policy incorporates the harm that individuals may do to themselves, means that the criteria involved is paternalistic. The issues involved with paternalistic intervention will now be discussed.

Paternalism

Gerald Dworkin describes paternalism as:

*interference with a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced.*²⁷

Mental health care is primarily concerned with actions intended for the patient’s benefit,²⁸ and this is where paternalism can arise. The state or practitioner interferes with the liberty of an individual, and this is justified by the claim that the patient could be protected from harm or will be better off if intervention occurs.²⁹ Thus, paternalism involves the limitation of an individual’s freedom or autonomy, justified by a certain specific type of reason; for example, that intervention is ‘in their best interest’ or ‘for their own good’.

The restrictive measures involved in paternalistic mental health treatment emphasise the responsibility to provide protection and care for others at times when their well-being and best-interests may be damaged. The term *Parens Patriae* refers to the government taking the right to use its ‘sovereign power of guardianship’ over an individual.³⁰ This means that the state legally takes on the role of decision-making in the place of the individual. The most widely accepted form of paternalistic interference involves intervention in the lives of those considered to be non-autonomous.³¹ Therefore this principle is often used to detain schizophrenics when it is considered that they are behaving, or making judgments, in a non-autonomous manner.

Two distinct types of paternalism are used to justify the coercive treatment of schizophrenic patients; they are 'strong' or 'weak' paternalism.

A strong paternalist "believes that people may be mistaken or confused about their ends and it is legitimate to interfere to prevent them from achieving those ends."³² Alternatively, a weak paternalist "believes that it is legitimate to interfere with the means that agents choose to achieve their ends, if those means are likely to defeat those ends".³³ Both of these particular positions will now be discussed in relation to their applicability to the current mental health treatments utilised.

Strong paternalism

The strong paternalist position does not address the individual's desires or choices when determining the necessity to protect that person. If an individual's wishes, desires or goals are deemed to be irrational, then strong paternalism deems coercive interference with the individual to be legitimate. Strong paternalism, as defined by Young, is intervention initiated to protect or benefit individuals, even though they have not consented to the proposed measures.³⁴

An important argument against the use of strong paternalism is the fact that it does not accord respect for the principle of autonomy, and for this specific reason its use in mental health care is often questioned. Objections focus on the fact that strong paternalism condones paternalistic interference intended to protect or enhance a certain goal or end state such as an individual's welfare or health,³⁵ regardless of how the patient weighs their health in relation to their other goals in life.

This means that under strong paternalism, respect is afforded to a particular value rather than to the patient. It is disconcerting that strong paternalism can justify coercive intervention into patients' lives to protect values held by others, even if those values are opposed to those of the patient.

Another factor used to question strong paternalism is the authority it gives to psychiatrists. When strong paternalism is applied in mental health law, psychiatrists determine what is good for patients using their own conception of the 'good', as opposed to that of the patients. Could this mean that psychiatrists are permitted a broader authority than necessary over individual's lives? Or, that they may authorise (and legalise) too much intervention in individuals' lives, resulting in the potential abuse of this power? One result of utilising 'strong' paternalism could be that psychiatrists are permitted to override schizophrenic patient's choices and goals in an excessive amount of cases. Ethically, this is of concern because patients hold rightful authority in their own medical treatment.³⁶

Weak paternalism, although it might lead to coercive intervention, does take into consideration a patient's overall goals. This means that strong paternalism is significantly broader than weak paternalism in the areas of intervention it supports.

Weak paternalism

'Weak' paternalism involves interference in a schizophrenic's life because their decision making capabilities are considered questionable or impaired at the time, and is justified on the basis that "*consent* to the interference would be forthcoming were the subject's decision-making capacities restored."³⁷ When taking this weak paternalist position, it is considered legitimate to interfere with an individual's liberty to assist them to achieve what (it is considered) they desire in life. Often, the justification for such intervention is that, if left untreated, the patient's means may defeat the ends that they aspire to when they are in their right mind.

So is weak paternalism, with its respect for patient autonomy, a more acceptable alternative? It involves attempting to do what the patient themselves would do if behaving rationally. Weak paternalism considers that what a patient values when rational plays an important role in paternalistic medical intervention and is therefore preferable.

However, there are a number of challenges to implementing weak paternalism. For example, there is often a difficulty in predicting what a patient would desire if rational. And even if predictions are made correctly, the patient *when recovered* might not agree with the specific treatment given. And exactly how do we determine whether or not a patient is *sufficiently* rational to make decisions?

Paternalistic intervention, utilising weak paternalism, can only be justified if it is genuinely considered that the patient, *prior* to the treatment, would have consented if rational. However, due to the nature of their illness, and because the experience of involuntary hospitalisation is often so severe, it is common for a schizophrenic never to concede they should have been treated in such a manner, even after they have recovered from a psychotic episode.

It is also common for schizophrenic patients not to desire the authority and control placed upon them, and when unwell it can be difficult to convince them to relinquish their autonomy. Weak paternalism is meant to nullify the objectionable features of the issue of consent. However if individuals, when they are again capable, do not thank us for interfering in their lives some difficulties with this position arise. Having said this, it is difficult at the time of *any* mental health intervention to predict what an individual would consent to in the future, particularly because of the state of their mental health. The consent model, therefore, revolves on an empirical generalisation.³⁸ Consequently, due to the nature of schizophrenia and the compulsory treatments currently instigated, there may (at times) be problems in justifying the use of weak paternalism. However, the elements of weak paternalism remain preferable to those of strong, as will now be discussed.

A significant advantage of weak paternalism is its focus on an individual's particular

set of values rather than the promotion of a chosen value. It involves respect for individual's right to make their own choices, and for their individual differences. However, even this can lead to problems. Under weak paternalism, patients must sometimes be permitted to make choices that appear irrational to others. In other words, they should be permitted to choose in a manner which may actually diminish certain aspects of their life.³⁹

This poses problems for informed consent within mental health because the assessment of an individual's competency often revolves around the ability to choose rationally. Paternalistic treatment is justifiably instigated if a patient is considered to be irrational. But what occurs in a situation where a patient's autonomous choice appears irrational to others? How do we then assess rationality?

In mental health treatments, two different mechanisms could help to solve the problems created by rationality. Firstly, a decision could be deemed irrational if it would result in an individual "suffering significant harm for a reason with which almost no one with similar knowledge and intelligence would".⁴⁰

A second reason could be that there is a clear indication that the individual's mental health is affecting their decision-making. This distinction is important as patients may be deemed schizophrenic, yet make autonomous and competent decisions and should, therefore, have their decisions respected. However, when they are obviously *affected* by schizophrenia, then overriding their wishes should be considered as removing the freedom to choose from persons who, if rational, would deem the intervention to be preferable because it may have prevented behaviour which is harm causing. This would justify a psychiatrist's intervention.

These arguments are important because, in life, we as individuals are never consistently rational, nor do we make decisions exactly as others would. It *cannot* be concluded that adequate reflection will always result in a decision that is deemed rational by others. It is only in circumstances where they are highly detrimental to the decision-maker, that decisions should be disrespected.

A key problem, in utilising weak paternalism, is with deciding exactly as the patient would have decided. This can be difficult due to the heterogeneity and individuality of patients. At times, schizophrenics may not be capable of giving consent, so decisions are made by a surrogate - this is then termed 'hypothetical consent'. It is important that a surrogate's decision should reflect what the schizophrenic would themselves have chosen, had they been rational, free and appropriately situated to choose.

At times, when this situation occurs, further problems with weak paternalism arise. This is due to issues of rationality. When surrogates are given the power to choose, it is often considered appropriate for them to select the course which appears to be

the most rational. This means that the surrogate, instead of choosing as the patient may have chosen, *is* often under pressure to decide in the manner deemed to be the most rational.⁴¹

Ethically, the notion of consent, when utilised in alignment with weak paternalism, only applies where a patient's own individual values are meant to matter. The surrogate is meant to choose in a manner representative of the patient, otherwise such decision-making is questionable. If it is evident that the surrogate has no indication of how the individual would have chosen, then decisions have to be made which are in the 'best interests' of the patient. The intricacies involved in such decision-making will be further discussed in Chapter 5.15.

Consequently, any implementation of legal boundaries will have to involve accepting the difficulties of determining what individuals, when rational, would actually accept.⁴² This is where 'Ulysses' contracts are useful in mental health. These contracts legally state what treatment an individual agrees to when well, and they can be implemented if that individual becomes unwell. The worth of such contracts will be analysed further in 5.14.

Thus, a significant problem with 'weak' paternalism lies not in the fact that a patient may not agree with the treatment instigated when no longer mentally impaired, but that it is difficult to decide what they would have accepted when rational. This, obviously, can be difficult, particularly so because the surrogate decision-maker will inevitably have some values, beliefs and ideals that differ from those held by the patient.

So how might we address such problems in mental health legislation?

Woodward makes the reasonable claim that a rational individual will always desire to maximize or preserve a certain level of values.⁴³ In mental health policy, the values upheld should be those considered desirable by the majority of us. This would result in an individual being permitted to choose freely as long as they respect certain key values; then if a patient fails to accommodate such values in decision making, any subsequent external interference becomes justifiable based on the fact that the individual is not being rational.

Although the preservation of a certain level of values in mental health may be a means of accentuating the patient's autonomy, this approach can in itself hold certain problems. When we look at choices in such a way, we promote an outcome – such as the patient's welfare. Thus paternalistic intervention is broadened to the extent that both strong and weak paternalism could be utilised to justify intervention. This occurs because we are moving away from deciding as the individual would decide towards selecting the best outcome for the individual. This is of concern, because under weak paternalism individual difference is meant to matter.

In utilising paternalistic intervention, it must be remembered that if other individuals impose their conception of the 'good' on us, we are denied the respect owed us, even if they do in fact provide us with a benefit and have a better conception of our needs than we do.⁴⁴ It is for these reasons that weak paternalism can be justified as preferable to strong paternalism in mental health care.

3.5 Anti-paternalism

Many writers who dispute the use of paternalism focus on the concept that as autonomous individuals we have a right to make our own decisions, even if they may be foolish or self-defeating.⁴⁵ To some people, paternalism is seen as an affront to an individual's sense of dignity, freedom, autonomy and individual liberty. Feinberg is one such writer, arguing against state paternalism and supporting civil liberty. He presents an important argument that the mere fact that a person suffers from a mental illness is insufficient cause to confine them therapeutically against their will.⁴⁶ According to Feinberg this is an objectionable use of paternalism. An individual must require protection, due to their illness, in order to be legitimately confined.

Paternalistic treatment of those classified as mentally ill occurs for many reasons, which can at times be concerning. In relation to this there are claims that some governments around the world are turning to the use of policies which are paternalistic to deal with difficult social problems. Such policy shifts have been clearly discernable in the U.S.A., U.K., and Australia;⁴⁷ they include policies related to immigration, criminal justice and welfare. A relevant example of this occurring, here in Australia, is the current stance taken by the federal government towards the indigenous people of Australia. The government, in attempting to resolve ongoing problems in these communities, has implemented policies considered to be 'in the best interests' of these individuals. This makes the policies implemented paternalistic in nature.

The problem which arises is that once such paternalistic policies and methods are deemed acceptable, it becomes increasingly easy for governments to use paternalism as a regular method to deal with social problems. Schizophrenics, because of the behaviour they sometimes exhibit and the problems their illness creates, can then be considered as a difficult social problem that needs to be dealt with by the authorities.

Sociologists, psychologists and social theorists who have analysed the emphasis upon anti-paternalism within society have attributed much of it to the class differences.⁴⁸ The psychiatrist is often upper-middle class, whereas those who are paternalistically treated are usually from the poorer, less-privileged classes. This raises ethical questions regarding the ability of those wielding paternalistic authority to act in the best interests of those they constrain, because of the significant difference in values they hold. The role and utilisation of values in

psychiatry forms an integral and important part of this thesis and the acknowledgement of values plays a key role.

The above theorists do not focus on whether paternalistic intervention is morally correct, but concern themselves with the abuses which may result from so-called paternalistic acts which do not “serve to benefit (or keep from harm) the individuals constrained”.⁴⁹ This is an important contention because current methods of treatment rely heavily on what is advocated by the psychiatrists. They hold great power over the treatment provided to the mentally ill.

In considering the harm that paternalistic treatment can cause, it must still be recognised that some types of paternalistic treatments are necessary. If society were to reject legal paternalism completely, the result would be that medical interventions instigated to protect individuals from various types of harm would not be considered a valid reason for instigating coercive treatment. This requires that mental health legislation be constructed in a manner which recognises the need for certain paternalistic treatments, but restricts them to those circumstances in which it is deemed appropriate – such as when an individual is making decisions which are self-defeating.

3.6 The ethics underlying coercive mental health treatment

In mental health it is important that any instruments constraining autonomy are used *only* as a last resort. Also, as Gerald Dworkin suggests, the application of *the least restrictive alternative* should be a basic principle.⁵⁰ This means that if there is any other way of achieving the desired result other than the restriction of liberty, even if more inconvenient or expensive, then as a society we should adopt it.

Importantly, any medical intervention should not produce a state where the schizophrenic becomes dependent on a psychiatrist or institution. Therefore, it should be used only to increase the schizophrenic’s dispositional autonomy,⁵¹ whilst not damaging their chance of returning to a successful life within the community. As discussed in Chapter 2.1, the preservation of dispositional autonomy is so important that this justification is frequently acceptable in the restriction of an individual’s short-term liberty.

The general public, because of media focus, has become concerned about patients absconding from treatment facilities, which has resulted in hospitalisation utilising increasingly strict security measures.⁵² Consequently treatment, instead of being seen as hospitalisation, is viewed by many as being ‘locked up’. It is necessary to emphasise that *treatment* is the main justification for involuntary hospitalisation, even though a patient may have been hospitalised to protect the public. Furthermore, the intervention should be of a limited duration, procedures need to be specified and followed, and the psychiatrist’s legal obligations should be clear.⁵³ Paying attention to these considerations may soften the influence of involuntary

treatment on the patient. This issue will play a role in my discussion on mental health law in Chapter 6.

Acknowledging the harshness of involuntary hospitalisation emphasises the necessity of guarding against the abuse of legislative power in coercive mental health legislation. A clear and substantial amount of proof must be presented by the authorities when a patient's autonomy is to be restricted. There is an ethical requirement that within legislation concerning the legitimate intervention with patient's liberty, the threshold applied for compulsory treatment should be set at a high level.

One criticism of present day psychiatric practice, which has occurred because of the current legalities involved, is that psychiatrists find it necessary (when issues of coercive treatment arise) to demonstrate, firstly, the presence of mental illness and secondly, the risks involved in releasing the patient. Due to the current focus of mental health care, psychiatrists apply this kind of reasoning as opposed to considering how the proposed treatment could therapeutically benefit the patient. In relation to the current treatments provided to schizophrenics, this is a matter of important concern.

3.7 Voluntary actions

A distinction can be made between actions which are performed voluntarily and those which are performed either non-voluntarily or with a degree of non-voluntariness. To be considered to be behaving voluntarily an individual must possess all the relevant information, and must be neither coercively pressured nor face serious psychological constraints. Obviously, non-voluntary behaviour can occur because of the symptoms induced by schizophrenia.

Why is this distinction important? It is because in using coercive medical intervention it is permissible to detain an individual on the *presumption* that they are behaving non-voluntarily. However, there is no justification for interfering with a person's liberty merely because they suffer mental illness and especially if they do not present any risk to themselves or others. This reasoning is supported by Feinberg who states that even those actions which are substantially non-voluntary deserve to be protected "unless there is good reason to judge them dangerous."⁵⁴

An example of non-voluntary behaviour which is not dangerous may occur when an individual continually talks to themselves in public – which can be a symptom of schizophrenia. Unless their behaviour presents a danger to others then the individual should rightfully be left alone.

Without personal knowledge of an individual, we may not be able to tell if their behaviour has been affected by their mental illness. However, if, at the outset, a psychiatrist judges an individual's behaviour to be self-damaging, and considers it to be behaviour in which other individuals would not engage, then it may be

considered as sufficient justification for interference.

Similarly, before an individual can be released back into the community their behaviour needs to be reviewed by a psychiatrist. This analysis is not to critically analyse the individual's choices, but to distinguish whether or not the choices they are making are genuinely theirs. In other words, an assessment is required to ascertain whether or not the individual is behaving authentically and autonomously. The issue of dealing with a patient's authenticity with the illness schizophrenia was discussed in Chapter 2.3.

The assessment of an individual's level of control over their own behaviour occurs to protect the individual from making self-defeating decisions. Therefore, non-voluntary behaviour presents a valid justification for coercively treating an individual. Thus, the state has the rightful power to intervene with an individual's liberty, to establish whether or not behaviour is voluntary, or alternatively to prevent self-harmful conduct which is substantially non-voluntary.

3.8 Non-interference versus autonomy

Section 3.6 identified that any intervention into a schizophrenic's life should be designed to minimise any effects on the patient's future autonomy, and maximise their ability to return to life in the community. On this basis, it is possible that a *lack* of intervention by psychiatrists can be harmful to the patient. A lack of intervention produces its own particular set of problems in psychiatric treatment.

Ackerman argues that a psychiatrist who is *not* interfering with a patient's life is actually disrespecting that patient's autonomy, because the autonomy of schizophrenic patients is affected by various constraints - physical, cognitive, emotional, and social.⁵⁵ Adherence to medical paternalism, according to Ackerman, requires psychiatrists to help to rectify any impediments that may be interfering with choices, and to help the patient in restoring control over their lives.⁵⁶ Assistance given should limit the psychological constraints that may inhibit the patient from making deliberations in the future.

For example, if a psychiatrist decides not to interfere with a patient's life out of respect for autonomy, this may unfortunately ignore the impact mental illness can have on the exercise of that patient's autonomy.⁵⁷ Thus, respect for the principle of autonomy, demands a clearer comprehension of the relationship between schizophrenic and psychiatrist. Merely respecting the patient's moral and legal rights (such as respecting the right to informed consent), will not fully address the disruptive effects of the illness.⁵⁸

Ackerman claims that psychiatrists need to have personal knowledge of their patient to achieve treatment goals. Mental illness can affect the individual in a variety of ways, such as their employment, their social position, their ability to carry out certain tasks, or even their leisure activities. When diagnosed as mentally ill, an

individual's life changes permanently, and this significantly impacts upon their ability to act upon their own life plans within the community. The social constraints that patients face must be addressed in their treatment.

To succeed in communal life, a patient requires assistance to adjust and accommodate the effects of their illness upon day to day life. Ackerman argues that a patient's autonomous status is regained only through an ongoing process.⁵⁹ This would result in the informed consent procedure becoming more than just an acceptance of treatment by the patient; it would be a developmental process, during the course of which the patient slowly recovers, adjusting to accommodate the restrictions their illness presents. In this way, the patient would be assisted in aligning and coordinating their activities in the community to accord with their medical realities.⁶⁰ Chapter 6.12 will further discuss this issue in relation to the construction of treatment plans which involves both the psychiatrist and patient.

Ackerman's argument applies directly to this thesis because he recognises that those who suffer schizophrenia are not independent atoms, but form an integral part of the society within which they exist. This means that they often suffer from the negative effects of this relationship; and this in turn impacts heavily on their mental health and future mental stability. Non-interference by a psychiatrist may therefore impact negatively upon a patient's ability to gain control over their personal life and future endeavours. In such circumstances, a psychiatrist's intervention could help to counteract the disruptive effects of schizophrenia, and ameliorate the impact of mental illness upon the individual.

It must be recognised, as noted in Chapter 2.10, that the traditional conception of autonomy which involves detached individuals existing as self-sufficient entities within society can be highly detrimental to the patient. Ackerman's argument highlights the importance of invoking medical paternalism where it is necessary to protect the patient. Such assistance is required for schizophrenics to achieve a sufficiently autonomous existence within the community, especially following coercive mental health treatment.

It takes time for an individual to come to terms with the fact they are suffering schizophrenia – to gain insight relating to their illness. It also takes schizophrenics time to understand the consequences it will have upon their life.

3.9 The therapeutic relationship

This thesis repeatedly refers to the benefits that can be derived from a therapeutic relationship between schizophrenic and psychiatrist. If informed consent is viewed as a contract, it then involves a sharing relationship between schizophrenic and psychiatrist. With a contractual relationship comes recognition of the importance of patients maintaining freedom and control over their lives, especially when the choices to be made are significant and will impact heavily.⁶¹

In practice informed consent can be described as ‘shared decision making’. The two parties bring different knowledge to the decision—the physician knows about diagnostic tools and treatment options, while the patients knows what their own goals and values are. Expressed in general terms, a patient might judge the possible benefits of a treatment as worth its costs, or alternatively might find the costs too high and the benefits too small to be worth the trouble.

Applying a contractual model to informed consent is important because within clinical decision-making it gives the assurance that both parties maintain their moral integrity.⁶² A contractual agreement enhances the ability of the schizophrenic to make some decisions, whilst still leaving them reliant on the psychiatrist for those they may not be able to make competently due to their illness. Thus, the patient may be afforded more autonomy, yet not totally control each and every decision relevant to their treatment if the informed consent process is implemented in this manner.

3.10 Conclusion

Acceptance that schizophrenia is a reality requires an acknowledgement that involuntary hospitalisation must sometimes occur. This in turn requires specific ethical procedures to be defined and in place. Coercive procedures have a central role in the treatment of schizophrenics. This chapter has focused on the importance of ensuring coercive measures are morally justifiable. This is important because we all act in ignorance at times, and make poor decisions.

The psychiatrist’s goal is to treat, and sometimes cure their patient, but at times they may only be able, at best, to alleviate some suffering. Prediction is involved as to just how a specific individual will respond with or without treatment. For example, the belief that involuntary hospitalisation will benefit an individual is an important justification for restricting their freedoms, but this may not always prove to be the case.

Thus, there is a complex combination of legal and humanitarian considerations involved in involuntary hospitalisation. Although a patient’s liberty may be infringed upon, this is done to combat the consequences of the disabling and dehumanising effects of schizophrenia. Thus, arguments about hospitalisation must encompass the benefits that may ensue to the individual, as well as possible infringements of their rights. Although individuals may value their freedom, some elements of schizophrenia can significantly impact upon their ability to remain within the community when unwell.

The reasons for implementing coercive treatment must be carefully considered by the psychiatrist, and in considering issues of harm to others there is the requirement to balance the interests and values of the patient, psychiatrist and public. Ultimately any decision made will be based on a prediction.

Paternalistic measures may legitimately be applied if it is considered that patients could harm themselves or others, or are incapable of making rational decisions. Any decision-making must revolve around what is considered best for the patient. But who decides what is best? Is it to be based on the values of the psychiatrist/team or on what the patient may (possibly) have decided if rational?

Questions revolve around whether the current legalities defining involuntary hospitalisation permit the psychiatrist too much power. However problems also arise if this power is removed from psychiatrists, because restrictive treatments *can* benefit schizophrenic patients. Denial of involuntary treatment could result in both the patient and community being exposed to maladaptive consequences.

Although many views have been expressed about the ethical values of aspects such as autonomy and informed consent, and how they should affect the treatment of patients, it is clear that these views, to be considered as relevant, should take into account the specific nature of schizophrenia.

The following chapter introduces the issue of informed consent when it is applied to schizophrenic patients.

Chapter 4: Informed Consent

4.1 Introduction

The following definition, originally designed for instruction in the teaching of medical ethics in medical schools and health care institutions, is illustrative:

Informed consent is defined as the willing and un-coerced acceptance of a medical intervention by a patient after adequate disclosure by the physician of the nature of the intervention, its risks and benefits, as well as of alternatives with their risks and benefits.¹

Since the mid 1970s, the primary goal of informed consent has been to protect an individual's autonomous choice, therefore protecting patient's rights.² The ideals underlying respect for informed consent were to reduce the risk of, and avoid, any undue unfairness or exploitation of patients.

Respecting schizophrenic's sovereignty in their treatment is important. One important reason for this is the imbalance of power³ within the relationship between psychiatrist and patient. Respecting schizophrenics' autonomy and right to consent to treatment, recognises that their rights should be considered and given respect.

Discussion of informed consent is especially relevant to those suffering schizophrenia because, due to their illness, they are more likely to have their right to informed consent disrespected. This chapter will show that although a valid consent should be obtained in a manner which meets legal requirements, and when an individual is psychologically stable, many other components play a vital role in its procurement from schizophrenics.

4.2 Informed Consent

Informed consent, in itself, is particularly important because of the fundamental values it promotes. Solid philosophical arguments can be presented for respecting informed consent because without this occurring it means that the individual is treated merely as a means.⁴ Informed consent is aligned with common morality in the sense that it reveals respect for the different choices made by different people. The legal development of informed consent has embraced the intrinsic value of the individual.

Although the procedure for obtaining informed consent has a legal foundation, it is essentially ethically based;⁵ the protocol for allowing an individual to give or refuse informed consent holds ethical significance in two different ways. First and foremost the process of obtaining informed consent is based on both the legal and ethical assumption that a patient possesses the intact decision-making capacity necessary for consent to the particular medical intervention suggested.⁶ Secondly, having respect for a refusal of medical treatment relies on the assumption that

patients are competently capable of fending for themselves.⁷ As has already been seen, the pervasive symptoms of schizophrenia often conflict with either both, or one, of the above considerations, making the issue of informed consent for schizophrenics both important and complex.

4.3 The moral principles relevant to informed consent

The three dominant moral principles associated with the process of informed consent are autonomy, beneficence and justice.

Firstly, the principle of justice requires individuals to be treated in a fashion which is either due to them, or owed to them. Therefore, an injustice occurs if individuals are denied a service or information to which they are entitled.⁸ Justice is important in health law because it engages in attempts to achieve outcomes which are both fair and appropriate.⁹

Secondly, the principle of beneficence is defined, from a medical perspective, by the following:

the positive benefit the physician is obligated to seek is the alleviation of disease and injury, if there is a reasonable hope of cure. The harms to be prevented, removed, or minimized are the pain, suffering, and disability of injury and disease. In addition, the physician is of course enjoined from doing harm if interventions inflict unnecessary pain and suffering on patients.¹⁰

The principle of beneficence is relevant to the treatment of schizophrenic patients. It is the principle most often adhered to by psychiatrists, but also the one that most often conflicts with the principle of autonomy in the area of informed consent.

If an individual is deemed to be acting non-autonomously, the moral issue relating to treatment is that of beneficence. Therefore the moral principle of autonomy and the autonomous decision-making that is every individual's right is respected, and adhered to, except where care and treatment of the individual demands adherence to the principle of beneficence.

Evaluative judgments revolve around the prioritisation by psychiatrists of these specific principles. Those who assign a high priority to the medical welfare of their patients hold that beneficence is more important than patient autonomy, and may argue for an extremely strict set of thresholds or tests of competence. In contrast, those who commit to the principle of autonomy will consider that more patients should have their authorisations and refusals honoured.¹¹ Consequently, the preferences of psychiatrists affect their considerations of the competence of a patient. As argued in Chapter 3.2 the psychiatrist's preferences and values are utilised more often in psychiatry than in other medical fields due to the nature of psychiatric diagnosis.

When considering the moral principles involved in psychiatric decision-making,

neither patient nor psychiatrist have overriding authority, because neither is pre-eminent within the relationship. Beneficence is the primary goal or rationale of mental health care, while patient autonomy sets the moral limitations upon the actions which psychiatrists may take in their pursuit of that goal.¹² Permitting either principle to be pre-eminent would mean sacrificing significant values, since both have value in medical treatment. Therefore the inclusion of alternative moral values within psychiatry even though they may conflict, both enhances and dignifies its practice.¹³

4.4 Two uses of informed consent

Fadden and Beauchamp claim that informed consent has two uses.¹⁴ Firstly, it is a particular kind of action: it is the autonomous authorisation given by a patient to the psychiatrist. I will refer to this type of consent as 'philosophical consent'. Secondly, informed consent is utilised in accordance with the rules which both govern public policy and mental health and in alignment with the institutional ethics regarding the treatment of those who are unwell. This second form of consent I will term 'policy-oriented consent'.

Policy-oriented consent concerns the manner in which patients should be treated in accordance with standard practices in mental health, which must accord with the rules and policies implicit to this field.¹⁵ The importance of this form of consent is that it is obtained through specific procedures which are legally enforced on practicing psychiatrists. It is the factor that monitors and enforces the requirements of psychiatric professional behaviour and procedures towards schizophrenic patients.

4.5 Authorisation and disclosure

Two components are particularly important in 'policy-oriented' informed consent relative to the law: these are 'authorisation' and 'disclosure'.

When an act is authorised it means that responsibility for it has been assumed, and the authority to proceed has been transferred to another. With regard to informed consent, such consent is nullified unless the schizophrenic understands this fact. Thus if a schizophrenic patient does not comprehend that in assenting to the psychiatrist's selected treatment they are giving them the right to begin treatment, then informed consent has not been acceptably obtained. This important step in the informed consent process has to be *clearly* explained to the schizophrenic. The patient must comprehend that they are committing to a treatment plan, which includes a health-related goal, and that there are certain steps to achieve that goal. This is a vital step in the informed consent process.

The satisfaction of rules concerning disclosure remains central to informed consent in respect to law.¹⁶ The psychiatrist must disclose all relevant information to the patient. The reason for the significance placed on disclosure in policy-oriented

consent is that the rules require it to be evident that an adequate disclosure of information has occurred.

Recently, a focus on the patient's comprehension has evolved, as opposed to a mere disclosure of all of the relevant information.¹⁷ Attention has shifted to an *understanding* by the patient of what the psychiatrist is explaining. This is important as schizophrenics may have difficulty comprehending the information given to them by a psychiatrist. Mere disclosure of relevant information may not be sufficient when dealing with schizophrenic patients.

4.6 Understanding

Due to the intricacies of medical treatments, a substantial level of understanding as opposed to complete understanding is acceptable for informed consent. Various factors can compromise understanding on both sides, and this holds especial significance when a patient is schizophrenic. What is important, however, is that to achieve an adequate level of understanding, a patient has to rely upon the psychiatrist, because the psychiatrist's perspective is often essential to the schizophrenic's deliberation and understanding.¹⁸

The attaining of mutual understanding depends heavily upon the extent to which communicants share a common background in language and knowledge, since individuals differ both linguistically and culturally. Sometimes the patient and the psychiatrist may come from different backgrounds with vastly different life experiences. Such diversities in backgrounds, beliefs and values create difficulties in the area of understanding.

One mechanism to improve exchanges of information is for a psychiatrist to invite the patient's participation. This helps to ensure the informed consent process is more personal, and permits schizophrenics to discuss their own desires, beliefs, and values with the psychiatrist.

Additionally, attention needs to be paid to the amount of information provided if a patient is to adequately understand the details, since too much information, or too little, can each pose problems for a patient's understanding. As humans we can process only certain amounts of information at any one time.¹⁹ Also, the time constraints placed on a psychiatrist, particularly in public mental hospitals, exacerbates the problem of providing adequate information to the patient.

Furthermore, a problem in the provision of adequate information, and understanding, to a patient is that the psychiatrist must often decide upon a course of treatment in a timely fashion. This is especially important with schizophrenic patients as prompt treatment can significantly reduce the severity of a psychotic episode.

If informed consent is to occur, it is important that the patient understands what

the psychiatrist is explaining. However, even if psychiatrists express themselves clearly there can sometimes be a discrepancy between what the patient understands and what the psychiatrist means. For example, a schizophrenic patient may be told that their new medication may make them drowsy, but it may be difficult to explain exactly how tired they will feel and how much this will affect their lives. This particular problem with disclosure does not only occur with schizophrenic patients, but all patients who are medically treated.

In addition, to the above distinct problems, a schizophrenic patient's intellectual functions and communication skills are often impacted by their illness. Obviously, this severely influences a patient's ability to discuss their treatment. One result may be that certain patients, although attaining an adequate level of understanding, have their consent to treatment refused because they lack the ability to communicate well.

A further problem is that an inability to communicate well with the psychiatrist may result in treatment which is not suitable, because any lack in the ability to communicate may have a direct impact on the psychiatrist's understanding of the patient's condition.

One reason that informed consent is such an issue within psychiatry is that schizophrenics often do not fully comprehend their condition. They often reject diagnoses that they feel are imposed upon them and are deeply affronted by the stigma involved with the label 'mentally ill'.²⁰ In fact, they often deny that there is anything wrong with them at all. 'Understanding' in the clinical context, involves comprehension by the patient that they are undergoing a clinical intervention;²¹ this means the patient must have a cognitive understanding of what the illness entails. In psychiatry there is often good reason to question whether the patient has sufficient understanding to qualify legitimately to make a relevant decision.

Therefore, the condition of schizophrenia, can in itself present problems when decisions need to be made in regards to diagnosis and treatment.

However, even if deemed incompetent, a schizophrenic patient who is being detained should be treated with respect in the area of understanding. This is because without adequate comprehension of their situation, coercive treatment can be an intimidating and frightening experience. It is important that patients should, as far as possible, understand both the legalities involved, and that they have certain rights which must be adhered to.

4.7 Knowledge

The attainment of knowledge plays a vital role in patient autonomy, and our modern day access to information has to some extent closed the gap between patient and practitioner in medical knowledge. When patients gain knowledge, it permits them to better utilise the options available to them. For example, Rodwell

argues that by gaining knowledge one becomes more able to change one's situation into a more advantageous one.²² Thus, having the appropriate knowledge regarding a situation empowers an individual, and empowerment is important because it permits one to be more autonomous.

Therefore, the provision of relevant information may allow an individual to become more autonomous,²³ and thereby less dependent on mental health workers and others. However, intentional withholding of information from a patient often occurs in psychiatry, due to individuals being considered unstable. The justification utilised is the avoidance of harmful outcomes such as severe emotional stress. In imparting knowledge to a schizophrenic, one must avoid overwhelming them with information which frightens them - especially if they are considered to be psychologically vulnerable.²⁴

So what information should be withheld? Psychiatrists should not normally withhold information just because it is unpleasant. The ethics behind informed consent permit withholding of information only where it has been requested by the patient or is considered detrimental to the patient's well-being.²⁵

The withholding of medical information from patients deemed sane would not normally be acceptable. So why is it any different with schizophrenic patients? It is because we are dealing with a 'mental' illness as opposed to a physical illness, and the patient is already vulnerable due to their illness; certain information may actually make the individual's mental state worse. Therefore, when providing information to the schizophrenic, consideration must be given to the stability of their mental health.

4.8 Appreciation

Gaining an appreciation involves a certain type of mental process.²⁶ In attaining informed consent, 'appreciation' involves the schizophrenic taking a further step beyond understanding. Rather than just *understanding* the information provided by the psychiatrist, the individual has to understand its relevance and applicability to their situation. This is important because schizophrenics, on occasion, suffer delusions which can affect this ability; they may affect a patient's appreciation even if not their understanding.²⁷ To explain: during psychotic episodes, schizophrenics may take on the belief that they are a religious entity, such as Jesus Christ; this can lead to a belief that they have great power and no harm can befall them. Yet in making a decision regarding their treatment it is obviously necessary for patients to appreciate just how the treatment will, in reality, affect them.

When a situation such as this arises it is important for the psychiatrist to allow the individual to provide evidence for the beliefs that they are currently holding, which are affecting their appreciation of the information provided to them. What is relevant for informed consent by schizophrenic patients is that they appreciate the

reality of the treatment plan and how it is going to affect them. Whether or not they are holding beliefs that appear delusional in other areas may not significantly impact on their ability to give informed consent to their treatment. A patient can be extremely delusional but still able to function quite highly in situations such as the giving of consent.

However, although there is no requirement for a patient to completely understand the effect of a specific treatment plan, a psychiatrist, in order to achieve a suitable level of appreciation of the treatment, may have to prove to a patient that a belief they are holding is false. Should a psychiatrist be permitted to do this? Beauchamp and Childress state that it appears wrong to claim that psychiatrists should not on occasion influence patients to alter what they believe, so that they will be able to comprehend the information being given to them; if ignorance prevents an informed consent, it may actually be “obligatory to promote autonomy by attempting to impose unwelcome information.”²⁸ Such a process may allow the schizophrenic a greater appreciation of why they are being treated in the manner they are, and how it may improve their life and help them to heal.

4.9 Competence

So what does competency entail? Firstly, it is task-specific; for example, an individual is or isn't competent to repair an automobile. Therefore, peoples' competence varies depending on what they are undertaking. This means that any analysis of a patient's competence will find differing degrees of competency according to the task being considered. This is especially apparent when treating schizophrenic patients because of the diverse ranges in competencies exhibited by those with this form of illness.

Thus, because of the episodic form in which schizophrenia takes shape, a schizophrenic patient who is incompetent at one point may be competent at another, which means that definitions of competence utilised in the area of mental health often present problems for psychiatrists. Further a patient may be able to make certain decisions competently, yet unable to give consent to serious treatments such as hospitalisation or anti-psychotic medication. The individual may have the capacity to consent to a simple medical procedure, while not being competent to consent to treatment involving a complex range of risks and benefits.

So what standard of competency should be applied? To be acceptable it should meet the following objectives: it must accommodate all legal requirements, be philosophically and psychiatrically sound, encompass the ethical values upon which informed consent is based, and be applicable within a clinical setting.²⁹ Two demands must be met: competent individuals should be permitted to decide on their treatment, and incompetent persons need to be protected from making decisions which may be harmful.³⁰

Philosophers debate about the level of competence possessed by schizophrenics when seriously ill. Are they able to deliberate rationally and effectively? In psychiatry some writers have taken the extreme view that even when patients are deemed competent to make a specific decision, the decision should not always be respected. This is because they consider the rational competence of any patient suffering mental illness to be questionable. They believe that medical paternalism should be invoked and the patient protected.

However, patient's participation in decisions relevant to their treatment is extremely important. For example, Harry Lesser highlights the importance of respecting each individual's right to give consent, unless it is obvious that their illness is impacting upon their decision-making. He argues that:

Only if the phobia, or the depression or indecisiveness, is evidently preventing the patient from thinking clearly at all, or if it is combined with an inability to give any reason for his or her expressed preference, is one justified in regarding the preference ... as irrational ... And the patient – however irritating this may be to some doctors – should be considered 'rational until proved irrational'.³¹

Therefore, the assumption should be made that the patient is rational, rather than assuming automatically that the individual is irrational because, and solely because, they suffer a mental illness.

Although patients having a psychotic episode suffer symptoms which may interfere with certain actions, an important point is that they usually retain some competency to make some decisions and act upon them. This competency should be respected. If certain less serious decisions are left to the schizophrenic patient, it provides the psychiatrist with useful feedback regarding how competently and autonomously the individual is making decisions and choices. This may help the psychiatrist to determine what level of competency the individual has and apply more beneficial medical treatment.

It is also important to recognise that if patients are given a restricted degree of autonomy to decide on certain aspects of their treatment, they may learn valuable lessons about their illness. Since legally the characteristics of a competent person in most respects match those of an autonomous person, it is arguable that an individual who can choose autonomously should be permitted to do so. The fact that all of us can behave incompetently at times also suggests that a limited amount of autonomy, in areas where the patient can do themselves no harm, could be permitted.

It is also important that the decision-making capacity of the patient is specifically considered as each decision arises, as the capacity to make decisions varies according to their mental state.

When choices have to be made on behalf of a schizophrenic, it is important to remember that the illness is (usually) episodic and that competence should return. In today's mental health climate the individual is often drugged and hospitalised and then released back into the community with little counselling. Exercises that promote and assist the patient's ability to make choices, and decisions, should become an important component of treatment.

4.10 Competence as a pliable concept

Some writers claim that the definition of competence should be made pliable, and should vary according to the clinical situation. Thus, if certain medical interventions only involve limited benefits and risks, patients may be permitted to refuse or consent to the treatment, since refusals wouldn't matter if any resulting harm would be minor. However, if a patient refused life-sustaining treatment, there would be a necessity "for the patient's refusal to be rational for the patient to be deemed competent."³² This concept has value in the area of psychiatry because of what I perceive to be a problem with the involuntary hospitalisation of schizophrenics – that once hospitalised, almost all decisions are denied to them.

Although a pliable account of competency in some ways sounds appealing, there may be certain problems in its application. A difficulty could occur when two psychiatrists differ in regards to a patient's diagnosis, which could result in the patient's condition being considered very serious, or alternatively, less serious. So although this conception is attractive, it may, in some situations, become unworkable. Further objections, to the pliable concept of competency, include claims that it may justify paternalistic behaviour by psychiatrists, whilst diminishing the patient's right of choice.

4.11 Influence and resistance

To make a decision voluntarily, a patient's actions must not be coerced or derive from an unacceptable level of manipulation.³³ As stated in Chapter 2, independence from control is important if an individual is to be autonomous, and to act autonomously. Involuntary actions may result from the internal symptoms schizophrenics face during their treatment. However, their autonomy can also be affected by the external influences that present themselves during their treatment, and this section will analyse situations in which this may occur.

The condition of having control involves the two concepts of influence and resistance. As individuals we are influenced subjectively in a variety of different ways and manners, and each of us are influenced differently by the various elements we face within our lives. Thus some of us are influenced more than others in particular areas.

So what is a controlled act and what is a non-controlled act? Firstly, one individual may be influenced by another without being controlled. An example, of this occurs

when doctors use their medical expertise to explain procedures to patients; they influence the patient's decision, but do not control it. A completely controlled act occurs when one individual's will is totally dominated by another person; such as when a psychiatrist refuses a schizophrenic's right to consent to treatment, thereby forcing them to comply with decisions regarding their care.

This, however, is not the only form of control which can occur in mental health. Due to the vulnerability which is a part of the existence of any schizophrenic, the individual can often be coerced and dominated by others without any actual coercive enforcement ever occurring. This is an important point to consider when discussing the implication of external pressures upon schizophrenic patients.

Examples of the interaction between resistance and control are easy to find in mental health. Often, in obtaining compliance from a schizophrenic in the taking of anti-psychotic medication, the psychiatrist will threaten them with involuntary hospitalisation unless they agree to their terms. When situations such as this occur the psychiatrist's recommendation is not *irresistible*, however, it is *difficult* for the individual to resist. Due to the nature of hospitalisation the patient in question will usually comply with the psychiatrist's request. As should be obvious, this type of coercive influence in such a scenario is questionable. However, such coercive measures play an important role in mental health treatment where such invasive pressures are commonly utilised in the treatment of schizophrenia.

Oshana also makes a valuable point; to make a validly autonomous choice requires options that are relevant.³⁴ A variety of choices is inadequate for autonomous choice if those choices all restrict one's autonomy. Unfortunately, because of the difficulties and constraints involved in treating schizophrenia, such restrictions can occur with psychiatric treatment. A patient may require treatment, due to the nature of the illness, and so will be given choices reflecting the necessity for treatment of that specific kind - the treatments presented to the individual will often be coercive.

4.12 Persuasion, manipulation and coercion

Ethically psychiatrists in their treatment of schizophrenics should only use persuasion which is not controlling, rather than manipulation - which can (at times) be controlling.

Persuasion plays an important role in informed consent, because it is a vital part of everyday psychiatric practice. It is (most commonly) morally required that professionals make an effort to persuade an individual to consent to the medical treatment considered necessary.³⁵ However, this influence must be restricted to an acceptable level of persuasion, to ensure that informed consent does not result from undue manipulation. The schizophrenic must make the decision depending on the information given rather than any external pressure.

To persuade patients, a psychiatrist must give reasons for their selected treatment and permit them to assess its strengths. It is often the reason that patients accept treatment, and is important because it enables patients to give an adequate informed consent utilising their own specific values and ideals.

In analysing manipulation, persuasion and coercion, it is manipulation which is the most flexible, because coercion and persuasion are fixed. To explain: coercion is considered to always be controlling, while persuasion is not controlling, and manipulation is a matter of degree.³⁶

Some manipulative influences are compatible with informed consent, whilst others are not. For example, a psychiatrist may carefully select the options offered to a patient, thereby modifying the patient's behaviour and choice, and justify this manipulation on the basis that treatment is required, and is likely to be more successful if the patient consents to it.

So in some instances manipulation can occur in mental health treatment in an acceptable manner, but, alternatively, it can also be used in a manner which is more destructive than any other measure – even than coercion. Examples include deception by lying, the wrongful with-holding of information, and utilising misleading exaggeration to lead individuals to believe what is not true.³⁷ These forms of manipulation are not compliant with the giving of authentic autonomous informed consent, and can be highly detrimental to a schizophrenic individual if they occur.

Further problems, involving manipulation and informed consent, arise because of the external pressures placed upon the individual by their family, friends, the community, the treatment team, etc., all of whom may heavily influence their actions and decisions. This means that there are many instances where the boundaries which separate controlling and non-controlling influences are disputable.³⁸

It is useful to provide an example of persuasion, manipulation and coercion in schizophrenic treatment. A psychiatrist, upon deeming the individual to be unwell and requiring immediate mental health treatment, may be able to elicit an informed consent from the patient without unduly forcing them to accept. The psychiatrist may achieve this by advising the patient that their life could be unduly impacted if they remain untreated and reside within the community; to a rational patient, this kind of persuasion would be compelling. It is only when such arguments fail to sway the patient that the psychiatrist should use reasonable manipulation to obtain an informed consent by restricting the patient's options. Finally, if these methods have had no effect, the psychiatrist will often be required to coerce the patient, by placing them on a treatment order without their consent. Because schizophrenia affects rational decision-making, such situations commonly arise.

In other areas of medical treatment, only minor manipulations are deemed to be acceptable. A higher level of manipulation and coercion are acceptable in mental health care because when individuals are deemed incapable of making their own choices or are behaving in a non-autonomous non-voluntary manner, coercive treatments often have to be applied. Thus, treatments given to schizophrenics may actually involve more coercion than occurs in other fields of medicine.

4.13 Ethical implications in psychiatric research

An area in mental health with significant ethical implications is that of research into medications and their effects on those that take them. Progress in this area clearly depends on research, but are those suffering from schizophrenia truly able to give consent to this type of research or are they being manipulated? There is a requirement to balance the advancement of knowledge against the protection of vulnerable research participants;³⁹ which is difficult if they are incapable of deciding whether or not to be involved in research. Since the involvement of patients is unavoidable, it is essential for procedures to be in place to protect vulnerable schizophrenic participants.

The development of treatments that may be safer and more effective is a high priority of psychiatric research,⁴⁰ because the effects of schizophrenia are often devastating. Research is necessary because, for example, treatments effective on milder forms of schizophrenia may not have any effect on more serious forms, and even if a medication is deemed effective it may have intolerable side effects. The development of new medications for schizophrenia focuses on the prevention of harm and the relief of suffering.

Haimowitz, Delano and Oldham state that it is those patients who are most disabled by their illness, and lack the ability to give informed consent, who are most in need of the new forms of treatment which research may produce.⁴¹ Thus there is a dilemma involved in conducting psychiatric research. While it is a necessity to combat the severe effects of schizophrenia, it may not be ethically appropriate to subject individuals to the process of trialling medications. Yet, the value of research into the illness is considered too vital for it not to occur, so research continues.

4.14 Policy-oriented consent versus philosophical consent

Informed consent can sometimes satisfy the requirements of both philosophical and policy-oriented consent, because within 'policy-oriented' consent there is a reflection or reliance upon the conditions implicit in 'philosophical' consent. This is because the procedure for obtaining informed consent is based on certain moral values, which results in a heavy reliance on philosophical consent when constructing mental health policies.

However, construction of a workable formulation of informed consent must accommodate not only the requirements of the mental health system but also

those of the patients, including the restrictions that mental illness places upon their capacity to make choices and decisions. It is at this specific point that philosophical and policy-oriented consents separate, there is an important distinct difference between the two.

Additionally, in applying 'policy-oriented' consent the role of psychiatrists, and what is fair and reasonable to expect from them, must be addressed. Considerations should include the ways in which the requirements of informed consent may affect the delivery and effectiveness of psychiatric care. This means that any evaluation of policy-oriented consent must include respect for the principle of autonomy, as well as the consequences of imposing burdensome requirements on the institutions and professionals involved.⁴²

Philosophical consent does not have to consider these problems. So although it is appropriate to adhere as closely as possible to philosophical consent certain practical problems can occur to prevent this. When this occurs it is the responsibility of those who implement such deviations to provide moral justification for having done so.

Consequently, even though philosophical consent is the basis for assessing and evaluating the moral adequacy of policy-oriented consent, there are differences between them. Ideally the requirements of policy-oriented consent should include many of the conditions inherent in philosophical consent. Ethically, this is particularly important because policy-oriented consent is utilised daily in mental health institutions to legally hospitalise individuals for a period of time.

The above discussion demonstrates the usefulness of contrasting policy-oriented and philosophical consent. Specifically, usage of the two types of consent will result in a more thorough assessment of informed consent in clinical settings, and enable beneficial change to occur in the areas where problems arise. Therefore, the inter-relation of the two distinct types of informed consent helps to broaden and enhance the area.

Overall, due to the intricacies of applying informed consent to clinical settings, policy oriented and philosophical consent differ. However, informed consent can still satisfy both. Yet it is because of the requirement for legal boundaries to apply, which differentiate between competent and incompetent patients that these differences occur.

4.15 The 'event model' and the 'process model' of informed consent

There is a further distinction we might make in relation to informed consent. With informed consent there are various different models, or types, on which the process can be based. This section will analyse two different alternative informed consent models which can be utilised in psychiatric care.

Arguments against informed consent claim that it is an 'empty ritual' within which patients are given complex information that they cannot understand and which has little impact on decision-making.⁴³ Thus it is seen as a waste of valuable time. To address this concern, Lidz, Appelbaum, and Meisel differentiate between two types of informed consent which occur clinically - the 'event model' and the 'process model'.

Utilising the 'event model', informed consent requires all of the relevant information deemed necessary to be given to the patient at a specific point in time, which is then followed by the patient selecting a course of treatment.⁴⁴ This model emphasises that the information provided must be complete and accurate, thereby satisfying 'policy-oriented' consent.

In contrast, the 'process model' entails supplying patients with adequate information and obtaining their consent through an ongoing process.⁴⁵ This model is more acceptable in the treatment of schizophrenic patients, because it actively involves the patient in decision-making, and addresses the problems implicit in the psychiatrist-patient relationship, and most closely approximates philosophical consent.

Allowing the patient to participate is recognition of their specific expertise. Their input is extremely beneficial because of patients' knowledge of their own history, their recognition of symptoms and changes, their ability to initiate health-care, and their responsibility for implementing changes in their own life-style.⁴⁶

The 'process model' involves the clarification of the various values held by both parties, as well as their expectations,⁴⁷ and allows patients time to identify their own values. It accommodates both the nature of schizophrenia and the manner in which it can change and evolve, thereby encompassing the need for psychiatrists to adjust their treatment plans in accordance with the patient's changing needs. Chapter 6.12 discusses the new role that has emerged in mental health in relation to the construction of treatment plans.

Continued supervision is important during the recovery of a patient who has suffered a psychotic episode. The 'process model' focuses on continuing treatment, and so requires follow-up care to be provided within the community upon release from an institution. Such interactions should continue to occur throughout treatment and involve reviewing of the treatment plan. Changes to the plan need to occur as they become necessary, and attention needs to be given as to how the plan has helped maintain or improve the patient's condition. Importantly, the final task is to re-establish patients' responsibility for their own health care, thereby making them less dependent - this task is often required after hospitalisation. This final phase is an important step towards re-establishing a patient's competency and autonomy.

The principles underlying informed consent emphasise the requirement for individuals to participate in their treatment. There is justifiable reason for accepting that any “participation is not to be valued merely for its own sake, but that it contributes to therapeutic outcomes.”⁴⁸ Thus, the implementation of an *effective* process model of informed consent holds much worth.

4.17 Conclusion

This chapter has shown that in practice the process of obtaining informed consent in mental health has certain important problems. These problems can differ significantly from those faced in other areas of medical intervention. One important problem is that in respecting an individual’s right to informed consent assumes that they have the competency to deal with any consequences of that decision. Schizophrenia can often influence an individual’s capability to do so.

The factors to be considered in gaining a sufficient informed consent from a schizophrenic patient are complex and subjective, and often rely heavily on the psychiatrist. The obtaining of an acceptable informed consent involves, not only the acceptance (by the patient) of the necessity of medical treatment, but that patients have competently understood the nature and reason for the treatment, and are therefore involved in their own care. Thus psychiatrists have a responsibility to communicate well with patients, understanding and accommodating their values as well as their limitations.

It is vital that the basic ethical and moral principles involved are accommodated, particularly when informed consent by a schizophrenic patient is not to be respected.

The following chapter will further analyse the informed consent process in relation to schizophrenic patients by considering the different elements of schizophrenia that specifically affect their autonomous decision-making in this area.

Chapter 5: Schizophrenia and its Impact on Informed Consent

5.1 Introduction

A focus of this thesis is upon the capability of a schizophrenic to adequately make informed decisions about medical treatment. Therefore, it is important to show how and why schizophrenia impacts on individuals, and can at times make informed consent difficult for them.

In this chapter, it will be shown that the manner in which schizophrenics form their beliefs can be different from that of the sane. However, the effects on their ability to be rational, and make competent decisions can vary considerably.

This chapter will discuss capacities that are important in considerations of informed consent and autonomous decision-making by schizophrenics. The elements discussed are usually analogous to those required for personal autonomy and the competence to make a decision. However, because of the specific pervasive influences of schizophrenia the elements included in this thesis are selected for discussion because of their particular influence on schizophrenic decision-making.

Consideration of the specific difficulties faced by schizophrenics in decision-making will be followed by a discussion of how the mentally ill, psychiatrists and mental health institutions respond to these problems.

5.2 Pervasive symptoms

Chapter 2.3 introduced the concept of the 'authentic' individual. It is important for individuals to relate adequately to themselves in situations where they are required to reflect or choose. This is especially relevant for schizophrenics, because the pervasive symptoms of schizophrenia can undermine the authentic self. When certain symptoms arise, their ability to undergo conscious thoughts, feelings, and actions and claim them as 'their own' sometimes disappears. 'Thought insertion' is one such symptom and is considered to be a defining symptom of schizophrenia.¹

So what is thought insertion? It is the denial of the ownership of a conscious thought.² During 'thought insertion', schizophrenics believe that another being is placing thoughts inside their minds. The impact of this can only be described as having an extreme influence on their sense of their own personal identity. Chapter 1.2 highlighted the importance of addressing an individual's personal identity in the treatment of schizophrenia. 'Thought insertion' is one of the reasons that this is so important.

Mental health experts consider 'thought insertion' to be a delusion, but it does not appear as such to schizophrenics, who will often be completely certain that what is occurring comes from outside of them. As Graham accurately claims, the individual is absolutely convinced of this and cannot be dissuaded.³ They will be absolutely sincere in conveying to others that what they are suffering seems absolutely real.

Thus, they have conscious thoughts and they understand the content, but fail to experience them as their own. Therefore, as Graham claims, they are failing to self-ascribe.⁴

Individuals who are failing to self-ascribe feel, upon reflection, that their thoughts bear no relation to any parts of themselves, and this means that they can then be considered to be non-autonomous (see Chapter 2.3). Schizophrenics may retain the ability to be autonomous and make rational decisions, but these symptoms undermine that ability. The reason that 'thought insertion' and other pervasive symptoms of schizophrenia are so undermining is that what appeared to be personal and part of themselves, suddenly appears to be foreign. They feel as though they are being heavily influenced by an external agent, whose thoughts and influence they cannot will away.

What occurs with thought disorder can also occur with feelings and emotions.⁵ Individuals can have feelings that do not appear to coincide with their reality. For example, they may feel angry when there is no apparent reason. Another symptom is auditory hallucinations, where they hear inner speech which sounds as though an external agent's voice is being heard within their own mind.⁶ These are often referred to as 'command hallucinations', as they command the schizophrenic to do certain things, and if the individual does not obey then the voices can turn nasty. These symptoms are also perceived by schizophrenics as being separate from the real 'them'.

So what is our personal identity and why is it so important? One's personal identity is the integration and customary unity which comes from one's own personal experiences in life.⁷ Certain symptoms can profoundly alter and transform a schizophrenic. Schizophrenic episodes can "expunge and distort memories and change cognitive function, beliefs, and values"; they can also "alter capabilities, personality, mood, emotional style, and response".⁸

Thus some symptoms may interfere with or deprive schizophrenics of the capacity to act in reference to their own values. Schizophrenia often leaves the patient feeling as though they have lost control over themselves, because their thinking is disrupted by these pervasive symptoms, and they feel that they are being governed by something outside their own control.

In extreme cases, individuals may suffer from a complete disappearance of their 'self'. In this case the issue alters; it is no longer just a question of informed consent because the patient needs to be dealt with in another way entirely. Instead, they need to be treated by psychiatrists as an object. Consent may be solicited from them, but there is no guarantee that it has been genuinely obtained.⁹

The loss and disruption of self-ascription has the greatest undermining effect on personal autonomy in schizophrenics, because:

*Self-ascription to oneself as a thinking agent is an essential requirement if we are to know about ourselves as thinkers, to control and regulate our thinking, and to decide which lines of thought to pursue, as well as to observe and train ourselves to think more carefully and intelligently.*¹⁰

This section has shown how schizophrenia can have the most disruptive of effects on patients. Internal forces can have a much more intense influence on schizophrenics than on other individuals, often impinging upon the schizophrenic's capacity for free will or in the orchestration of their own life plan.

5.3 Common sense and informed consent

Consideration of a schizophrenic's ability to give informed consent often involves an assessment of their level of common sense. It is a fact that one's common sense can be affected by schizophrenia, which causes (in most cases) a reduction. Schizophrenia can even be interpreted (as is by Wolfgang Blankenburg) as pathology of common sense.¹¹

'Common sense', as a whole, can be understood as the "capacity to see and take things in their right light".¹² For example, the mental health that the majority of people possess operates by overlooking the obvious as being obvious.¹³ A severe lack of common sense is not normal and indicates to a psychiatrist that something is wrong. However, there is great variability in this area even amongst those who are sane and adding to this problem is the fact that common sense is extremely difficult to objectify or measure.

A loss of common sense often leads to a loss of interpretive skills and the ability to utilise one's judgment. One result is a reduction in the ability to participate and deal with daily life, and the individual loses the ability to cope within society. This has a significant impact on those schizophrenics who reside within the community.

Thus, mental illness may effectively remove the individual from the rest of society to a place where they become inaccessible.¹⁴ One reason for this is that it is extremely difficult to explain one's experiences to a person who has not experienced the same reality. Such an affliction further alienates schizophrenics who are already finding it difficult to relate to society's other members.

Blankenburg suggests that common sense be described as an 'organ', which is "formed in communication for the purpose of communication".¹⁵ Thus, he claims that common sense is "formed in reciprocal interaction for the sake of this interaction."¹⁶ As is obvious, for an individual to lose the ability to interact with the surrounding world is an extremely isolating experience. This often occurs with those suffering schizophrenia.

At first the individual loses the ability to see things in their right light; then other symptoms emerge, such as a loss of tact and understanding of what is proper, a loss

of awareness of one's surroundings (such as fashions), and a general indifference regarding what could be disturbing to others.¹⁷ Consequently there is a general loss of understanding about what others are thinking and doing, what is appropriate, and what particular situations demand. This means that a schizophrenic feels emotions, has reactions and makes judgments which ultimately result in acts which do not correlate with social reality.

This presents a problem for informed consent, because in making decisions which are highly important for future life, an individual's interpretation of their own life must be taken into account. As Govier argues, one cannot completely abrogate decision-making to another in the key areas of memory, interpretation, and judgment.¹⁸ And one must only reassess these elements when provided with evidence that one is mistaken. In life, one must rely and trust oneself in these areas, to decipher what has occurred. Loss of the ability to interpret what is occurring around you has a significant effect on the ability to make autonomous choices.

This huge effect, on the individual, which coincides with the loss of common sense, should not be ignored. Schizophrenics may no longer have faith in the continuity of their own reality, and may ultimately believe that dire and terrible things could occur.¹⁹ Therefore loss of one's faith in the world that surrounds us, as well as in the ability to comprehend that world, can only be described as devastating, and it seriously affects one's ability to be autonomous in life.

5.4 Self-assessment

In order to give informed consent, and possess autonomy of action, individuals must have some capacity to comprehend the degree to which they are capable of undertaking that action.²⁰ This involves the ability to self-assess.

Self-assessment is not precise - it is always a matter of degree. Sometimes one overestimates, sometimes one underestimates. So why is self-assessment required for autonomy? It is because it involves the connection between an individual's intentions and actions. Without the capacity for self-assessment, there is a disconnection between the two.

Consistently inaccurate self-assessment should be apparent for an individual to be considered non-autonomous. However, attention always needs to be paid to this aspect of mental illness because a reduced capacity to self-assess could mean that a schizophrenic is susceptible to making mistakes, some of which could be serious. When we are competent we can identify when we make errors, at times schizophrenics may lack this ability.

Nevertheless, the situation is not straightforward. For example, schizophrenics who deem themselves well enough to be released from hospital into the community may understand the intrinsic value of being autonomous in the community. It could be contended that their "pursuit of an unattainable ideal reflects not a confused

self-assessment but a clearheaded commitment to the intrinsic value of the pursuit itself²¹.

The reason that this point is so important is because an individual's determination to remain in the community is often considered by the psychiatrist to be a lack of perspective regarding their illness. However, this may be questionable, since the impact of being retained in hospital is often so disempowering and confronting that the individual may well be behaving rationally in pleading for freedom.

In situations, where psychiatrists must consider an individual's level of self-assessment, the greater their uncertainty about the level of self-assessment that can be attributed to the individual, the greater the necessity for caution to be taken in determining whether a patient qualifies as autonomous.²² Therefore, patients will often be retained against their will due to a psychiatrist's judgment that they are lacking perspective in regards to the seriousness and the nature of their condition.

What this section shows is that, due to the problems inherent to psychiatric treatment, any refusal of involuntary treatment should not be the only consideration used to determine an individual's ability to self-assess. Other important aspects need to be considered, such as their acceptance of their illness and the degree to which schizophrenia has impaired their ability to undertake action and make decisions.

5.5 Self-trust, self-esteem and self-respect

A schizophrenic must possess certain other capabilities to function competently. The pervasive nature of schizophrenia can influence the ability to trust oneself; this can be further exacerbated when informed consent is not accepted by the authorities involved, since this confirms to schizophrenics that their thoughts and actions are not to be trusted. Possession of a certain degree of self-trust is an important and necessary condition for both self-respect and personal autonomy.²³

Self-trust means that an individual retains the willingness to depend upon themselves, as well as accepting that at times they can be vulnerable. It is of intrinsic value in decision-making since one needs a certain amount of self-trust to competently make a decision. However, self-trust is always a matter of degree.

It becomes relevant in the following circumstances:

*trusting one's perceptions and observations; interpretation of events and actions; feelings and responses; values and evaluation; memory and judgment; instinct, talent, common sense and choice; deliberation, will and the capacity to act; flexibility, competence and the ability to cope with the unexpected.*²⁴

Many of these elements have already been discussed in this thesis, showing how important they are in the making of important decisions. Thus, self-trust involves a

range of vital elements which significantly influence one's ability to make choices.

So how does self-trust link in with autonomy and informed consent? It is important because in order to consider and appraise one's options, and to select an appropriate decision, individuals must trust themselves.²⁵

Self-trust is important in difficult situations when one needs to depend on oneself; such as in involuntary hospitalisation when individuals can feel incompetent, unworthy or inadequate. A degree of self-trust in such a situation can be "a major resource for resistance and emergence".²⁶ Emergence from an episode of schizophrenia, which has required coercive treatment, is vital for an individual to once again exist autonomously within the community. Without regaining self-trust, an individual may relapse and require rehospitalisation. Therefore, this element in the treatment of schizophrenia requires attention.

Self-esteem is also valuable. A certain amount is indispensable in the competence to give consent. It refers to the opinion one has of oneself. A schizophrenic's personal happiness can be severely affected by a lack in self-esteem, and this will significantly influence their quality of life. This highlights the importance of empowerment in the treatment of schizophrenia.

Self-respect also plays a role in the capacity to give informed consent; because in the making of decisions an individual with self-respect honours one's own values and principles. Those with self-respect believe that their interests and beliefs have value and worth, and in difficult situations they can adequately defend themselves.

In the treatment of schizophrenic patients it is important to recognise that manipulation or exploitation over a period of time will seriously undermine self-respect. This is one of the key reasons that it is important to respect one's personal autonomy in mental health treatment. Further, in chapter 3.4 it was acknowledged that the use of weak paternalism is preferable to the utilisation of strong paternalism. This is because, if an individual in their treatment

*becomes solely a tool enabling others to achieve their ends, one's sense that one's own ends, goals, and interests have worth is unlikely to survive.*²⁷

Therefore, it is important to actively foster and encourage self-respect, and acknowledge that schizophrenics have their own values which motivate their intentions and goals and these should be given a certain amount of credence in treatment.

Self-trust, self-esteem and self-respect can *all* be affected by involuntary hospitalisation or other coercive psychiatric treatments. A schizophrenic patient who is treated disrespectfully will feel incompetent, of no importance, and may experience immense frustration which may lead to failure.²⁸ Being deemed incompetent to make one's decisions can be internalised, and result in further lack

of faith and confidence. Schizophrenics will lose their sense of worth and become unable to exist competently and autonomously within the community unless treated gently and with due respect in their treatment.

5.6 The importance of judgment

In *Madness and Reason* (1985), Radden discusses the effects of mental illness upon the mentally ill. She focuses predominately on irrationality, and how mental illness can cause certain patterns of feeling or perception that ultimately lead to “irrationally held beliefs and desires and to errors of judgement.”²⁹ An example of this can be ‘thought insertion’ as mentioned in Section 5.2. When seriously unwell, schizophrenics may make defective judgments which then impact on their ability to make their own informed choices. Radden explores the reasons that a schizophrenic’s decision-making capacities can be influenced in this way.

In comparing the sane with the insane in areas of judgment and action, the sane are able to avoid errors, whilst the mentally ill may lack this ability.³⁰ The sane can competently scrutinise their actions and engage in reflective thinking, checking them against the experiences that they have in life. Of course, it is not true that they can *successfully* reflect on their lives all the time, because it is impossible for any of us to be consistently correct. However, schizophrenics may lack this ability *because* the illness itself can cause disorder and confusion for the individual concerned, resulting in them making errors which are not prevented, isolated or anticipated to the same degree as with other members of society.

Radden’s argument is relevant to this thesis because she identifies *similarities* between the sane and the insane, which help us to relate better to schizophrenics, and their experience of illness. One important parallel she identifies is that every one of us (sane or insane) can experience dreams and illusions.³¹ When schizophrenics suffer delusions, they appear to them to be as real as the dreams that the rest of us experience whilst sleeping. Thus we can, to a degree, relate to the delusions and psychotic experiences that a schizophrenic suffers.

What occurs when a schizophrenic experiences certain key cognitive symptoms is commonly termed a ‘loss of contact with reality’.³² This is defined as an “inability to distinguish false from veridical perceptual experiences and beliefs.”³³ When experiencing hallucinations and other symptoms, they have difficulty in distinguishing between what is real and what is a part of their psychotic experience.

When schizophrenics lose touch with reality this highlights an important difference between them and the rest of society. This is due to the manner in which they register their life experiences and hold beliefs.³⁴ For those who do not suffer schizophrenia, what they perceive perceptually actually corresponds with what has occurred. As was discussed with issues of common sense - this may not be the case for schizophrenics.

Thus, schizophrenics may suffer from false images. This is extremely isolating because they also lack the validation offered by inter-subjective agreement with other humans.³⁵ A psychotic person remains isolated and alone with their experiences. Gillet states that this is an extremely unsettling circumstance for those “whose entire cognitive system is based on principles of convergence in judgment, affirmation, and validation.”³⁶

5.7 Delusions and rationality

Radden investigates the processes by which we as individuals reason, analysing the imperfect irrational thinking of the sane and comparing it to the irrationality often exhibited by the insane. She assesses the ability of schizophrenics to reason adequately and argues that their reasoning may be influenced, at times, by the presence of delusional thoughts.

Delusions held by schizophrenics are defined as “false beliefs persistently held in the face of inadequate evidence or evidence supporting a contrary conclusion”.³⁷ Radden disputes the supposition that delusions always indicate a lack of reason, arguing instead that a schizophrenic’s delusional thinking involves a simple inability to distinguish between what is and isn’t reality.³⁸ What Radden means is that they lack the ability to distinguish between what is delusion and what is not. When an individual continually maintains a delusional belief, even after assurances that it is a false belief, this may be founded on evidence received through hallucinations. According to this argument, the hallucinations can justify the delusional belief(s) of the individual, so that the issue is not a lack of reason.

Thus, the individual’s ability to reason may not have been affected, since they may still function normally in this area. They may still be able to reason sufficiently to give informed consent. This may remain a fact even if the individual has been otherwise affected by the symptoms of their illness.

So if Radden is correct, delusions do not of themselves indicate that a schizophrenic is lacking in reason. Acceptance of this concept may well improve the current medical model’s approach to treatment, and the processes involved in gaining informed consent from schizophrenic patients. It may be necessary to assess other factors which influence an individual’s decision-making (such as common sense) before the conclusion can be reached that the patient is lacking reason.

5.8 Schizophrenic reasoning

Although Radden points out similarities between the thinking of schizophrenics and the thinking of others, it is important to differentiate between a sane individual’s illogical thought - which is just muddled - and that of a seriously mentally ill individual.³⁹

An individual can be highly irrational without suffering a mental illness. For example, some people believe they have been abducted by aliens, and this scenario

seems to imply delusional thought. However, it may not be accompanied by the other pervasive symptoms commonly faced by a schizophrenic.

Furthermore, a sane but delusional individual's irrational belief would (most commonly) be limited to that specific area and commonly be based upon values or convictions which are powerfully held. With schizophrenics, the formation of false beliefs may happen more freely and without a necessity for it to relate to other aspects of themselves in any fixed way.

Delusional thought occurs to a schizophrenic when the individual concerned is influenced by their illness. Treatment may result in the individual once again becoming capable of distinguishing between normal and delusional beliefs. It is the *mental illness* that has caused the delusional thinking, which is significantly different from the irrational thinking that can occur in others.

5.9 Rationality and informed consent

The remainder of this chapter will involve consideration of the responses by the patients, their treatment team and mental health institutions to the specific problems schizophrenics face in the area of informed consent to medical treatment.

Rationality holds a pivotal position within a psychiatrist's area of expertise, and plays a significant role in the assessing of an individual's ability to give informed consent. Therefore, issues of rationality need to be addressed by psychiatrists when dealing with schizophrenic patients. As seen in Chapter 1.4 writers dispute whether schizophrenics, when unwell, have the ability to think rationally and make competent decisions.

The issue of rationality is important because it relates directly to the distinction between physical and mental illness. When a patient's decision is overruled in other fields of medicine, it is generally because the patient cannot adequately understand or appreciate the facts,⁴⁰ which results in their decision regarding their treatment being irrational. In contrast, when a refusal of treatment occurs with schizophrenics, it may actually be due to the illness itself – which can affect the individual's rationality. Therefore, although, some refusals of treatment are given because of irrational fears or desires in all areas of medicine, it occurs more commonly in mental health.

When a schizophrenic's autonomous choice regarding their specific medical treatment is considered to be non-autonomous it is often based upon the individual being considered irrational, or lacking the ability to reason. This means that reason plays an important part in this argument. Although, as argued above, schizophrenics may still be able to reason sufficiently when suffering from their illness, this is not always the case. Therefore, if an individual is deemed to be substantially irrational, then treatment decisions will often be made for them by the psychiatrist involved.

However, although rationality is important, there is no necessity for an individual's decisions to be completely rational or reasonable. As people our rationality varies with circumstances and time, as was discussed in Chapter 3.4. With schizophrenics, as with others, any slight lapse in rationality does not indicate the presence of mental illness; that is indicated by behaviour which is extreme and persistently irrational.

In everyday life, other people, not just the mentally ill, hold beliefs which may not appear to be objectively grounded, such as various religious ways of thinking, and these beliefs often express a person's most deeply held values.⁴¹ So respect for autonomy is paramount in such situations. In such circumstances, the psychiatrist may decide to respect a seemingly irrational request if its basis is a deeply held value - such as a religious belief. This is because it is important that the professional accepts and respects the importance of a patient's specific values when making decisions on treatment.

A common view of irrational behaviour considers actions which are unusual to be irrational, because they are unacceptable morally, socially, or in some other manner.⁴² Thus just being different may be considered irrational. Although not all 'unusual' actions are considered irrational, some may be. As has already been discussed in Chapter 3.3, an individual may be detained and assessed for the presence of mental illness by exhibiting abnormal behaviour.

As discussed in Chapter 3, the concept that irrationality pertains to the infringing of social norms can hold significant problems, because such forms of behaviours are common to the sane, and the insane, resulting in a wide variety of behaviours then earning the description of 'irrational'. Consequently, although rationality holds an important place in discussing a schizophrenics' ability to make informed decisions, irrational behaviour should not be utilised as the *only* justification for disrespecting one's right to give informed consent. So how is rationality assessed?

The assessment of rationality is based on the notion of reasonable or rational acts. To be considered rational, one must have "justified beliefs and desires which have been acquired in accord with the laws of logic and evidential reasoning".⁴³ On this basis, a specific act or belief can be considered irrational depending on whether or not the reasons underlying it appear to be logical. In this view of irrationality it is the manner in which a belief is developed that is important, rather than whether it is true or false. This concept accommodates Radden's argument in relation to the ability of schizophrenics to reason. If the schizophrenic can provide a logical argument (even if based on delusional thought) to justify their decision, then their ability to reason has not been unduly affected by their illness and their ability to make decisions competently should be respected.

Thus, when a patient can explain a belief to the psychiatrist showing that it is compatible with the values they uphold, then holding that belief should not be a

concern for informed consent. It is more important that the “evaluation, principle, value, or desire is adopted or held in virtue of the grounds that would justify its adoption to any rational agent.”⁴⁴

So which elements of rationality are important in the relationship between schizophrenic and psychiatrist? Edwards has selected certain key elements to help discern whether or not a patient is thinking rationally. For example, patients can be deemed rational if they think logically and avoid beliefs which are logically contradictory, can support their beliefs with empirical evidence, and are capable of giving reasons for their behaviour and beliefs.⁴⁵ Each of these elements relate directly to the ability of the individual to think competently and with rationality.

5.10 Role constraints in institutional settings

The effect of involuntary hospitalisation on schizophrenics should be acknowledged by psychiatrists, and the relevant institutions, and requires a response and appropriate action from them.

As this thesis has shown, medical intervention in the area of mental health care, can involve the restriction of a patient’s desires and wishes and this most commonly occurs with the enforced hospitalisation of schizophrenics. When this occurs, schizophrenics find themselves in a situation where they feel relatively powerless whilst the psychiatrist holds great power and control. Consideration of this fact is important because a patient’s capacity to behave and act autonomously *must* be affected to some degree by their circumstance.

When placed involuntarily in a mental health institution, patients may be left with no alternative but to become passive participants in their treatment. The experience is often so confronting and frightening that they adjust by allowing authorities to control and dictate their behaviour in ways they generally would not permit.⁴⁶ The impact of hospitalisation may cause them to refrain from responding to even their most personal preferences. Since the psychiatrist’s role can at times require them to take over decision-making for a schizophrenic, which is usually justified as being for the schizophrenic’s own sake, it is with involuntary hospitalisation that the vast distance between the position of doctor and patient is most highlighted.

Lidz and Meisel discuss the ‘good-patient’ and ‘bad-patient’ roles adopted by patients as a mechanism to cope with the loss of control which is a part of involuntary hospitalisation.⁴⁷ They focus not only on schizophrenic patients but on all individuals who may find themselves in this type of situation.

‘Good’ patients are described as behaving in a manner which is cooperative, undemanding, and respectful, attempting to impress staff. In contrast, ‘bad’ patient’s behaviour often involves the exercising of their autonomy;⁴⁸ they will criticise and complain and question the authority exerted over them. One form of

behaviour exhibited by 'bad' patients may be to insist on being informed of all decisions relevant to them. This can result in them discovering *more* about their legal rights and opportunities than 'good' patients who do not demand such information.

The result of adopting either of these roles has implications for the patient. 'Good' patient behaviour is rewarded and encouraged, whilst 'bad' patient behaviour may result in negative reactions from staff, such as psychiatric referrals, condescension, the ignoring of complaints, and overmedication.⁴⁹ Thus the assumption of a 'good' patient role results in better care, even though it is care over which the patient has no control. This may encourage patients to adopt a 'good' patient role and result in schizophrenic patients failing to verbally demand that their rights be enforced. This means they may be more easily manipulated than those who take on the 'bad patient' role.

One element of particular concern regarding the adoption of a 'good' patient role is that patients may adjust their behaviour to such a degree that they appear to be more stable than they actually are. This can be fuelled by their desire to return to life in the community, but it results in problems, since a relapse is more likely to occur if they are not adequately recovered before release into the community.

An important argument in this thesis is that the influence of life situations impacts seriously on the individual - hospitalisation is one such example. Subjectivity clearly plays a significant role, as there are major variations in how schizophrenic patients respond to hospitalisation, but hospitalisation most commonly results in a patient responding compliantly,⁵⁰ which is of concern because they then behave less autonomously.

Under South Australian mental health law, a detained patient has the right to appeal against the psychiatrist's decision before a specialised board whose role it is to assess such situations (see Chapter 6.13). This is important because the controlling nature of involuntary hospitalisation may affect a patient's judgment to such a degree that they comply with the psychiatrist to avoid further restrictive interventions being placed upon them. Informing patients of their legal rights may provide encouragement for them to utilise their right of appeal. This would reduce the problem of over-ready compliance with the proposals presented by a *powerful* psychiatrist, and reduces the impression that one *must* comply with the psychiatrist in matters such as hospitalisation and medication.

In the treatment of schizophrenia, it is also important to recognise that patients' ability to function will be significantly compromised unless they are given certain powers of decision, but, because patients differ so much, it can be difficult to distinguish when and by how much an individual's decision-making and autonomy should be restricted in their treatment.

The temptation for psychiatrists to perpetuate a patient's dependency during treatment, rather than promoting their autonomy, is a concerning element.⁵¹ They should help equip the schizophrenic for an autonomous life, empowering them to take control of their lives after release. However, an approach such as this is time-consuming, and psychiatrists in the public health system are already severely time-constrained. Yet, without procedures being put in place to resolve such problems, patients leave hospital ill-equipped to face life's decisions. This is even more concerning if they have no friends or family upon whom to rely after being released into the community.

5.11 Medications: and their effects on personal identity

Psychiatrists need to acknowledge the far-reaching affects of anti-psychotic drugs. While recognising the value of anti-psychotic medications, their overall effects upon the individual must be recognised. Therefore, the effects of the medication upon the patient must be weighed against the significant impact of subsequent psychotic episodes which could occur. This demonstrates that when prescribing a medication, its possible effects on an individual's life, need to be considered very carefully.

Although the side effects to anti-psychotic medication can have a negative physical effect, such as weight gain, the negative effects can also be mental, seriously affecting the individual. Typical examples are: its effects on one's ability to think clearly, or creatively, or to feel motivated in any way. These specific symptoms, caused by medication, can be direct obstacles to an individual's achievement of a 'normal' life in society. Therefore, when prescribing medication, psychiatrists needs to address the manner in which the medication has affected the patient's life and whether (on balance) the medication has helped or improved their life overall. The mentality of a schizophrenic is clearly of vital importance when prescribing drugs, but other aspects of their existence, such as employment, are also important and need to be considered.

There are, however, more serious side effects to medication. For example one's personal identity can be affected by anti-psychotic drugs. An individual's behavioural responses, disposition, moods and capabilities can be affected by certain medications,⁵² which may change an individual's personality to such a degree that their entire self is influenced dramatically. This has serious implications for surrogate decision-makers. Are the same beliefs and values which were important to the patient being upheld? Therefore, once again issues of personal identity arise in schizophrenic treatment.

Additionally, although it is an important concern that medication can alter an individual's personal identity, it is also important to recognise that the illness itself (if left untreated) can greatly alter an individual's personal identity. Therefore, the reverse can and does occur, and it is often necessary to prescribe medication to stop the individual's personal identity from being unduly affected by their illness.

Considerations such as these indicate that psychological counselling should be a more important component in the treatment of schizophrenics. Treatments should aim to reintegrate the psychic parts of the individual that need reunifying.⁵³ The therapeutic goal behind psychiatric treatment should be to restore or enhance the unity and coherence of the patient, thus restoring the ability to behave and act as an autonomous agent.

5.12 Re-aligning our beliefs with our principles

The re-alignment of their beliefs with their principles is an important and necessary response to mental illness by schizophrenics. At times their principles may dramatically alter when they are seriously unwell.

As humans we have the ability to acquire new knowledge and apply it to our own set of principles, values and beliefs. Those of us with the capacity to apply logical thought, and utilise reasoning based on evidence, should have the capacity to hold well-grounded, truthful beliefs most of the time. However, none of us have complete consistency in our beliefs, so we need the ability to restore consistency when an alteration to our beliefs proves to be necessary. It is in circumstances where a schizophrenic patient comprehends that they are mistaken or confused about their beliefs that retaining this capacity is vital.

Therefore, we need the capacity to formulate and re-formulate our beliefs to ensure they conform to our other desires and principles. As discussed in Chapter 2.3, a consistency of this kind is imperative if we are to make informed judgments that represent our specific standpoints. When we are well, we can make decisions that reflect ourselves, whether or not those decisions are considered to be correct or incorrect. The important fact is that they are relevant to us as individuals.

This realignment of the core self is important when schizophrenics are treated. More recognition of this aspect of care in modern day treatment is necessary as a lack of coherence may affect the individual's capabilities to be autonomous and *particularly* to exist autonomously in the community. Counselling, or other similar such treatments, should become an integral part in the treatment of schizophrenia.

5.13 The authentic self

As has been argued in this thesis, experiences such as psychotic episodes and involuntary hospitalisation can dramatically alter a person, generally via a revision and reinvention of the elements that combine to make us whom we are. Circumstances such as alterations in one's situation or new information becoming available can cause change to our beliefs and ideals. When this occurs, the less significant a belief is (the more peripheral it is) the more easily that belief will change.⁵⁴ However, events as confronting as mental illness or involuntary hospitalisation can have a major impact on a person.

In normal life we take on new attitudes and reject others, and these changes tend

to be internally motivated. Changes to a core attitude mean that we are evolving according to our own specific internal logic. It is this internal logic that determines how much an individual changes in reaction to an alteration in circumstances, such as dealing with the consequences of being considered incompetent to consent to one's own psychiatric treatment.

When psychological changes occur in this manner, "the new configuration of the self is an authentic continuation of the previous one".⁵⁵ An important point, for this thesis, is that a psychological change that does *not* happen in this manner results in a *new* configuration that is *not* an authentic continuation of the previous one. This is particularly relevant when discussing the specific effects of schizophrenic symptoms on personality. Any change occurring when schizophrenics are unwell may alter those specific attitudes which form their true selves, but do it in a way which does not reflect what they were initially.

It is also important to recognise that having one's right to informed consent disrespected can significantly influence the configuration of the authentic self. To put this more directly, when surrogates make decisions for a schizophrenic, the patient's values and ideals may be severely impacted. To give an example: individuals may prefer to remain un-medicated because they feel more motivated and energetic; they may highly value this aspect of their life. In contrast, a surrogate may believe that the individual is far better off medicated because they believe it slows the patient down and calms them. If the surrogate's wishes are respected, the patient's life is indelibly changed by another's decision-making. Those changes have *not* resulted from one's own specific capacity to control one's own mental life. For this reason a surrogate's decision must involve reference to the patient's own specific ideals and values, it is important to prevent too much disparity between the decisions that are made and the wishes of the schizophrenic.

The impacts of schizophrenia can be horrendous. The first episode of psychosis may change the individual's perspectives to such an extent that they become a person vastly different from their previous self. This consideration must be part of any surrogate decision-making. To make decisions which reflect the patient, the surrogate must know what the patient (currently) values and believes in.

The ability to refashion one's own character is an important aspect of learning to live with the disabling aspects of schizophrenia. Schizophrenia typically influences individuals in particular ways, and any treatment which follows must provide assistance for the patient to reorder and redefine their own particular set of beliefs and values. Psychological counselling is of assistance in achieving this, because it has a focus on assisting the schizophrenic to become, once again, an autonomous individual who is capable of residing successfully within the community.

5.14 The 'Ulysses' contract

A requirement for autonomy is that one looks at the impact of one's past experiences. Therefore it is important that an individual's experience of their mental illness, and how to deal with that illness, be given credence by the psychiatrist. And it has to be remembered that although different schizophrenics often have similar symptoms, and are provided with similar treatments, there are still enormous differences between individual sufferers. This means that a psychiatrist's task is not easy.

A patient's ability to cope and deal with their mental illness should be promoted, for example, by permitting them a certain degree of authority in decision's concerning treatment. This experience, of being included in their recovery, can be an important factor in that individual's future mental stability. And since schizophrenia can be episodic, the experience of having previously dealt with a psychotic episode can be useful if future episodes occur. Evaluation of further options for treatment by a psychiatrist *should* therefore take into account past experiences the patient has undergone in these areas.

In response to this situation, and in anticipation of the effects wrought by schizophrenia, some individuals attempt to control their future treatment and various aspects of their lives, this is known as 'future oriented' or 'precedent' autonomy.⁵⁶ The 'Ulysses' contract is an advance-care directive regarding the treatment and care to be issued to an individual if they fall unwell and need care in the future. These directives are also known as psychiatric wills.

A description of an 'Ulysses contract' is: if an individual understands when relatively well that they may resist treatment whilst suffering a psychotic episode at a later date, then they may sign a contract which ensures that in the future any refusal of treatment can be legitimately overridden. Due to the episodic nature of schizophrenia these wills have a special significance in the area of informed consent and psychiatry, because the episode that the individual suffers is *likely* to be temporary.

At times there are problems with advance-care directives. The existence of a 'Ulysses' contract guarantees that a psychiatrist will over-ride the wishes of patients when they are deemed unwell. However, patients may feel that they are not sufficiently unwell for the contract to be invoked, whereas the psychiatrist may disagree. Conflict then occurs between the patient and the psychiatrist.

Due to such problems, philosophers debate the ethics of 'Ulysses contracts'. Often, the focus is upon the fact that the individual may actually be competent to refuse future treatment. What then are the ethical issues involved in the enforcement of advanced-care directives?

Radden argues that ethical questions with regards to whether the 'Ulysses contract'

should be honoured centre on issues of personal identity. For example, it may be unfair to privilege the wishes of the earlier person and not those of the later person.⁵⁷ This relates to a person's autonomy, and as previously affirmed in this thesis, respecting patient autonomy is vitally important in psychiatric care.

So should Ulysses contracts at times be over-ruled? As has already been argued in this chapter, a significant part of being autonomous and behaving autonomously is having the ability to reconsider, adapt, and change direction either due to experience or new information. A schizophrenic's experience of past and current episodes of psychosis will leave indelible marks, from which they may well have learned more about their illness, which may in turn have changed how they perceive it should be treated. Significantly, their input to treatment decisions can be invaluable.

Therefore, there are arguments in support of an overriding of an advance-directive at a later date, because one's beliefs and choices change over time. However, ethical problems arise when a patient's current choice contradicts their previous choices, which were designed explicitly to prevent any future change of mind.⁵⁸

So is there any way in which the patient at a later date can terminate or modify a previously agreed contract? In response to this problem some philosophers have introduced the notion of authenticity. Their argument is that when a patient refuses to be treated, and has previously signed a 'Ulysses contract', the dilemma should "be resolved through privileging whichever manifestation of the patient's will is the more authentic".⁵⁹ As previously explained in this thesis (Chapter 2.3), a person's authenticity is determined by their relationship with their true selves. Therefore, a patient who can present an argument which is in alignment with their other specific principles and values should legitimately be released from the contract.

Although at times problematic, it is important that Ulysses contracts be recognised in mental health law, because they promote a patient's autonomy by defining their desires when they are not affected by illness.⁶⁰ However, the patient should understand that the order can be revoked at any given time, as long as they have the mental capacity to do so. It is also important that the signing of an Advance Care directive should be done with no coercion, pressure, or influence.⁶¹

E.R. Saks' in her influential book, 'Refusing Care', published in 2002, argues with regard to involuntary hospitalisation, that a patient's autonomy should be disrespected during their first episode because they have never experienced mental illness and have no experience concerning the treatment of their illness.⁶² A higher standard should be applied after the initial episode, because the individual will have formulated their ideals on the basis of experience, and have had time to construct a Ulysses contract and/or form their own preferences.

5.15 Making choices for schizophrenics

Due to the fact that decisions must at times be made for schizophrenics when they are seriously ill, an appropriate response must be in place for society, psychiatrists and institutions to deal with this situation when it arises.

In the area of mental health, a patient's requests can be overridden by psychiatrists or a surrogate. Legally, the surrogate may be an institution, a psychiatrist, a family member, a friend or a court of law. Most commonly, however, this role is filled by the psychiatric professional in charge.

Normally, to give informed consent adequately, a patient must be supplied with all necessary information whilst external pressures, as far as possible, should be removed. However, matters are vastly different for those deemed incompetent, because a third party is given the authority and information, and the treatment decision will be reached by the surrogate and not the patient.⁶³

How does one make an informed choice for a schizophrenic? In discerning what the patient would autonomously decide, it may be necessary to take account of the attitudes they normally hold, including what they prefer and accept. In some instances this may be easy; it could involve a religious belief or a fear. In other circumstances it may be extremely difficult to decide exactly as the patient would have done themselves. In analysing the issues involved in surrogate decision-making, Beauchamp and Childress suggest three general standards - substituted judgment, pure autonomy, and the patient's best interests.⁶⁴

These standards are based on the importance and value of protecting and promoting patient autonomy.

Substituted judgment may be conceived as stepping into an individual's shoes and making a decision as they would. Respect for the principle of autonomy means it should only be used for patients who were once competent, because it can only be applied when it is believed that the decision will be made exactly as the patient would make it. The decision-maker's relationship with the patient must be sufficiently close that the decision will reflect what the patient values.⁶⁵

The substituted judgment standard is important because it deals with the issue of consent from once-competent patients whose preferences can be identified.

The *pure autonomy standard* covers situations where advance-care directives have been made. It can only be applied to those patients who, when autonomous, have expressed a relevant preference.⁶⁶ It is not a necessity that this is via a 'Ulysses contract', as prior judgments deemed autonomous can be accepted. Thus the pure autonomy standard focuses explicitly on the values, goals and preferences preferred by the patient.

In the application of this standard, however, there can be certain practical

problems. For example, the surrogate may apply more credence to a specific value than the patient themselves would. This means that advanced care directives should be constructed explicitly and clearly, otherwise it may be difficult for the surrogate to discern clearly what the individual would have decided, and errors may be made.

Finally there is the *best interest standard*; according to which any surrogate decision-making must focus on the available option that gives the highest net benefit. The surrogate is obliged to comparatively assess the different viable treatments, in order to maximize any benefits.⁶⁷

This last standard involves an assessment of the risks and benefits involved, meaning it relates directly to quality of life. It also involves utilising a strong paternalism framework (discussed in Chapter 3.4) to make decisions for those unable to make their own health care decisions. A patient's values and beliefs are only considered to the extent that they influence the interpretation of which decision will involve the most benefit. The key problem with this standard is that it permits values irrelevant to the patient to become part of the decision.⁶⁸

In a court of law, if an individual's preferences cannot be identified the 'best interests' standard applies. However, it is only when there is no indication of the patient's own desires or wishes (such as through an advanced-care directive) that the best interest standard should rightfully be instigated.

The United Kingdom has a better developed 'best interests' jurisprudence in place, as compared to Australian legislation. The approach taken is that the decision involves, and includes, issues which are not *only* medical, but also encompasses other areas of the individual's life such as emotional and welfare issues.⁶⁹ Such a procedure has many virtues. It enhances the benefits, which are a part of surrogate decision-making, by achieving a more complete analysis of which decision would best suit the patient. An alteration such as this would be worthwhile in Australian mental health law. A major implication of adopting this approach is that the decisions made would be more personal.

Thus, a more careful analysis of the patient's social situation may enhance the decision-making process. For example, in the case of children who are schizophrenic, the parents may legitimately override a decision even if the child is deemed competent. A major justification is that the family itself is directly affected by the treatment selected.⁷⁰

Therefore, in a similar manner, although children and adult schizophrenics are different, when a psychiatrist takes over the decision-making for an adult schizophrenic patient, the treatment plan should take the patient's social situation into consideration. If the patient trusts and relies on certain individuals in the community, then their participation in treatment decision-making is vitally

important because they will better understand the effects of a decision upon that individual's life.

In reality, however, such involvement is not always possible. Some patients will have no such persons to turn to, or they may not trust other individuals sufficiently to involve them in a manner which would be of benefit. This may well occur with schizophrenics, since they may become paranoid and wary of other peoples involvement in their lives. Consequently, problems presented by the illness, can make it hard to include others in decision-making.

So how valuable is surrogate decision-making to a schizophrenic patient? It obviously is meant to protect the patient as much as possible, which is a positive value. However having one's own self-determination holds the intrinsic value that one is then able to determine one's own ideals. The right to self-determination of adults and children, including schizophrenics, should be respected as it results in increased future self-sufficiency, and this factor must always be taken into account when considering surrogate decision-making.

This section has highlighted that the involvement of surrogate decision-makers may be beneficial in many ways. However, psychiatrists need to remain wary of the coercion which can result from the practice. Surrogate decision-makers must ensure that the choices they make do not reflect their own personal values, but what the patient themselves would have chosen.⁷¹

5.16 Confidentiality

The issue of informing others about a patient's state of mind and situation leads into questions about privacy and confidentiality. Privacy is considered to be a basic human right, so issues of confidentiality and privacy in mental health care present serious ethical problems. Revealing highly personal information could violate an individual's right to privacy and show disrespect towards them as a human being.⁷² Since schizophrenics are already vulnerable because of their illness, a psychiatrist has an obligation to fulfil the requirements of confidentiality towards them.

In mental health, generally, patients trust the doctor, whilst the community at large trusts those in the medical profession. Trust in one's doctor involves a range of expectations including the protection of patient confidentiality which was first articulated in the Hippocratic Oath - a code of medical ethics and professional etiquette. It is clear that ancient practitioners were "well aware that truthful disclosure of personal information by the patient without fear of embarrassment, stigma or incrimination was vital to an efficacious therapy".⁷³ Scientific studies have confirmed this many times.

Patients behave in a certain manner during a consultation with a psychiatrist because they believe it is truly private,⁷⁴ and in such situations they often disclose intimate facts about themselves. Facts that they would not wish others to know.

This emphasises the importance *to a patient* of the information given to a psychiatrist. So how much information should a psychiatrist give to a surrogate decision-maker? How much control should a patient have over the disclosure of information? The fact that patients feel that certain information may reflect badly on them is one reason that the law prevents the disclosure of patient information. The patient could be violated and injured if the information were to fall into the wrong hands.

Therapeutically, any breach of patient confidentiality can damage the patient/psychiatrist relationship, and could result in serious impairment of future medical benefits. In fact, the therapeutic relationship could be irretrievably broken. Thus, a powerful reason to maintain confidentiality is that it aids in improving the schizophrenic's mental state. The 'bond of trust' between psychiatrist and patient is important in the diagnosis and treatment of a patient,⁷⁵ so meticulous care should be taken to guard a patient's information.

In spite of the delicate issues of confidentiality there are certain situations whereby it is considered permissible for psychiatrists to give personal information to other individuals. This is usually justified as being for the patient's sake.

So when can the principle of confidentiality legitimately get over-ridden? A common situation is when it comes into direct conflict with the welfare of the schizophrenic involved.⁷⁶ For example, if an individual divulges that he intends to kill himself, other people may be notified in order to protect the patient. Another justification occurs when a patient's condition conflicts with the welfare of another person. For example, if a patient suffers a delusion related to a particular individual, the psychiatrist may need to warn that individual.

When decision-making of this kind is undertaken by the psychiatrist, there are similarities to involuntary hospitalisation. With hospitalisation there can be a similar tension between what may be good for the patient and what may be good for others. However, the overriding of confidentiality when it is feared a patient may hurt themselves is not an issue of conflicting rights. Instead the psychiatrist is overriding a *right* to confidentiality out of concern for patient welfare. With medical confidentiality, the burden of proof resides with the psychiatrist who makes the decision.

There are significant concerns about how much control an individual may retain over information applicable to them in mental health care. The case files of a patient could be very revealing if exposed to others, and this has led to concerns about privacy, because medical records can often be read by a wide range of hospital staff. Problems have arisen due to current modes of treatment. Many schizophrenics are now treated in large public hospitals with a large number of staff, as opposed to treatment in the separate institutions as occurred in the past. If a patient has other medical problems the question of confidentiality and privacy

becomes even more problematic.

The establishment of a separate record for psychiatric treatment, and a policy of revealing information only to those who need to know, might alleviate this problem.⁷⁷ Unfortunately this could present other problems, such as the fact that a separation of medical records would imply a difference between psychiatry and other medical fields, thereby driving them further apart. Such a procedure could also result in there being a separate record for each and every medical problem, which would be impractical. Also, splitting a patient's medical records could affect the provision of adequate care if specialists from different fields were thereby denied relevant information.

A further factor arises because the provision of health care is changing due to the evolution of information technology. The most notable change is the introduction of an electronic health record in Australia,⁷⁸ which will store all an individual's personal health information. It is hoped that this will improve the safety, quality and efficiency of Australian health systems.⁷⁹ However, it may lead to further problems due to the sensitivity of mental health information, and highlight the importance of informational security.

Patients should be well informed about what medical confidentiality actually entails *before* surrogate decision-makers are included in their care. They should be given the opportunity to decide whether to reveal their entire record, or whether certain parts are private and should be accessible only to the psychiatrist or designated people.⁸⁰ There should be a clear distinction between what information is to be revealed and what is to be kept confidential. It is important that a patient be given this choice, because as previously stated, the impact of disclosing personal facts to individuals whom the patient does not trust may impact seriously on a patient's mental health and future recovery.

A patient often has to rely heavily on family and friends whilst living in the community. Consideration must therefore be given to the possibility that disclosure of confidential information to such individuals may sever those bonds of trust which will be highly important for the schizophrenic's future existence.

And of course there is the basic issue of the right to privacy.

5.17 Conclusion

This chapter is pivotal for this thesis, because it deals with ways in which schizophrenia affects patients and how this interferes with the giving of informed consent, and also with associated aspects of informed consent such as surrogate decision-making and privacy.

Schizophrenia has its own particular problems for informed consent, because it gives rise to irrational beliefs and desires, and leads to errors of judgment.

Symptoms such as thought insertion and hallucination compound the problem, leading to an inability by the individual to distinguish with what coincides with reality, and what is false. A further concern is that unlike most people, schizophrenics may lack the ability to see that this is happening.

A major concern is that the effects of schizophrenia will influence an individual's perspectives during their treatment and, consequently, the rest of their lives. Thus attention should be paid to the severe alterations in personal identity which go hand in hand with suffering from schizophrenia, and with the current forms of treatment provided. This chapter has recognised that in the treatment and care of schizophrenia the life-altering issues involved must be taken into account.

Factors such as the use of surrogates, anti-psychotic medications, the treatment of schizophrenics in hospital and patient confidentiality, can all affect the on-going life of the schizophrenic. This means that, as far as possible, the schizophrenic must be permitted and encouraged to participate in treatment. This is significant, because, unless given opportunities to regain confidence in their decision-making abilities, their future life may be seriously compromised.

The following chapter will focus on mental health law – specifically South Australian mental health law. This last chapter will consider where there may be difficulties in applying consistent, non-discriminatory mental health law to the particular problems posed by schizophrenia. It will also consider changes to mental health law which may be beneficial or, alternatively, detrimental to the care and treatment of schizophrenic patients.

Chapter 6: Mental Health Policy

6.1 Introduction

Mental health policy is vitally important. Its aim is the provision of a legislative framework which ensures that society can fulfil its obligation to care for those suffering mental illness.¹ Clive Unsworth points out that law effectively constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates the relationship between those who carry out mental health functions within society.²

Legal criteria for coercive treatment must balance competing interests of stakeholders, as well as achieving policy objectives; the rights of the patient and the public have to be balanced against what is best for the patient's health and well-being, ensuring that mentally ill people obtain the treatment and care they need. Thus mental health legislation intertwines the protection of the rights of those subjected to coercive care with respect for the principles of autonomy, beneficence and justice. Since this is a complex task, legal application of these principles must be carefully specified.

6.2 The Mental Health Act 2009 S.A.

Much of this final chapter will focus on South Australian mental health law. The South Australian Mental Health Act governs the treatment, care and rehabilitation of people with a mental illness in South Australia. The *Mental Health Act 1993* of South Australia was replaced by a new Act proclaimed on 1st July 2010.

Why did South Australia require a new Mental Health Act? There were some broad concerns with the previous Act, many of which related directly to the topics covered in this thesis. The following themes emerged: the rights of both carers and consumers required articulation in legislation; issues related to confidentiality needed attention; an emphasis was required on treatment in the community (not just on hospital services); more flexibility in treatment was needed; treatment plans had to be regulated; and the review procedures required attention.³

These specific issues required alteration because they were unduly impacting on the type of treatments provided to schizophrenics and the manner in which treatments were provided. Some of the alterations to the new Mental Health Act were designed to promote the ability of the mentally ill to participate in their treatment and make decisions relative to their care. This thesis has already highlighted the importance of this aspect of psychiatric care, especially where compulsory treatment is concerned. However, have the alterations gone far enough? And how does the new Act deal with the concerns discussed in this thesis?

6.3 Mental health law: Involuntary treatment

The *Mental Health Act 2009 SA* defines specific criteria to be met before coercive treatments can be instigated. This is important; since it is unlawful to wrongly detain an individual in a psychiatric institution, there must be protection against ‘unbeneficial’ or ‘overly intrusive’ treatments. Whilst permitting authorities to hospitalise individuals against their wishes under Detention and Treatment Orders (DTOs), place them on Community Treatment Orders (CTOs,) or compel them to take various medications, the Act also controls such treatments. This is extremely important because treatments can produce unpleasant side effects, such as feelings of powerlessness, worthlessness and a lack of self-esteem. These are all important aspects of a schizophrenic’s life and their significance was discussed in Chapter 5.

In Australia mental health law is predominantly rights-based. This can present certain problems. For instance it results in a clear division between those with mental illness who are able to exercise their rights, and those who cannot,⁴ because they are considered incapable. One result is inadequate support being provided for those deemed incapable to consent to treatment. Once deemed incompetent they lose the right to decide about their treatment (which is usually coercive) or to have their views seriously considered.

Therefore, an individual’s rights rely heavily upon the clinical diagnosis given by psychiatrists.

In the new Act this problem is meant to be addressed by the inclusion of the South Australian Guardianship Board (the Board) as the authority who supervises practitioner’s decisions regarding the mentally ill. However, as will be discussed in Section 6.13 of this chapter, in this area the Board commonly places undue reliance on psychiatric diagnosis. This can pose serious problems at times.

Throughout this thesis concerns have been raised regarding the level of influence psychiatrists currently hold over patients. This influence looks likely to continue in South Australia since the new mental health law is predominantly rights-based.

A key element of rights-based legalism is respect for personal autonomy, and this thesis has highlighted the importance of respecting patient autonomy in psychiatric treatment. However, a complete focus on autonomy in mental health can be limiting. Why is this so?

Firstly, because a total focus on personal autonomy means that the decisive factor in determining a patient’s rights depends on the capacity to participate in decision-making. Since it is generally the psychiatrist who determines that capacity; this leads to the system being overly paternalistic.

Secondly, a total focus on the principle of autonomy can fail to protect the rights of those deemed incapable of consenting to treatment by making the patient’s views,

wishes and preferences irrelevant to the decision-making process.⁵ This highlights the necessity for the mental health system to provide appropriate independent overview.

Thirdly, whilst autonomy-based legislation can provide protection against unwanted treatment, it does not ensure that appropriate treatments are delivered.⁶

This raises the question: Can a system completely focusing on autonomy actually provide appropriate care? As is obvious from the discussion in this thesis, in psychiatric care respect for an individual's autonomy is gravely important; it shows respect to the individual as a person and brings with it moral entitlement. However, as this thesis has also revealed it is not the sole goal in providing adequate care, since other aspects of an individual's life deserve protection. For instance, the symptoms of mental illness can interfere with an individual's ability to achieve their goals and, therefore, intervention to protect the goals that the individual aspires to may be required (see Chapter 3.4). Therefore, although respect for autonomy is important it is not the sole goal in the provision of adequate psychiatric treatment.

Additionally, it is possible that respect for the principle of autonomy in mental health care may become a reason (or 'excuse') for providing less support and care than is actually necessary, resulting in the provision of insufficient care, and a failure to provide an appropriate level of funding. Clearly, the manner in which schizophrenics are afforded greater autonomy needs careful consideration.

6.4 Human rights - Australian inquiries

In 1993, a National Inquiry into Human Rights and Mental Health in Australia led to the Burdekin Report, which pointed out that those with a mental illness were amongst the "most vulnerable and disadvantaged in our community".⁷ Additionally, the report claimed that the mentally ill in Australia suffered widespread and systematic discrimination and were denied both the rights and services to which they were legitimately entitled.

Since then various actions have been undertaken, including four national mental health plans and various strategies to improve mental health care. These responses were meant to rectify and improve the problems that could be identified with Australian mental health care. However, in the *Not for Service* Report, compiled by the Mental Health Council of Australia and the Brain and Mind Research Institute in 2005, it was pointed out that:

*... after 12 years of mental health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected.*⁸

A National Survey of Mental Health and Wellbeing that was conducted by the Australian Bureau of Statistics in 2007 indicated that only 35 per cent of individuals

with a mental disorder of 12 months in duration received any care.⁹ This indicates that the genuine empowerment of those with mental illnesses in Australia has not been achieved.

6.5 Deinstitutionalisation

The above discussion shows that the current provision of psychiatric services throughout Australia is lacking. This was the case prior to any change of legislation in South Australia and will remain that way unless certain issues are addressed. Many of the problems which occur can be blamed on the failures of deinstitutionalisation. The shift from institutional care to community care has resulted in many individuals being unable to access services, resulting in serious and systematic neglect.¹⁰ Services should be provided in an accessible, acceptable, available manner and be of good quality.

Deinstitutionalisation came about due to economic considerations and a change in social climate – the public no longer supported the confinement of those classed as mentally ill in asylums. Unfortunately, it was introduced concurrently with a lack of sufficient resources being allocated to community-based services; the result is an over-reliance on emergency services and a crisis-driven mental health system. It has been observed in N.Z., Canada, and the U.S.A., that a stressed system produces a cycle for the patient of crisis, then refusal and then aggressive intervention.¹¹

The community's confidence, in services provided by the state in South Australia, is considered by some to be 'at an all time low'.¹² This is partly due, to the failure of deinstitutionalisation, since schizophrenics are much more *visible* within the community than when institutionalised. A lack of funding, adequate community support services and, importantly, of supported residential facilities for the mentally ill has meant that the failures of the public mental health system are clearly evident to the S.A. public.

The fact that so many problems are apparent shows that the state's expectations about implementing community care and deinstitutionalisation have not been fulfilled. The new Mental Health Act does address some of the above serious issues which require immediate attention; but additional funding to support the changes in the Act is required if the situation is to improve.

The rights of the mentally ill have to be extended beyond the walls of mental health institutions and into the community. Adequate care in the community is a necessity; schizophrenics leaving hospital require intermediate treatment and rehabilitation support to recover successfully and remain autonomous. Any lack of services is exacerbated because their behaviour often alienates them from the rest of society. They frequently lack friends or family to support them, and become reliant on the government and other agencies. Inadequate support in the community has severe implications for their state of mental health.

6.6 The Mental Health Act 2009 S.A.: Accessibility

One of the aims of changing the South Australian mental health law was to make mental health services more accessible to those who become unwell in the community. This has been achieved by permitting '*Authorised health professionals*', as well as doctors, to make Level 1 Community Treatment Orders (CTO) and Level 1 Detention and Treatment orders (DTO).¹³ As an important check on coercive powers, an individual placed on an order must be examined by a psychiatrist or medical practitioner within 24 hours of the order being made. If this is not possible, it must occur as soon as is practicably possible. The medical professional may then revoke or confirm the order.¹⁴

The alteration follows a growing trend, internationally and in Australia, of granting other health professionals the power to undertake tasks which previously have been reserved to doctors.¹⁵ In South Australia the professionals, selected by the minister, will include registered nurses, psychologists, social workers, occupational therapists and Aboriginal health workers.¹⁶ They will have the power to instigate treatment measures which are restrictive and coercive. In other words – they will be given the power to deny individuals their liberty and freedoms.

This has negative and positive aspects. A negative aspect is that coercive medical interventions can now occur on the basis of decisions by mental health professionals who lack the qualifications of a psychiatrist. Although this criticism is relevant, it can also be argued that the qualifications of a general medical practitioner to assess mental illness are questionable; yet they also retain the right to instigate coercive treatment.

A positive aspect of the change is that it will facilitate the provision of continued care, since orders can now be passed by individuals who have prior knowledge of the patient, and importantly (in the context of this thesis) of their particular values, beliefs and social situation. It will provide the patient with the opportunity to receive more personalised treatment than was possible under the former Act, which should result in better diagnoses and more beneficial treatments.

6.7 The Mental Health Act 2009 S.A.: Community care

CTOs are now a standard feature of mental health legislation in Australia. The new Act promotes patient autonomy by increasing their use. This should reduce the detention of people to compel them to take medication, and, therefore, minimise the curtailment of their freedoms. The aim is to encourage the mentally ill to reside in the community as independently as possible, while providing access to intervention and support whenever necessary.

The measures which have been put in place in the new Act to protect individuals from receiving unnecessary treatments under CTOs match those of DTOs. In other words, equal consideration is given to the criteria which must be met to instigate

CTOs as is given to the more coercive treatment of involuntary detention. This is a positive step.

Under the previous Act, the Guardianship Board was the only authority that could authorise a CTO, which drew complaints from mental health professionals because it was difficult to obtain urgent meetings with the Board to pass CTOs. This resulted in it being easier for psychiatrists to place individuals on a DTO rather than to recommend a CTO as the appropriate form of treatment. However, a benefit with the previous system was that an external body helped to maintain (and regulate) the therapeutic relationship between treatment team and patient.

Under the new Act, Level 1 CTOs or DTOs can be made by psychiatrists, a medical practitioner or by the newly appointed authorised health professionals. However, all Level 1 CTOs must then be reviewed by the South Australian Guardianship Board - which has the power either to revoke the order or enact a Level 2 CTO.¹⁷

The Act has two tiers of CTOs, whilst the DTOs have three tiers. The difference between each of the tiers is the amount of time for which the order is to be instigated, thus reflecting and accommodating considerations of the seriousness of the patient's condition. The instigation of either Level 2 CTOs or Level 2 and 3 DTOs can only occur after a decision has been passed by the Board.

When a person refuses, or fails to comply, with certain aspects of their CTO, such as taking their medication, the new system of CTOs in South Australia permits ready admission into hospital.¹⁸ The new law permits the psychiatrist, or treatment professional in charge of the individual to enforce this aspect of the Act if considered necessary. This is because non-compliance is usually seen as an indication that the individual requires more supervision in their care. Although this element of the Act is coercive, consideration must be given to the fact that patients may actually welcome measures of intervention being undertaken when they fall seriously unwell. Therefore, the inclusion of ready admission in the Act reflects the concern, that even when placed on a CTO, individuals may still become seriously unwell and require the instigation of more restrictive care.

In Australia, although the right to place patients in hospital due to non-compliance is not commonly utilised, it is widely considered (by psychiatrists) to be an essential component of CTOs.¹⁹ One reason is because, understandably, the threat of detention is compelling to patients. The threat of involuntary hospitalisation is a means of pressuring patients to comply with the treatments selected for their care.

In the U.K., where a similar scheme was set up under the Mental Health (Patients in the Community) Act 1995, health workers felt that the utilisation of these powers badly influenced their therapeutic relationship with the patient, as was discussed in Chapter 1.9. This is important because these relationships are extremely valuable, therefore, consideration must be given to the fact that the use of these powers may

be detrimental to treatment.

This raises questions as to the appropriate level of restriction required. Would a regime permitting more freedoms and empowerment for the patient be more successful? Or would it be at the cost of elements that make the current system workable?

Although CTOs are meant to be (to a degree) coercive, they are still viewed as overly restrictive by some. Opponents of the increased use of CTOs criticise them as 'unjustifiable' and 'unnecessary' counter-therapeutic extensions of social control that discourage individuals from reassuming responsibility of their lives.²⁰ Those suffering mental illness, and placed on a CTO, have identified certain negative effects that result, such as: feeling controlled or restricted or under constant surveillance.²¹ As was discussed in Chapter 2.6, the use of coercion always carries with it a price, which must be considered when deciding upon appropriate treatment.

Such considerations could support the view that CTOs should *only* be used for those with a high number of hospital admissions, who have poor medication compliance and require aftercare.²² Currently, in many instances, CTOs are utilised for exactly these reasons, however, at other times they may be instigated for other reasons - such as the supposed dangerousness of the patient. As discussed in Chapter 3.2, continued supervision in the community can significantly decrease the likelihood of an individual behaving violently. They are a less restrictive means of providing appropriate treatment for an individual who may be disposed to violent behaviour due to their illness. Therefore, although there are concerns about their use, CTOs may rightfully be used in such situations.

An ethical problem with CTOs is that they normally apply to patients who are more stable than those who are involuntarily hospitalised. Therefore, do they warrant such restrictive treatment measures? As with all coercive treatments the state needs to validly justify this form of treatment. There must be a rational relationship shown between the measures utilised and the outcomes sought.²³

So what outcomes should be sought? The main justifications for treatment via a CTO are that it improves the individual's quality of life, prevents relapses and reduces the severity of their illness, reduces stress upon family and friends and enlists sustained attention and support from the mental health system.²⁴ CTOs may also promote social inclusion and increase personal autonomy.

However, if individuals appear to be highly coerced by the CTO, or if the treatment is doing little to promote their capacity to achieve their own desires, or does not support their family members or friends, or adds little benefit to treatment, then they should (justifiably) be discharged from the CTO and reassessed.²⁵

The success of the new system of CTOs will depend on the nature, quality and extent of services provided to the mentally ill in the community. Unless adequate community services are provided, it will benefit few with a mental illness, for they will face life in the community with inadequate support and care in many vital areas. Without adequate assistance, schizophrenics are placed at a significant disadvantage, and as many lack the ability to contribute autonomously within the community, they face undue discrimination.

6.8 Accommodation

Despite efforts to improve the civic status of the mentally ill, there is still valid concern about the level of support allocated prior to the proposed changes. For example, the provision of suitable housing is central to a shift towards community care. Supported accommodation promotes recovery by assisting individuals to remain in the community, and reducing their dependency on the public mental health system, thus promoting their autonomy. Currently, despite the fact that there are several hundred people on waiting lists for supported residential accommodation in South Australia facilities are continuing to close.²⁶

The lack of supported accommodation also impacts on those involuntarily hospitalised. The S.A. Mental Health Department claims that a number of hospitalised patients could be immediately discharged if more accommodation services were made available.²⁷

In South Australia the relevant government Minister is responsible not only for the health system, but also for disability services, family and community services, and housing. The extent of the portfolio acknowledges the fact "that the determinants of good health are often connected to the environment one lives in and one's social and personal circumstances."²⁸ This connection is vitally important and needs to be considered in the current treatment provided to schizophrenics. It is one of the main conclusions reached in this thesis. Currently, inadequate respect has been afforded these issues in the care provided to the mentally ill.

It was pointed out in Chapter 1.10 that those with a mental illness do have the right to live in the community, and make the same choices as other members of society. Participation and inclusion in mainstream life ultimately aids and supports their mental stability. However, people with a disability have for a long time been subjected to marginalisation and exclusion from the life led by others within society,²⁹ and this results in social oppression as discussed in Chapter 1.12.

To prevent such discrimination schizophrenics must be provided with sufficient and reasonable accommodation. The issue of providing reasonable accommodation to the mentally ill challenges the traditional separation there has been between civil and political rights, and economic, social and cultural rights.³⁰ The provision of suitable accommodation will help ensure that rights of all kinds are made available

in a meaningful manner.³¹ Community care requires the recognition that all rights are imperative for the provision of adequate care.

In South Australia the Department of Health claims that as many as 80% of the homeless in Adelaide have mental health problems. A better-funded non-government sector would be able to extend its services; but the public mental health system clearly requires more funding.

The issue of supported accommodation is fundamental to the implementation of the new Act, because of its emphasis on community care.

6.9 Funding and other issues

Mental health law determines “what and how services are funded, organised, regulated, managed, operated and governed.”³² Therefore, the government, in funding the mental health system, has a degree of control on its focus. It is the authority which decides on any alterations to the type of treatments provided.

In the construction of the new Act *existing* services should have been taken into account. For example, current shortfalls in staff and facilities have led to an over-reliance on medication and coercive interventions – it is a crisis driven system. Thus, although the South Australian government may have constructed a suitable legislative framework, concerns remain about the lack of expertise, work-force resources and facilities needed to implement it.³³

Adequate funding is imperative for any system to work. Insufficient funding results in the mentally ill being given fewer treatment options. In an under-resourced system, the most vulnerable will be amongst those most heavily affected.

As in other Australian states and Western countries, an important concern is that institutional care demands a high contribution from the mental health budget. Even before the legislative changes, there were problems because the shortage of acute beds in mental health institutions affected the efficiency of the system and placed patients at risk.³⁴ The current demand for acute beds to some extent reflects an inadequate provision of community services - without adequate support, more patients require periodic hospitalisation. Unless this issue is addressed it will continue after implementation of the new Act.

The expansion of CTOs will increase the workload in particular areas, but how this will affect the system is not yet known. Mere changes in legislation will not suffice; appropriate resources and effective administration are required.

6.10 The *Mental Health Act 2009 S.A.*: Flexible treatments

A failing of the previous Mental Health Act was that it centred upon the regulation of involuntary treatments, rather than provision of the highest possible standards of care. The new Act addresses a patient’s right not to be unduly coerced, but

attention also needed to be paid to the actual success of the treatments provided.

As emphasised in Chapter 1.7, those requiring assistance from the mental health system are heterogeneous; there is immense variability amongst patients in values, character, personal history, etc. Consequently the new Act should have included a wider range of viable treatments (such as therapy and psychological counselling) to provide a more *flexible* system. Other types of treatments, including non-coercive measures, may better accommodate personal differences and the wide variability in values held by key players.

Where coercive treatments have failed, other methods need to be considered. Involuntary hospitalisation and anti-psychotic medications remain common modes of treatment, but of concern is that many of those seriously affected never become well.³⁵ Current treatments can be extremely coercive and questions need to be asked about the general well-being of those who are placed on them over long periods of time.

For example, in reference to the enhanced use of CTOs in the new Act, the South Australian Public Advocate states that instead of increasing the use of coercive treatments, the new Act could have permitted: “proactive community mental health services that go out to people and actively engage consumers”.³⁶ This criticism of the new Act is relevant. Engaging individuals in their own care is extremely beneficial as those who are ‘actively engaged’ are more likely to adhere to their treatment recommendations.³⁷ Instead of focusing on coercive care, the new Act could have implemented a system which included and involved patients in their own care, rather than providing additional forms of treatment they may not want. Many schizophrenics resent *any* interference with their lives – and this includes the less invasive measure of CTOs.

Further, the impact of society and its pressures on individuals needed to be addressed in the new Act. The promotion of individual’s autonomy within mental health care requires that attention is paid to those aspects of life which impinge on their recovery. Ackerman, as discussed in Chapter 3.8, emphasises that psychiatrists should intervene when necessary to promote their patient’s autonomy;³⁸ for example, by supporting their adjustment to life in the community *with* their mental illness. The Act could have identified and accommodated aspects of schizophrenics’ lives that directly impinge on their autonomy and thus recovery. This has especial significance due to the increased use of community care in the new Act.

6.11 The *Mental Health Act 2009 S.A.*: Voluntary treatments

In Chapter 3.6, Gerald Dworkin’s ‘least restrictive’ principle was discussed. The ethical basis of mental health treatment highlights the necessity to employ the least restrictive alternative in treatment. The less restrictive the environment in which

individuals are treated, the more their autonomy is respected and promoted, and the greater the benefits for the individual involved.

However, implementing a less restrictive system relies on (and is subject to) the availability of resources. In an under-resourced system, inappropriate treatment may have to be imposed on those who could have legitimately been treated voluntarily.

The Act recognises that voluntary means of treatment should be considered before instigating enforced treatment methods. It states that:

consideration must be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis.³⁹

This is important because it is at this point that the values and desires of the patient become an important component of their care. However, as discussed in Chapter 4.2 this only applies, ethically and legally, if the individual is capable of giving informed consent and can adequately participate in their treatment.

Although voluntary patients generally have more understanding of their condition, they are still extremely vulnerable to coercion or abuse. This is because they may only be 'compliant' due to a lack of understanding of their rights, fear of coercive treatment, pressure from others or because of their cognitive impairments.⁴⁰ The new Act may provide protection from these elements by its inclusion of a 'statement of rights'.

This 'statement of rights' informs the patient of their legal rights and must be given to every patient,⁴¹ whether voluntary or involuntary, as soon as practicably possible.⁴² Obviously this provides some protection to patients. However, some will not have the capacity to understand the content of the statement and steps must be taken to adequately convey the information.

Importantly, and as a further protection of patient autonomy, there is a requirement for the 'statement of rights' to be given to another person - such as a friend, guardian or relative, etc.⁴³ This is a key step in providing further protection to patients against inappropriate treatment, however, many mentally ill will have no individuals to whom they can turn for support.

There are many benefits to providing voluntary treatment which have been highlighted throughout this thesis. The evolving use of voluntary treatment may lead to less stigma and fear by those who need to access mental health services. This could lead to the further promotion of patient autonomy and elicit more cooperation from consumers in their treatment. It may also facilitate stronger therapeutic relationships which may result in better treatment outcomes.

6.12 Supported decision-making and treatment plans

Unfortunately, rights-based legalism assumes not only that many suffering mental illness do not have the capacity to make decisions, but that they also lack the ability to contribute to decision-making.⁴⁴ This limits the extent to which clinical decisions can be influenced by the preferences of the individual, or by their own experience of their mental illness. In the new Act this problem has been addressed by including the construction of treatment plans.

Chapter 1.12 highlighted the fact that the empowerment of patients is an important component of their care. The new Act attempts to empower them by facilitating partnerships, within which schizophrenics will contribute towards their own treatment plans, and will involve collaboration with key players - such as treatment teams, carers and surrogate decision-makers.⁴⁵

Constructing a treatment plan in such a manner will help patients to understand the reasoning behind their treatment and why it is important. It will also permit the patients values and beliefs to play an important role. The recognition of this in the new Act may have a beneficial influence not only on patients' immediate recovery, but also their sustained future mental health.

The United Nations *Convention on the Rights of Persons with Disabilities* (the CRPD) encourages the ideal of 'supported' decision-making. The implementation of a supported decision-making system will have benefits, as it permits some participation by patients in decisions about their own treatment – albeit with a suitable level of support provided. Supported decision-making can effectively encompass the level of the individual's capabilities, include the social factors relating to the patient, and involve the desires of the patient.⁴⁶ Thus, its implementation, via treatment plans, in the new Act, could benefit the individual greatly.

In its acceptance of supported decision-making the CRPD acknowledges that the decision-making process will involve patients who are vulnerable and can be unduly influenced by the interests of others.⁴⁷ However, this does not mean that patients need to make decisions in isolation from other individuals; instead, they should be actively encouraged to consult others.⁴⁸ Thus, discussions may involve individuals selected by the patient. However, even though discussions would include those whom the patient trusts, it will always be necessary to assess the level of coercion involved.

The Act acknowledges the importance of schizophrenics being given the right to select or nominate a person they wish to support them during their illness and recovery.⁴⁹ Although this may not always be feasible, it is important that the patient does choose whenever possible as opposed to the decision being made for them. Otherwise, as previously mentioned in Chapter 5.15, the participation of other

people may actually be detrimental to the patient's care due to the specific symptoms of paranoia in schizophrenia.

The aim of treatment should be to provide the most appropriate care. The combination of collaborators who have input to the treatment plan will ensure the consideration, not only of social and psychological factors, but also of medical and therapeutical aspects. Studies have shown that patients who have participated in this form of decision-making have a higher level of compliance to treatment and better therapeutic outcomes.⁵⁰

The Act states that:

*Patients (together with their family or other carers or supporters) should be provided with comprehensive information about their illnesses, any orders that apply to them, their legal rights, the treatments and other services that are to be provided or offered to them and what alternatives are available.*⁵¹

This may provide protection for vulnerable patients, but assumes that the 'other' individuals involved can cope adequately.

Importantly, the provision of information to the patient *and* to other relevant individuals will promote a more careful analysis of psychiatrists' decisions. Psychiatrists may well have to re-consider the options for a patient's treatment if those supporting the patient believe the options are not going to benefit them. In circumstances such as this, *the supporting individual* has the right to appeal to the South Australian Guardianship Board.

6.13 The South Australian Guardianship Board

A mental health system must have adequate safeguards erected to protect patients against abuse because of the serious implications of detaining innocent people against their will. In South Australia this role is filled by the Guardianship Board.

The role of the Board is vitally important, because respect for human rights emphasises the right of the individual to participate in decisions which affect their human rights – such as their liberty or privacy.

The Board does not function like a traditional court because it operates as a tribunal, and is intended to be this way. It includes members who are non-legal, which brings a broader spectrum of understanding, and integrates the protection of individual's legal rights with appreciation of other contexts, such as medical and social.⁵² It provides an important check and balance to the use of coercive powers in treatment.

To fulfil its role efficiently, the Board must ensure that legislative criteria are specifically and rigorously addressed, and that the processes it engages in are pro-therapeutic. It is important that it functions efficiently and effectively, otherwise a

basic protection afforded to the mentally ill becomes unavailable. The District Court of South Australia hears appeals against the Board's decisions but as is common throughout Australia, such appeals are relatively rare.

There are certain problems with the review system. For instance, as discussed in Chapter 3.2, an individual can justifiably be detained on the basis of a prediction of dangerousness. The current system provides little opportunity for the mentally ill or their families to dispute the decision, because in these areas the Board generally adheres to the psychiatrist's opinion and errs on the side of caution.⁵³ Additionally, advocates who legally represent patients, report that great weight is placed on psychiatric reports.⁵⁴ This last consideration applies, not only to patients who are considered dangerous, but to all patients dealt with before the Board.

The fact that a psychiatrist's judgment is generally not overturned highlights the importance of enlisting legal representation to support individuals in their dealings with the Board. Patients can receive free legal representation if appealing against their specific treatment order.⁵⁵ However, in South Australia, as is common throughout Australia, legal representation before tribunals is comparatively unusual.⁵⁶ This raises questions about the ability of the Board to make decisions appropriately. Without the presence of legal representatives it may be difficult for the Board to investigate patient's claims effectively. This is a serious consideration because of the implications of constraining an individual's liberties. The review system of South Australia needs to function fairly, or serious abuse can result.

Although the provision of legal representation is meant to preserve a patient's right to refuse treatment, and enable their perspectives and interests to be presented, the Board is at liberty to refuse the patient their wishes – even with legal representation. However, a vital aspect of legal representation is that it does provide patients with a voice.

In relation to hearings before the Board, an additional concern is that many consumers complain that mental health tribunals look at the illness as opposed to the person.⁵⁷ This raises concerns because it can permit the blanket decision that those who suffer mental illness require coercive treatment as opposed to decisions being made based on the individual and their specific situation.

There are other problems too:

- patients argue that the evidence of case-managers, social workers, nurses, etc., should be presented more frequently, because the psychiatrist has little knowledge about them, aside from the written data from those who deal with them daily.⁵⁸

Recognition of this problem would permit the treatment provided to schizophrenics to be more personal. Their values and needs could be better accommodated if

other members of the treatment team were permitted to play a larger role. Additionally:

- family or friends may be able to provide an account which is more favourable than is found on file;⁵⁹

These are valid concerns regarding the manner in which the current review system in South Australia operates.

Further problems can be identified. Due to the implications of rights-based legalism, many admissions are never reviewed, because of the shortened average length of detention – and this goes against established human rights principles.⁶⁰ Article 5 of the European Convention on Human Rights establishes that a speedy review is necessary for a mental health system to be working effectively. In many instances this does not occur.

Additionally, once a Board hearing is scheduled, psychiatrists have to ensure that patients meet the criteria if they are to continue treatment. There are reports that because of this requirement, patients are being discharged in the days prior to the hearing,⁶¹ thereby failing to have their detention reviewed.

Consequently, in regards to both issues, an individual's treatment then remains on file. These records may then be used to justify coercive treatment in the future.

Overall, although the concept of the Guardianship Board is good, there are aspects to its operation such as increased legal representation, the involvement of treatment team members, and speedier Board hearings which require further review.

6.14 The *Mental Health Act 2009 S.A.*: Diagnosis

'Mental illness' is defined in the Act as "*any illness or disorder of the mind*".⁶² Detention or coercive treatment is not permitted unless mental illness can be detected by a professional holding the power to instigate mental health treatment. This is intended to prevent any inappropriate repression of an individual's right to be different from the majority within society.

The problems that can occur because of the unusual behaviour of schizophrenics were discussed in Chapter 3.3. Even though schizophrenics' may differ in their behaviour from others in society, it is ethically wrong that they should be detained on such a basis, and denied their basic freedoms.⁶³ Detention should only be considered ethically correct when an individual's behaviour poses a serious threat of danger to themselves or others. This may occur due to the specific symptoms of mental illness.

There are few mechanisms by which to diagnose whether an individual is suffering from mental illness. Diagnosis depends highly on the interpretation of behaviours as

being abnormal,⁶⁴ which can obviously pose problems. Factors other than mental illness may contribute to a person seeming to be less than psychologically functional. For example, drug-induced psychosis can be misdiagnosed as schizophrenia. Since problems ensue from such mistakes, great care must be taken in diagnosis.

The new Act addresses this problem by defining criteria which are not to be considered as justification for a diagnosis of mental illness, or for the instigation of involuntary treatment. Criteria in Schedule 1 of the Act encompass those topics (or perspectives) about which individuals can often form strong personal preferences. The inclusion of these criteria is important because of the diverse range of ideals and values possessed by members of Australian society. The Act states:

*A person does not have a mental illness merely because of any 1 or more of the following ... [and the list includes] ... political opinions, religious opinions, philosophy or sexual preferences, as well as any immoral or illegal conduct.*⁶⁵

Therefore, an individual's specific political, sexual, etc., beliefs should not be considered as an indication of mental illness, and thus, that there is a requirement for coercive care. Acknowledging that such problems can occur highlights the dangers of social constructivism in relation to mental illness diagnosis, as discussed briefly in Chapter 1.4. Care must be taken that authorities are not too overly inclusive in consideration of what they deem to depict mental illness.

In summation, mental illness must be present for involuntary treatment to legally occur; which prevents the use of psychiatric treatment as a means for social or political control.⁶⁶ Additionally, for treatment to be justifiable the mental illness of the individual must be treatable. For example, the individual must have schizophrenia, rather than a personality disorder, which cannot be treated utilising psychiatric care.

6.15 The *Mental Health Act 2009* S.A.: Criteria for Medical Intervention

Although there are significant concerns about the use of involuntary hospitalisation, it is sometimes necessary. It provides safety and security for the patient, and at times is necessary for recovery and rehabilitation. The use of involuntary treatment is currently based on the elements of mental illness, dangerousness and treatability.

The previous Mental Health Act required a practitioner, making a DTO to be '*satisfied*' that the patient required medical treatment, and it permitted hospitalisation of those unable to look after their own health and safety. Concerns were raised because although this permitted intervention at a point of crisis (such as a suicide attempt) it did not always prevent the deterioration of an individual's state before it reached this point.⁶⁷

This fact that this problem *consistently* occurred has been disputed by the Law Society of South Australia, who argued that examples can be found of cases before the Board, and the District Court, which upheld detention or treatment based upon issues of safety less serious than either suicide or homicide.⁶⁸ The Society was informed of this by legal advocates who had played a role in these cases. However, arguments supporting alteration of the criteria prevailed, because the Coroner and police supported the change due to frustration at the number of those who clearly required medical intervention, but were denied treatment because the practitioner was uncertain of a diagnosis or of the need.⁶⁹

In the new Act, for both CTOs and DTOs, the new Act replaces the word '*satisfied*' with '*appears*';⁷⁰ it must now '*appear*' that the patient requires treatment. This makes it easier to detain individuals. The criteria utilised in the new Act for DTOs and CTOs are that:

- '*the person has a mental illness*';
- '*because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm*';
- '*there is no less restrictive means than the particular form of order in question for ensuring appropriate treatment of the person's mental illness.*'⁷¹

The criteria for compulsory intervention are critical because they determine when autonomous decision-making, and selection of treatment, is acceptable from a patient suffering mental illness. So does the new Act provide appropriate thresholds for permitting limitations of the liberty of an individual who suffers mental illness in South Australia?

Congruent to the argument in this thesis, the new criteria in the Act is concerning. This is because of the wide variance in what might be described as '*harm*'; as the extent of the '*harm*' required is not defined in the new Act. The government's justification for having done this is that there is no way to predict accurately whether a person left untreated will cause harm to themselves or others;⁷² so the responsibility for determining the severity of potential harm lies with the practitioner.

In Chapter 3.4 it was argued that the harm exhibited, or predicted, must be of a highly risky nature before coercive treatment can legitimately be instigated. This highlights the two-fold concern: on the one hand, intervention is required before a serious problem such as attempted suicide arises; on the other hand, coercive treatments should not be used until there is genuine potential for '*harm*' - whether that is harm to one-self, or to others. In making decisions such as this, authorities must acknowledge that judgements regarding harm are unreliable, and be careful that they do not just accede to the worst case scenario.

Chapter 3 recognised that involuntary treatments can justifiably be instigated when there is a *serious* threat of harm, to society, or to one of its members. The inclusion of the word 'serious', within the criteria of the new Act, preceding the word 'harm' would have been beneficial. The terminology 'serious harm' would have then set a higher limit to the justifications that can be utilised to treat patients coercively. As there is no such inclusion the new Act has significantly increased the powers of psychiatrists.

In addition, the presence of the phrase '*including harm involved in the continuation or deterioration of the person's condition*' within the criteria, seems to indicate that the mere presence of mental illness is considered to be 'harm' in itself. The result is that there is no requirement for any form of further harm to be demonstrated to justifiably initiate coercive treatment.⁷³

In relation to the issues involved with harm, J.S. Mill wrote of the importance of respecting an individual's right to behave as they choose - unless the behaviour is harm-causing to society or any of its members. According to Mill, society then legitimately gains jurisdiction over the individual's behaviour.⁷⁴

However, when people's behaviour only ultimately affects them, they should be permitted their freedom. Acknowledging this is of vital importance, as it permits individuals to act as they choose and to then withstand the consequences of their actions,⁷⁵ which is beneficial. However, in utilising this manner of thinking, the specific symptoms of mental illness can cause problems. Due to their illness, individuals may behave non-voluntarily or non-autonomously, and this may cause behaviour which is self-harming. Therefore, the state is justified in intervening with an individual's liberty of action, when their behaviour is considered to be detrimental to themselves, and mental illness can be detected. As discussed in Chapter 3.7, treatment can justifiably be instigated when this occurs.

Consequently, it can be argued that the Act fails to provide appropriate limitations on the use of psychiatric powers which deny individuals their liberty. This is because involuntary treatment may occur on the basis of broad criteria which include only limited safeguards for patients. It becomes justifiable to presume that an individual lacks capacity, and so ignore their refusal of treatment, primarily because they have been diagnosed with a mental illness.⁷⁶

Thus, a major failing of the new Act is that the criteria for coercive treatment in South Australian mental health law appear to afford a lower level of protection for patient autonomy than that afforded patients in other areas of medical treatment. The practitioner has gained greatly increased control in this area.

6.16 Mental health law and capacity

Legally, patients do have a right to refuse treatment considered vital to their health.⁷⁷ In mental health, any rejection of treatment by the individual does not of

itself prove incapacity. Furthermore, as discussed in Section 2.8, a schizophrenic patient's capacity is never static or uniform, it varies. When periods of incapacity occur (due to the episodic nature of schizophrenia) a person's wishes and desires have the same legal validity as they would have in general medical practice and must duly be considered. Consequently, individuals who meet legal requirements should be permitted to refuse treatment.

The question of capacity arises when patients refuse treatments recommended in their 'best interests'. This causes problems – as was discussed in Chapter 3.4. Lack of capacity *cannot* be determined on the basis of refusal of treatment, even if that decision seems ill-advised or irrational. Legally, lack of 'capacity' depends on a person's ability to partake in the decision-making *process*, not the quality of the decision.⁷⁸ A principle of autonomy is that capable people, including those suffering a mental health illness, should be permitted to make unreasonable decisions unless they are considered to be mentally incapable at the time. This, of course, includes only those decisions which directly affect themselves alone (see previous sections discussion regarding Mill).

In Australian mental health care, concerns have been raised about the automatic assumption that an individual suffering severe mental illness lacks capacity. Evidence can be found of this occurring here in Australia; and Weller asserts that this is reflected by

*the propensity of mental health professionals to determine that patients who refuse, or try to negotiate, recommended medical treatment, even when the negotiation is directed toward securing an alternative form of recognised treatment, meet the legislative criteria for involuntary civil commitment.*⁷⁹

Obviously this is a concern. Additionally, when it occurs, patients feel, that it emphasises the fact that mental health professionals, consider involuntary treatment to be the principal *clinical response* to the treatment of mental illness.⁸⁰ This is in contrast to patients treated in other medical fields, and warrants further discussion as it indicates discrimination.

The premise underlying differential treatment is that patients with a mental illness are different from others. However, this clearly does not provide valid justification to refuse any patient with mental illness the right to make their own treatment decisions. As discussed in Chapter 3 the individual must require treatment or care for coercive care to be instigated.

6.17 Schizophrenia and discriminative treatment

Donnelly identifies two reasons that may justify discriminative treatment in psychiatric care.⁸¹ Firstly, an individual's right to their autonomy must be considered differently when mental illness is present. Secondly, consideration must be given to the prevention of harm to others, since harm could occur if an individual does not

obtain treatment when necessary.

In addressing the first consideration, as was discussed in Chapter 3, a common goal of medical mental health intervention is the restoration of a patient's autonomy. This means that some limitations of the right to refuse treatment can be justified in respect of this greater goal. However, a problem with this argument is that the assumption that a patient's autonomy will be restored is merely speculative.⁸²

In addressing the second consideration, and as discussed in Chapter 3, 'harm' plays a significant role in the restriction of autonomy, but do schizophrenics pose sufficient threat to justify differential treatment? The mere possibility that harm to others may occur should not be sufficient to justify a wholesale overriding of individuals' autonomy. However, this is how the system operates, because of the difficulties in predicting harm, and out of concern for the welfare of others. Yet, as argued in Chapter 3, this should only be permitted to occur when the risk and degree of harm is considered serious to the public. Therefore, the inclusion of the word 'serious' in the involuntary treatment criteria within the new Act would have been beneficial.

United Kingdom epidemiological data reveal a slightly greater propensity for serious violence amongst those with a mental disorder (when compared with the rest of the population), however, the increased risk due to mental disorder is relatively low compared to other factors (such as those discussed in Chapter 3 - gender, age, socio-economic status, drug or alcohol usage, etc).⁸³ This indicates that the level of risk presented by schizophrenic patients is insufficient to justify a differential legal approach to autonomous decision-making if none of the above 'other' factors are found to be present.

This reveals that the differential treatment of schizophrenics is at times unjustified. However, at times the restriction that mental illness can have on an individual's ability to behave autonomously, and the dangers presented by their behaviour towards others requires that, in certain situations, restrictive, coercive care be implemented. This is due to the implications of mental illness.

6.18 Refusing Care

In relation to the discriminative treatment of the mentally ill, this has been addressed in the U.S.A., courts by the recognition of their right to make autonomous treatment decisions – this includes those with schizophrenia; they are not to be treated as having a lesser status or level of dignity.⁸⁴ The increased recognition of patient autonomy in the U.S.A. was controversial, because the psychiatric profession feared it would lead to a large number of patients refusing treatment. However, this did not occur. Instead it was found that when patients refused treatment, and the situation was reviewed, they were generally found to lack the capacity to make that decision.⁸⁵ Ultimately, the change rarely resulted in

patients being left untreated.

There would be benefits to implementing a system, operating in this manner, in South Australia:

- the enhanced right to refuse care may increase a patient's trust and confidence in mental health professionals (and the system in general);
- it may improve the psychiatrist-patient relationship and increase the patient's motivation to recover;
- additionally, as Winick argues, patients will respond much better to treatment, and will comply more willingly, if they are internally *motivated*, rather than externally *pressured* to undergo treatment.⁸⁶

Obviously, however, these benefits can only occur, when patients are capable of contributing adequately towards their care.

In reference to this, Peter Bartlett claims that anecdotal evidence suggests that few individuals who refuse treatment in Australia are actually refusing *all* medication or treatment.⁸⁷ Instead, refusals are most often centred on the need for treatment teams to engage with the patients in regard to decisions that affect them. Therefore, refusal is more commonly about the articulation of the patient's own desires, and the retention of individual dignity, than being treated as a clinical object.

6.19 Non-consensual treatment utilising anti-psychotic drugs

Mental illness is costly to treat, so reduction of costs is one reason the government relies heavily on medications to treat mental illness. In relation to the use of pharmaceuticals in treatment, the Commonwealth government's superior revenue-raising capacity means that South Australia depends upon it to subsidise certain aspects of its mental health services.⁸⁸ Significantly, this includes medication.

Therefore, when it comes to the current psychiatric care provided by the South Australian government, a degree of control is held by the Commonwealth. In other words, the Commonwealth has a significant influence on the provision of care in South Australia. However, this does not apply to all medications, since not all are available on the Pharmaceutical Benefits Scheme (PBS).

It does mean, however, that a move away from relying predominantly on medication may be an expensive endeavour for the state government, and this has impacted on the government's decision-making in this area.

This issue is one of concern because the compliance of patients who are prescribed drugs is low, raising questions about their willingness to participate in the treatments currently provided. It must be remembered that non-compliance may reflect an aversion to the way that drugs affect their psychological well-being and other important aspects of their lives rather than an inaccurate self-assessment of

their mental condition.

Self-assessment, as discussed in Chapter 5.4, can be termed 'insight' in mental health – so inaccurate self-assessment is defined as a lack of understanding relating to one's medical condition. Insight is a useful component in the treatment of schizophrenics, as it reflects directly on their ability to give informed consent and to the possibility of using less restrictive treatments. Studies have shown a correlation between poor levels of insight and a low level of adherence to medication.⁸⁹

Jonathon Lacro and colleagues analysed studies on levels of non-adherence to psychotropic medications amongst those with schizophrenia, and found them to vary between 41.2 and 49.5 per cent.⁹⁰ The factors most consistently associated with non-adherence included not only a lack of insight, but negative attitudes towards medication, previous non-compliance, substance abuse, inadequate discharge planning or aftercare environment and poor therapeutic relationships. This reveals that there are often several reasons why an individual may fail to comply with medication-based treatments.

Non-consensual treatment using anti-psychotic drugs is an important issue and raises ethical questions about civil liberties. Some schizophrenics find the enforcement of medication to be the most invasive treatment they face, being more upset by being made to consume medication than they are to hospitalisation. This is understandable as it is offensive to some to be ordered to take a medication that one does not wish to consume – especially if one has prior personal knowledge of its effects. And studies also show that the symptoms of some medication can be similar to those of mental illnesses.⁹¹

Weller, citing several writers, raises concerns about the enforcement of medication, because of the debilitating psychological effects which can occur with it. The experience (which often is repeated) of losing autonomous control combined with the non-consensual invasion of the self (and the body) that is congruent with involuntary treatment can be extremely debilitating.⁹² Therefore, the combination of enforced medication and restricted liberty can have an extremely detrimental effect.

Research indicates that other approaches, such as cognitive behavioural therapy, may produce results which are better (in the long-term) than those of medication,⁹³ whilst promoting patient autonomy and encouraging more participation in treatment.

Anti-psychotic medication is currently seen as the prime means of treating mental illness, often combined with other coercive treatments. However, the effects of medications on a person, as discussed in Chapter 5.11, mean that strict attention needs to apply to why and how they are used.

6.20 The *Mental Health Act 2009 S.A.*: Appeals against treatment

When an individual appeals against the treatment order they have been placed on, should they be medicated and treated prior to their appeal being heard before the Board?

With this issue, as with many others in the area of informed consent to psychiatric treatment, it is often found that doctor's support immediate initiation of treatment, whilst lawyers support the patient's right to refuse treatment. This reflects the difficulties posed by this particular aspect of mental health care.

Consequently, the Law Society of South Australia considers that no treatment should be given without consent to a patient who is waiting for an appeal against a DTO or a CTO.⁹⁴ Clearly, this position holds much worth, and is highly relevant in certain situations. However, time constraints mean that it cannot be applied to *all* patients placed under involuntary care. This is because when the instigation of treatment is delayed, there is often a risk of further deterioration to a patient's condition. Therefore, care must be taken by the professionals involved.

Under the new Act, (as under the old one) an application to appeal can be made not only by a patient, but by the Public Advocate, a guardian, medical agent, relative, carer, friend or any other individual who satisfies the Board that they have a proper interest in the matter.⁹⁵ Having such a wide range of individuals permitted to intervene is appropriate; since those undergoing coercive treatment may find it difficult to understand how to get assistance or to raise concerns about their care, it provides an important source of support.

This also helps to promote the individual's personal autonomy in a disempowering environment, such as involuntary hospitalisation – see Chapter 5.10. However, even if there are good reasons to appeal against an enforced treatment, patients most commonly continue to be treated whilst awaiting their appeal.

In relation to this, the new Act states:

*The Board may, on the application of the appellant, vary or suspend an order, or make an order restricting or imposing conditions on, the treatment that may be administered to the appellant, pending determination of the appeal, if the Board thinks special reason exists for doing so.*⁹⁶

This reveals that the new Act does permit non-consensual treatment to be stopped, but only in certain situations. This, at times, can be concerning because the individual may have a just and reasonable cause to appeal against their diagnosis and treatment. However, because of the nature of mental illness, treatment is often begun to counteract the affects the illness may have upon an individual's ability to function normally, and to protect their future endeavours. This obviously is of vital importance. However, since the effects of the prescribed medication can also have

a detrimental impact on the individual's well-being, this issue will remain contentious.

6.21 The *Mental Health Act 2009 S.A.*: Confidentiality

In the new Act the section dealing with the issues involving confidentiality and mental health care is an important adaptation from the old. The confidentiality of 'personal information' is a serious issue in mental health care and the government in their construction of the new Act paid particular attention to this fact. The restrictive confidentiality legislation, of the past, which inhibited mental health professional's communication with other relevant individuals about patients' conditions and treatment plans, is now gone. The new system, legislated in the new Act, is much more flexible in this area.

Due to community care having become the most common mode of treatment, there have been certain confidentiality problems which have arisen. The necessity to share information with various agencies and departments means that there is often a wide range of information compiled about individual's suffering mental illness which can become available. Various types of information, out of necessity, need to be provided to separate services and agencies, dealing with social support, accommodation, voluntary services, etc., and this occurs for a variety of different reasons.

In South Australia, one reason that confidentiality issues have become a major concern is that the State Coroner has pointed out that the deaths of certain patients could have been avoided by the better sharing of information.⁹⁷ This reveals that, in the past, serious difficulties have occurred due to issues related to confidentiality. This increased calls for the confidentiality of patients in the mental health system to be less restrictive.

The new Act's confidentiality section deals with when it is appropriate for information to be released to other parties, and matches those elements discussed in Chapter 5.16. In relation to this, the new Act includes provisions for the release of information when issues of safety arise. The Act states that the disclosure of information is appropriate when:

*reasonably required to lessen or prevent a serious threat to the life, health or safety of a person, or a serious threat to public health or safety*⁹⁸

Additionally, the Act allows lawful disclosure of information to a relative, carer or friend if the disclosure is 'reasonably required for the treatment, care and rehabilitation of the person' and not 'contrary to the person's best interests'.⁹⁹ However, voluntary patients may still direct for this information to remain confidential.

These specific alterations, to the new Act, acknowledge that the inclusion of others

in the care of the mentally ill deserves recognition. The provision of information to a relative, carer or friend *may occur* when the information is reasonably required for the ongoing care of the patient, and the guardian, family member or carer will be involved in providing that care. As was discussed in Chapter 5.15 the involvement of family members, or relevant others, can be justified by their contribution towards patient care.

The provision of information to others rests upon a paternalistic justification, and the broadening of confidentiality rights in the new Act will require treatment teams to “develop a working knowledge of acceptable grounds for paternalistic interventions”.¹⁰⁰ Once again this will revolve around considerations of physician beneficence and patient autonomy. Obviously, in the future this will, at times, be difficult and professional discretion will be required.

6.22 Conclusion

The new South Australian Mental Health Act has introduced some important elements to the State’s mental health legislation. A genuine improvement has been made by legislating to involve both surrogate decision-makers and patients in the construction of treatment plans. This should facilitate a more holistic approach to decision-making, encompassing the individual’s values, desires, needs, their social situation, and the effects of medication and treatment upon their lives. It should also provide for the genuine empowerment gained by participating in one’s own care.

The new Act has also improved the accessibility to mental health care services by redefining CTOs. This will be further promoted by permitting authorised health professionals to instigate coercive treatment. However, although these changes are meant to improve the system, services will fail without the provision of adequate community care. This is especially important in areas such as supported accommodation. The increased use of CTOs requires that further attention be given to improving the quality of life of individuals residing in the community whilst suffering from mental illness.

Additionally, if the system is to function appropriately, it requires an appropriate level of funding. Changing the legislation has the intent of improving the system, but this must also be accompanied by the provision of the facilities necessary for its implementation. Without this happening its effects are likely to be severely constrained.

In summation, the new legislation does not go far enough in addressing some of the concerns raised in this thesis. Insufficient consideration has been given to the implications of society’s influence on those with schizophrenia, as well as adequate respect for patient diversity. Permitting the use of a wider range of available treatments could have increased the autonomy of those requiring treatment, and

allowed for more options and choices, thus providing greater flexibility and better treatment. In these areas, the new Act does not differ greatly from the old, and this is disappointing as it was an opportunity to overhaul the state's mental health system towards functioning in a more productive manner.

Overall, although there are good aspects to the new legislation, a major concern is that the balance of power remains firmly within the psychiatrist's possession. The considerable weight the Guardianship Board allocates to psychiatrists' recommendations on diagnosis and treatment can result in a lack of respect and adequate protection being afforded to those schizophrenics facing coercive care.

Conclusion

The nature of schizophrenia ensures that its diagnosis and treatment present ethical, legal and medical problems, which will continue to fuel conflict and debate in the future. Philosophical discussion of mental health legislation and policy is important, and should ensure careful analysis of the role of ethics, but it often fails to provide a systematic approach to solving moral problems in the field. However, philosophical theory should help to reveal mechanisms which could benefit the current mental health system as it stands.

In psychiatry there may have been more acceptance of moral disagreement than in other fields of medicine, due to its more scientifically complex nature. This is because personal values, ideals and beliefs form an integral part of mental health treatment and care. Therefore moral disagreement will remain an implicit part of mental health care in the future and will continue to need to be resolved - to the extent that schizophrenic patients can be treated effectively. Moral disagreements can occur between patients, the treatment team, and those creating policy, and when they happen can hinder the work of psychiatrists and cause conflict and bitterness amongst patients.¹

This thesis has revealed that on occasion there are strong arguments in support, both of retaining patient autonomy, and of limiting it. In summary, the schizophrenic's right to choose autonomously needs to be respected, except in situations where their decision-making abilities can reasonably be questioned. In such circumstances it may be justifiable to limit both autonomy, and the right to give informed consent to medical treatment. However, respecting an individual's personal autonomy is so important that interfering with this right should only occur when strict justifications can be presented by the authorities involved.

Throughout this thesis, similarities and differences between the mentally ill and the sane have been presented. An important similarity is that in everyday life, just as mental illness can affect an individual's decision-making capabilities, we can all make decisions which are self-defeating. This means that we all, to some extent, share the same problems that can affect schizophrenics. Realising this, it is easier to accept paternalistic intervention (coercive treatment) when its intent is to either restore or protect the patient's autonomy. Similarly it is much easier to accept methods of mental health treatment that preserve and enhance the schizophrenic's capability to rationally make decisions in the future.

The experience of schizophrenia gives rise to irrational beliefs and desires, which can lead to errors of judgment. This problem is compounded by symptoms such as thought insertion and hallucination, which lead to an inability to distinguish with what coincides with reality, and what is false. A further factor is that unlike most people, schizophrenics lack the ability to see that this is happening, resulting in their decisions not corresponding with social reality.

These factors present significant problems for informed consent, which is based on the assumption that patients comprehend the nature of their condition, and are competent both to make the decision required, and to deal with the results of that action. Clearly, this is not always the case with schizophrenics.

In this thesis, it is argued that there is moral worth in respecting informed consent, because allowing a schizophrenic to utilise their rational capacities results in personal growth which continues throughout treatment. Consistency of experience is important for the retention of one's sense of self, since we actively construct our consciousness and self-knowledge through all our experiences. Therefore, psychiatrists need to consider this in all decisions which have significant consequences upon a person, such as enforced medication and involuntary hospitalisation.

Additionally, the experience of having schizophrenia has profound implications on one's own person, so continuing participation in one's own treatment is vitally important. This may well benefit the patient in the future, and has especial significance for schizophrenic patients as the illness is often episodic and future episodes may occur.

As revealed in this thesis, although the anti-psychiatric movement presents interesting arguments about whether or not schizophrenia is a medical reality, the authenticity and severity of schizophrenia's symptoms in real life cannot be denied. This demands acknowledgement of the particular problems it presents for patients, their carers, and society in general.

What would occur if the current treatments provided for the illness were halted? Those considered to be schizophrenic could never be involuntarily hospitalised or treated and the involvement of surrogates to assist in decision-making would cease. Schizophrenics would lack the level of services currently provided to accommodate their specific difficulties whilst residing in the community. This reveals that it would be extremely counter-productive to totally abandon the current medical approach taken towards mental illness.

The importance of respecting the human rights of schizophrenics in their treatment has been highlighted, revealing that the concerns regarding the quality of mental health care in Australia which have arisen over the last few decades need to be addressed. As this thesis has shown, many of the problems identified are valid - for example, the current inadequate provision of reasonable accommodation needs immediate attention. Appropriately, in providing adequate mental health services to consumers, there should be the inclusion of a safe environment for sufferers – whether this is in the community or in hospital. The treatments provided should also involve respect for a patient's values, their specific social situation, and their individuality.

This thesis emphasised the necessity to find a balance between control and treatment in the care provided to schizophrenics. Currently two opposite ends of a scale are utilised: coercive treatment versus community care lacking in sufficient support. A middle ground needs to be found, which accommodates the immense range and diversity of schizophrenic sufferers, whilst providing appropriate patient choice and support to those being treated.

The quality of treatment provided to schizophrenics is at times outside their control. This means that appropriate protocols must be applied to protect both them, and others, during treatment. For example, justice in care requires that patients have the right to an independent review of their compulsory treatment, coupled with reasonable and fair access to support and treatment within the community.

When the treatments provided adversely affect patient's lives, it is understandable that they do not want to participate or co-operate in their care. Therefore a balance has to be achieved between what we are seeking to *protect*, and the way we actually *benefit* patients. Enforcing treatment on an individual which is going to impact negatively on an individual's life, such as their employment, is neither therapeutically or medically helpful and can lead to such serious expressions of pain as attempts at suicide.

Carefully designed and implemented mental health legislation is a necessity. The current treatment and care procedures in place are vital, but they cannot work as intended unless matched by accessible infrastructure and human resources. The new South Australian *Mental Health Act 2009* has provided significant improvements in protecting patients and their rights, but there are still areas which could be improved, such as the disproportionate powers held by psychiatrists in the treatment of schizophrenics.

Mental health law tends to focus on, and emphasise, rationality and cognitive ability. This can result in insufficient weight being given to values and emotions. In this thesis there have been repeated references made to the importance of values in the treatment of schizophrenia. The accommodation of values in treatment would personalise mental health care, and help to address the immense variability amongst patients and treatment teams.

Additionally, there could be much benefit gained by increasing the range of treatments provided – making treatment more flexible. Enhanced flexibility in treatment would provide a system which respects both patient autonomy and the differences which can apply to each and every patient. Currently, there is a focus on whether or not a patient is capable to assent or refuse treatment, but if it were possible for a patient to be presented with several treatment options, it would permit them to select one of which they approve. Treatments which appeal to the patient will be far easier to implement and enforce.

Utilising community care has many benefits – it permits individuals to reside outside of hospital yet to be provided with a certain level of care. However, those who experience schizophrenia suffer strange and weird symptoms, which serve to alienate them from the rest of society. They are left alone in a world which has become unfamiliar. Unfortunately, they are further ostracised because the label ‘schizophrenic’ affects society’s perception of them and their illness.

Consequently, although the majority of schizophrenics reside in the community they (in many ways) fail to share in the community life that others enjoy. Due to the manner in which they are dealt with by society, charity organisations and the government they often lack the freedom to participate in decision-making regarding certain aspects of their lives. Of especial importance is the restriction this has on the individual’s ability to direct the course of their own existence and live autonomously within the community.

The research undertaken to write this thesis, has revealed that many interesting and insightful pieces of literature have been written with kindness and understanding in regards to the mentally ill, and many arguments constructed around the protection of their rights. However, there is still room for massive change in mental health care. Attempts are continually being made to achieve this. What this means for those suffering schizophrenia, and for those directly affected by mental health care, is that it holds the promise and hope that it may provide for a better future.

If opportunities to participate in their own lives and treatments are reduced, schizophrenics tend to become passengers in their own existence, often retreating, and lacking the confidence or courage to express or even identify points of concern. Failure to allow the individual the right to give informed consent encourages their belief that they are not capable of making informed decisions, in turn leading to a lack of belief in their own ability to be autonomous in their lives. Without opportunities to regain confidence in their own decision-making abilities, the future life of schizophrenics is seriously compromised. This highlights the significant worth of respecting patient autonomy, and the importance of encouraging, supporting and providing a suitable environment for informed consent.

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Conclusion

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