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# Who's Talking About Us Without Us? A Survivor Research Interjection into an Academic Psychiatry Debate on Compulsory Community Treatment Orders in Ireland

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Received: 7 August 2018; Accepted: 18 September 2018; Published: 25 September 2018



**Abstract:** This paper presents a user/survivor researcher perspective to the debate among psychiatrists on the suggested introduction of Community Treatment Orders in Ireland. Critical questions are raised about evidence and the construction of psychiatric knowledge. Important questions include: How is this evidence created? What and whose knowledge have not been considered? Some critical issues around coercion, 'insight', and attributions of 'lack of capacity' are briefly considered. Further legal considerations are then introduced based on the United Nations Convention on the Rights of Persons with Disability. The paper concludes with a human rights-based appeal to reject the introduction of coercive community treatment in Ireland.

**Keywords:** community treatment order debate; what is evidence; mental health service user perspectives; survivor research; insight; consent; UN CRPD

## 1. Introduction

Community Treatment Orders (CTO) and the arguments presented in their favor contradict the basic principles of recovery-oriented, person-centered services (Heun et al. 2016; Mental Health Commission 2008; Pūras 2017). They are unacceptable from a human rights perspective: in particular from a perspective informed by personal experience of psychiatric treatment. User, consumer, and survivor perspectives are entirely absent in a recently published four-part debate between four professors of psychiatry (McDonald et al. 2017). Professors McDonald and O'Reilly presented their case (McDonald and O'Reilly, in McDonald et al. 2017), followed by arguments against CTOs from Professor Kelly (Kelly, in McDonald et al. 2017) and Professor Burns (Burns, in McDonald et al. 2017). McDonald and O'Reilly offered a rebuttal of these arguments and the paper concluded with a final joint rebuttal from Kelly and Burns (Kelly and Burns, in McDonald et al. 2017). McDonald and O'Reilly argued that CTOs must be introduced in Ireland to facilitate compulsory community treatment of people they believe will benefit from such treatment. Professors Burns and Kelly reject McDonald and O'Reilly's arguments, offering an informed critique of the evidence base for CTOs, highlighting the cost to service users and their families, and critique the credibility of the profession itself for following 'poorly evidenced fads'.

As a contribution to this debate, this paper introduces a user/survivor researcher perspective and raises questions about evidence and the construction of psychiatric knowledge. I re-present the arguments introduced by McDonald and O'Reilly in order to contextualise the evidential debate. I ask how this evidence created and whose knowledge is left out of consideration. I also briefly consider some critical issues around coercion, 'insight' and 'lack of capacity'. I introduce further legal considerations based on the United Nations (UN) Convention on the Rights of Persons with Disability

(CRPD). I conclude with a human rights-based appeal, given the flawed evidence claims and the abusive history of psychiatry, to reject the introduction of CTOs in Ireland.

Before I continue, I position myself for the reader. I had long experience with both forced and then passive psychiatry treatment for much of my earlier adult life. I managed to break this cycle and extract myself from psychiatric control, finding sanity through other supports. I did what many have done and became active with reform efforts. My subsequent involvement spanned advocacy and committee work, research, and teaching and training, plus seven years on a lay panel for mental health tribunals. I since completed a PhD in medical sociology, building an accidental and precarious academic career following two decades of such involvement. I have researched the knowledge base developed globally since the 1970s by user/survivor researchers and activists. I have had the privilege of meeting many wonderful people including some skilled, emotionally intelligent clinicians, humble and wise enough to know they do not have all the answers, and sometimes not even the right questions. I have also been inspired and supported by a growing network of fellow travelers in local and global social movements of people seeking either reform of, and/or alternatives to, current practice. I, along with many in the user/survivor movement, quietly went about our efforts trying to improve the experience of encountering psychiatry for the people subjected to it, and especially those with no choice in the matter (Brosnan 2014). Later, I have been more persuaded by the idealists among us who work toward the abolition of forced psychiatry (<https://absoluteprohibition.org/>). I am aware that the user/survivor community is a broad group, and while there is no general consensus about an abolitionist stance on forced treatment (e.g., Spandler and Anderson 2015), no survivor to my knowledge has ever argued for the introduction of CTOs.

## 2. Background

The power to treat people against their will and preference is underpinned by mental health legislation in Ireland as well as in most jurisdictions. Mental health legislation sets out the parameters of what is legal and how and where people can be involuntary detained and treated. Psychiatric facilities are heavily regulated as many people are treated under compulsion in these in-patient settings. The Irish Mental Health Act (2001) (MHA) was introduced in response to concern by the European Court of Human Rights about outdated legislation (Mental Treatment Act of 1945) regulating statutory services in Ireland. The MHA was introduced in two phases. Part One mandated the establishment of the Mental Health Commission (MHC) in 2001—a statutory body charged with developing and administering the regulatory framework for all involuntarily detained patients in Irish Mental Health Services. Enactment of Part Two of the MHA followed a five-year period to allow mental health services to prepare for independent, external review of each involuntary detention order by mental health tribunals. In Ireland, tribunals are automatically convened once someone is involuntarily admitted to an approved center. Initial involuntary orders must be reviewed by a tribunal within 21 days and thereafter at each subsequent renewal of the order at specified intervals (three months, six months, and then at yearly intervals). Under the MHA, a treating consultant has the power to grant ‘approved leave’ to someone who is under the MHA provision.

The MHA also stipulated the operation should be reviewed within five years. The MHA (2001/2006) was reviewed by an expert group appointed in 2011 by the Minister for Mental Health and Disability. The review made 165 recommendations seeking to shift from paternalistic interpretations of mental health legislation to legislation that respects the rights of people (‘in so far as possible’) to determine their own will and preferences for treatment (Department of Health 2015b). One such paternalistic application of the MHA is the extension of the ‘leave of absence’ to someone to live in the community while remaining under an involuntary order that applies to in-patient treatment.

The issue debated in this paper is whether the power to treat people involuntary in inpatient settings should be extended to compulsory treatment in the community, as it is in over 75 jurisdictions (McDonald et al. 2017, p. 295). Proponents of CTOs argue that the extension of compulsory powers is justifiable on the basis of the evidence from research studies in jurisdictions where psychiatry has

this power. Compulsory treatment orders take various forms and have different names (Assertive Community Treatment Orders, Involuntary Outpatient Committals) but generally, and for the purposes of this paper, they are referred to as Community Treatment Orders (CTOs). In Ireland, there is currently no legal basis for compulsory psychiatric treatment in the community. However, practice has informally evolved to extending absence with leave to people under a MHA detention order to living in a community setting as long they comply with psychiatric directives. The person is required to take medication as directed and comply with the conditions set by their treating psychiatrist. These people can be legally compelled (as long as they are still under the provision of the MHA) to return to the in-patient unit if so directed by their psychiatrist. People on this leave are under a de-facto or quasi CTO. There is no oversight or regulation of the conditions under which these quasi CTOs are imposed or how they are implemented. Practice has developed whereby people are brought back to the acute unit in time to have the in-patient involuntary treatment order reviewed by a Mental Health Tribunal.

Section 75 of the MHA 2001 required that the operation of the Act be reviewed by the responsible Minister within five years. In 2011, the then Minister appointed an expert group of 16 stakeholders (including one service user) to review the Act. This expert group deliberated at length on the issue of whether compulsory treatment in the community should be legitimised. They decided against extending the legislative mandate to treat people not detained in hospitals. The ‘absence with leave’ practice has been called out as de-facto compulsory community treatment by the expert group, who recommend that this practice should cease, or at minimum be limited to 14 days (Department of Health 2015a, p. 51).

### 3. The Psychiatrists Debate

In the following discussion, the arguments of McDonald and O’Reilly are reproduced using their own words, as a synopsis cannot do justice to the tone. (McDonald et al. 2017). They begin by appealing to their colleagues with a statement presented as incontrovertible fact: ‘Every psychiatrist knows that the commonest cause of relapse of psychotic illness in patients living in the community is non-adherence with medical treatment’ (McDonald et al. 2017, p. 295). This certainty is not shared by many of their colleagues: including Burns and Kelly, their responders in this debate. Nor is it shared by the Royal College of Psychiatrists (Heun et al. 2016). There is ample evidence that blind adherence to the efficacy of psychiatric medication is misplaced (Whitaker 2005, 2010). People can find symptoms of distress returning for many reasons not necessarily linked to non-adherence to medication. McDonald and O’Reilly appear to concede this:

Of course, like any therapeutic approach, CTOs do not work for every patient. Patients who respond poorly to medication do not do well on CTOs and a few patients who have entrenched oppositional personality traits may actively resist the CTO. Often these poor candidates are recognizable a priori, but in some cases a trial of treatment under a CTO is required to determine if it will help. (McDonald et al. 2017, p. 296)

The application of the term ‘entrenched oppositional personality traits’ to resistance to CTOs is interesting evidence of psychiatric power to pathologize defiance to their authority. The first authors observe that people who respect the authority of law do well, even if they fail to ‘recover full insight’. McDonald and O’Reilly then appropriate the concept of distributive justice to argue for compulsory treatment in the community as follows:

Distributive justice demands that all citizens have an equal right to treatment and should not be deprived thereof because they lack the capacity to recognize a need for treatment. We do not deprive demented or intellectually impaired individuals of the treatment they need when they lack capacity and equally we should not deprive people with mental illness. This *parens patriae* duty has long been accepted as a basic responsibility of a society to take care of vulnerable citizens. (p. 297)

The paternalistic and authoritative tone of this argument is offensive to anyone who has experienced compulsory treatment and to those who recognise the equal right of people with dementia

or intellectual disabilities to be treated with dignity and respect. They equally deserve to have greater decision-making control over their lives, rather than have paternalistic professionals decide every aspect of their daily living in congregated settings under the guise of care (Flynn et al. 2019). It does the psychiatric profession no credit to equate the deplorable and shameful institutionalization of people with dementia and/or intellectual disabilities who are more vulnerable to total medical capture with the concept of ‘duty of care’. Disability rights’ advocates demand that people who need extra support are listened to about the form of care and support they require to live in the community. This does not happen for people with intellectual disability, with dementia, or psychosocial disabilities. There are concerns about the coercive misuse of psychotropic medications as behavioral control measures in all institutional settings where people with cognitive disabilities have been historically congregated (Moncrieff et al. 2013; Peisah and Skladzien 2014; Tsiouris 2010). The thrust of de-institutional efforts is to dismantle the total institution and ensure people have the resources they need to live in the community (Fabris 2011). Yet, McDonald and O’Reilly illustrate one of the biggest hurdles to achieving these rights for people with cognitive disabilities: the denial of capacity. These authors equate refusal of treatment with a lack of capacity, a topic I shall examine further below while discussing insight and informed consent.

McDonald and O’Reilly argue that CTOs need to be properly resourced to ensure ‘attendance for clinical reviews, administration of medication by long-acting intramuscular injection, or supervised administration of medication by a healthcare worker or care provider, residing in designated supervised accommodation’ (McDonald et al. 2017, p. 297). There is no argument that mental health services are inadequately funded and that progressive, person-directed supports are required to enable people to live full lives in the community. What is objectionable is to tie such supports to coercive measures. These authors appear oblivious to the controlling and oppressive regime they recommend in treating people against their will and preference, contrary to the principles of the UNCRPD. Finally, genuine distributive justice would ensure the provision of adequate resources to support people with dementia, intellectual disabilities, and mental health problems to live full and meaningful lives where and as they choose.

### 3.1. *The Evidence Debate*

Psychiatry claims to be an evidence-based science, with an elevated respect for RCT: a position critiqued from within the profession itself (Bracken et al. 2012; Thomas et al. 2012). Bearing this in mind, it is interesting that the main point of difference between the two positions in the debate is the quality of evidence provided by RCT. McDonald and O’Reilly claim the evidence is inconclusive due to the limitations of RCT studies, not because the treatments are failures. However, the UK Royal College of Psychiatrists does not agree. In a commissioned review of the available evidence, they found an absence of convincing evidence that CTOs had a significant impact on patient outcomes and called for more rigorous research (Churchill et al. 2007). McDonald and O’Reilly ignored the conclusions of three members of the executive committee of the Royal College of Psychiatry who reviewed three independent controlled studies and a meta-analysis and found false negative results (Heun et al. 2016). Heun et al. concluded that if the same standards were applied in general health care given the weak (at best) results for CTOs, ‘no clinical procedure would have any support from any regulatory institution’ (Heun et al. 2016, p. 117).

An initial proponent for the introduction of CTOs in the UK, Professor Burns has ample evidence of their failure to achieve the hoped-for outcomes (Lawton-Smith et al. 2008). He subsequently led an extensive series of pragmatic RCT trials over 30 sites in the UK that failed to show that the results of the CTOs justified their oppressive control over people’s lives in terms of better outcomes (Burns et al. 2013). The research concluded that CTOs did not reduce the rate of rehospitalisation over the one-year follow-up, nor in any other of the hospitalisation outcomes (delay, duration, etc.) (Burns 2017, p. 301). Yet, McDonald and O’Reilly argue that legislative reform in Ireland will allow them conduct research in the search for evidence that has failed to be convincing elsewhere. They disregard the provision in Section 70 of the MHA which states that patients under the Act

are not to be subjected to clinical trials. People in that position are in no position to give informed consent due to the likelihood of actual or perceived coercion to participate.

After reviewing the limitations of the evidence provided by deeply contested interpretations of RCTs results, Burns concludes with a note of caution to his fellow psychiatrists.

Patients will find their liberty restricted without any clinical benefit in return. Care providers will have their hopes falsely raised. Clinicians have probably the most to lose. CTOs bring with them bureaucratic and time-consuming obligations that distract us from other more effective and evidence-based activity. Perhaps most important, it will perpetuate an image of our profession as one that follows fads and fashions and ignores the evidence when it is inconvenient. (Burns 2017, p. 301)

Professor Kelly also argues against introduction of CTOs in Ireland, and cautions against the legislative creep of compulsory treatment into the community (Kelly, in McDonald et al. 2017). Legislative creep occurs inevitably once CTOs become an option available to psychiatrists. For instance, Lawton-Smith (in Lawton-Smith et al. 2008, p. 97) argues that it is far easier for someone to be placed under a CTO than to have it removed. People remain on them far longer that they would be under compulsory treatment as an in-patient with an average 3.5 months in hospital versus nine months on a CTO. In addition, although proponents of CTOs use treatment of ‘revolving door patients’ as justification for their use, the experience in other jurisdictions demonstrates that too many people are placed on them upon first contact with services, thereby considerably increasing the scope of who is placed under a CTO. Legislative creep is dismissed by the first authors, who propose that people be placed under CTOs without even being admitted first for inpatient treatment, demonstrating a lack of insight into how legislative creep co-exists with, and facilitates, abuses of power. They also seem to lack insight into the ethical issues inherent in their proposal to keep using CTOs for people without knowing if they will benefit. Kelly makes a strong argument that there is a moral duty on psychiatrists to ensure that patients benefit from treatment provided. Hence, to introduce any further legal power, there must be enough evidence it will work. ‘To allow treatments of ineffective or of unproven efficacy, (and) providing it to patients is a violation of the basic precepts of medical practice and an abuse of trust’ (Kelly, in McDonald et al. 2017, p. 299).

Burns and Kelly rightly remind the profession to consider its history and avoid further damage to its scientific credibility. The latter position is affirmed by the report of the Special Rapporteur on Health (Púras 2017), essential reading for those concerned with the future of mental health services. Púras, a child and adolescent psychiatrist, concluded: ‘There is now unequivocal evidence of the failures of a system that relies too heavily on the biomedical model of mental health services, including front-line and excessive use of psychotropic medicines, and yet these models persist’. The evidence is derived from studies that place the concerns of people subjected to biomedical model treatment at the center of the research process, rather than the concerns of clinicians. He continues:

Justification for using coercion is generally based on “medical necessity” and “dangerousness”. These subjective principles are not supported by research and their application is open to broad interpretation, raising questions of arbitrariness that has come under increasing legal scrutiny. “Dangerousness” is often based on inappropriate prejudice, rather than evidence. There also exists compelling arguments that forced treatment, including with psychotropic medications, is not effective, despite its widespread use. (Púras 2017, p. 14)

In the report, he calls for more research to be directed toward social treatments. He suggests that psychiatric leadership engage with the need for reform of the dominant biomedical treatments, highlighting that the global obstacle to good mental health is a power imbalance rather than a chemical imbalance.

### 3.2. Missing Evidence in the Debate

I argue that the evidence base itself is deeply flawed because the Professors of psychiatry fail to include the knowledge developed by survivor research. Survivor researchers argue that clinical research fails to acknowledge the implicit bias and limitations of how this evidence has been constructed (Faulkner 2015). RCTs plus systematic reviews and meta-analyses are the pinnacle of the evidential hierarchy. Yet, they do not consider the experiential knowledge of those subjected to coercive treatments. We in the survivor movement ask: What and whose knowledge counts? (Beaupert 2018; Rose 2017). Evidently not that of the people subjected to academic psychiatry's research and practice. Therefore, a significant body of knowledge is being omitted in this debate.

A serious flaw in the credibility of such 'scientific' evidence is derived from the epistemic politics of funding and research, and the privilege afforded biomedical, neurological, applied clinical service-focused, and pharmaceutical industry-driven research (Faulkner 2017; Pūras 2017; Rose 2017; Whitaker 2018). Academic psychiatric research draws on a positivist paradigm that uncritically privileges RCTs and marginalizes the knowledge or evidence produced by mental health service users and survivors (Faulkner 2015). Faulkner observed that this means little research space is provided to theories that challenge or conflict with the medical model. How, then, are service users to have their views and voices heard within this system and structure? 'This brings us to the need to acknowledge the power differentials that exist in research production and how they influence the knowledge that is given the most status, authority, and funding' (Faulkner 2015, p. 12). It is exceedingly difficult to have any research funded that does not adopt the dominant dogma of bio-psychiatry (Kalathil and Jones 2016; Jones and Brown 2012). The quantitative methodologies privileged by funders of clinical research do not allow for in-depth explorations of how people experience compulsory treatment, and 'outcomes' of treatment more generally. For instance, Whitaker (2018) demonstrated how the purpose behind clinical studies shapes the results found. If researchers seek evidence to support a hypothesis that people do well coming off psychiatric medication, they are more likely to find it. By contrast, setting the research question negatively is more likely to generate evidence that people do poorly. Likewise, the research on CTOs has produced conflicting evidence depending on what the clinical trial set out to explore. These are the questions of bias that are critiqued by survivor researchers who examine research on psychiatric medication and coercion (Gordon and Ellis 2013; Russo 2018). Survivor research focuses on those outcomes that matter to services users, including developing 'user-generated outcomes' (Rose et al. 2011; Evans et al. 2012). This means that mainstream psychiatric research has a limited evidential base, mostly focused on brains and drug treatments (Russo 2018). Brain functioning alone does not explain human beings. Human beings are inherently social and live in social worlds. However, there are few resources afforded research about different types of social interventions that service users know could work for them, such as non-medical and peer-operated crisis respites (Bola et al. 2005; Bola et al. 2009; Ostrow and Hayes 2015), trauma-informed care (Sweeney et al. 2016), Hearing Voices work (Corstens et al. 2014), culturally informed services (NiaNia et al. 2016; Maar et al. 2009), Open Dialogue (Seikkula et al. 2006), and Intentional Peer Support (Mead 2014; O'Hagan et al. 2010). These various approaches have strong evidence bases but have gained no traction in bio-medically dominated services in Ireland.

Knowledge developed through research conducted by user/survivor researchers (Beaupert 2018; Beresford 2002, 2010; Beresford and Wallcraft 1997; Blanch et al. 2012; Costa et al. 2012; Fabris 2011; Faulkner 2017; Faulkner and Basset 2012; Gordon and Ellis 2013; Kalathil and Jones 2016; Jones and Brown 2012; Russo and Sweeney 2016; LeFrançois et al. 2013; Penney 1997; Rose 2001, 2014, 2017; Rose et al. 2011, 2018; Russo and Wallcraft 2011; Shimrat 2013; Sweeney et al. 2009; Wallcraft 2010; Wallcraft et al. 2009) is rarely cited in academic psychiatric literature, including debates such as this. This research, conducted either independently or in close collaboration with allied academics, is ignored because it asks different questions about the issues that actually mean something to people encountering mental health practice. We ask where is research funding directed and to what end?

(Rose et al. 2018). Meaningful ‘distributive justice’ would provide proper resourcing to user- and survivor-led initiatives and research—funding more of the user-led alternatives we know can work to reduce people’s need for crisis admissions.

Another gap in the evidence base is contextualisation of the factors that might be at play when research appears to suggest CTOs are effective. Remarkable work exploring the topic and reviewing the research on CTOs informed by personal experience is available, but is not widely known or cited (Fabris 2011; Fabris and Aubrecht 2014). Fabris discusses the literature on the impact of psychotropic drugs on people, the sole treatment offered to those under CTOs in Ontario, Canada. He uses institutional ethnography and interviews mental health professionals working with people under CTOs. He details the social and political climate preceding the introduction of CTOs in Ontario in 2000. Following some tragedies, intense lobbying by medical and psychiatric professional bodies and bereaved families and sensationalist media reporting resulted in moral panic and populist political reaction. CTOs were introduced despite sustained opposition by the local survivor movement, allied with the Ontario branch of the Canadian Mental Health Association and the Canadian Civil Liberties Association. The same domino effect of moral panic and political populist reaction following sensationalist reporting of tragedies linked to imputed mental health difficulties is evident everywhere CTOs have been introduced (Brophy and McDermott 2003; Moller 2002). Psychiatric lobbies reassure the general public and politicians that ‘dangerous’ people will be detected, detained, and treated to prevent tragedies. This is an impossible promise with devastating results for many people who are never a danger to themselves or others. In order to attempt to prevent one individual tragedy associated with mental distress, thousands of non-violent individuals are forced to accept involuntary treatment in the community under a social control imperative (Lawton-Smith et al. 2008). This would not be acceptable with any other population, yet is routinely experienced by too many psychiatrised people following the introduction of CTOs. Fabris (2011), following detailed examination of evidence including how clinicians understand the practice and impact of CTOs on the people subjected to them, concludes that CTOs are not necessarily less restrictive than detention, have draconian implications for those subjected to them, and are, in effect, chemical incarceration in the community (Fabris 2011).

A recent user/survivor-led study from Norway asked people under CTOs about their experience of engagement with well-resourced assertive community teams (ACT) who enforced the orders (Lofthus et al. 2018). This research strongly suggested that those who did well under CTOs did so because of the additional resources made available to them as a consequence of the increased support they experienced. The ACT deployed resources to support people with the basics of daily living, such as help maintaining a home and access to transport to social events and even shops. Such support for people living in isolated rural situations transformed their daily lives, and so they believed their lives were improved by virtue of the CTO status. The conditions and supports, which might conceivably render CTOs effective in more socially equitable societies such as Scandinavia, are not present in Ireland. McDonald and O’Reilly suggest the imposition of CTOs in Ireland as a means to ensure community mental health services are available to people experiencing distress. The opposite is indicated by the experiences in other jurisdictions. Heun et al. (2016, p. 117) observed an urgent need for greater transparency over the resource costs of CTOs, including administration, report writing, and bureaucracy, which divert attention from person-centered, recovery-focused community supports. He estimates the time clinicians spend on reports and mental health tribunals associated with CTOs to range from 8 to 24 h depending on the person. This is an additional consideration when there is little evidence that anyone benefits except politicians, who claim CTO legislation is an answer to high profile tragedies. In this respect, survivors and progressive mental health professionals can agree, more money is needed to support people in communities. It is morally unjust and counter-productive to tie these resources to coercive measures.

#### 4. Clinician and Cultural Bias

An old adage states: ‘doctors differ, patients die’. In the case of people with long exposure to psychiatry, people do die much earlier than those who are not exposed to lifetime overuse of psychotropic medications (Whitaker 2005, 2010; Moncrieff 2008). People differ in their experiences of mental distress and services interactions; one of the most consistent differences being their relationships with individual treating clinicians, the extent to which they feel meaningfully involved in their treatment, and whether there is a free choice to engage with such treatments (Pridham et al. 2016). As Rugkåsa and Dawson (2013) and Brophy et al. (2018) observed, within the same jurisdiction, CTO use varies considerably between regions and individual psychiatrists.

Despite psychiatry’s claim to be evidence-based, scientific, and objective, there is ample evidence to the contrary from writers who have studied the implicit cultural bias of mental health services (Carr 2015; Fernando 2014, 2017; Kalathil et al. 2011; Thomas 2015; Thomas et al. 2012). People closest to the consequences of disadvantage and discrimination have more forced psychiatric interventions (Brophy and McDermott 2003; Holly 2017; McCann et al. 2013; Morrow and Weisser 2012; Van Cleemput 2010). Any two or more interlocking positions of social disadvantage (e.g., race and gender, or class and sexuality) and experience of trauma multiplies to increase one’s risk of involuntary encounters with psychiatry. For instance, a meta-analysis found a disproportionate rate of CTOs imposed on non-native, non-English speakers in Australia (Kisely and Xiao 2017). As the UN Special Rapporteur has observed, the challenges facing psychiatry are not chemical imbalances so much as power imbalances (Pūras 2017).

#### 5. Consent and Insight

McDonald and O’Reilly appear to consider the moral and ethical requirement to obtain informed and free consent as being inconvenient for research should CTOs be introduced in Ireland. I have co-written elsewhere imagining what informed consent would look like in a world that respects the aspirations and direction of the UN CRPD (Brosnan and Flynn 2017). We proposed that the same standard to legally defend against violation of someone’s bodily autonomy (as in the case of rape) be applied to consent to treatment, i.e., that treating clinicians must demonstrate every effort to actively negotiate free and informed consent to treatment, not just rely on implicit or explicit coercive threats. As evidenced by McDonald and O’Reilly’s arguments reproduced above, determination by psychiatric authority that someone lacks capacity removes that individual’s right to be a decision maker. Instead, psychiatrists impose ‘substitute decision-making’ under mental health laws. Substitute decision-making is the term used by Legal Capacity scholars for all regimes of imposed decisions on people with disabilities, including treating people without their explicit free and informed consent (De Bhailís 2019). People deemed to lack capacity by psychiatric assessment have no legal right to refuse treatment (Brosnan and Flynn 2017). Treatment is imposed coercively, and this treatment is invariably psychotropic medication. People’s reasons for not consenting to such treatments are ignored, as medical authority deems any resistance as irrelevant because they lack insight and the capacity to make decisions professionals believe are in their best interests.

I claim the authority demonstrated by the first authors and state categorically: every person who has encountered psychiatric services knows the coercive power of psychiatry. We know people advise each other in acute units: ‘if you want to get out, watch what you say, do what they want, and convince them you will take the drugs’. I ask any fair-minded person to explain how that dynamic can build a genuine therapeutic relationship? Moral and ethical practice requires convincing people medication will improve their lives and then obtaining their informed consent (Kaminskiy 2015). Truly informed consent must include genuine choices but at a minimum clearly explain the potential risks (metabolic disorders, organ failure, weight gain, and sexual and other lifestyle consequences) of psychotropic medication (Carvalho et al. 2016; Mitchell et al. 2011; Moncrieff et al. 2013; Whitaker 2005). If this information about potential risk is provided, individuals can make informed risk-benefit decisions about the pay-offs in terms of the hoped-for reduction in mental distress being off-set by

the potential negative health effects and likely dependency. This must apply to all people prescribed psychotropic medication. Also, the reluctance to take medication must be understood and respected. Instead, McDonald and O'Reilly appear to lament the trial where the New York Police Department (NYPD) did not cooperate and return people to detention and forced medication. A principle yet to be understood by psychiatry is that free and informed consent necessarily includes the right to dissent or refuse.

Let me turn to another objection I have with the first authors' arguments. Insight or the lack thereof is used as a construct to justify coercive treatment (Diesfeld 2003; Diesfeld and Sjöström 2007; Sjöström 2006). Yet, insight has no objective reality—it lies in the individual assessment of clinicians. As such, it is a tautological construct, not clearly definable and has no commonly accepted and objective measure. Research rating scales have been developed and all too frequently appear in quantitative papers that claim insight has been measured, when instead it is always based on clinical judgement. When there is no objective reality to measure, its application to individuals and use as a 'language device' (Sjöström 2006) varies between individual clinicians and studies. Insight is also used as a language device to determine if someone has capacity. Once 'lack of' insight is deployed, legal capacity is removed. Consequently, someone can be determined to 'lack capacity' and decision-making rights are denied. Given the power dynamics in how insight is utilized, insight is most commonly determined to be present when the individual is in concordance with the doctor (Hamilton and Roper 2006). Most astute individuals in psychiatric encounters know one's relationship with services are least problematic when one demonstrates 'insight', which lessens the risk of being denied capacity to consent to, or refuse, treatment.

## 6. Legal Considerations

The unintended consequences of laws seeking to control for a few rare and disturbing situations have ramifications far and beyond the original drafters' intentions. Hard cases make bad law, states an astute old legal adage. Once laws are enacted, they are notoriously difficult to reverse. Professor Burns himself has good reason to know this and argues against allowing legislative creep to compound the coercive element of psychiatry when the evidence fails to justify more arbitrary powers.

Kelly outlines legal and human rights concerns, obviously shared by many user/survivor activists. He refers to the European Convention on Human Rights (ECHR) being a benchmark for human rights protections, but interestingly omits the Convention on the Rights of Persons with Disabilities (CRPD) (United Nations 2006). Although the argument is presented that courts in Europe generally accept the ECHR, meaning its rulings have justiciable weight, the CRPD is beginning to influence the decisions of the ECHR (Gooding 2017). We need to move beyond thinking that may have been progressive in 1953. The CRPD takes the argument to a different level beyond the ECHR, which is 70 years old (Degener 2017; Series 2015). The CRPD introduces a new paradigm for mental health and human rights. General Comment One in Article 12 of the CRPD expressly prohibits removing people's legal capacity to consent solely on the basis of a disability, or assessment of mental capacity, and instead demands adequate and appropriate support with decision-making for people with disabilities (Gooding 2017; Minkowitz 2013; Simmons and Gooding 2017). Article 14 prohibits involuntary treatment and detention (Minkowitz 2006). The UN Committee charged with oversight of how States are implementing stronger safeguards for the rights of persons with disabilities consistently require States and policy makers to be more imaginative and creative in reforming laws that allow people with disabilities to be detained and treated without their consent (Degener 2017). For instance, the CRPD Committee called on Australia to take 'immediate steps to replace substitute decision-making with supported decision-making', including with respect to a person's right, in their own capacity, to give and withdraw informed consent for medical treatment' (UN CRPD Committee 2013, p. 4, para. 25). The call on New Zealand the following year was similar (UN CRPD Committee 2014): both jurisdictions have exceptionally high rates of CTO use (Brophy et al. 2018). The concluding report on the UK recommends repeal of both legislation and practice that allow non-consensual

involuntary, compulsory treatment and detention of persons with disabilities both inside and outside hospitals on the basis of actual or perceived impairment (UN CRPD Committee 2017, p. 8, paras. 34, 35). In this spirit, it behooves psychiatry to address the failures of services evident in revolving door episodes in people's lives (Pūras 2017). Research informed or led by people with experience of services demonstrates the importance of relevant experience shaping research and responses to distress (Rose et al. 2011; Rose 2014; Russo 2018). This is also a principle enshrined in the CRPD: the inclusion of people with disabilities (actual or perceived) in both Article 4(c) to ensure all policies and programs are informed by the rights of persons with disabilities. However, I am arguing beyond inclusion in mainstream mental health research and service user involvement, latterly known as public and patient involvement (PPI). What is needed is research conducted by people with first-hand experience of distress, including experience of CTO and other forms of coercive practice, asking questions about what needs to change and how care could be provided differently.

## 7. Conclusions

Psychiatry is the only branch of medicine that has generated an active and sustained global resistance movement (O'Hagan 2004). The biological explanations and chemical treatment of distress are frequently unhelpful and unsatisfactory (Pūras 2017). If psychiatric treatment was as effective as McDonald and O'Reilly would have us believe, there would be no need for widespread forced treatment underpinned by mental health law. Mental health legislation is not informed by the lived experience of people subjected to the practices by which it is underpinned. Psychiatric research is not informed by the experience and direction of people who live with first-hand experience of distress. Therefore, it is incomplete and fails to address the contexts of social and economic inequalities and injuries that cause or compound emotional and mental distress. I conclude with a simple plea. Do not give more arbitrary power to psychiatry in Ireland to treat people in communities against their will. True 'distributive justice' (as distinct from McDonald and O'Reilly's interpretation) would divert more resources away from forced biomedical treatment toward alternative initiatives that have been shown to help people reduce their need for crisis admissions, and toward survivor research that asks the questions that matter. That would be genuine distributive justice and a direction most right-minded professionals and users/survivors who want an end to coercive practices could support.

**Funding:** This research received no external funding.

**Acknowledgments:** This paper has developed over many drafts and re-iterations since beginning in response to the debate published in the Irish Journal of Psychological Medicine in 2017. Many colleagues offered support and encouragement, especially Yulia Kartalova-Doherty, Linda Steele, and Sheila Wildeman. Thank you. I want to thank the editor of this edition of Laws, Penelope Weller, for encouraging me to submit to this special edition. I am also grateful for the very helpful comments provided by the anonymous reviewers and academic editor's suggestions that have helped shape the final draft of the paper.

**Conflicts of Interest:** The author declares no conflict of interest.

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