

The Right to Refuse Treatment for Involuntary Patients (Justice Action 11/09)

'... it is the inherent nature of all human beings to yearn for freedom, equality and dignity, and they have equal right to achieve that.'

His Holiness The Dalai Lama, New York, April 1994

The right to decline medical treatment has long been established in other areas of law. However, it has only recently become an issue in mental health. The issues surrounding mental health regulation are complex, resulting in ineffective or unjust outcomes for patients. This paper explores questions relating to the right to refuse treatment for involuntary patients. Firstly, the correlation between involuntary confinement and involuntary treatment raises concerns in relation to both human and civil rights. International instruments encourage the protection of the rights of the individual and ideally, should be reflected in domestic legislation. This paper will also examine the justification of involuntary treatment, for patients involuntarily confined, by reason of 'dangerousness,' a 'need to treat' or lack of capacity or competency. Furthermore, the removal of the right to make decisions regarding treatment demonstrates an element of discrimination. International standards and commentary, particularly by the Mental Disability Advocacy Centre, which is supported by the Council of Europe, demonstrates recognition of the rights of mental ill patients. Furthermore, many jurisdictions no longer equate involuntary treatment as an automatic result of involuntary confinement. In examination of the Australian position, it is argued that the *Mental Health Act* NSW removes any rights from patients to be involved in treatment decisions if they are involuntary patients. This paper concludes with the idea that consensual treatment is the most ideal form of therapeutic care and the approach of the NSW legislation does not equate to the 'best possible treatment,' as outlined in the parliament objectives.

Human Rights

Literature on the right to refuse treatment for mental health patients is grounded in the United Nations human rights ideals and international principles on the right of the individual. This includes, but is not limited to, *Principles of Persons with Mental Illness and Improvement of Mental Health* adopted by General Assembly Resolution in 1991, the *United Nations Convention on the Rights of Persons with Disabilities*, 2007, and the *United Nations Standard Rules for the Equalisation of Opportunities for Persons with disabilities*, 1993.

Countries such as the United States and Canada have an entrenched bill of rights, thus a legal basis by which action can be taken for violation of an individual's rights. Equality and autonomy are paramount to civil rights. Although Australia's protection of human rights is somewhat present in domestic legislation, such as the anti-discrimination legislation, current trends in the treatment of mental ill patients within institutions demonstrates that there is a lack of correlation between the protection of rights and the treatment of involuntary patients.

Justification for involuntary treatment

Common justification for involuntary treatment includes ‘dangerousness,’ a lack of competency or a ‘need to treat’, which demonstrates a lack of ability.

The erroneous belief that mental disorder negates the ability of patients to make valid decisions is a major contributing facet in the debate on involuntary treatment.¹ Research has shown that mental illness does not make a person incompetent to make decisions about their treatment. The *MacArthur Treatment Competence Study*² has shown that, in relation to the ability to make treatment decisions, there is little difference between those with a mental illness and those without. This has led to the push for involuntary detained persons with a mental illness to be assumed competent, unless proved otherwise, and therefore be given the right to refuse or consent to treatment. Just as the legal system assumes innocent unless proven guilty, so too should the burden of proof err on the side of caution and create a rebuttable presumption that involuntary patients are competent, unless proved otherwise.

The notion of incompetence is also associated with idea of a ‘need for treatment.’ This implies a duty or an obligation to meet those needs.³ On the other hand, some jurisdictions justify compulsory treatment on the notion of ‘dangerous.’ It could be argued that ‘dangerous’ could be seen as weaker requirement, merely *permitting* the state to interfere as opposed to an *obligation* to interfere. Although both standards are used in different jurisdictions, changes in such wording have not shown to affect commitment rates.⁴ Appelbaum (1997) concludes that the lawyers and judges bend the wording so to conform to ‘fixed’ or shared moral institutions.⁵ Therefore, regardless of the justification for compulsory treatment, a ‘dangerous’ or a ‘need to treat’ approach, there is a lack of security and minimal safeguards on the rights of the patient.

When determining whether a patient has the capacity to decide on their own treatment plan, those involved must examine the specific context in which it is present. Appelbaum (1994) has found that only 10% of inpatients that have refused treatment usually did so for a short amount of time and reasons for refusal was often the dislike or distrust of the side effects.⁶ Even those who cannot provide reasons for their choices may still be clear as to their preference and their decision should be honoured. It can also be argued that in many ways patients are the experts on both the effectiveness and side-effects of the medications.⁷ This reinforces the importance of a holistic treatment plan in which the patients opinion and experience is of paramount importance.

In short, determination of capacity or competency is a central point in determining whether a patient’s right of autonomy will be respected. Thus, in order to review a patient’s capacity in the specific context in which it occurs, an independent

¹ Allan, Alfred *The Past, Present and Future of Mental Health Law: a Therapeutic Jurisprudence Analysis*. (2003) 20 *Law in Context* 24-53, 33

² Paul s and Appelbaum & Thomas Grisso, ‘The MacArthur Treatment Competence Study: I. Mental Illness and Competence to Consent to Treatment,’ 19 (1995) *L & Hum. Behav.* 105 in Fischer, ‘A Comparative Look at the Rights to refuse treatment for involuntary Hospitalised Persons with a Mental Illness’, 29 *Hastings International and Comparative Law Review* 153 (2005)

³ Radden, J ‘Forced Medication, Patients’ Rights and Value Conflicts’ (2003) 10 *Psychiatry, Psychology and Law*, 4

⁴ Radden, J, above n 3, 4

⁵ Radden, J, above n 3, 4

⁶ Appelbaum, P (1997) *Almost a revolution*, Oxford University Press cited in Radden, J, above n 3, 5

⁷ Radden, J, above n 3, 4

application should be required to rebut the presumption of competence. This removes the ‘dangerousness’ and ‘need to treat’ decisions from the hands of the treatment team and forces an independent assessment of the patients ability to make treatment decisions. An independent application will also require the treating party to sufficiently and justifiably demonstrate that the patient lacks the competency, or capacity, to make their own treatment decisions. Importantly, this approach would remove the connotation between involuntary confinement and involuntary treatment.

Discrimination

‘The delivery of a non-discriminative, autonomy-based legal framework for all treatment has been the goal of many reformers.’⁸

It is increasingly being recognised that ‘wherever possible the principles governing mental health care should be the same as those governing physical health.’⁹ It has been argued that mental health legislation discriminates against a category of people because of their mental disorder. Reviews have demonstrated that legislation governing involuntary patients demonstrates a lower degree of respect and patient autonomy than is afforded to other patients.¹⁰ *Mental Health Act 1986* (Vic) and *Mental Health Act 2007* (NSW) removes patient’s ability to refuse treatment, as the treating psychiatrist can override lack of consent by the patient.¹¹ Although there is another right to a second opinion, the ultimate decision lies with the treating psychiatrist.

The differential treatment of involuntary patients should require further justification than merely their ‘involuntary status.’ It has been found that the increased risk arising from mental disorders is low in comparison to other factors such as age, gender, socio-economic status, drug or alcohol usage, or family breakdown.¹² Thus, it is difficult to argue, as a general proposition, that the risk involved with involuntary patients justifies the restriction of civil and human rights.

Right to autonomy may be impeded for a number of reasons such as ‘intense pain, anxiety, temporary lapses in consciousness, or other forms of vulnerability.’¹³ Undeniably there may be more patients suffering a mental disorder that are impeded in their decision making by the underlying disorder, than those suffering a physical illness. However, this does not provide justification for a legal system that denies treatment decisions for those suffering a mental illness.¹⁴ Furthermore, the assumed inability to make a ‘correct’ decision for mental health patients about treatment is not in line with other social standards. Refusal of life-saving treatment is a right that physical patients have. Self-harm does not justify interference with an individual’s right of autonomy.¹⁵

⁸ Donnelly, M ‘From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights’ (2008) 26(2) *Law in Context*, 37

⁹ The Richardson Report (1999) *Review of the Mental Health Act 1983: Report of the Expert Committee* London: Department of Health cited in Donnelly, M, above n 8

¹⁰ Donnelly, M, above n 8

¹¹ *Mental Health Act 1986* (Vic), s12D

¹² Donnelly, M, above n 8

¹³ Matthews, E (1999) ‘Mental and Psychological Illness: An Unsustainable Separation?’ in N Eastman and J Peay (eds), *Law Without Enforcement: Integrating Mental Health and Justice* Oxford: Hart Publishing cited in Donnelly, M, above n 8

¹⁴ Donnelly, M, above n 8

¹⁵ Donnelly, M, above n 8

Courts in the US have recognised that individual autonomy in treatment decisions extend ‘equally to mentally ill persons who are not to be treated as persons of a lesser status or dignity because of their illness.’¹⁶ It can be inferred that any legislation that removes all treatment decisions from patients, purely because of their involuntary confinement status, is in fact discriminatory.

International standards

A legal authority, in Europe, for the right to for individuals to make decisions in relation to medical treatment, can be found in the right to privacy in Article 8 European Convention on Human Rights (ECHR), or the right to be free from inhuman treatment contained in Article 3.¹⁷

The Mental Disability Advocacy Centre (MDAC), supported by the Council of Europe, states ‘that right to decide is not contingent on the convenience of economic efficiency to the state of the person being treated, nor whether the a decision to refuse treatment by the patient is not the correct thing to do. It is simply a right that we enjoy.’¹⁸ Historically, this right has not extended to patients with a mental illness.

MDAC argues that the relationship between compulsory detention and treatment does not necessarily follow.¹⁹ Theoretically there is nothing inconsistent with involuntary detention and allowing the individual the authority to make treatment decisions.²⁰ Although it has been argued that justification of confinement was for medical benefit, this is not the way human rights law in general, and the ECHR in particular, have viewed confinement.²¹ According to the MDAC, the Strasbourg Court has never suggested that for justification of confinement there must be an effective treatment plan.²² Confinement has been determined on dangerousness and severity, rather than treatability. Thus, even if a patient is confined on grounds of dangerousness, there should be not automatic removal a patient's rights to treatment decisions.

There is an increasing international view that if patients are able to understand relevant information in relation to treatment decisions, they ought to be able to decide, regardless of their place of residence. The Committee for the Prevention of Torture outlines this view:

‘Patients should as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether

¹⁶ *River v Katz* (1986) 67 NY 2d 485 cited in Donnelly, M, above n 8

¹⁷ European Convention on Human Rights (ECHR) cited in Lewis, O., Thoronld, O & Bertlett, P ‘The European convention on Human Rights and the rights of people with mental health problems and/or intellectual disabilities’ (2003) *Mental Disability Advocacy Centre* at http://www.mdac.info/documents/MDAC_ECHR_training_pack_-_English_2nd_edition.doc

¹⁸ ECHR, MDAC, above n 17, 13

¹⁹ ECHR, MDAC, above n 17, 13

²⁰ ECHR, MDAC, above n 17

²¹ ECHR, MDAC, above n 17, 13

²² ECHR, MDAC, above n 17

voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention.²³

MDAC advocates that the right to make treatment decisions should depend on capacity, rather than diagnosis or confinement.²⁴ What constitutes ‘capacity’ itself is a debated issue. The individual should have the intellectual capacity to understand the diagnosis and basic information. It is the responsibility of the doctor to explain the treatment information in basic language. The United Nation reinforces this responsibility with Principle 11 of the ‘*Principles for the protection of Persons with Mental Illness:*’

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

- a) the diagnostic assessment;
- b) the purpose, method, likely duration and expected benefit of the proposed treatment;
- c) alternative modes of treatment, including those less intrusive; and
- d) possible pain or discomfort, risks and side effects of the proposed treatment.

Furthermore, skepticism on behalf of the patient should not equate to incapacity.²⁵

Although there have been many applications to the Strasburg Court, few have been concerned with mental health issues. The right to be free from inhuman treatment or torture, in Article 3 of the ECHR, was challenged in *Herczegfalvy v Austria*.²⁶ Although the court found no violation, it recognised that the outcome could have been different had it been shown that she was capable of making the decision herself.²⁷ It also highlighted that the situation of vulnerability and powerlessness of persons detained in psychiatric institutions requires special vigilance on the part of the authorities.²⁸ Furthermore, as this case was heard in 1992, and as the ECHR is a ‘living instrument,’ there is much support that Courts today would come to a different decision.²⁹

An invasion of a person’s body is an interference with private life under Article 8 of the ECHR. However, Article 8(2) allows for medical treatment ‘for the protection of health.’ The courts have, however, emphasized the need for vigilance when assessing whether someone ‘needs’ medical treatment. *Bensaid v United Kingdom*³⁰ reinforced that ‘mental health must be regarded as a crucial part of private life associated with the aspect of moral integrity.’

The Council of Europe has established that treatment without consent should be based on law and ‘only relate to strictly defined exceptional circumstances.’³¹ Treatment without consent must therefore be based on clear grounds related to the health or safety of the patient or to the protection of others.

²³ Committee for the Prevention of Torture ‘VI. Involuntary placement in psychiatric establishments’ Extract from the 8th General Report [CPT/Inf (98)12]’ 2002

²⁴ ECHR, MDAC, above n 17

²⁵ ECHR, MDAC, above n 17

²⁶ *Herczegfalvy v Austria* (1993) 15 EHRR 437

²⁷ ECHR, MDAC, above n 17

²⁸ *Herczegfalvy v Austria* (1993) 15 EHRR 437

²⁹ ECHR, MDAC, above n 17

³⁰ *Bensaid v United Kingdom* 6 Feb 2001

³¹ The CPT Standards, Chapter VI, para.41 at <http://www.cpt.coe.int/en/docsstandards.htm>.

Article 8 is clearly applicable to complaints that concern a matter of ‘private life;’ a concept that covers the physical and psychological integrity of a person.³² It reiterates that a person's body concerns the most intimate aspect of private life. Thus, a compulsory medical intervention, even if it is of minor importance, constitutes an interference with this right.³³

In some Canadian jurisdictions, patients with the capacity to make treatment decisions are able to exercise the right to make those decisions. Although this has been the case for almost twenty years, the medical profession received this approach with great concern. Contrary to their fears, implementation raised few practical problems and with time the medical profession are broadly content with this approach.³⁴ The recognition of the right to make treatment decisions has resulted in closer consultation and relationships between the treating doctor and patient.³⁵

American courts rejected the argument that involuntary hospitalisation equates to a patient's incompetence to make treatment decisions. In *Lessard v Schmidt*³⁶ it was established that finding of ‘dangerous to self or others’ is necessary in order to deprive a person of their individual freedoms. Furthermore, it was found that lengthy hospitalization may increase symptoms of mental illness and make transition into society more difficult.³⁷

The court held, in *Rodgers v Okin*³⁸, that hospitals could not forcibly medicate voluntary or involuntary patients with a mental illness except in cases of an emergency in which failure to do so would cause harm to the patient or others. The court also highlighted that;

1. Involuntary hospitalization did not equate to incompetence,
2. detained patients with a mental illness had a qualified right to refuse psychotropic and antipsychotic drugs; and
3. some kind of procedural mechanism taking into account the issue of side effects and other factors was necessary to ensure effectuation of the right.³⁹

In *Rennie v Klein*⁴⁰, the district court took a similar approach and decided that, in the absence of an emergency, the right to refuse treatment is grounded on the emerging constitutional right to privacy. The court noted three factors when this can be overridden:

1. whether or not patient can be confined without endangering other patients or staff, if the medication refuse would have curbed the dangerous tendencies,
2. whether the patient is competent to make the decision, and
3. whether or not there is a less restrictive alternative available.

Since *Rennie and Rodgers*, all states except Utah recognize a right to refuse treatment separate from the involuntary hospitalization treatment decision.⁴¹

In *Flemmings v Reid*⁴² a Canadian court found that an involuntary psychiatric patient expressed, while he was competent, that he did not wish to be medicated. Court

³² (see *X and Y v. the Netherlands*, judgment of 26 March 1985, Series A no. 91, p.11, § 22).

³³ (see *X v. Austria*, no. 8278/78, Commission decision of 13 December 1979)

³⁴ ECHR, MDAC, above n 17, 14

³⁵ ECHR, MDAC, above n 17

³⁶ *Lessard v Schmidt* 349 F. Supp. 1078 (ED Wis. 1972)

³⁷ Fischer, above n 2, 158

³⁸ *Rodgers v Okin*³⁸ 478 F. Supp 1342 (D Mass 1978)

³⁹ *Rennie v Klein*³⁹ 462 F. Supp 1131 (D.N.J 1978); *Rodgers v Okin*³⁹ 478 F. Supp 1342 (D Mass 1978) in Fischer, above n 2

⁴⁰ *Rennie v Klein*⁴⁰ 462 F. Supp 1131 (D.N.J 1978)

⁴¹ Fischer, above n 2, 158

⁴² *Flemmings v Reid* [1991] D.L.R 298

found that setting aside his competent wishes was contrary to his right to life liberty and security under section 7 of Canadian Charter.

In the UK, it is possible to be involuntary hospitalized without treatment. Likewise, Scottish law does not allow compulsory treatment simply based on involuntary admission. It requires a separate compulsory treatment order.⁴³

The Australian Experience

In some Australian jurisdictions, as in the United States and Canada, clinical standards alone are no longer considered a sufficient justification for the restriction and loss of liberty involved with the care of mentally ill patients.⁴⁴ The statutory tests for compulsory treatment, although different depending on the jurisdiction, generally consist of a number of objective criteria superimposing a ‘dangerousness’ or harm prerequisite over a ‘need for treatment.’⁴⁵ The *Mental Health Act 2007* (NSW) for example, is more representative of the ‘dangerousness’ standard in its requirement that ‘care, treatment or control of the person’ must be necessary in order to prevent ‘serious harm’ likely to flow from their mental illness.⁴⁶ The *need for treatment* and the benefits that are likely to flow from such treatment, is the approach taken in the Victorian and ACT provisions.⁴⁷ The Victorian Act requires that the person’s illness must require *immediate* treatment (in line with the standard preferred by the court in *Lessard v Schmidt*).⁴⁸

International legal frameworks may be contrasted to those in NSW, Victoria and the ACT, ‘under which a person subject to an order authorising compulsory treatment may generally be provided with medication regardless of whether or not they object.’⁴⁹ This stems from the understanding that involuntary patients are incompetent to make treatment decisions while in confinement.⁵⁰ ‘However, this justification is far from compelling, given that there is no express incompetence prerequisite for compulsory treatment.’⁵¹

Regardless of the validation that is given in the legislation, in a practical sense, the NSW legislation, in particular, simply creates a blanket authority that an involuntary patient does not have any right to refuse treatment that the treating doctor ‘thinks fit.’ There is no need or requirement for external application to give a doctor this power; rather legislation assumes incompetence on behalf of the patient regardless of the specific circumstances of the individual.

Australian mental health statutes, specifically the *Mental Health Act 2007 NSW*, go further than listing a set of objectives regarding the provision of care and treatment. They contain an attempt to give direction to decision-makers to implement those

⁴³ Fischer, above n 2, 175

⁴⁴ Carney, T, Tait, D, & Beupert, F. ‘Pushing the Boundaries: Realising Rights Through Mental Health Tribunal’ (2008) 30(2) Sydney Law Review, 7

⁴⁵ Carney et. al., above n 44

⁴⁶ *Mental Health Act 2007* (NSW), s14(1)

⁴⁷ Carney et. al., above n 44

⁴⁸ Carney et. al., above n 44

⁴⁹ Carney et. al., above n 44

⁵⁰ Carney et. al., above n 44, 9

⁵¹ Carney et. al., above n 44

objectives with little or no input from the patient, rather at the discretion of the treating doctor.⁵²

For example the Objects of the *Mental Health Act 2007* (NSW) are:

- (a) to provide for the care, treatment and control of persons who are mentally ill or mentally disordered, and
- (b) to facilitate the care, treatment and control of those persons through community care facilities, and
- (c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and
- (d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and
- (e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.⁵³

However, s 84 governs the treatment of patients and states that:

‘An authorised medical officer of a mental health facility may, subject to this Act and the *Mental Health (Forensic Provisions) Act 1990*, **give, or authorise the giving of, any treatment (including any medication) the officer thinks fit to an involuntary patient** or assessable person detained in the facility in accordance with this Act or that Act.⁵⁴’

This broad authorisation allows involuntary patients to be treated against their will in NSW. There is little safeguard of the patients rights and no need for any other independent application to get authorisation to override lack of consent. The NSW position is not in line with any of the international standards and trends. As international law develops to recognise the right to refuse treatment, even for those involuntary hospitalised, NSW has stood still in the protection of civil and human rights.

The *Mental Health Act 1996* (Tas) provides a more desirable approach to the treatment of involuntary patients, than other jurisdictions in Australia. Under the Act, a patient in the Tasmanian jurisdiction cannot be forcibly treated merely when the treating doctor ‘thinks fit.’ Rather, an application has to be made under the *Guardianship and Administration Act 1995* and the Board determines whether to grant the application.⁵⁵ Tasmanian legislation appears to have erred on the side of caution for the rights of the patient and created a rebuttable presumption that involuntary patients are competent, unless decided otherwise by the Board. The approach taken in Tasmanian demonstrates that, while patients can be involuntarily detained, they are able to maintain some level of recognition of their rights.⁵⁶

⁵² Carney et. al., above n 44

⁵³ *Mental Health Act 2007* (NSW), s3

⁵⁴ *Mental Health Act 2007* (NSW), s84

⁵⁵ *Mental Health Act 1996* (Tas), s32

⁵⁶ Langford, L. ‘The New Mental Health Act in Tasmania (1996): A comparative Review with the Former Act (1963): Can They Now Die with Their Rights on?’ (2003) 10 *Psychiatry, Psychology and Law*, 140

Sedation

The practice of sedation for involuntary patients, particularly in NSW, further highlights the abuse of rights and lack of respect shown to some of the most vulnerable member of society. NSW Health Policy Directive gives guidance to the sedation practices and clearly outlines the circumstances in which sedation may be used on a patient. The Policy Directive states that these ‘chemical restraints’ can only be used in ‘extreme circumstances when other forms of management of a least restrictive nature have been proven unsuccessful.’⁵⁷ Furthermore, ‘an injection without consent should be given only in the interest of the immediate physical safety of the patient or those in his or her vicinity.’⁵⁸ As noted, any other unauthorised IV sedation that does not comply with this Policy Directive may be considered assault.

The Policy Directive also gives direction in relation to restraint in psychiatric in-patient facilities. Again, ‘restraint should only be applied for the minimum time necessary and its application must take into account the principle of care in the least restrictive manner.’⁵⁹

On the surface, these principles of care within the Policy Directive are safeguards for vulnerable patients. However, when read in conjunction with the *Mental Health Act* (NSW), the safeguards that protect patients can be easily abused.

When a patient is held down and jabbed with a syringe, that effectively knocks him out, one would assume this is classified as IV sedation, and thus governed by the directives established in the Policy Directive which states sedation should only be used in ‘extreme circumstances.’ However, the legislation has given treating doctors the ability to hide behind the notion of ‘treatment.’ If a patient complains that they are being sedated without justification, the treating doctor merely classifies the injection as ‘treatment’ and therefore is not bound by the Policy Directive. The NSW Health system does not adequately protect the patient’s rights. Power is placed in the hands of the treating doctor. Even with restrictions on sedation, the doctor has ultimate discretion to the treatment of the patient. Sedation is not uncommon with mental health patients in forensic hospitals and violates the rights of the person when it is implemented outside the guidelines. Criminal charges of assault can be laid for breaches of the Policy Directive and should act as deterrence to abusive doctors. The problem arises from the difficulty in separating ‘sedation’ from ‘treatment.’ The NSW health system needs to update the guiding principles of patient care and remove the ability for doctors to abuse the authority they wield over mental health patients.

A positive result from the right to refuse treatment

The ability to refuse treatment by patients is also seen by some as therapeutic, as it recognises the right of the patient to privacy, competency and recognises their autonomy. Refusal of treatment has also been seen to encourage practitioners to communicate more effectively with the patients and be more patient oriented. In turn, this

⁵⁷ NSW Health ‘Policy Directive: Seclusion Practices in Psychiatric Facilities’ (2007) PD2007_054 at <http://www.health.nsw.gov.au/policies/a-z/s.asp>, 17

⁵⁸ NSW Health, above n 56

⁵⁹ NSW Health, above n 56

may encourage a patient's compliance.⁶⁰ Ignoring a patient's right to refuse treatment can also lead to disempowerment.

'There is evidence that practitioners take more care that the medication they recommend is appropriate, monitor its effects well, and listen to the concerns of the patient.⁶¹ Greater transparency in the treatment process contributes to the overall recovery of the patient. Psychiatric medication is also often accompanied by severe side effects and can be highly invasive. Allowing patients to make treatment decisions utilises a patient's ability to understand themselves and their body's reaction.⁶²

There are grounds to argue that the right to refuse treatment also can have non-therapeutic implications. It has been suggested that right to refuse treatment reinforces uncooperative behaviour, and may even encourage it. Furthermore, it may lead to more disruptions and encourage more attention to be paid to those refusing than those complying with treatment plans.⁶³ However, although there is competing and conflicting research in the area, it has been shown that a patient responds more favourably to treatment when staff treats them fairly as intelligence aware human beings. Furthermore, *Lessard v Schmidt*, highlighted that studies have shown that due process protections provide therapeutic benefits and reduce the misuse of medication.

Consensual treatment is the ideal form of therapeutic care. Allowing patient to make decisions enhances relationships and patients trust and confidence in the treating psychiatrist. It increases motivation to recover. Patients are said to respond better to treatment if they are internally motivated to comply with treatment as opposed to externally required.⁶⁴

⁶⁰ Allan, above n 1

⁶¹ Allan, above n 1, 34

⁶² ECHR, MDAC, above n 17

⁶³ Allan, above n 1

⁶⁴ Donnelly, M, above n 8

Forensic Mental Patient Treatment- A Case Study of the Impact of the NSW Forensic System

Written by Justice Action⁶⁵

Mr Saeed Dezfouli

The treatment of Mr Saeed Dezfouli at the hands of the NSW government highlights the problem with government bureaucracies dealing with challenging people at the individual level. The lack of compassion, concern or even rational behaviour by government is the worst expression of community responsibility. The case of Mr Saeed Dezfouli highlights it well.

History

He was born in Iran 1958 and came to Australia 1983. Upon coming to Australia as a refugee he had a degree in Bachelor of Arts and majored in political sciences. In 1986 he became a citizen of Australia and was working as a court interpreter for the Ethnic Affairs Commission NSW. He became fearful of his life and safety and said that he had been receiving death threats in and around 2001. He felt that he was constantly under surveillance. He said that he warned the authorities by sending them letters about his concerns.

He was accused of setting fire to the foyer of the Community Relations Commission (formerly the Ethnic Affairs Commission) at Ashfield by using a container of petrol. Three female employees were trapped by the flames and were taken to hospital in an unconscious state. One of them, a 53-year-old woman from Bonnyrigg, died from her injuries. There are other mitigating facts. Unfortunately on the day of the fire the Emergency Fire Exit Door was locked and the rubbish in the Foyer hadn't been collected and ultimately the rubbish blocked the path of the employees escaping the smoke and flames. He was taken to Burwood police station where he was insulted, assaulted and unlawfully interrogated by the NSW Police and then charged with several offences.

In February 2002 he was transferred to Long Bay Prison Hospital and in 2004 he was found not guilty due to mental illness. Since that time he has been held indefinitely and subjected to continuous abuse.

His treatment by the staff of Justice Health and the Department of Corrective Services in LBH-1.

A number of times they kept Saeed naked in a solitary confinement cell for days to "break him down".

The first time, when they forced medication into him by injection they broke two of his ribs.

The second time they left him bruised all over and in severe physical pain for days.

⁶⁵ http://www.justiceaction.org.au/index.php?option=com_content&task=view&id=223&Itemid=124

Twice they left him in a cell without toilet paper for four (4) days.

DCS Officers broke a number of his bones in LBH-1.

In January of 2005 Saeed got brutally assaulted by DCS Officers and as a result got a permanent back injury.

Saeed was taken to Prince of Wales Hospital Emergency Room for the injuries inflicted upon him by DCS Officers.

Saeed now is suffering from heart condition, ulcers and diabetes as a result of the side effects of anti-psychotic medications combined with going through a daily oppressive and suppressive regimen.

This intelligent man says:

"I am a patient with patients' rights, an inmate with inmates' rights and a human being with human rights". These rights have been fundamentally and severely violated by the unprofessional, and sadistic state government employees in the positions of psychiatrists, psychiatric nurses, and prison officers. They are required to go by the law, regulations, policy and procedures, codes of conduct practice and ethics, but they don't.

What's going on here is totally inhumane and unlawful. It is passive and active physical and mental torture, sexual harassment and sexual assault, which are severe violations of the Provisions of NSW Mental Health Act 2007 (including sections 3, 68, 69, 74 and 105) and NSW Crimes (Administration of Sentences) Regulations 2001 (including sections 6, 60 [3a], 119, 120, 121, 153, 243, 245, 246, 247, and 280 [2] and The Universal Declaration of Human Rights (including Article 5 which states, "No one shall be subjected to cruel, inhumane or degrading treatment or punishment").

They have a 'sit down, put up and shut up policy' in here. Otherwise we get grabbed and dragged to our cells, and get injected whilst being assaulted. Many of us don't talk to doctors for months. There are many days we don't see nurses in the ward for hours."

A petition from the patients was reported in The Australian Newspaper on 31 October 2005.

"26 of the 30 patients at Long Bay Prison Hospital in the ward have complained to the Health Care Complaints Commission and the NSW Ombudsman about notes on their psychiatric conditions that are fabricated and saying the nurses and doctors rarely bother to talk to them. Several prisoners had gone on hunger strikes. Many patients have been overdosed and medicated against their will."

Saeed wrote to the NSW Ombudsman and received a response dated 22 June 2005.

Samantha Guillard Complaints officer wrote "I confirm that the petition was received in this office on 7 June 2005". She forwarded the complaint on to the HCCC for consideration. She said the complaint was about the conduct of medical officers. She also said the office would not pursue the issue. Nothing happened.

His original complaint raised the following issues regarding the medical treatment of patients residing in Long Bay Hospital Area.

1. That patients are grabbed and dragged to the cells and get injected whilst being assaulted;
2. That the nurses do not provide adequate nursing care to patients;
3. That the nurses' fabricated notes and call them nurses notes;
4. That the Psychiatrists show up for a couple of days a week for a couple of hours a day, read the nurses' notes and then write prescriptions without seeing patients.
5. That some patients do not speak to a doctor for months;
6. That many nurses do not speak to many patients for months;
7. That some patients don't speak English for their English is limited and that no doctors or nurses speak to them at all;
8. That a number of patients were kept in segregation by false and fabricated accusations and allegations lodged against them by the nurse or prison officers; and
9. That many patients are being over dosed.

Attached to the complaint were the signatures of twenty-five patients. Noted in their letter HCCC stamped 11 October 2005 by Kieran Pehm Commissioner but no charges occurred.

Current complaint details Sexual Assault

HREOC case no 081005

On the 26th of March 2007 Saeed said that officers at Long Bay Prison Hospital in C Ward sexually assaulted him. He said he complained about it to numerous watchdog agencies, organizations, and the media.

He said that a number of times he has been insulted, assaulted, injured, sexually harassed and sexually assaulted by some DCS officers and staff of Justice Health. As a result he believes that his complaints have usually backfired on him. For instance he said that the prison officers said they would go on strike and voted to get him moved out of the C-Ward area of the prison hospital. He said he was then transferred to D Ward, which is a very violent and unpredictable ward where he was twice assaulted and injured by DCS Officers and once by an Inmate/Patient.

Saeed was placed in DCS Segregation as soon as he complained about being sexually

assaulted by DCS Officers.

“My allegations of sexual assault against prison officers have now been referred to the Administrative Decision Tribunal and set down for hearing at Central Local Court on 9 April 2008 at 10.00am. I have been physically and mentally tortured, sexually harassed and sexually assaulted by some prison officers and staff of Justice Health in this Abu Ghraib Prison of NSW, Australia. I am renouncing my Australian citizenship to get repatriated to my country of birth Iran. I brought the issue to the attention of all of our democratically elected representatives, politicians and leaders. I refer to my attached petition that has the signatures of 25 other inmates about being overdosed and mistreated at the Long Bay Prison Hospital.”

Still nothing has been done about a community overview of the facilities.

The following documentation of a meeting between Saeed, the primary carer and the treating doctor highlights the disconnect between the ideals and objectives of legislation and the first hand experience of Saeed Dezfouli, and the interaction between the parties involved.

Meeting with Treating Team 2/7/09

Report of meeting between Saeed Dezfouli, psychiatrist Dr Jeremy O'Dea the head of his treating team, nurse Andrew James and Brett Collins, Saeed's primary carer, on Thursday July 2, 2009 set for 11am.

Saeed sat at the small table in the room on Brett's left, Andrew sat on Brett's right, and then a tall slim balding man about 60 came in. He was the head of the treating team psychiatrist Dr Jeremy O'Dea.

Jeremy shook hands and said he felt it was important to talk about the primary carer role and to remember to differentiate Brett's carer role from that of being a JA Coordinator.

He said that Saeed was not engaging with his treating team, and that he, O'Dea was not going to negotiate through Saeed's primary carer. The primary carer was entitled to be told after decisions on treatment had been made, but not consulted before. He wasn't going to have three way conversations and wasn't going to write down anything for Saeed. It would all be done orally. He referred to s.71, 72 and 78 of the Mental Health Act and spent some time talking about what each meant. He referred to ECT and surgery as issues where the primary carer would be informed of that treatment, but then assured Saeed that didn't apply to him. There was a discussion as to whether prior notification would be offered and provide an opportunity for challenge, but this was not clarified by Jeremy.

Discussion ensued about what obligations were due to the primary carer. Saeed drew attention to s.3e of the Act requiring involvement, s.68(j) and s.105(g).

Jeremy said there was no need for prior notification at all, and that Saeed should appreciate that he was an involuntary patient. This could mean that informed consent wasn't possible in some situations, and altered the level of consent required. Brett asked whether it would be better to get the patient's agreement to treatment, Jeremy said "I don't think it would be useful"

Academic research points to the impact of allowing a patient to be involved in treatment plans, regardless of legislative requirements. There was acknowledgment that indeed Saeed was more comfortable talking to the team when the primary carer was present, as this created a more trusting environment and dialogue was created.

Jeremy agreed that the fact that Saeed was talking now around the table was a breakthrough and a positive thing that had occurred due to the involvement of the primary carer.

Then there was a discussion about trust. Saeed referred to a Psych Central report on delusional disorder which stated how essential it was to have the trust of the patient for the treatment to be effective. Jeremy said that Saeed complained about everyone and it didn't make a difference. He said that Saeed was paranoid about his support. Jeremy was quite confronting on a number of occasions to the extent that Brett intervened and talked about working together, but Saeed was very calm and reasonable.

When there is no incentive to provide a 'trusting' environment and concerns of the patient are not taken seriously, the best results for the patient are harder to achieve. Indeed, if there was improved communication and the treating doctor was more patient orientated, patient's compliance levels would increase. However, in the NSW system the power of the treating doctor allows for patients to be excluded from their own treatment process. Saeed's treating doctor has obviously overlooked the importance and effect of internal motivation, rather than just external requirements.

In relation to a possible transfer to Morrisett:

He agreed that Saeed hadn't been told the result of his request to go. He would ask them to formalize the response. Saeed asked for a written response but Jeremy said "No".

Involuntary patients are in a position of vulnerability and to ensure due process and transparency, documentation should be made of all correspondence, particularly something as significant as the possibility of transfer to another facility. It could be inferred that there is some fear of the appearance inconsistencies being found, thus refusal of formalize responses.

Jeremy said he needed to have a working treatment plan, but that he didn't want to deal with the primary carer in creating and negotiating it. "Why not?" asked Brett. Jeremy said it wasn't a requirement of the Act. Brett pointed out the benefit that had happened already in communication.

Power inferred on the treating doctor through, the NSW legislation, creates a barrier to

open and two-way communication. The role of the primary carer is paramount in the treatment and well being of mental health patients. The ability to deny the primary carer involvement, is denying the patient the best possible care and is in conflict with the objects of the *Mental Health Act 2007* (NSW) which states that the object include (e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.

Other first hand experiences of the NSW forensic system...

Contrary to the legislative objective and protections, the first hand experience of forensic patients, in NSW, demonstrates a lack of correlation between care of the patients and a system that fosters their needs through treatment.

Consumers have described their experiences as unpleasant and painful. Dialogue relating to medication highlights the unwanted, and unpleasant, side effects. One patient recalls that there was no priority placed on the psychical suffering of patients, nor any relief offered.⁶⁶ Treatment, for this patient, took years to be adjusted.

Patients have also questioned the validity of 'independent treatment'. Recalling their experience, one patient noted that the independent opinion she was able to receive, due to a breach of her rights, was nothing more than another junior psychiatrist on the ward.⁶⁷ Furthermore, she was unaware of what her diagnosis was for her 'incurable' illness. There is a strong lack of consumer participation when the decision-making process occurs even though it plays a central role in the effective treatment of patients.

Consumers have also witnessed first hand the stigma attached to mental health patients that they are somehow a 'dangerous explosive' in need of immediate 'de-detonation'⁶⁸ through the extensive use of drugs.

The 'deconstruction of battlegrounds' is needed in the health care system, according to a patient.

Many highlight the crossover between prisons and mental health facilities as a concern. The prison system is 'cruel' to consumers and the mental health facilities often treat patients like criminals. The facilities, although now upgraded?, were described as equivalent to that of a prison, and not in line with the standards of other hospitals. Rather, the 'absolutely ghastly' conditions were an attempt to try to remove any incentive for a prisoner to feign an illness.⁶⁹ This begs the question of the treatment and level of care provided if the idea was to create an environment that deterred people from ever wanting to be there.

Prison hospitals have also been described as an environment centred on intimidation.⁷⁰ Were patients are given little, if any, right to reply and are treated in the same manner as criminals.⁷¹ This patient stated that professional ethics of psychiatry do not exist for forensic patients.⁷²

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