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Article 12 and Suicide Prevention

Introduction

I wish to draw the Committee's attention to an aspect of Article 12 that is not currently getting any consideration. This is the relationship between Article 12 and suicide prevention. This submission is based on my PhD research, which I believe is still the world's only PhD on suicide by someone who has attempted suicide. This research, along with my current work with several disabled people's organisations, has made me increasingly aware of the need for suicide prevention to engage with the human rights discourse of the CRPD – and vice versa.

In brief, I argue that current mental health laws that permit psychiatric treatment without consent – such as we have in Australia and many other countries around the world – actually contribute to the suicide toll rather than reduce it. I summarise the key points of this argument below.

Although I will be attending the Day of General Discussion as a representative of Disabled Peoples International (DPI) – and its Australian member, the Australian Federation of Disability Organisations (AFDO) – I make this submission as an individual. The views expressed here are therefore not necessarily the views of either DPI or AFDO.

Lack of evidence for the efficacy and safety of involuntary psychiatric treatment

One of the primary justifications offered for involuntary psychiatric treatment is to protect suicidal people from themselves – i.e. to prevent suicide. To this extent it can be viewed as a medical intervention. But such an intrusive medical intervention would never be permitted without strong evidence that it was both effective and safe.

No such evidence exists for the efficacy and safety of involuntary psychiatric treatment for the purpose of suicide prevention. The reason for this lack of evidence is that it is simply not researched which, if we pause to consider, is really quite extraordinary.

There is some research, though still very little, into the efficacy and safety of involuntary psychiatric treatment for purposes other than suicide prevention. But the indications are that it is in fact not very effective. For instance, a study published by the reputable Cochrane Collaboration in 2008 is a comprehensive meta-analysis of the research literature into the efficacy of community based involuntary psychiatric treatment[i]. Although suicide prevention was not one of the variables of the study, the lack of efficacy of Outpatient Commitment (or OPCs as they are called in the study) was quite stark for the variables that were examined:

> *In terms of numbers needed to treat, it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest.*

Of particular relevance for the Day of Discussion on Article 12, the author's conclusions in this study include the following observation:

> *It is, nevertheless, difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest.*

The risk of danger to self or others

A common assumption in most mental health legislation that permits involuntary psychiatric treatment is that people who are "mentally ill" pose a risk to themselves and/or to others in the community. This assumption is popular throughout the community and often promoted by sensationalist media, but is not supported by any evidence.

To consider the evidence, it is first necessary to distinguish between the risk of danger to self and of danger to others. The focus of this submission is suicide – the risk of danger to self, which is more complicated – but the evidence of danger to others is quite clear. A recent study published in the Archive of General Psychiatry[ii] confirms previous studies that "severe mental illness did not independently predict future violent behaviour". It also confirmed once again that the strongest predictor of violence by mentally ill people was not their mental illness but rather other factors, most notably substance abuse and a past history of violence – i.e. much the same as for any other population.

There is, however, significant evidence that people with psychiatric disorders – i.e. with a psychiatric diagnosis – are more likely to self-harm, including suicide. Caution is needed with this data, however, as some of it comes from "psychological autopsies" – i.e. retrospective psychiatric diagnosis – rather than a diagnosis prior to the self-harming or suicide. Despite this, the evidence of a link still seems quite strong.

In this submission the issue of concern is not the specific medical interventions that might be imposed on people at such times (typically psychiatric medications). Rather, the issue is whether imposing these interventions *without consent* is helpful or harmful. But once again we come up against a total absence of any solid research for either efficacy or safety of denying people the right to refuse psychiatric treatment.

In the absence of any scientific evidence, we must look to other arguments for or against involuntary psychiatric treatment for the purpose of minimising and preventing self-harm and suicide. Until such scientific evidence appears, this analysis now becomes an imperative with the advent of the CRPD.

The common sense argument

The suicidal person, almost by definition, is emotionally distressed and struggling to find a reason to live. A common sense argument says that it does not make sense to assault a person who is struggling with such a crisis with their sense of self. Some people who have lived the experience of forced psychiatric treatment call it torture or compare it with rape, but

at the very least it must be seen as an assault on the body and mind of the person. It must be stressed that it is not the medical treatment itself that makes it an assault, but the imposition of it on a person without their consent.

One consequence of this is that people sometimes abscond from a psychiatric ward specifically in order to kill themselves. This is typically blamed on the person's mental illness but once again there is very little research into why people abscond from psychiatric care. There is good research that shows that suicide rates are high for those in the first few weeks of discharge from psychiatric care, but once again there is little research into why this occurs so frequently.

A second, and in some ways even more serious, consequence of mental health laws that rely on psychiatric force is that very many people – such as myself – go to great lengths to avoid a mental health system that is supposed to exist to help people like us. The fear of being locked up and having potent mind-altering drugs forced into you drives many people who might be in need of care "underground" and out of reach of mental health care services. Mental health systems that have involuntary treatment at their foundation, such as we have in Australia, are the primary source of the so-called stigma or discrimination that most people wish to avoid.

There is no evidence that psychiatric force helps prevent suicide. There is a strong common sense argument that it can harm already fragile and perhaps suicidal people. Some already suicidal people are pushed over the edge by psychiatric force. Others are avoiding the mental health system that is supposed to help them and also falling into suicide. There is therefore good reason to at least suspect that mental health laws that impose psychiatric treatment without consent with the aim of reducing the risk of danger to the self is actually adding to the suicide toll rather than reducing it.

The human rights argument

For the Day of General Discussion, the common sense argument above is consistent with a parallel argument based on the human rights principles of the CRPD, and in particular Article 12. Human rights are important precisely because the consequence of depriving a person of their basic rights is inevitably harm and suffering.

Suicide as a crisis of the self is exacerbated when the state deprives the suicidal person of their basic citizenship rights. Article 12 is one of the most fundamental of these rights.

A note on the "pragmatic argument"

One argument that is sometimes offered to justify involuntary psychiatric interventions for suicidal people is that it saves more lives than it costs. This argument includes testimonials from people who say that involuntary treatment saved their lives, testimonials which must be respected. But following the arguments above, there can be no doubt that some people are pushed over the edge by psychiatric force, plus other suicidal people are avoiding the mental health system that is supposed to help them.

The "pragmatic argument" for psychiatric force must include the need to calculate a gruesome equation – what is an acceptable ratio of lives saved versus lives lost due to

involuntary psychiatric treatment? And once again we find that is impossible to currently do this calculation due to inadequate research and insufficient data.

A note for those who advocate substituted decision-making

The need for substituted decision-making such as involuntary psychiatric treatment has been the status quo assumption behind most mental health legislation around the world. This assumption has gone unchallenged so that those campaigning for the end of psychiatric force have had to make the argument for its abolition.

With the advent of the CRPD this must now change. Advocates of substituted decision-making are now obliged to make the argument and present the evidence for it. In mental health this has never occurred anywhere in the world.

In conclusion

There is no evidence that substituted decision-making helps prevent suicide. Alongside this, there are strong arguments that it can actually contribute to the suicide toll by either pushing some people over the edge into suicide or by failing to support the needs of suicidal people.

Any attempt to dilute Article 12 in order to maintain substituted decision-making in mental health legislation must take these issues into consideration.

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[i] Kisely S, Campbell LA & Preston N, "Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review)", The Cochrane Collaboration. Published by JohnWiley & Sons, Ltd, 2008

[ii] Eric B. Elbogen, PhD & Sally C. Johnson, MD, "The Intricate Link Between Violence and Mental Disorder – Results From the National Epidemiologic Survey on Alcohol and Related Conditions", Archive of General Psychiatry Vol 66 (No 2), Feb 2009