Chapter 16

The Human Rights of People with Severe and Persistent Mental Illness

Can Conflicts between Dominant and Non-Dominant Paradigms be Reconciled?

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Introduction

The human rights of people with disability

Historically the mental health human rights movement derived human rights for people with mental illnesses from other rights movements. The disability rights movement co-opted techniques from women’s rights and black rights movements, and in turn the mental health consumer movement took many cues from the broader disability movement.

People with mental illness were relative latecomers to civil and disability rights activism. They were left out of these movements because they were still institutionalized when this movement was gathering steam, and partly because of the stigmatized views from within the movement, that individuals with psychotic disorders were too violent, volatile, or irrational, and unable to meaningfully participate in empowerment (Cook and Jonikas 2002).

There is now a clearly defined advocacy sector that is overt in trying to define disability rights. Various nations have enacted disability legislation, culminating in international disability rights conventions ‘in an attempt to articulate what social justice means for people with disabilities in receipt of government funded services.’ (Robin Banks—PIAC personal communication).

Whereas the old paradigm for disability viewed a disabled person who cannot function because of a particular impairment, the current paradigm assumes that, whether the disability is physical or psychiatric, the person needs some specific aid or accommodation in order to function. In this ‘social model, disability is socially constructed, essentially in social and/or environmental terms (see Belfer et al. in this volume). While self-determination is an important component of the current aspirations of the recovery movement involving individuals with mental illness, claims for total self-determination seem over-idealized and unrealistic. Practical conceptions of self-determination and autonomy must allow for a balance with inter-dependence, social connectedness, and the social aspirations or will of real communities (Cook and Jonikas 2002). Consequently autonomous living with a disability becomes a dynamic interaction between the characteristics of the individual and the features of their social, cultural, natural, and built environment (Cook and Jonikas 2002). To maximize self-determination of those involved, we need to consult with individuals with psychiatric disabilities, their families, and other stakeholders regarding what this would take for each person or group.
Mental health advocacy movements

Barry (1983) identifies three distinct mental health advocacy movements that emerged from these origins in North America: Dorothea Dix’s campaign for ‘the humane treatment of the mentally ill’ through the building of state hospitals (i.e. institutionalization as a reform), Clifford Beers’ influence in establishing the mental hygiene movement leading to community mental health services, and the grass roots emergence of the mental health family and consumer empowerment movement (exemplified in the National Alliance for the Mentally Ill: NAMI). Tucker (2001) traces the origin of the consumer empowerment movement in the UK to the flattening of the authority structure inherent in the development of the then clinical therapeutic community movement, though arguably this was not so pervasive nor as long lasting as the movements just mentioned. However, it was influential in making the walls around psychiatric institutions more permeable in countries where therapeutic communities did operate. It also may have partly responsible for a shift towards community health care, and consumer voices and needs beginning to be heard by service providers.

The human rights movement in health has been enshrined in instruments such as the UN Universal Declaration of Human Rights (UDHR), which endowed every person with a claim to basic healthcare (Robertson G 2007). In mental health this has led to professional and family advocacy for the right to psychiatric treatment, which they insist should be enforceable if necessary. Mental health consumers challenge this however, denying they need compulsory treatment, whether due to their claim to having made an adequate recovery in their own terms, or to lack of insight or appreciation of the perception of others. Tucker (2001) argues that full consumer participation with greater service user–provider equity is inherent in all high quality mental health care systems, such as therapeutic communities, and that ‘add-on’ consumer participation is artificial and should be unnecessary. Unfortunately, not all service systems recognize the value of such integrated participation as yet, and may need to enforce consumer participation for some time to achieve satisfactory acceptance by services.

Mental health human rights and politics

Political climates, legal changes, and judicial activism have both impacted and frustrated rights advocacy for people with mental illness. From the consumer viewpoint, the rights to both obtain treatment and to refuse treatment ideally should together constitute the right to mental healthcare (Mizrahi 1992; Barrett et al. 1998), and this balance of rights was upheld judicially in parts of US from the 1960s. In the US and other Western countries, attempts by conservative politicians, such as Reagan and Thatcher, to almost simultaneously rescind the rights of and retrench services for individuals with mental illness (Sedgwick 1982) have been tempered by grass-roots local and national advocacy (Mizrahi 1992). In Italy, the emancipation of individuals with severe and persistent mental illness (SPMI) from the mental hospitals, their closure and replacement with largely community-based facilities, and the insistence on the rights of people with SPMI to full citizenship and valued membership of the community, were enshrined in the national laws of 1978 (Basaglia 1987a), and 1998 (Allison 2006; Mezzina 2007, personal communication). Hospital-based patients and staff were empowered at the same time to stand up for system-wide reforms to improve the quality of their lives and working relationships. When the arch-conservative Italian Prime Minister Berlusconi tried to reverse these reforms, the national family movement rose up against his government until it relented (Dell’Acqua 2010).

Reform agendas do not always improve human rights

Top-down imposed ‘Mental Health Reforms’ cannot always be guaranteed to be ‘a good thing’. They are not always in the interests of individual service-users, and their misuses further down the
track may be hidden, insidious, or unpredictable at the time of implementation (e.g. governmental abuse in Nazi Germany of fairly advanced psychiatric epidemiological tracking systems in the 1930s to identify mental patients for extermination) (Seeman 2007). Reorganization of services can be seen historically as cyclical, causing discontinuities of care with each turn of the wheel. So, it is important to have a mechanism such as a Mental Health Commission to consider all proposals for change carefully in advance through well-developed partnerships and regular forums among all stakeholders (Seeman 2007; Rosen et al. 2010). It is equally important to ensure that a more enabling culture (e.g. encompassing human rights, holistic, and recovery-oriented care) is nurtured and grown for endurance with any reorganization, such as a shift towards community-centred services. This is also where implementation of both squarely evidence-based and values-based practices should meet (Woodbridge and Fulford 2004; Rosen et al. 2010).

Mental health human rights and the law

Ratified legislation on unlawful detainment, torture, inhuman, or degrading treatment can and has in recent times been unreservedly over-ruled on the grounds of ‘tacit medical necessity’ (Hale 2007). The established principles of medicine have been decisive in such cases, on the grounds of ‘medical exceptionalism’. That is, a therapeutic necessity cannot be regarded as inhumane or degrading.

The law generally takes a paternalistic view tempering the upholding of all rights to autonomy (Richardson 2007) involving three considerations: (a) the protection of the patient’s health and safety; (b) the protection of others, that is public safety and keeping the peace, though it is unclear why mental disorder has been singled out for the application of special social protective powers; and (c) the right of the mentally ill person to treatment and to access to health care, which may be enforced if the person is deemed not to have decision-making competence to consent to or refuse medical treatment. This represents one of the classic dilemmas of biomedical ethics, between respect for patient autonomy and the demands of beneficence (Beauchamp and Childress 2001).

This is countered by a libertarian legal critique of involuntary commitment (McCafferty et al. 1990): that it debases fundamental rights which should not be denied on the basis of arguments for the need to protect people with mental illness and others in their orbit. Gostin (2000) argues that human rights are so basic that they should be self-evident, permanent, and widely agreed. In mental health however, that recognition has been elusive. The conflict concerning involuntary treatment provides a counter-example, where different rights are in tension with each other.

Whereas previous mental health laws had no provision for consent, more recent laws in Western countries (e.g. Hamilton 1983) have enshrined voluntary treatment, informed consent, and least restrictive care as civil rights, to be upheld whenever possible. At the same time, the 1976 landmark Tarasoff Case in California enshrines the principle that mental health professionals are legally accountable to third parties likely to be harmed by their patients. This has made mental health professionals more alert to indications that their patients may harm others, so they feel more obliged to override such rights and take measures to protect those who may be at risk of becoming victims (Elfstrom 2002).

Some have questioned the judicial verdict of not guilty and/or psychiatric commitment for criminal behaviour by reason of mental illness. Benditt (2001) considers that psychiatric commitment instead of penal incarceration is appropriate if the behaviour is criminal, if it is recurrent despite repeated detention and punishment, especially if it is associated with perceived symptoms of mental illness, and if there is some evidence that the behaviour could be ameliorated by treatment. The penal system, by contrast, presupposes offenders should be able to control or take responsibility for their behaviour, or at least be able to learn from the consequences of their behaviours. However this distinction does not safely distinguish such behaviour from the behaviours of people with mental illness. This grey area is illustrated by those mentally ill individuals who are
competent to give consent to treatment when well but who do not, despite knowing they are liable to become violent when unwell (Elfstrom 2002). Arguably, they should be placed in the same legal category as the voluntarily intoxicated. That is, it is argued that they should be held responsible for their condition and legally accountable for acts performed under its influence (Elfstrom 2002).

Human rights can be seen initially as a restraint on state power over the individual, which is a precursor to the rights to provision of services and resources to ensure social, cultural, and economic justice (Akuffo 2004). Three fundamental relationships have been identified between mental health and human rights (Gostin 2000; Akuffo 2004): (a) mental health policies, programmes, and practices, through their exercise of government power to restrain, treat, and deprive people of basic citizenship rights (e.g. involuntary treatment), can violate the human rights of individuals designated mentally ill; (b) the adverse effects of severe human rights violations (e.g. incarceration, torture, genocide, sexual assault, malnutrition, starvation, intimidation, and neglect), can have on a person’s mental health; (c) the mutuality which exists between mental health and human rights as both are complimentary approaches to the betterment of human beings, their well-being, and quality of life.

The UN Principles for Protection of Persons with Mental Illness and Disability Convention

In 1991, the UN adopted a resolution endorsing ‘The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’ (United Nations General Assembly, 1991). These principles are sweeping in their breadth and promise concerning a wide array of rights for people with SPMI. However, they also contain some compromises regarding certain basic civil liberties, for example between the desire to treat (stating that beneficence entails the right to receive the best current mental health care), and the libertarian imperative to leave someone alone when they don't want treatment. The right to refuse treatment was removed from an earlier draft. However, it was a resolution, not a treaty, and hence not legally binding, unlike such UN declarations for other groups suffering from prejudice and discrimination, such as refugees, women, and immigrant workers (Rosenthal et al. 1993).

The UN Mental Illness Principles emphasize respect for the inherent dignity and autonomy of the human person receiving psychiatric care. They state that facilities for care, support, treatment, and rehabilitation 'should as far as possible, be provided in the community in which they live, and that hospital-based care should only occur when such community facilities are not appropriate. This preference is stated repeatedly in the principles, requiring the guarantee of vocational training and placement opportunities to assist community reintegration.

From a human rights perspective, a prime reason for prior abuse of people with SPMI in psychiatric care has been that paternalistic, albeit sometimes well-meaning, practices have over-ridden autonomy. Such a perspective must drive procedural safeguards which can serve as a brake against unwarranted coercion, because 'coercion in the name of treatment, once unleashed, is very difficult to control' (Rosenthal et al. 1993). The Drafts of the UN Principles state that they only 'represent the minimum UN standards for the protection of fundamental freedoms and human and legal rights'.

Primarily due to its non-binding nature, the UN Mental Illness Principles statement may be perceived as little more than a 'paper victory' (Perlin 2000, 2009). However, the principles were soon followed by drafting and adopting of the new Convention on the Rights of Persons with Disabilities (Perlin 2000, 2009)—a far sturdier legislative mechanism for countries with strong records on human rights, and likely to be the foundation of future legal challenges in the name of people with SPMI.
Definitions and phases of mental illness

Early stage mental illnesses

First we should consider early stage and onset issues where delays in the recognition of the ‘ill health’ and delays and insensitivities in engagement of individuals who are prodromal or in early stages of psychosis may result in the benefits of treatment being very compromised (Jackson and McGorry 2009). A key future strategy is to create stigma-free or ‘soft entry’ to care. This means muting the psychiatric tone of the initial help seeking environment and allowing maximal patient participation and choice in the initial treatment or care options. Engagement and initial relief of distress is the immediate goal and stepwise care in relation to a clinical staging model (McGorry, 2010a,b; McGorry et al. 2006, 2007, 2010), which delicately balances benefit and risk at each stage, is a helpful approach. This is a preventive strategy which maximizes choice and the chances of recovery with minimal coercion.

What is severe and persistent mental illness?

Severe and persistent mental illness (SPMI) is not a unitary construct. It is not confined to DSM Axis I psychiatric conditions, nor should it be defined centrally in terms of diagnosis. Rather it should be defined in terms of the six Ds: Disability, Distress, Duration (and severity) of symptoms, Disorganization, Danger (to self and others), and 'De family' or Disaffiliation (lack of family support or social isolation). It can also be defined in terms of complexity including vulnerability to co-morbidities (e.g. drugs and alcohol, persistent physical health problems, intellectual disabilities, brain injury, etc) and other factors, including forensic involvement, socio-economic deprivation, psychiatric stigma, rural or remote location, and indigenous or transcultural background. For an Aboriginal person with a mental illness, a cascade of such factors can entrench disadvantage.

SPMI can also be defined in terms of the lived experience of the illness, associated disabilities, deprivations, stigma, and discrimination. Psychiatric functional impairments and disabilities include (as mentioned) social isolation and disorganization, expressed as lack of ability to adequately manage one’s finances, housing, nutrition, domestic and self-care, education and training, and to find or retain a meaningful occupation. Other associated deprivations include poverty, dangerous environments, lack of protection, and neglect or abuse of one’s children. All these factors contribute to stressors which exacerbate mental illness and make them persist, in those who are vulnerable. They are also consequences of such episodes. Poverty, endemic in developing countries, contributes to both higher incidence of, and poses worse outcomes for, mental illnesses in developing countries (Maingay et al. 2002; Robertson G 2007; Lancet Global Mental Health Service 2008)

The lived experience of having a severe and persistent mental illness can be wearying and fraught, and other people in the community have difficulty understanding what that experience is like: the personal and family impacts of co-morbidities, disabilities, multiple disadvantages, life disruptions and dislocations involved, and of psychiatric stigma, which many individuals with SPMI report as being much worse than the disease in its impact on their lives (Rosen et al. 2000). People with SPMI are often falsely perceived as dangerous, non-human, unapproachable, unemployable, and unmarriedable. They therefore become shunned or marginalized by the community. The organizational equivalent is ‘structural stigma’, an extension of the sociological concept of structural discrimination, which is the indirect or unintentional act of stigmatizing a group of people through institutional procedures, legislation, and barriers (Schomeros et al. 2007; Corrigan et al. 2004).

Finally, an area which has been increasingly scrutinized in the last five years or so is the burden of physical, including iatrogenic, illness for people with SPMI. This includes such problems as failure to seek help, diagnostic overshadowing of physical illness by having SPMI, substance
(including nicotine) dependence, failure of clinicians to detect serious physical illness in individuals with SPMI and their failure to offer definitive technological solutions to such individuals, and the unwanted, enduring physical consequences (e.g. metabolic syndrome) of psychotropic medications such as anti-psychosis and mood stabilizing medications, especially in young people (Correll et al. 2009). The right in some jurisdictions to refuse medication is a related and often vexed issue, as it may prevent unwanted effects of medication, but it may also postpone recovery, sometimes indefinitely (Barrett et al. 1998).

Rights to humane care should include a holistic, well-coordinated approach which encompasses strategies to deal with all of these complexity factors (Hunt 2007).

**Domestic (Western) paradigms of rights for individuals with severe and persistent mental illnesses**

By ‘dominant paradigms’ of rights we refer to prevailing understandings and influences in international psychiatry, mental health, and rights which are mainly Western (e.g. European and/or North American) in origin, and which are frequently reflected in WHO and United Nations statements on this topic. (However it should be noted that the UDHR and the Bill of Rights were also shaped by non-Western international input). People with SPMI have internationally recognized sets of rights, and a growing expectation that they should be met. The World Health Organization (WHO) has attempted to spearhead multi-country systemic reform of mental health services, including the promotion of human rights standards and principles in mental health legislation and procedures (Arboleda-Flórez 2008; WHO 2005).

The WHO articulates ten principles that are considered basic to proper mental health systems and for the protection of the rights of the mentally ill: see Box 16.1.

### Box 16.1: WHO Principles for Service Systems to protect the Rights of People with Mental Illnesses (WHO 2003, 2005; Arboleda-Flórez 2008)

i. Promotion of mental health and prevention of mental disorders
ii. Access to basic mental health care
iii. Mental health assessment in accordance with internationally accepted principles
iv. Provision of the least restrictive type of mental health care
v. Self-determination
vi. Right to be assisted in the exercise of self-determination
vii. Availability of review procedures
viii. Automatic period review mechanisms
ix. Qualified decision-makers
x. Respect for the rule of law

The WHO document endorses the 25 principles contained in the United Nations Resolution 46/119 that covers a gamut of areas that impact the rights and care of the mentally ill, such as the following: see Box 16.2.
The Declaration of Madrid of the World Psychiatric Association (WPA) specifically reminds psychiatrists and other mental health professionals that the patient should be accepted as a partner by rights in the therapeutic relationship to allow the patient to make free and informed decisions, and that when the patient is incapacitated and/or unable to exercise proper judgement because of a mental disorder, the family should be consulted and, if appropriate, legal council should be sought, to safeguard the patient’s dignity and legal rights. The declaration also urges psychiatrists and other mental health professionals as members of society to advocate for fair and equal treatment of the mentally ill, for social justice, and equality for all (World Psychiatric Association 1996).

Is there a ‘right to treatment’?
Treffert (1973) coined the phrase ‘Dying with their rights on’ to describe uncooperative individuals who are an impending danger to their own lives, yet do not meet the criteria for involuntary treatment under mental health laws that strive to uphold the rights of people with severe mental illness. He recounts instances where it was well recognized that such individuals needed commitment but did not qualify. Entirely predictably, they went to their graves with their rights intact, which could be seen as a morbid medico-legal triumph or a pseudo-heroic moral failure. Treffert (1973) states: ‘persons concerned for the patient’s rights to be sick and free have been more vocal and persuasive recently as the perpetual pendulum has swung from frank paternalism to frank abandonment. Both of these extremes are distasteful. There must somehow be a proper balance between these two rights to prevent the several kinds of injustices possible.’

Is there a right to self-determination for individuals with SPMI?
A related question is whether people with severe and persistent mental illness have a right to self-determination. The human right to self-determination has its roots in the right to individual freedom. Franklin D Roosevelt postulated four freedoms: of expression, of worship, from want, and from fear. However as the subsequent advent of McCarthyism showed, acceptance is not universal but contested. Human rights are rarely bestowed but rather are gained incrementally through struggle and then must be guarded vigilantly against erosion. Heron (1981a, 1981b)
argues for a further all-pervasive right, of people to participate in decision-making that affects the fulfillment of their needs and interests. There are special cases of this right, or subsidiary rights. The right to information concerns any proposed treatment, the right to choose, and the right to informed consent. For example, the review (2007–10) of the Australian Mental Health Service Standards (1996) recommends that informed consent should be routinely and carefully sought from both voluntary and involuntary patients (Miller et al. 2009). Also relevant are the right to freedom of association and contract, and the right to political membership of the community as full citizens—that is the right to participate in the framing and working of political institutions. These rights—including the right to dissent, to vote, to stand for an official post, and to be a member of a jury—are often denied to individuals with mental illness in many US state jurisdictions, amounting to institutional forms of structural stigma and discrimination (Corrigan et al. 2004).

Thus in concluding this section, people with SPMI generally have the right of citizens to protection of their civil liberties. However, this exists in tension with the right to humane, least restrictive, and most effective treatment, and the furtherance of the person’s economic, social, and cultural rights. For some, this right could override their civil liberties as citizens. This is related to the beliefs and responsibilities of the society in which the person with SPMI lives.

Questions nevertheless remain. In the case of physical illness, people have a responsibility to manage their own illness. Does this apply to people with SPMI even if they aren’t able to manage their daily affairs? This is dubious, particularly if the person has a poor degree of insight or awareness of their condition and the actual or potential consequences of their beliefs on themselves and others. The iatrogenic consequences of treatment, as noted above, and the need for screening and treatment also complicate this question of responsibility.

Also, do the rights of the community override the rights of people with mental illness? Society has the right to protection from disturbance of peace and order, including due to mental illness. Does this override the rights of citizens who have SPMI? This is still contentious, but within the dominant paradigm, the rights of the community are usually assumed to override the rights of the individual with mental illness.

There is another related dilemma: concerns have been expressed widely for some time that the use of involuntary orders in English-speaking countries has been excessive. At the same time, research studies in these countries have indicated that more unfettered access by mental health professionals to the use of involuntary hospital admissions (Large et al. 2008) and Community (outpatient) Treatment Orders (Ajzenstadt et al. 2001; Segal and Burgess 2008, 2009) has saved lives, in terms of lessening danger to self and others, and has improved clinical outcomes. This may indicate that in present circumstances, many services have not adequately systematized the skills of developing therapeutic alliances so that they would not need to resort so much to involuntary orders. Consequently, involuntary orders in many jurisdictions have been made increasingly cumbersome to initiate because of the defensive fear by human rights advocates that they will be invoked too readily. This appears to have been a tit-for-tat symmetrical escalation. Ideally mental health professionals should be taught a more effective repertoire of negotiating skills to ensure voluntary collaboration, and therefore use involuntary orders much more sparingly. Then, when they are urgently needed, involuntary orders should not be too difficult to initiate. However, once invoked, they must have appropriate human rights checks and balances via the routine overview by independent umpires or authorities that include advocates acting on behalf of individual service users (see also Introduction, pp 32–34; Chapters 3, 7, 10, 32–33; commentaries 3–5; and throughout).

**Non-dominant (non-Western) paradigms**

These paradigms include invoking, sometimes simultaneously, collectivist as well as individualistic, multifaceted, and even contradictory models of reality, intervention, and human rights.
Collectivist models of human rights and care

Collectivist conceptions of human rights exist as alternative and complementary viewpoints rather than as a parallel universe to more individualist models. One such ‘social justice’ model attempts to acknowledge and to account for the sizable unattributed gap between purely scientific or clinical conceptions of mental disorder and disability, and the experienced realities of the social world. Wakefield (1992) argues that mental disorder lies on the boundary between the ‘given’ natural world and the ‘constructed’ social world: a disorder exists when a person’s internal mechanisms fail to perform their natural functions, so as to impinge harmfully on the person’s well-being, as defined by social values and meanings. Wakefield cautions against falsely pathologizing social phenomena (eg: ‘dрапетомания’, the colonially concocted affliction of slaves that run away from their masters), or conversely, accepting claims that SPMIs like schizophrenia are purely socially constructed or even do not exist.

Crow (1996) argues for a similar revision of the social model of disability to articulate more compatibility with a clinical model of impairment or disorder, so that both social and medical perspectives can interpret the range of bio-psycho-socio-cultural factors that determine social injustices and discrimination associated with psychiatric disabilities. She states that ‘Disability is still socially created, still unacceptable, and still there to be changed, but by bringing impairment into our total understanding, by fully recognising our subjective experiences, we will achieve the best route to that change, the only route to the future that includes us all.’

Another leading example is that of indigenous healing systems, and the use of social integration and social support to compliment clinical interventions or in place of clinical or formally enforced treatment. There is robust evidence accumulated over more than 25 years that outcomes for schizophrenia may have been better in developing countries and traditional societies (Harrison et al. 2001; Rosen 2003; Warner 2004; Hopper et al. 2007; Hopper, 2008). This indicates the likelihood of partial or complete recovery may be improved significantly by systematically delivering both evidence-based interventions and particularly traditional cultural congenial healing practices in combination in day-to-day practice (Rosen 2006). Factors at play may include; externalization of the problem (sometimes ascribed to external sorcery); social inclusion and acceptance by the extended kinship system, rather than marginalization; the ease of finding a valued work role in a subsistence economy; and the oracular or shamanistic value placed on transmitting content of hallucinations of ancestors, particularly if your social communication is reasonably intact. These factors are at the hypothesis level, and have required a more detailed study to determine which of them may be operative. Despite cautions not to idealize these findings or minimize the associated hardships in these settings (Rosen 2003, 2006), or the significant limitations of these studies (Cohen et al. 2008) many of which had already been stated by the original authors (Hopper et al. 2007; Hopper 2008), these results have proven to be robust and enduring over many years (Harrison et al. 2001; Warner 2004). However, it may be becoming increasingly difficult to attempt to replicate these differences because of encroachment of modernity on such indigenous communities.

Complexity vs reductionism, and rights

Arguably, mental health is the discipline that most emphasizes the assessment of complexities (that is final common pathway impacts of multifactorial etiologies and precursor and precipitating factors leading to clinical disorders and dysfunctional states) and complex approaches to care (multimodal interventions and the need for coordinated service delivery systems). Contemporary approaches to medicine emphasize that, for it to function optimally, it must operate as a complex adaptive system, considering both its elements and the web of relationships between them as crucial dimensions (Institute of Medicine 2001, 2006). In some ways, we have contributed this combined biomedical-psycho-socio-cultural-ecological outlook to other clinical disciplines,
largely through consultation-liaison psychiatry services to medical and surgical wards, emergency departments, and general practice. A further level of complexity is the impact and care of co-morbidities (e.g. drug and alcohol, intellectual disability, brain injury, and physical illnesses). The next level of complexity is social deprivations and the impact of social and cultural determinants on psychiatric disorders (Lancet Global Mental Health Series 2008). However, there is another overriding layer of complexity: the impact of psychiatric disorders on the assumption and exercise of human rights, and reciprocally the impact of human rights on treatment.

Too often, complexity is considered to be a burden in medicine, so every effort is sometimes made to over-simplify assessment and treatment, reducing the clinical care of people to just eliciting and treating bunches of symptoms and signs. Complexity should rather be celebrated, and psychiatry should be proud to be a discipline and a field of endeavour that unashamedly stands up for consideration of complex multi-faceted realities in all aspects of health care. We could then celebrate being a discipline that willingly combines and seeks to balance the clinical and social sciences, ethics, social justice, and human rights.

**Hidden meanings and miscommunications between stakeholders**

Miller (1990) demonstrates how protagonists in the ongoing discourse about the rights of people with SPMI—for example, legal and mental health professionals, consumers, and families—define key concepts and objectives differently. Though these differing assumptions may be clear to their respective advocates, they sometimes disguise different agendas.

For example, behind patient advocate groups upholding their rights to refuse treatment, is their determination to exert their right to decide what treatment they receive, and sometimes to receive no treatment or care at all, ever, under any circumstances (Treffert 1993; Barrett et al. 1998). This is not a negotiating position. Sometimes the legal insistence on the right to treatment, and clinicians’ insistence on providing clinical care, may be regarded as unspoken professional attempts to retain paternalistic authority over these matters, to exert social control over deviance and to protect economic interests in dealing with persons with SPMI (Ajzenstadt et al. 2001). Patient advocate groups may suspect parents who seek to secure hospital admission, to argue against discharge, and to ensure effective financial management of their afflicted offspring affairs, of perpetuating parental control and dependency.

While this prevails, Miller (1990) argues that we will continue to speak at cross-purposes, and yet still be surprised when judicial and legislative decisions reflect misunderstanding of the often obscure motivations underlying these arguments.

**Collectivist cultures and practices regarding people with SPMI**

In collectivist cultures, where individual subjugation to communal will is generally internalised, some cultures habitually blame people with SPMI for their illness. For example, shame-based cultures in Asia (Rosen 2003, 2006) often discriminate against such individuals and their families on this basis. In some developing countries and cultures the cause of mental illness is externalized: for example, that it is ‘sorcery’ imposed by an enemy or competing clan. The upside of this is that individuals with mental illness are therefore not shunned or excluded from the community and consequently suffer less discrimination (Rosen 2003, 2006) (though some critics regard such observations as representing either a partially idealized or ‘primitive’ view). The downside is that the extended family or clan may focus their attention on externalized resentment and their efforts on revenge, and may ignore the need for clinical assessment, treatment, and care. Kirmayer (see Chapter 4) deals with the relevance of individual and communal human rights to collectivist cultures.
Systemic neglect and abuses of psychiatry

Countries which neglect the human rights of people with mental illness, particularly of those in psychiatric hospitals, also tend to be those where the funding and quality of mental health care are very poor, and both need simultaneous upgrading (Lancet Global Mental Health Group 2008).

In authoritarian regimes which punish most forms of political and social dissent, questionable psychiatric diagnoses may be exploited for political purposes such as social control, for example the former Soviet Union and China [see Chapter 12]. All these require examining practices concerning mental disorders and non-Western ('frontier') psychiatry within different cultural contexts, including extreme cases, conditions, and/or political changes that would challenge dominant rights perspectives.

Kingdon et al. (2004) invoke the human rights provisions of the Council of Europe against psychiatric abuses, such as psychiatric incarceration and forced medication for political purposes, electroconvulsive treatment (ECT) without anaesthetic, and excessive use of physical restraint, seclusion, and involuntary treatments. Chappell (2004) and Onken (2008) decry the frequent denial of human rights for those whom police may attempt to bring into custody for disturbing the peace or erratic behavior, police killings during such police investigations or arrests; and people with SPMI who are in correctional services custody for criminal activity. Mental health legislation and related practices must ensure that forensic patients are offered contemporary psychiatric treatment in an appropriate environment, accorded rights equivalent to other patients, possibly with the exception of leave and discharge, and decisions regarding discharge must be made by an independent body, not at a political level. Abusive practices have always haunted psychiatry, arising from ignorance, neglect, exhaustion, cruelty, or criminality. Birley (2003) specifically condemns the premeditated and purposeful intimidation and 'neutralizing' of healthy people, who are regarded to be a threat to the existing political system, by threat of and actual admission to a psychiatric hospital, and forced psychiatric medicating, thus damaging their power, autonomy, reputations, their brains, and their bodies.

Possible resolutions for people with SPMI

Current attempts to remedy possible human rights abuses

It is often argued that Westernization, democratization, or building of quasi-capitalist economies will liberalize the mental health system over some time, and will induce increased transparencies and accountability. This may then lead to exposure of the most blatant human rights abuses, and may foster communal upholding of human rights for people with psychiatric disabilities. This is questionable. The European Union has tried to place pressure upon ex-Soviet countries entering the EU to raise the access and quality of mental health care, to standardize the minimal level of services, and to eliminate human rights abuse. Political changes were followed by updated legislation (Furedi et al. 2000). So far implementation has not occurred for various reasons. Accelerating economic growth in China has not, in itself, promoted personal freedoms and the human rights agenda. However increasing media scrutiny and public access to information has raised the standards of humanitarian responses to internal national crises, such as the 2008 earthquake and infant milk contamination scandal, beyond the imperative of just saving face. These developments may provide some hope for a more humane approach to the public health scourges of suicidality and mental illness in China, which may overcome the entrenched stigma and systemic neglect associated with these conditions.
Recent advances in models of treatment/early intervention

Prevailing models of early intervention in psychosis (Jackson and McGorry 2009) are increasingly widening to include other psychiatric disorders in young people (Headspace 2007, 2008; McGorry et al. 2007; Purcell et al. 2011) and have several features conducive to upholding human rights. These include: an emphasis on low-key voluntary care wherever possible, relying on attention to establishing and sustaining engagement; shared decision making; providing choice within a range of interventions; providing extensive information and group discussions with other young people, who are further along the road to recovery; providing access via shopfront community youth-orientated centres; normative holistic general health care; involving the young person’s family wherever possible; and prescribing low dose medication when necessary in the context of a stepwise or ‘staged’ approach (McGorry et al. 2006, 2007, 2010; McGorry 2010a, b). Such early intervention strategies are having an increasing influence on services for other phases of care (Shiers et al. 2009). Investing upstream is a best buy not only in terms of cost-effectiveness but also human rights, as much more timely and effective care can be delivered in more congenial circumstances with much less coercion (McGorry 2010a, b). This inevitably means a shift in focus to emerging adults and the creation of a missing portal and stream of care (McGorry et al. 2007).

Working harder to minimize involuntary treatment

Service systems could work much harder to minimize or dispense with involuntary treatment, locked doors, asylums, seclusion, and restraint. The Italian mental health reform movement, led by services in Gorizia and Trieste, have increasingly dispensed with psychiatric hospitals, involuntary admissions, locked doors, seclusion and restraint, over-medicating, psychosurgery and ECT, warehousing of longer term clientele, and passive dependent roles for psychiatric patients. Since even before the 1978 national mental health reform laws, these traditional methods have been progressively replaced with very small psychiatric inpatient units in general hospitals with only voluntary beds, no locked doors, no use of restraints, only very occasional use of the Mental Health Act and involuntary admissions, less emphasis on solely technical interventions and token support, 24-hour community mental health centres, community-based residential respite with ample separated facilities for men and women, more psychosocial interventions focused on recovery and regaining full citizenship, and work cooperatives or social enterprises providing real work for real pay (Basaglia 1987b; Mezzina 2005; Mezzina and Johnson, 2008; Rosen and Mezzina, 2005; Rosen et al. in press).

Advent of more recovery oriented services

There has been a gradual shift from an emphasis on ‘clinical’ or ‘service-based’ definitions of recovery to ‘personal’ or ‘user-based’ definitions (Slade et al. 2008; Burgess et al. 2011). The former are located within a medical model and relate to sustained remission, typically evidenced by reduction of symptoms and/or improvements in functioning. The latter have emerged from the ever-strengthening consumer movement in mental health, and draw on the documented ‘life journeys’ of people experiencing mental illness. These accounts share in common a theme which forms the basis of the alternative definition of recovery which suggests that recovery is much more than the absence of symptoms and functional impairment, and is more akin to a change in outlook that is related to leading a meaningful, purposeful life, with or without ongoing episodes of illness (Burgess et al. 2011).

Services based on similar principles as those in Italy above are now developing in centres as diverse as Madison Wisconsin, Boston, and San Francisco (US), Lille (France), Scotland and Essex (UK), Auckland (New Zealand), and Wollongong, Melbourne, and Geelong (Australia) as well as Eastern Europe, South America, and parts of the developing world.
Being subject to the same laws as everyone else
Some people with SPMI advocate being subjected to the same laws as everyone else, not special laws (e.g. Mental Health Acts). Meanwhile, more activist parts of the consumer movements and service providers shift from the emphasis particularly placed by English-speaking countries on seeking a more explicit balance between involuntary treatment provisions, and are seeking better checks and balances with more formal recognition in law of human rights of these individuals.

Humane strategies for individualistic cultures

Living wills
Some individualistic cultures that champion the primacy of individual self-determination (for example, the US) have debated the issue of ‘Living wills’ and sometimes with encouragement from the consumer movement, have taken tentative steps towards legislating for them. Thus, long term service users may circumvent times of diminished personal capacity, by specifying during periods of lucidity how they would like their next episode to be handled. This might include who should be contacted, what medication should be used if possible, and at what stage hospital admission or respite should be considered. Where such directives have overriding legal standing as a durable Power of Attorney, or where they are used to bolster an absolute refusal to take psychotropic medication, enthusiasm has chilled among clinicians, even as it has been stoked among patients opposed to all treatment (Appelbaum 2004). However current research indicates that most individuals who complete advanced directives do not use these directives to decline all treatment with medication, but rather to indicate a preference among alternative treatment, or to inform future treaters of particular concerns—for example, the care of their pets while they are hospitalized (Appelbaum 2004). Arguably, to achieve wider and bilateral acceptance and more practical utility, they should be framed especially in the latter two ways. Research evidence is emerging for the effectiveness of psychiatric advance directives and their variants, joint crisis plans and wellness/recovey action plans (Henderson et al. 2008). They vary to the extent they are legally binding, and as to whether health care workers and families are involved in their development, and an independent facilitator assists in their production. Different types of advance statements may co-exist and interact in complementary ways (Henderson et al. 2008).

Power of Attorney
Alternatively, or as a second-best or back-up strategy, a temporary or enduring Guardianship or Power of Attorney can be delegated or granted legally in advance by the individual with a mental illness causing mental incapacity, in some jurisdictions to a trusted confidante for transient periods during which the individual is incapacitated, though in other jurisdictions such powers are more designed for application in approaching permanent or continuous incapacity.

Shared decision-making
In applying the Institute of Medicine’s (IoM 2001) bridging of the Quality Chasm to mental health services, shared decision-making has emerged as one of the top rules to guide the redesign of health care. It is defined as a collaborative process (Deegan et al. 2008) between a client and a practitioner, both of whom recognize one another as experts and work together to exchange information and clarify values in order to arrive at healthcare decisions (Deegan et al. 2008). The intervention can be computer aided, using touch-screens and peer support workers working alongside, responding to a set of questions regarding the client’s concerns. The printed report is then reviewed by both client and practitioner together, entering trade-offs or negotiated solutions
to concerns in the resulting joint plan. There are now high quality studies emerging, with promising preliminary evidence likely to support its systematic implementation in mental health services (Adams and Drake 2006; Deegan and Drake 2006, 2008; Patel et al 2008; Simmons et al. 2010). Ethically, such joint decision-making amounts to a Rawlsian Social Contract, which is the rational agreement struck following consultation between participants who are ‘rational choosers’ to not act in a manner which disadvantages others, and the submission of the participants to an overriding power to enforce the contract (Robertson M. 2007). The aim here is to actively explore ways to convert assumed ‘non-rational choosers’ to participants in rational joint decision-making wherever possible.

Reconciling individualistic with collectivist societal solutions
If enhanced societal value is placed by the wider society on traditional healing factors, this will favour the survival and flourishing of wider communities by synergizing the most effective of traditional and contemporary evidence-based strategies. Moreover, it will also enhance pride in and respect for traditional strategies within indigenous communities themselves (Rosen 2001, 2006). This in turn may restore the pride, curiosity, and interest of younger generations in indigenous communities in acquiring the associated traditional knowledge and skills, so that they will not be lost (Rosen et al. 2010).

These traditional strategies have an emerging evidence-base of proxy strategies in the clinical literature, e.g. the restoring of the respected role of storyteller and elder; multiple family groups as proxies for extended kinship groups (Rosen 2003, 2006). If these strategies are more widely valued, they are more likely to be studied rigorously. If these strategies are subjected to quantitative and qualitative research projects, to determine their effectiveness, they are then more likely to be resourced together with already recognized ‘evidence-based’ practices (Rosen et al. 2010).

Resolving seemingly contradictory approaches
How can a model that upholds human rights in the mental health sphere both encompass apparent contradictions and remain simple enough to understand and implement, so as not to create a system of unworkable complexity and/or unwieldy bureaucracy?

There are ways of lessening conflicting paradigms in mental health service policy and medico-legal systems, such as:

Integrated and wholistic approaches
For complex disorders involving multi-factorial aetiologies, and multiple clinical and functional needs, it makes sense to employ increasingly evidence based multi-modal approaches or interventions (Rosen 2001, 2006).

Pluralism—tolerating and accommodating different perspectives
‘We are doomed to choose, and every choice may entail an irreparable loss’ (Berlin 1988).

Despite sometimes heated ideological differences, on a day-to-day practical level professionals of different disciplines often work together cooperatively (Pilgrim and Rogers 2005). An integrative model to utilizing the synergies between social and medical frameworks has been detailed by Middleton and Shaw (2007).

Isaiah Berlin posited a ‘richness of buzzing confusion (a term coined by William James in 1891) contributing to creative solutions’. Berlin’s Three Level Model of Value-Pluralism rejects the foundational Western doctrine that all moral and practical dilemmas are soluble in principle through a quest for perfect co-existence or definitive resolution.
He dismisses any such quest as an appeal to divine intervention to create a perfect state of human life (Gray 1995; Berlin 1978; Berlin 1988; Berlin and Hardy 1997). The dilemma in this case is the right of the individual to live autonomously and with the dignity-of-risk (Parsons 2008) versus the right of the person’s family and the community to their own peace, safety, and protection. Many desirable values such as these are rivalrous and conflictive, and their opposing pulls cannot be reconciled by applying an overarching rational standard. Arguably, most core values cause such a quandary, such as considerations of free will versus determinism.

Berlin’s three-level model firstly states that conflicts will arise between codes of conduct which cannot be resolved by either theoretical or practical reasoning. Secondly, each of these values is often internally complex and inherently pluralistic, containing conflicting elements. For example, the opposite of free will contains possible elements of determinism, including fate or divine causation. It may also include communal pressures to conform, laws, and other communal constraints. Thirdly, different cultural or sub-cultural forms or traditions (e.g. individualistic vs collectivist) often develop which specify differing and incommensurable virtues. These amount to a cultural pluralism which can also be tolerated and even embraced. Hopefully we can then appreciate and learn from the richness of and creative tension between these values and traditions.

Complexity is not conflict

Do I contradict myself?
So I contradict myself,
(I am large, I contain multitudes.)

Walt Whitman, 1819–1892

Song of Myself

The brains and minds of human beings have an enormous capacity to tolerate and accommodate apparently contradictory frameworks simultaneously without necessarily experiencing cognitive dissonance. The neologistic term ‘sonance’ was coined to describe this capacity, which challenges the assumptions upon which cognitive dissonance concepts and research has been based (Rosen 1975).

For pragmatism and simplicity in the face of apparent contradictions and mounting complexities, mental health service providers should integrate multi-modal, bio-psycho-socio-cultural combinations of evidence-based interventions and proxies for traditional healing factors. These should be individually planned around the needs of each individual and family. The vehicle for integration of these interventions may be the evidence based service delivery subsystem employed (e.g. Assertive Community Treatment Teams, Early Intervention in Psychosis Teams).

‘Super Rights’

There are pervasive human ‘Super Rights’ (Heron 1981a, 1981b) that override contradictions between stakeholder claims to rights & responsibilities—in particular: ‘the all-pervasive rights of individuals to participate in decision-making that affects the fulfilment of their needs and interests.’ However, our society, while implicitly accepting this premise, is slow to adopt actions that truly address this right.

The politics of reflective practices

What appears to be lacking is a systemic and inclusive implementation of ‘reflective practice’ (Schon 1987, 1990). Kemmis (1985) argues that ‘reflection’ is not a purely individual, internal psychological process—it is a social and political process, serving human interests and shaping
and shaped by ideology. It is action oriented and historically embedded. The logical development from this concept should be communities of practice, which network between teams that perform similar functions, and include all stakeholders, learning from each other’s problems, mistakes, and service innovations. Regular forums for crisis teams, assertive community treatment, and rehabilitation and residential teams which occurred during the development of more rigorous community-based components of service in Australia, all exemplify this.

**Ways forward**

In a system that demands a balance between upholding the rights of people with SPMI and the rights of the community, what are the keys to satisfying both? There are two main ways. One, and initially the easiest to implement, is to systemize ways of minimizing involuntary care. The second and more enduring way is to make key changes to allow full participation by consumer and family groups in the governance, structure, and function of services, and to provide them with formal regular input into mental health law reform and challenging of public and governmental discrimination, as they affect individuals with SPMI. Simultaneously the power imbalance in services must be addressed.

**Systematized strategies to decrease involuntary treatment**

This can be done by optimizing practices which foster therapeutic alliances and which favour consultative and collaborative care with consumers and their families. These should include early detection and intervention strategies, convenient access, and mobile, flexible, respectful, welcoming, and age appropriate engagement practices, joint decision-making strategies, jointly constructed individual treatment and recovery plans, early warning sign/relapse signature plans, and living wills, involving routine and regular consultation with individual consumers and their families.

**Social inclusion as the key to upholding human rights in mental health services**

Social inclusion in this context involves ensuring that every stakeholder group is seen and experiences belonging the community, has its voice heard, seriously considered, and acknowledged as legitimate (Huxley 2007). Social inclusion can form a strong bridge between the older and newer paradigms of human rights for people with SPMI. Practically this means having an open and continuing discourse within service and policy arenas with all constituencies represented. In research, this intermittently exists, informing decisions and actions. It attempts to be representative and purports to protect the interests of the least powerful stakeholders (e.g. standing ethics committees).

All stakeholders (including consumers, carers, and local community) need to be represented in legitimate positions with direct influence on the executive authorities of mental health systems. This means positions on executive management and boards, leadership of clinical teams, service provider roles in clinical teams, and service commitment to genuine and regular consultation with stakeholder groups.

**Service-wide consumer and community participation**

Such a widening of service participation models could be fostered by shifting our perspectives to joint service provider, consumer, and carer collaborative initiatives, such as shifting ownership from artificially narrow silos of responsibility (e.g. health department) to a consultative-all-of-government and all-of-community endeavour. This is beginning to happen in a number of
Western states and countries to mixed critical response (e.g. Mental Health Commissions of Canada, New Zealand, and Western Australia (Rosen et al. 2010)). The obstacles that must be overcome with such initiatives are the lack of consensus between interest groups, lack of co-operation and/or coordination, and lack of will and resources to enact and roll out integrative systemic changes in service delivery organizations.

Harmonize mental health and legal perspectives
Policy changes must be coordinated with legal change. As new mental health policy evolves, we must eliminate any gaping chasms between the clinical and legal spheres—e.g. in the US, in the same jurisdiction there are mental health service system policies which are rights-based and recovery orientated, while archaic laws remain on the statutes which contradict these policies and restrict civil liberties (Corrigan et al. 2004)—for example, incompetence laws whereby individuals with SPMI can lose the right to vote, to marry, and to serve on a jury. Laws affecting such individuals are often based on prejudice, being overtly weighted towards stereotypes of people with mental illness being universally dangerous and irrational, and protection of the community. They result in undue discrimination and denial of full citizenship.

Holistic mental health service models
We also need to adopt a genuine holistic or multi-faceted bio-psycho-socio-cultural approach to psychiatric interventions, rather than the prevailing dominance of a narrow bio-medical model. The medical model can be a powerful tool and metaphor for constructive action (Beels 1989), and individuals and families are entitled to accurate clinical information, as long as it is not allowed to eclipse all other considerations. It should not be allowed to overwhelm the other approaches needed to achieve recovery (for example, social justice, social action, individual and collective empowerment perspectives). Such multi-modal approaches underline the shifting of the balance of power from medical dominance towards more interdisciplinary and collaborative decision-making and care (Rosen and Callaly 2005).

Squarely address the power imbalance
How do we avoid managerial tokenism, gestural consultation, or the co-opting and assimilation of official or employed consumer advocates into the pre-existing power elites? In indigenous relations with colonizing populations, indigenous negotiators are often viewed with suspicion by both the less and more powerful groups, and sometimes are accused of being ‘double agents’ by both groups. Such suspicions will always prevail while there is a strong power imbalance in the management arrangements. Joint decision-making in management and service planning requires movement towards equalization of power between stakeholder groups. Most of the possible resolutions that we have advocated work towards equalizing of such power relations.

Conclusion
The modern mental health rights movement had its roots in the Western disability movements. De-institutionalization was both a product of the movement and the instigator of a now established international advocacy sector. It was instrumental to the beginning of serious consideration of the social model of disability in psychiatric circles.

As human rights in mental health have become codified both within and between countries there has been a global push for meaningful consumer participation in mental health service delivery.
There have at times been political and ideological counter-movements to rescind newer rights. Sovereign protection of the newer rights since de-institutionalization has not always been whole-hearted.

Top-down reforms have historically been erratic in their guiding principles. Unfortunately there have been times when people with SPMI and their rights have fallen through the cracks during larger mental health service and mental health law restructures.

The law has been at the heart of many social, political, and medical human rights battles. Laws have both validated freedoms of and legitimized abuses towards people with SPMI. On the whole, in most democracies the focus has been on balancing the individual's rights with the community’s interests, though some major legacies of bygone attitudes remain in legislation, e.g. structural stigma enshrined in some voting and jury exclusions of individuals with a mental illness.

Proponents of strands of law across the world have seen a mandate grow around least-restrictive forms of care, while the increased litigiousness of the Western world has pushed mental health services to adopt more conservative policies to manage risk, thus demonstrating the knots that mental health law can find itself in.

Recent UN principles and conventions have concentrated on individual rights. While the latest convention, the Convention on the Rights of Persons with Disabilities, is the strongest yet, little of this work has filtered down so far to significant change in national laws.

SPMI is a functional description recognizing the full bio-psycho-socio-cultural influences on the aetiology of mental illness. The lived experience is central to such a view, and this approach allows for structural links to be observed so that both explicit and tacit systems of discrimination can be addressed.

An inherent ‘right to treatment’ may be debatable, but a right to access treatment on an equitable basis is becoming generally accepted. A right to self-determination is the most fiercely debated issue. This right is widely applied and upheld with the amount of passion and rigour attributed to upholding other similar individual rights provided within a jurisdiction.

In countries where newer restraints on autonomy are put into policy (e.g. CTOs), governments and general populations are yet to settle on the level of autonomy that satisfies all stakeholders.

What many models of mental health human rights provisions lack is the flexibility to question the individualistic paradigm within which most issues are assessed. More collectivist societies seem to offer drastically different solutions to the ‘self-determination dilemma’, albeit the evidence-base is still ambiguous regarding differential outcomes, and their political rhetorics can be antagonistic to Western policy reform processes.

Regardless of paradigm, stakeholders are the key to harmonizing theoretical and popular human rights concerns. Most stakeholder groups are naturally biased towards their own interests, though just as vast complexity need not be a barrier to solutions, bias can be factored for in seeking optimal benefit.

There appears to have been a symmetrical escalation between those who are concerned about how Western countries are escalating their uses of involuntary orders and want to raise the bar to make them harder to initiate, and those who demonstrate that involuntary orders can save lives, who want to make them easier to implement. Ideally, mental health professionals should be taught a more effective repertoire of negotiating skills to ensure voluntary collaboration, and therefore use involuntary orders much more sparingly. Then, when they are urgently needed, involuntary orders should not be too difficult to initiate. However, once invoked, they must have appropriate human rights checks and balances via the routine overview by independent ‘umpires’ or authorities that include advocates acting on behalf of individual service users.
So what can be done to enhance and ensure the more consistent exercise the human rights of people with SPMI, partly by decreasing the need for resorting to involuntary orders?

- Implement more consultative and recovery-oriented service models, including wholistic biopsychosocio-cultural aspects of care, with some aspects borrowed from traditional cultures, such as assisting individuals to complete their psychosocial life transitions (or rites of passage) and involving the support of an extended kinship network or proxies for it.

- Early intervention and other methods of timely engagement in more congenial settings (‘meeting people on their own turf’) to prevent delays which increase severity and toxicity, and to minimize involuntary treatment.

- Review and reform of mental health related laws will reduce barriers to equal citizenship due to structural stigma.

- Living wills and shared decision-making are processes that would work especially well in individualistic societies.

Perhaps the most important method of progressing human rights for people with SPMI is to move beyond the notion that individual rights and community interests are necessarily dichotomous, whenever friction occurs due to multiple and complicated needs, and apparently competing interests.

Pluralism and pragmatism and the routine implementation of ‘super rights’ may crystallize common-ground solutions if emerging models of early intervention, recovery and social inclusion become systematized as regular ingredients of service delivery and mental health law.

Acknowledgements

This chapter has been informed by discussions and site visits organized by Dr Roberto Mezzina and Dr Peppe Del’Acqua, Trieste, Italy; Professors Ron Diamond and Len Stein, Madison, Wisconsin; and Professor Steven Segal, Berkeley, USA; and by conversations with Mr Douglas Holmes, Ms Leonie Manns, Ms Paula Hanlon, Ms Janet Meagher, Mr Ron Coleman, Mr John Jenkins, Ms Jenna Bateman, Ms Vivienne Miller, Dr Ken Thompson, Dr David Shiers, Professor John Strauss, Dr Kalyanandarum, Dr Courtenay Harding, Ms Marianne Farkas, Dr Jean-Luc Rolande, Dr George Witte, Dr Michael Dudley, and Dr Fran Gale.

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