

**An Interview with David Webb**  
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**What do you feel the role of legislation is with regards to people with mental illness?**

The current role of legislation is to authorise the state to deprive people labelled as mentally ill of some of their most fundamental human rights. In particular, the current Mental Health Act gives the state the power to detain a person without them committing any crime and to impose medical treatment without their consent. The state attempts to justify this as providing essential medical treatment to people who, according to a psychiatrist, need psychiatric treatment but lack the competence to make this decision for themselves.

But this explanation does not stand up to scrutiny. The real purpose of our mental health laws is to contain and control people whose behaviour the community finds disturbing. Under our Mental Health Act, psychiatrists become policemen and cease to be doctors because it is impossible to be both. Indeed, they become judge, jury and executioner, as well as policemen, because our mental health legislation does not have the checks and balances and the separation of all these powers that we find in the criminal justice system.

There is a need for legislation to protect people labelled as mentally ill from discrimination. Some would say that we have this already in the Equal Opportunity Act but this does not protect us at all from the state sanctioned discrimination of the Mental Health Act. It is my hope that Victoria's new Human Rights Charter will soon provide this protection, though current indications are not at all promising.

The Charter has a strict requirement that a Charter right, such as the right to refuse unwanted medical treatment, can only be limited if it can be demonstrably justified in a free and democratic society. It then gives some criteria that must be considered as part of such a justification, such as the nature of the right, the purpose of the limitation and the relationship between the two. A proper human rights analysis of psychiatric force such as this has never been presented to the people of Victoria. Rather, all we have had has been status quo assumptions based on ill-informed fear and prejudices that mad people are dangerous and need medical treatment.

The evidence that psychiatric force works simply does not exist. On the contrary, the little evidence that does exist suggests that it does not work at all well. And there is a strong human rights and also a common sense argument that it does great harm. The current rationalisation for psychiatric force can be compared to the Stolen Generation policies where a prejudiced majority in partnership with a powerful elite violate the rights of vulnerable and powerless people on the assumption that it is for their own good. Another parallel with the Stolen Generation is that many of the perpetrators of psychiatric force do it with genuine good intentions. But also like the Stolen Generation, we find that in mental health the road to hell is paved with good intentions. As the UN Special Rapporteur on Torture recently pointed out when he looked at involuntary psychiatric interventions, good intentions are not a justification for human rights violations.

The review of the Mental Health Act currently underway in Victoria is supposed to be observing the new human rights law of the Charter but so far has completely ignored it. Submissions to the review are now closed following the community consultation forums and a Consultation Paper by the Department of Human Services. But still there has not yet been any justification offered for the psychiatric force that is simply assumed as necessary in the Consultation Paper.

The source of this fatal flaw in the review process is that it should never have been set up as an in-house departmental review by the DHS. A law with such serious human rights issues as the Mental Health Act needs to be reviewed by the Law Reform Commission, who I doubt would disregard the Charter as blatantly as the DHS have done. The Charter is quite clear that as a citizen of Victoria I am entitled to a public statement from the government of any proposal to limit my rights so that I can exercise my democratic right to query and, if need be, to challenge the justification offered for psychiatric force. But so far, there's still no sign of this from the Victorian government. I've not yet given up on getting the current review halted and started again under the Law Reform Commission.

### **Your PhD has been on Suicide Prevention – can a rights-based framework assist in preventing suicide?**

I have to answer this question in a kind of back to front way because our current mental health system is based on depriving people of their human rights. So the question becomes would restoring the rights of people labelled as mentally ill help prevent suicide? In my view it would because I believe that our current mental health laws contribute to the suicidal toll rather than reduce it. This might seem a sweeping statement that requires some evidence to support it, so let me say why I think this is the case.

From my research, along with my personal experience, I think that suicide is best understood as a crisis of the self rather than the currently prevailing view that it is the consequence of some notional mental illness. There really is no evidence to support the popular belief touted by people like beyondblue that depression causes suicide. Such simplistic explanations of suicide confuse correlation with causation. Suicide is not primarily a medical issue. Suicide and suicide attempts occur when a person chooses death rather than life. It is a deliberate, cognitive, psychological decision that a person takes, not a biological malfunction of the brain. And this decision is invariably taken under a complex set of life circumstances that have so challenged and undermined a person's sense of self that death seems preferable.

With this understanding, the failure of our current mental health system for suicide prevention, and indeed its harmful consequences, become obvious. If you present yourself to our public mental health system with suicidal intent and/or behaviour, you almost certainly get a psychiatric diagnosis, probably of depression but maybe others depending on how the doctors see your symptoms. If the doctor believes that you are at imminent risk of suicide then you will also very likely be made an involuntary patient – in fact many doctors feel legally and perhaps morally obliged to commit you. And when this happens, you will probably be forced to take certain psychiatric medications, or perhaps ECT, whether you consent to it or not.

The doctors and our mental health laws call this involuntary treatment. Many people who have experienced it call it something else. Some call it torture, others compare it to rape. In any other setting, for instance if I approached you with a loaded syringe and a couple of bouncers to restrain you if you resisted, it would at the very least be described as a violent assault on your body and mind.

For someone who is so distressed that they're thinking seriously about killing themselves, I fail to see how assaulting them is supposed to help them. For many people, the psychiatric ward represents their last hope that they might find a way out of their crisis. But instead they find themselves assaulted, which only reinforces and adds to their feeling that life is not worth living. Except now they have finally exhausted all their options. It is hardly surprising that some people escape from these places specifically to go and kill themselves. Nor should we be surprised that many people, such as myself, will do whatever we can to avoid our public mental health system.

In the absence of any real evidence that psychiatric force works, the common sense argument I've used here is supported by an argument based on human rights principles. If we violate people's fundamental human rights then the inevitable consequence is harm and suffering. Good intentions are not enough.

It is extraordinary that the efficacy and safety of psychiatric force is not researched. No other medical intervention would be allowed with so little evidence to support it. I find it equally extraordinary that the suicide prevention experts fail to ask the question, "Do our mental health laws help or hinder suicide prevention?" In the new human rights era that we are now in, this question must be asked. In the meantime, psychiatric force should be prohibited until there is some decent, solid evidence and not just prejudiced, status quo assumptions offered to justify it.

A final comment in response to your question is necessary. I'm not proposing that we just leave people on the street and under the bridges to suffer and perhaps die. Nor am I saying that psychiatric drugs don't have a role to play. There is a human rights argument that people are entitled to the assistance and support they need, including but not only medical treatment, as appropriate. We need to move away from relying on psychiatric force and create a mental health system that responds to what people really need during times of intense emotional crisis. There are many people doing great work with meaningful alternatives to force that people would actually choose. But they are under-resourced by a mental health system where the bulk of the available resources are gobbled up by a medical approach that relies on force.

Applying a human rights framework would mean that resources only go to those services that comply with human rights principles. This would mean an end to psychiatric force. It would also help reduce the suicide toll.

### **How do you feel the UN Convention for the Rights of Persons with a Disability impacts on people with mental illness here in Australia?**

At the moment the impact has only been slight because there is not yet much awareness of the Convention in the mental health sector. This is partly because mental health is still dominated by a medical model that resists the social model of disability that underpins the

Convention and its emphasis on human rights. It's also partly because many mental health consumers don't identify as a person with a disability. But I'm confident this will change fairly rapidly as people learn that the Convention is more about their human rights rather than their medical status.

No-one disputes that the Convention applies to people who experience psychosocial disability, regardless of whether it's called psychiatric disability, psychiatric disorders or, if you really must, mental illness. This includes the state and federal governments of Australia, which are all now obliged to observe this new international law.

The Convention doesn't create any new laws for people with disability. Rather, it came about because it was apparent that other human rights treaties and Conventions were failing to overcome the entrenched discrimination against people with disabilities. This discrimination is usually called stigma in mental health but it's the same thing. So a separate Convention was needed to make clear that people with disability have the same rights as everyone else in the community, in the same way that other Conventions have been needed to assert the rights of women, the rights of children and some other specific groups.

The underlying principle of the Convention is that it prohibits any discrimination on the basis of disability. This includes a prohibition of discrimination on the basis of a person's medical status, so that it is simply no longer permitted under the international law of the Convention to deprive a person of their basic human rights because of a medical condition – such as a psychiatric diagnosis. This puts the Convention in stark conflict with our mental health system where a psychiatric diagnosis is the basis of current laws that deprive people of their right to liberty and their right to refuse unwanted medical treatment.

Another feature of the Convention has been described as a 'paradigm shift' away from the substituted decision-making model of current guardianship and mental health laws to a model based on what's called supported decision-making. With substituted decision-making the state appoints someone to make decisions on behalf of a person who is judged to lack decision-making capacity. This traditional approach is fraught with many dangers and has a long history of human rights abuses and the inevitable harm and suffering that follow as a consequence, especially in mental health where psychiatric force is so widespread and so harmful.

In contrast, supported decision-making says that a person has the right to make their own decisions and that if support is required – for whatever reason – then that support should be made available. A simple example is that if a person needs an interpreter in order to be able to give informed consent to a medical procedure then this should be made available. But the interpreter does not make the decision on behalf of the person. In mental health, the supported decision-making model of the Convention obliges the state to make available non-coercive alternatives to psychiatric force to support people to make their own decisions based on free, full and informed consent.

Despite psychiatry's claim that there are no less restrictive alternatives to psychiatric force, many examples of non-coercive alternatives can be found all around the world. The real problem is not that alternatives don't exist but that they are starved from development by the dominance of the medical model and the reliance on psychiatric force. A good introduction to some of these alternatives is Peter Lehmann's book "Alternatives Beyond Psychiatry".

The need for this paradigm shift towards supported decision-making in mental health is urgent here in Victoria where psychiatrists have quite extraordinary substitute decision-making powers. Not only does the psychiatrist make the judgement about a person's decision-making capacity but they also then become the substitute decision-maker. Contrast this with our guardianship laws where there is a clear separation of these powers. Our guardianship laws still currently permit substituted decision-making but at least they have some checks and balances against its misuse. The unfettered power of psychiatry in Victoria has led to over 5,000 people on Community Treatment Orders (CTOs) which the President of the Mental Health Review Board, John Lesser, says is the more than any other jurisdiction in the world.

Another significant contrast between guardianship and mental health in Victoria is that the Office of the Public Advocate (OPA), which administers our guardianship laws, takes the Disability Convention seriously. Unlike the mental health division in the Department of Human Services and the Royal Australian and New Zealand College of Psychiatrists, the OPA have been pro-active in engaging with the Convention, including the critical issue of supported decision-making. A further contrast is that the OPA endorses that the recently announced review of our guardianship laws will be undertaken by the Law Reform Commission, who should have been given the review of the Mental Health Act.

### **How do you feel your views on this subject compares with general opinion in the sector?**

First of all, I'm well aware that mine is a dissenting voice to the prevailing view on these issues in much of the general community. This is largely because of the irrational and unjustified fears and prejudices that I mentioned above. Despite popular opinion to the contrary, mad people are no more dangerous than other groups in the community (and much less dangerous than some), and psychiatric force not only doesn't work but often makes a bad situation worse. Although unfortunate, it is perhaps understandable that there is this misunderstanding in the general community when you look at the misinformation that is spread about these issues.

I'm one of many people who are increasingly concerned about the growing medicalisation of everyday life that is sometimes called disease mongering. This is happening not only in mental health but it is in mental health where it is particularly extreme and especially damaging because of widespread, legally sanctioned psychiatric force. The medicalisation of madness is largely blind to the psychological, the social and the spiritual dimensions of what it is to be human. There is a kind of medical fundamentalism happening with a biological reductionism that says we are "nothing but a pack of neurons", to quote Francis Crick, one of the discoverers of DNA and a champion of this fundamentalism.

Modern biological psychiatry is preaching a similar fundamentalism when it claims that my madness is due to a malfunction of my brain, and especially its scandalous, unscientific myth that it is due to a chemical imbalance in my brain. Madness, at least in its distressing forms, is like suicide in that it goes to the heart of our sense of self. My personal biology is only one part of this and often only a minor part. My psychological mind, my social and cultural relationships in the community, and my spiritual values and needs are all at least as important to my sense as self as my biological body.

Within the mental health sector itself, the medical model of biological psychiatry and psychiatric force still dominate the agenda. But there are many people calling for a more human and more humane response to people struggling with distressing madness. In particular, many mental health consumers know from direct experience that a more holistic approach is needed to live with, recover from and hopefully survive madness. Similarly, there's many people working in the psychosocial disability sector that Vicserv serves who are crying out for radical changes to how we help people struggling with madness. There's even quite a few psychiatrists who see beyond the biology of the brain, though even if they do speak up publicly they still tend to remain silent on psychiatric force.

I feel I need to make clear my views on psychiatric drugs. I'm not saying ban them. They have their place. They can help some people sometimes, especially at times of intense distress. But they do not fix or "cure" anything. They are best understood as psychological painkillers so they can help in the same way that morphine is a good idea when you break a leg even though it will not heal the broken bone. To understand both the benefits and the limitations of these drugs, I'd recommend John Watkins book "Healing Schizophrenia – Using Medication Wisely". The real issue is not the drugs but forcing them on people without consent.

The biggest obstacle to real and meaningful change towards a sensible mental health system is our reliance on psychiatric force. There is a kind of chicken-egg thing happening where we will not get rid of psychiatric force until the known alternatives to force are developed and expanded but this won't occur until we get rid of psychiatric force. Making the transition to a non-coercive mental health system will be difficult in the face of the fears and prejudices in the community and the power and influence of psychiatry. But the current system, based on psychiatric force, is broken and change must come.

The Disability Convention now gives us a way forward. Although it is now international law that Australia has signed on to, its greatest value will not be as a legal document. It is also a framework or model of how we must proceed if we are to end the discrimination and human rights abuses that are intrinsic in a mental health system that relies on psychiatric force. Based on the social model of disability, the Convention recognises the human rights of people who experience psychosocial disability as full citizens entitled to the same rights as everyone else. It marks the end of the era of paternalistic, substituted decision-making and psychiatric force, and the beginning of a new era of supported decision-making based on full, free and informed consent.

The future is clear, though we know it will be resisted by many. Every one of us has to decide whether we will be part of making this inevitable new era a reality sooner rather than later, or whether we will resist it and cling to the old, broken and harmful status quo of psychiatric force.