

Post Print

This is a pre-copyedited, author-produced PDF of an article accepted for publication in *International Journal Of Law And Psychiatry* following peer review. The definitive publisher-authenticated version [Sascha Callaghan, Christopher Ryan & Ian Kerridge, 'Risk of Suicide Is Insufficient Warrant for Coercive Treatment for Mental Illness' (2013) *International Journal of Law and Psychiatry*, 36: 5-6, 374-385] is available online at <http://www.sciencedirect.com/science/article/pii/S0160252713000757>

Risk of suicide is insufficient warrant for coercive treatment for mental illness

Sascha Callaghan, Christopher Ryan & Ian Kerridge

(Final version, 5 June 2013)

Abstract

Mental health laws in many jurisdictions currently permit coercive treatment for persons with mental illness who are thought to be at risk of harm to themselves or others. These laws are often used to provide involuntary treatment to persons who are thought to be at risk of suicide.

In this article we argue that legislated coercive psychiatric treatment should not be triggered by an assessment of the likelihood of harm, including a likelihood of suicide, but should be available only where a person is found to lack capacity to make their own decisions about their own health risks, after appropriate support has been given. We suggest that current opposition to this approach may find its origin in factors including uncertainties about the idea of vulnerability and its relationship to capacity as well as tendency to minimise the real costs of psychiatric treatment and coercion against the aim of suicide prevention.

Given the limits of suicide risk assessment, we argue that a public policy that allows involuntary preventative detention of competent persons thought to be at risk of suicide, places too great a burden on all persons living with mental illness to be justified. We suggest that we are better placed to serve the interests and respect the human rights of people with mental illness if we respect and support the right of persons to make decisions, rather than focussing on perceived vulnerabilities and calculations of suicide risk.

Introduction

In early 2012, two human rights cases were heard within weeks of each other in British courts. The contrast between them caught the attention of the authors of this article, who at the time were considering how best to frame laws that permit coercive treatment for mental illness when there is a perceived risk of suicide.

The first case, *Rabone v Pennine Care NHS Foundation Trust* (hereafter '*Rabone*'), concerned a 24 year-old woman who had been diagnosed with depression, and who hanged herself two days after being granted leave from the hospital where she was voluntary psychiatric patient.¹ The Supreme Court determined that failure to keep the woman in hospital, against

¹ *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2 ('*Rabone*').

her will if necessary, amounted to a breach of her 'right to life' as articulated in article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms ("the European Convention") (Council of Europe, 1950). In the second case, *Nicklinson v Ministry of Justice* (hereafter '*Nicklinson*'), a man in his late fifties, who was severely disabled after a stroke, sought assistance from doctors to end his life.² The High Court found there was an arguable case that laws which would prevent a doctor from assisting his suicide would be incompatible with his right to 'private life' under article 8 of the European Convention.

On one view these cases are very different. They involve people at very different stages of life and in different circumstances. Their differing facts also give rise to opposing moral intuitions. Most people will feel that Melanie Rabone, a physically healthy but troubled young woman, should not have killed herself and that her death should have been prevented. On the other hand, many will feel that Sean Nicklinson, a middle-aged, profoundly disabled man, was perhaps *entitled* to end his life, and that being incapable of doing so, it would not be wrong to help him. And these differing moral assumptions, in turn, underpin two quite distinct legal approaches taken in each case.

However these cases also had crucial things in common. Both involved suicide. Both engaged the right to autonomy in medical decision-making, and both raised questions of competency and vulnerability as possible factors that might extinguish that right. It is these commonalities that we wish to set as major points of reference in this article, as we reflect on how best to frame laws about coercive treatment of persons with mental illness who are thought to be at risk of suicide.

We will argue that the intuitions involved in these cases illustrate a concerning tendency to equate mental illness (tho not necessarily physical illness) with incapacity. Furthermore, when these intuitions are given legal weight, they erode the respect for autonomy that is due to all persons – irrespective of whether or not they have mental illness – by reference to concepts that lack moral or practical rigour, including "vulnerability" and protection from risk of harm. We will argue that this approach is unsound and that autonomy should be considered the paramount right for all persons, including persons with mental illness, and that the right to make self-determining decisions should be based on whether or not a person has decision-making capacity, *not* on whether a person has a mental illness or is considered to be "vulnerable". We will argue that this remains the case even if the person is thought to be at risk of suicide.

In the first part of this article, we examine the concept of autonomy as it is described in ethics and law. We then re-state a case for its position as the paramount value above all others in medical decision-making provided a person has decision-making capacity. We conclude our analysis by arguing that persons with mental illness should be entitled to legally protected autonomy in medical decision-making on the same basis as others, and should have decisions to refuse treatment honoured wherever they retain decision-making capacity.

In the second part of the article, drawing on comments from the bench in *Nicklinson* and *Rabone*, we explore two alternative approaches to autonomy. The first is that persons who are "vulnerable" (such as people with mental illness) should be prevented from making decisions that might be harmful to them. We will posit that vulnerability is a dangerous

² *Nicklinson v Ministry of Justice* [2012] EWHC 304 (QB) ('*Nicklinson*').

concept in that it enables discredited and discriminatory approaches to capacity based on a person's "status". Specifically – that a person with a mental illness may be judged both to be disabled and vulnerable and deprived of their decision making freedom on that basis – rather than on the basis of any consideration of their actual abilities.

The second is the notion that suicide is so repugnant that it should be considered outside the scope of autonomous decision making, and that where persons are 'at high risk of suicide', coercive detention in hospital should be permitted where it is thought necessary to prevent that eventuality. However we will argue that such an approach is weak on two grounds. First, the goal of suicide prevention is normatively weak, as what constitutes unacceptable self-killing defies coherent description and attempts to do so in law appear to be based less on a sound metaphysical or jurisprudential footing than on shifting intuitions about which lives are worth preserving and which are not. Secondly, as will be explained in the third part of the article, this approach is empirically unsound. Even if suicide prevention was a clearly definable goal, we cannot usefully categorise people needing psychiatric care into those who are at higher or lower risk of suicide. Given the limits of what we can know about an individual's likelihood of suicide, we argue that a public policy that allows involuntary preventative detention of competent persons thought to be at risk of suicide, places too great a burden on all persons living with mental illness to be justified.

We conclude that we are better placed to serve the interests and respect the human rights of people with mental illness if we respect the right of legally competent persons to make decisions, rather than focussing on perceived vulnerabilities and calculations of suicide risk.

1. Autonomy – first among equals

Individual autonomy is often seen to be the most important moral principle in health care regulation and the right to autonomy is strongly protected in law. Indeed the right to self-determination is so well established in ethics, law, clinical practice and the broader politico-legal culture that it seems to go without saying.

The situation is somewhat different however in the area of mental health, where persons with mental illness have historically had weaker claims to autonomy and even citizenship (Blais, Massicotte, & Yoshinaka, 2001; Leonard, 2012). In this environment, where the importance of autonomy is not seen as 'self-evident' in the Jeffersonian sense, the case needs to be made from scratch as to why autonomy is important. It is necessary to establish whether, relative to other values (such as the need to protect vulnerable people from preventable harms), the right to autonomy can claim to be the *most* important, and whether, if it is to take precedence, it should do so *all* the time. Within the spectrum of potential answers to these questions lie vastly different legal approaches to decision-making in mental health law and how to deal with the spectre of suicide risk. In this first section we will argue that the right to autonomy as the paramount value should be protected in law for persons with mental illness on the same basis as it for other people.

1.1 Autonomy in health care ethics

Although Beauchamp and Childress' four principles were originally conceived as being *prima facie* 'equal', autonomy tends to be given the greatest weight – to the point where Gillon has declared it "the first among equals" (Gillon, 2003). In general health care, presumptions about the primacy of autonomy are evident in the law of consent to medical treatment and

in proposals for law reform (New South Wales Law Reform Commission, 2008; New South Wales Legislative Council's Standing Committee on Social Issues, 2010). Even so, the reasoning behind autonomy's dominance is often opaque, so the following is an attempt to clarify what respect for autonomy means in health care, why it is important and why it might be permitted to prevail over other important values.

The primary reason may of course be the most obvious one – that we live in an era in which the harms that can be inflicted through the exercise of medical power without consent have become iconic and reformers since Nuremberg have agreed that the most effective means of preventing abuse is the assertion of autonomy as the paramount principle in health care ethics. In addition to the horror of the Nazi medical experiments, the scandals emerging from Tuskegee and Willowbrook, and experimentation with deep sleep therapy (Boettcher, 1992), psychosurgery, and shock treatments in psychiatric medicine (Valenstein, 1986) have become cultural emblems of the grave risks of failing to allow 'subjects' the ultimate say in whether or not they will participate in research or medical treatment. Consequently, the central legitimizing feature of modern medical practice since World War II, has been the primacy of patient autonomy and the need to obtain consent for all research and medical treatment. That this has not been a feature of the law of involuntary treatment for mental illness has undermined its standing as a justifiable approach to patient care (Fennell, 1986).

However the value of "respect for autonomy" is not actually directed towards protection for harm as such. Rather, it operates to prevent *coerced* harms – allowing that other harms, or risks, may be voluntarily chosen. This is because autonomy is concerned with self-determination – and the idea that self-determination is important for human flourishing. The philosophical antecedents to autonomy in 20th century bioethics make this clear, even if it can be lost from time to time, in bioethics itself. The most important theoretical source for autonomy in bioethics is John Stuart Mill's liberal philosophy, in which he insisted that the only legitimate use of the coercive powers of society against an individual is the prevention of harm *to others*. The individual's "own good, either physical or moral, is not a sufficient warrant" (Mill, 2006, p. 16). But if Mill was clear that the reason for personal freedom was not protection from harm, he also asserted a particular good that would be derived from this freedom – in particular he asserted that autonomy was the means of cultivating individuality, which he saw as key to all the wonder and achievement of humanity. He wrote,

"It is not by wearing down into uniformity all that is individual in themselves, but by cultivating it, and calling it forth ... that human beings become a noble and beautiful object of contemplation; and as the works partake the character of those who do them, by the same process human life also becomes rich, diversified, and animating" (p70).

Mill also saw autonomy as an essential source of self worth, stating, "In proportion to the development of his individuality, each person becomes more valuable to himself, and is therefore capable of being more valuable to others" (p. 70). This view is echoed by Ronald Dworkin, who noted that a person cannot see his life as important "unless he insists on living that life himself, not being ushered along it by others, no matter how much he loves or respects or fears them" (Dworkin, 2011, p. 239).

Other liberal theorists have noted more pragmatically that, despite centuries of effort, human kind has yet to come up with a universally agreed set of values, which define a good or bad life. That being the case, it may simply be that a person's best interests can only be

usefully defined as those things that matter to him. Accordingly, as Dworkin describes it, autonomy “[protects] people’s capacity to lead their lives out of a distinctive sense of their own character, a sense of what is important to and for them” (Dworkin, 2011, p. 224). It is because of this, Dworkin argues, that in the medical treatment, “[w]e allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values” (p. 239).

Furthermore, if the interests in living according to one’s own values, wishes and preferences derives naturally from the condition of being human, it can be no less important to one class of persons than to another – and certainly no less important for people with mental illness. In fact consumer advocates argue that autonomy is of *particular* importance to people with disabilities because the history of systematic denial of this right has been disabling in itself. Activist Patricia Deegan, reflecting on her own experiences with schizophrenia, writes that:

“when those of us with psychiatric disabilities come to believe that all of our efforts are futile; when we experience that we have no control over our environment; ... when we find that staff do not listen to us and that they make all of the major decisions for us; when staff decide where we will live, with whom we will live; under what rules we will live, how we will spend our money, if we will be allowed to spend our money, when we will have to leave the group home, and at what time we will be allowed back into it, etc. etc. etc. then a deep sense of hopelessness, of despair begins to settle over the human heart.” (Deegan, 1996, p. 6).

Indeed, overcoming the malaise brought about by lack of a sense of personal control is said to be central to the process of recovery. To quote Deegan again: “The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. ... We are human beings and we can speak for ourselves. We have a voice and can learn to use it. We have the right to be heard and listened to. We can become self determining. We can take a stand toward what is distressing to us and need not be passive victims of an illness.” (Deegan, 1996, p. 2).

So if the goods that flow from autonomy are at least as important to people with mental illness, the Millian edict that the risk of harm to a person is not sufficient to curtail their right to autonomy, must also apply equally to such persons.

Of course there have been many criticisms of the liberal conception of autonomy – most notably from communitarian (Mulhall & Swift, 1992) and feminist (Mackenzie & Stoljar, 2000) perspectives. These critiques have raised important questions about the cost to other values of elevating individual freedom, scepticism about the reality of ‘free choice’ (McKinnon, 1987; Nussbaum, 1998) and concerns about the ‘thinness’ of liberal autonomy if it is seen merely as a right of non-interference, rather than a quality which may require support and enrichment if it is to be properly exercised. While these critiques make important suggestions for nuancing the liberal conception of autonomy – especially in terms of the need to support developing capacities in disadvantaged groups – few argue that it should be dispensed with completely. Certainly few writers, if any, expressly support outright coercion against a competent person’s known wishes.

We suggest that autonomy is best seen, if not the ‘first among equals’ in Gillon’s terms, as the best of an imperfect lot – when alternatives based on ‘responsibility’ or ‘beneficence’ also involve significant risks. As Donnelly notes, “respect for autonomy keeps the individual at the centre of ethical discourse and in doing so provides some degree of protection against

potentially oppressive forces. It may do this in a flawed and limited way but its contribution is fundamental” (Donnelly, 2010 p 41). Experience shows us that oppression can be generated by those who have good intentions and even by those who care for us most, whether medical professionals or members of the societies in which we live, and it is difficult to justify on any grounds the overriding of the expressed wishes of a competent adult, where no other person will be harmed by it.

1.2 Capacity – the threshold for autonomy

No conceptualisation of autonomy suggests that persons should be ‘abandoned’ to their own decisions without consideration of what is necessary to make genuinely autonomous decisions. Mill required that that in order to be free to make choices, persons must be “of full age, and the ordinary amount of understanding” (Mill, 2006, p. 16). Indeed all conceptions of autonomy in moral and political philosophy have some basic requirement of capacity for its exercise.

There are many ways in which a person’s capacity might be assessed and many standards of competence to which a person might be held (Stewart & Biegler, 2004). For example, the common law and many statutory instruments³ adopt a ‘functional’ approach to capacity, whereby capacity to make a legally enforceable decision is granted where a person has the requisite cognitive ability to make a decision. Functional approaches reflect Mill’s prescription for capacity, in that if a person has the requisite ability, their decision must be respected, no matter the person’s circumstances or the content of the decision itself.

A functional approach to capacity may be distinguished from ‘outcomes’ approaches, which focus on the actual decision in question and whether it deviates from social norms. A third alternative is a ‘status’ approach, where members of a particular group are deemed not to have capacity – as is the case for with young children for example. Mental health legislation that permits involuntary treatment for mental illness, and laws that permit the overriding of competent consent given by ‘vulnerable’ people are also often interpreted this way.

Outcomes and status-based approaches have long been criticised for unfairly restricting autonomy, the former by imposing external evaluations of the desirability of a personal decisions, and the latter by focusing on the characteristics of a person, rather than their capabilities. (New South Wales Legislative Council's Standing Committee on Social Issues, 2010; Stewart & Biegler, 2004). Functional approaches by contrast, have the advantage of focusing on individuals. There is now a great deal of evidence that persons with mental illness can, and often do retain functional decision-making capacity (P. Appelbaum & Grisso, 1995; Okai, et al., 2007; Owen, et al., 2008; Skipworth, Dawson, & Ellis, 2013). This cannot be properly exercised in approaches that focus on presence of mental illness or risk of harm.

Functional approaches have also been subject to critiques however. Some disability rights theorists have suggested that functional capacity tests may unfairly restrict autonomy by excluding those with cognitive impairments from making decisions according to their own preferences (Minkowitz, 2007; Quinn, 2010). While these critiques highlight the weakness of an approach to capacity that extinguishes the ability of those who lack capacity from having any input into a decision at all, if coercion was *ever* to be warranted, lack of capacity must presumably be demonstrated if denial of autonomy was to be justified. Certainly

³ *Mental Capacity Act 2005* (UK).

disability rights would not support coercion of any person with disability who retained functional decision making capacity.

1.3 Autonomy in law

Law in general health care

For more than a century the common law has reflected the Millian conception of autonomy as the paramount value in the law of health care decision making. It is now well-established in law that a competent person may refuse medical treatment for any reason, even if it will likely lead to the person's own death or serious injury.⁴ Thus, providing medical treatment without consent, or in the face of a competent refusal, is a trespass at common law.⁵

All adults are presumed to have capacity to make general health care decisions at common law, but if a person is shown to lack capacity their decision may be overridden – either by a doctor in an emergency, where treatment is necessary in the person's best interests, or by order of a court exercising the *parens patriae* jurisdiction.⁶ Guardianship laws provide for consent to be given by a substitute decision maker in the same circumstances.

The common law test for capacity is a functional test of decision-making ability. It has been expressed in various ways but generally a person will be taken to be competent to refuse medical treatment if they are able to (1) understand and retain treatment information; (2) use and weigh the information among other factors and reach a decision;⁷ and (3) communicate that decision by some means. A similar test is employed in the *Mental Capacity Act 2005* (UK). In line with Millian liberal philosophy, a competent decision to refuse medical treatment does not have to be sensible or well considered in the opinion of others.⁸ A valid refusal may be thought to be foolish or mistaken⁹ and the reasons given by a competent person may be rational or irrational, unknown or even non-existent.¹⁰ The law

⁴ That principle has been established by decisions in each of the major common law jurisdictions, including the United States (*Schloeindorff v Society of New York Hospital* 105 NE 92 at 93 (1914); *Bouvia v Superior Court of Los Angeles County* 179 Cal App 3d 1127 (1986), 1137 and 1139 - 1141); Canada (*Nancy B v Hotel-Dieu Quebec*(1992) 86 DLR (4th) 385; *Malette v Shulman* (1990) 67 DLR (4th) 321, 328); the United Kingdom (*Airedale NHS Trust v Bland*, 857 (Lord Keith) and 864 (Lord Goff); *Ms B v An NHS Hospital Trust* [16] - [21]); New Zealand (*Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, 245) and Australia (*Hunter and New England Area Health Service v A* [2009] NSWSC 761 [9] - [15]; *Brightwater Care Group v Rossiter* [2009] WASC 229 [26]; *H Ltd v J & Anor* [2010] SASC 176 [33] - [46]).

⁵ *Malette v Shulman* (1990) 67 DLR (4th) 321, 328; Secretary of the Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 (Marion's Case); *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [9] - [15].

⁶ *Re T* [1993] Fam 95 at 103 (Donaldson LJ) cited with approval in *Hunter and New England Area Health Service v A* [2009] NSWSC 761 at [31] - [34].

⁷ *Re MB* [1997] 2 FCR 514 at 553 - 554 (Butler-Sloss LJ) cited with approval in *Hunter and New England Area Health Service v A* [2009] NSWSC 761 at [25]; *Brightwater Care Group v Rossiter* [2009] WASC 229 at [13].

⁸ *Re T* [1993] Fam 95 at 116 (Butler-Sloss LJ) cited with approval in *Hunter and New England Area Health Service v A* [2009] NSWSC 761 at [10].

⁹ In *Malette v Shulman* 67 DLR (4th) 321 (1990) at 328 (Robins JA), cited with approval in *Hunter and New England Area Health Service v A* [2009] NSWSC 761 at [14].

¹⁰ *Re T* [1993] Fam 95 at 113 (Butler-Sloss LJ) cited with approval in *Hunter and New England Area Health Service v A* [2009] NSWSC 761 at [15] and *Brightwater Care Group v Rossiter* [2009]

is also clear that having an active mental illness will not, by itself, preclude a finding of capacity provided the effects of the illness do not directly impact the person's ability to make the decision in question.¹¹

In addition, freedom from medical treatment without consent has been recognised as a human right by the UN Committee on Economic, Social and Cultural Rights as part of the right to the highest attainable standard of health. And non-consented medical treatment has been acknowledged as a potentially constituting torture, or cruel, inhuman or degrading treatment (Minkowitz, 2007 para 59; "Torture and other cruel, inhuman or degrading treatment or punishment," 2008).

However, the law with respect to coercive *psychiatric* treatment is entirely different.

Law in psychiatric treatment

Currently mental health laws around the world permit coercive treatment of persons with mental illness, whether or not they have decision-making capacity, in circumstances where treatment is thought to be necessary to prevent harm to the person him- or herself or to other people.¹² The decision whether or not to use state power to coercively treat a person with mental illness therefore depends, not on a determination of whether or not the person has the capacity to make their own decision regarding that treatment, but rather on a finding that they have a mental illness, and an assessment of their likelihood of future harm. A sufficiently high perceived likelihood of serious harm – classically a concern that the person may soon attempt suicide – triggers treatment with the full coercive power of the state behind it.

This state of affairs derives from long history of equating mental illness with legal incapacity, likely originating during the Norman conquests and providing the foundation of the *parens patriae* jurisdiction of the English courts. This jurisdiction was grounded in a presumption that 'lunatics' among others, were incapable of managing their own affairs and the court was given powers to make orders for the care of the person and the administration of their finances (Powell, 2003). Gradually *parens patriae* powers in the UK and in colonial jurisdictions including Australia, were translated into legislation, and the presumptions contained within them were carried over too. Contemporary mental health laws in Australia and the UK can trace a direct line back to English lunacy laws, in which the word "lunatic" was to be "construed to mean any person found by inquisition idiot, lunatic or of unsound mind and incapable of managing himself or his affairs".¹³ As a consequence, nearly all civil

WASC 229 at [27]. However in *Hunter and New England Area Health Service v A* [2009] NSWSC 761, McDougall J noted at [15] that "*the lack of any discernible basis for a decision to refuse treatment may be something to take into account in assessing the competence or validity of the decision.*"

¹¹ *Re C (Adult: Refusal of Medical Treatment)*[1994] 1 All ER 819.

¹² An arguable exception to this broad statement is the *Mental Health (Care and Treatment) (Scotland) Act 2003* (UK). This requires that a compulsory treatment order may only be applied for where "the patient's ability to make decisions about the provision of such medical treatment is significantly impaired" (s 57). The same capacity criteria applies for emergency detention (s36(4)) and short term detention (s44(4)) in hospital. The "significant impairment test" is similar to, but not the same as a common law capacity test and has been described by Appelbaum as a "soft" incapacity test (P. S. Appelbaum, 2010, p. 28).

¹³ *Lunacy Regulation Act 1853* (UK), s 2.

commitment statutes allow mentally ill persons to be involuntarily detained and treated without clearly requiring a separate determination of legal incapacity for that to happen.

Equal treatment – an argument for reform

If we accept the claim of all persons to equal treatment before the law, the perpetuation of a historical distinction between the law as it applies to people with mental illnesses and the law as it applies to others, is difficult to justify. For this reason it is increasingly argued the rights and interests of persons with disabilities would be best served by bringing involuntary treatment laws into line with those used in general medicine – requiring that persons with mental illness who retain decision-making capacity should be able to refuse medical treatment on the same basis as others, regardless of perceived risk of harm. These calls are supported in particular, by reference to the United Nations Convention on the Rights of Persons with Disabilities, which specifies that persons with disabilities are entitled to enjoy legal capacity on an equal basis with others (United Nations, 2006, art. 12(2)).

However, it is not clear necessarily what a call for ‘equality’ means in the context of a mentally ill person refusing treatment in circumstances where they are thought to be at risk of suicide. There are two reasons for this.

First, the law has not unequivocally endorsed the right to take make decisions that lead to ones’ own death, in the context of treatment refusal or in suicide – regardless of whether or not a person has mental illness. It may be that decisions to die are still a special category within the right to autonomy that even persons with capacity are not unequivocally free to take.

Secondly, it is not clear what ‘equality’ itself requires – recalling Aristotle’s demand that we ‘treat equals equally and unequals unequally’ for justice to be done. Some suggest that for justice to be served – and for an ‘equal’ result for all persons - vulnerable persons require special protection. If persons with mental illness are presumptively vulnerable, this may require special rules for the prevention of serious harm in respect of persons with mental illness, regardless of formal capacity.

The next sections critically examine these proposals.

2. Autonomy under pressure

The law is now accustomed to considering two types of death-decisions, and both are apparently lawful where the decision-maker has capacity. A competent person may refuse medical treatment even if his life is put at risk by that decision; and a ‘non-medical’ act of suicide once characterised as a *felonia de se*, or “self murder” (Russell & Turner, 1958, p. 616) is now “within the range of conduct lawfully open to a person” provided the person is competent.¹⁴ Nevertheless, the courts have displayed a marked ambivalence about endorsing death-decisions and have not declared a common law ‘right to die’ – despite a century of jurisprudence pointing in that direction. The arrival at hospital of a person who seems to be likely to attempt suicide, but who is competently refusing treatment for mental illness in circumstances where such treatment may decrease that likelihood, thrusts us into the middle of very complex legal territory – being at once a refusal of medical treatment

¹⁴ *Reeves v Commissioner of Police* [1999] 3 WLR 363 (‘Reeves’), 386 E (Hobhouse LJ).

where life is apparently at risk and potentially the last point of state contact before a later act of suicide.

As it turns out, death-decisions seem to sit right at the limits of the radically private space Mill defined as “the part [of a person’s conduct] which merely concerns himself” (Mill, 2006, p. 16). Indeed jurisprudence suggests that John Donne’s sentiments that death “diminishes” us because we are all “involved in mankind” are widely shared. It would appear in fact, that death-decisions strain perhaps to splitting point, the Millian membrane between private and public spaces: between what merely concerns a person himself, and what seems to involve us all. Attempts to deal with this can be seen in two ways. The first is by employing a type of outcomes approach – where an exception to autonomy is created for decisions to die. The second is by reference to the concept of ‘vulnerability’ – which is located within the person themselves, and may be used to justify paternalistic overriding of a vulnerable person’s decisions when their life is put at risk.

2.1 Suicide as an exception to autonomy

Is there a right to suicide?

Following a series of landmark court decisions in the 1990s, the lawfulness of medical treatment refusal decisions appeared to have been put beyond doubt – even where death was a certain outcome.¹⁵ However these cases were deliberately distinguished from suicide cases and the common law has still reserved an ill-defined public interest in preserving life and preventing suicide – even when this conflicts with the right to autonomy.¹⁶

Thus, despite the widespread decriminalisation of suicide, and considerable pressure from euthanasia advocates and litigants seeking help to end their own lives, assisting suicide remains a criminal offence in most jurisdictions,¹⁷ and some jurisdictions offer statutory protection for persons who use force to prevent suicide.¹⁸

Indeed in Europe, just as the “right to private life” in article 8 of the European Convention is being gradually broadened to protect a right to make death-decisions,¹⁹ the “right to life” itself is being broadened too, and article 2 of the European Convention is now understood to entail a duty on the part of the state to act to prevent individual suicides in certain circumstances.

However in the medical cases, it has often been difficult for the courts to draw a sharp line between treatment refusal and ‘suicide’ and attempts to do so have been marked by inconsistency and suspicious sidelining of ‘inconvenient’ facts. Indeed it is a feature of

¹⁵ In the UK: *Airedale Hospital Trustees v Bland* [1992] UKHL 5 ('Bland'), *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18 ('Re T'). Canada: *Malette v Shulman* [1990] 72 OR (2d) 417 ('Malette'). USA: *In re Quinlan* (70 N.J. 10, 355 A.2d 647 (NJ) 1976).

¹⁶ For example “the interest of the state in... preventing suicide” was acknowledged but excluded from consideration in *Re T* [1992] EWCA Civ 18 (Butler-Sloss LJ). For further discussion, see Stewart, C. (2001).

¹⁷ This prohibition has been challenged several times in the UK – most recently by Tony Nicklinson.

¹⁸ See for example: *Crimes Act 1900* (ACT) s18; *Crimes Act 1900* (NSW) s574B; *Criminal Law Consolidation Act 1935* (SA) s13; *Crimes Act 1958* (Vic) s463B.

¹⁹ *Pretty v United Kingdom* (2002) 35 EHRR 1; *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45.

medical refusal cases for presiding judges to insist that the case being heard is “not about the right to die”²⁰ but rather, that it ‘simply’ concerns other less confronting rights such as the right to refuse medical treatment. This has even been asserted when a quadriplegic patient ordered the hospital in which he lived to withdraw artificial feeding and hydration, because, as he told the court, he “wish[ed] to die” but lacked the physical capacity to bring this about.²¹ Nevertheless the court insisted that the case was “[not] about the right to life or even the right to death. ... The only issue which arises for determination in this case concerns the legal obligations under Western Australian law... when [a] patient clearly and unequivocally stipulates that he does not wish to continue to receive medical services which, if discontinued, will inevitably lead to his death.” This demonstrates how far the court is willing to stretch the bounds of credulity to avoid actually endorsing suicide.

In non-medical cases, the old crime of *felo de se* has been abolished and suicide is lawful for a person with legal capacity. It is also unlawful for the state to obstruct that choice,²² however the principle is applied with great caution. In *Reeves v Commissioner of Police*,²³ a case decided before the *Human Rights Act 1998* (UK), the court considered whether prison officers had acted negligently in respect of John Reeves, who had, apparently with legal capacity, hung himself by his shirt sleeves from a point left available to him on the door of his remand cell. In considering the negligence application brought by his estate, the court noted that:

“Suicide is within the range of conduct lawfully open to a person: personal autonomy includes the right to choose conduct which will cause that person's death ... Imprisonment does not deprive the prisoner of that autonomy.” (citations omitted)²⁴

Nevertheless, the parties agreed that the state owed a duty of care to prisoners to protect them from suicide because of the uniquely stressful environment in prison and the state’s general duty to take reasonable care of people in custody.²⁵ On that basis it was held that the Commissioner of Police was liable in negligence to Mr Reeve’s estate for failing to take proper care to limit his opportunities to kill himself – even though the act itself was apparently within his rights.

The ‘right to suicide’ was also acknowledged in the European Convention case of *Savage v South Essex Partnership Foundation Trust and MIND*,²⁶ which considered the scope of the state’s duty to preserve life under article 2 of the European Convention in respect of psychiatric patients who were formally detained under the *Mental Health Act 1983* (UK).

²⁰ See for example, in *Re T* [1992] EWCA Civ 18: “This appeal is not in truth about the ‘right to die.’ There is no suggestion that Miss T wants to die. I do not doubt that she wants to live and we all hope that she will. This appeal is about the ‘right to choose how to live.’ This is quite different, even if the choice, when made, may make an early death more likely.” (Donaldson LJ).

²¹ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [11] (Martin CJ).

²² *R (on the application of Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)* [2002] 1 AC 800; *Pretty v United Kingdom* (2002) 35 EHRR 1; *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45; *Rabone* [2012] UKSC 2, [100] (Hale LJ); *Reeves v Commissioner of Police* [1999] 3 WLR 386; *Bland* [1992] UKHL 5; *St. George's Healthcare NHS Trust v S* [1999] Fam 26.

²³ *Reeves* [1999] 3 WLR 386.

²⁴ *Reeves* [1999] 3 WLR 363, 386 (Hobhouse LJ).

²⁵ *Reeves* [1999] 3 WLR 363, 387 (Hobhouse LJ).

²⁶ *Savage v South Essex Partnership Foundation Trust and MIND (Intervener)* [2008] UKHL 74 (‘Savage’)

Article 2(1) provides simply that “Everyone’s right to life shall be protected by law”. This has been interpreted broadly by the European Court of Human Rights and is now understood to include a positive obligation on states to protect life in particular circumstances. This entails an obligation to take “preventative operational measures” to protect specific individuals from “real and immediate” risks to their life, in circumstances where the state is found to be responsible for the person.²⁷

On the issue of suicide, Scott LJ noted that:

“As to persons known to be a suicide risk, the state has no general obligation, in my opinion, either at common law or under article 2(1), to place obstacles in the way of persons desirous of taking their own life. The positive obligation under section 2(1) to protect life could not, for example, justify the removal of passport facilities from persons proposing to travel to Switzerland with suicidal intent. Children may need to be protected from themselves, so, too, may mentally ill persons but adults in general do not. Their personal autonomy is entitled to respect subject only to whatever proportionate limitations may be placed by the law on that autonomy in the public interest. The prevention of suicide, no longer a criminal act, is not among those limitations.”²⁸

Again, however, the Court found that the state was liable in respect of this particular suicide, committed as it was, by a person detained in a psychiatric facility, because it was held that the state exercised a high degree control over persons in detention and that such people were especially vulnerable. Similar obligations to prevent suicide have also been found in respect of prisoners,²⁹ people in immigration detention,³⁰ and military conscripts.³¹

This reasoning, which had previously only applied to formal detainees was extended to voluntary psychiatric patients in the *Rabone* case.³²

Twenty-four year-old Melanie Rabone was admitted to a psychiatric unit as a voluntary patient after a series of apparent suicide attempts. During a recent previous admission she had been diagnosed with “a severe episode of a recurrent depressive disorder”.³³ After more than a week in hospital, Melanie requested two days and nights leave to go home to her parents’ house. Her psychiatrist agreed to this, although her parents were concerned for her safety. In the late afternoon on the second day, Melanie said she was going to visit a friend but shortly after leaving home, she hanged herself from a tree in a local park. Melanie’s parents sued the hospital’s trust for breach of article 2 of the European Convention. Article 2 provides that “everyone’s right to life shall be protected by law”, and the Rabones argued that the hospital’s decision to allow her home leave violated this right.

On basis of expert psychiatric evidence concerning her risk of suicide, the Court concluded that Melanie faced a “real and immediate” risk to her life from which she should have been protected. The Court also found that there was a “simple and obvious”³⁴ way of protecting

²⁷ *Osman v United Kingdom* (2000) 29 EHRR 245

²⁸ *Savage* [2008] UKHL 74, [11] (Scott LJ)

²⁹ *Keenan v United Kingdom* (2001) 33 EHRR 49.

³⁰ *Slimani v France* (2006) 43 EHRR 487.

³¹ *Kilinc v Turkey* (Application No 40145/98).

³² *Rabone* [2012] UKSC 2.

³³ *Rabone* [2012] UKSC 2, [2] (Dyson LJ).

³⁴ *Rabone* [2012] UKSC 2, [35] (Dyson LJ).

her from that risk – by refusing her requested leave, and if necessary by exercising coercive powers of detention available under the *Mental Health Act 1983*. Failing to take those steps, the Court determined, had amounted to a breach of Melanie’s human rights.

‘Unacceptable’ deaths

These disparate tendencies in the law – at once permitting death-decisions, while at the same time finding frequent reasons to curtail them, seem to defy a coherent, rational explanation. One reason may be that our approach to death-decision is not exactly rational, but rather is based on an intuitive aversion to death except in very limited circumstances.

Robert Burt has gone to some length to challenge rationalist conceptualisations of death as a morally neutral phenomenon or an ordinary life event over which we can assert rational control. He is sceptical about the autonomy-centred approach in the common law that seems to only require that a death-decision be made with capacity, in order to be justified. In particular, Burt suggests that a pervasive cultural belief that death itself is ‘wrong’ defies the legal requirement that persons with capacity should simply be able to choose it. He writes:

“In our Western cultural tradition, death is not viewed simply as a fearful event; there is an aura of wrongfulness, of intrinsic immorality, attached to the very idea of death. In the Western religions tradition ... death made its first appearance in God’s created universe as a punishment for wrongdoing. If Eve and Adam had not eaten the fruit of the tree of knowledge, if they had obeyed God’s specific commandment, they would have lived forever; but they disobeyed, were expelled from the Garden of Eden, and lost eternal life” (Burt, 2004, p. 12).

Burt argues that this deep cultural bias against death cannot be easily overcome by evidence of a person’s decision-making capacity – but it may help if the *reasons* given are good enough to neutralise the deeper moral concerns in play. Indeed it is a feature of the medical cases that reasons *are* given when approval is being sought for a decision to die – despite the fact that they are not legally required.

As it happens, where a person actively seeks death (rather than refusing a particular medical treatment in risky circumstances – as is the case when Jehovah’s Witnesses refuse blood products) the only reasons that have so far been acceptable to the court are those that point to a degree of physical ‘debasement’ that suggests the human quality of the life in question has already been lost. Testimony from those seeking death characteristically features images of a return to a highly dependent ‘childlike’ state, inability to control basic bodily functions, and a general loss of dignity that seem to suggest the loss of personhood itself. This testimony is largely outside the strict parameters of the legal questions to hand, but arguably helps to render these decisions comprehensible to the court and to the community.

In *Nicklinson*, Tony Nicklinson told the court:

“I need help in almost every aspect of my life. I cannot scratch if I itch, I cannot pick my nose if it is blocked and I can only eat if I am fed like a baby... I have no privacy or dignity left. I am washed, dressed and put to bed by carers who are, after all, still

strangers. You try defecating to order whilst suspended in a sling over a commode and see how you get on...”

“ Indeed, I can expect to dribble my way into old age. If I am lucky I will acquire a life threatening illness such as cancer so that I can refuse treatment and say no to those who would keep me alive against my will.”³⁵

The Court had no quarrel with Mr Nicklinson’s own assessment of the intolerability of his circumstances, noting and apparently endorsing his “recognition” that “they are circumstances which evoke the deepest sympathy”.³⁶

When Tony Nicklinson’s case was considered for judicial review, he was joined by a co-applicant known as “Martin” whose circumstances were described in similar terms:

“Martin is fed by people putting food into his mouth... He wears a convene (a sheath over his penis, attached to a tube, into which he urinates). He defecates into special underwear...

“... he finds his life and his condition following his stroke to be undignified, distressing and intolerable. He does not wish to go on living like this. And, because he finds his current life unbearable, he wishes to end his life as soon as possible.”³⁷

Again, although the Court found that that any further extension of the law towards permitting deliberate killing would be a matter for parliament, it had no difficulty in accepting either man’s testimony concerning the value that they placed on the burden imposed by their continuing lives and their desire to die. Rather, the judges noted separately that:

“Tony’s and Martin’s circumstances are deeply moving. Their desire to have control over the ending of their lives demands the most careful and sympathetic consideration.”³⁸

“No one could fail to be deeply moved by the terrible predicament faced by these men struck down in their prime and facing a future bereft of hope.”³⁹

And finally:

“the dire physical and emotional predicament facing Tony and Martin and their families may intensify any tribunal’s unease identified by Lord Mustill in *Bland* (at 887) in the distinction drawn between ‘mercy killing’ and the withdrawal of life sustaining treatment or necessities of life.”⁴⁰

³⁵ *Nicklinson* [2012] EWHC 304 (QB), [3].

³⁶ *Nicklinson* [2012] EWHC 304 (QB), [4] (Charles J).

³⁷ *Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin), [7-10] (Toulson LJ).

³⁸ *Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin), [150] (Toulson LJ)

³⁹ *Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin), [151] (Royce LJ)

⁴⁰ *Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin), [152] (Macur LJ)

In a separate case, Baroness Hale seemed troubled by the nature of such testimony precisely because it seemed to negate the liberal account of autonomy. While Hale LJ was sceptical about the justification for preferring some suicides to others, she noted that the community did seem to have this view:⁴¹

“I have also been concerned about whether account should be taken of the reasons why a person might wish to die. If we are serious about protecting autonomy we have to accept that autonomous individuals have different views about what makes their lives worth living. There are many, many people who can live with terminal illness; there are many, many people who can live with a permanent disability... but those same people might find it impossible to live with the loss of a much-loved partner or child, or with permanent disgrace, or even with financial ruin. Yet in attitudinal surveys the British public have consistently supported assisted dying for people with a painful or unbearable incurable disease from which they will die, if they request it, while rejecting it for people with other reasons for wanting to die (National Centre for Social Research, British Social Attitudes, The 23rd Report, 2007, chapter 2).”

Baroness Hale concluded that “it is not for society to tell people what to value about their own lives. But it may be justifiable for society to insist that we value their lives even if they do not”.⁴² However the lives of those in intolerable *physical* circumstances appear not to attract this kind of insistence from the court – and none was apparent in the cases cited here. Certainly Tony Nicklinson and his co-applicant’s testimonies about the worthlessness of their lives were not challenged, but rather, were used to render credible, if not ultimately persuasive, the applicants’ arguments.

Quite a different approach tends to be taken, however, when people with mental illness express suicidal ideation in circumstances when they are physically healthy, and in cases involving suicides in those circumstances, horrifying images are used to opposite effect. In Melanie Rabone’s case for example, they supported the opposite starting point – that it was her *death* that was debased, not her life, and coercive measures should have been taken, if necessary, to avoid it.

Ms Rabone’s three previous episodes of self-harm, described as suicide attempts by the court, were set out in considerable detail by two of the three judges in her case. In the facts as set out by Dyson LJ, “On 4 March 2005, she tried to commit suicide by tying a pillow case round her neck”; then “On 31 March, she cut both of her wrists with broken glass” and “On 11 April, she tied lamp flex round her neck”, until finally, on the 20th of April “[some] time after 17.00 hrs, she hanged herself from a tree in Lyme Park.” The impact of these descriptions is cumulative and alarming. Melanie Rabone did not simply die after being released from hospital. She did not simply suicide after a recent history of self-harm. Rather, she was 24 year-old woman, with a loving family, who were desperately concerned about the possibility she might hurt herself and about her being at home. She had previously used broken glass to cut her wrists, she had tied household items – pillow cases, electrical cords – around her neck, and on this final occasion, after telling her mother on a Sunday afternoon that she was going to visit a friend, she *hanged herself from a tree in Lyme Park*. This description is given three times in two separate judgements,⁴³ creating a strong

⁴¹ *R (on the Application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45, [66] (Hale LJ).

⁴² *R (on the Application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45, [68] (Hale LJ).

⁴³ Per Dyson LJ at [1] and [6]. See also Hale at [91] “she hanged herself from a tree in a well-known local beauty spot”.

sense that Melanie suffered an abject, shocking and manifestly tragic death that *prima facie*, should have been prevented.

The *Nicklinson* and *Rabone* judgements present interesting examples of how the law shies away from examining decision-making capacity when faced with particular outcomes – in these cases viscerally objectionable outcomes coloured by vivid accounts of suffering. It is arguable that in both cases there should have been a rigorous assessment of decision-making capacity, followed by consideration of whether or not the person’s decision – in *Nicklinson*, to seek directly to end his life, and in *Rabone*, to leave hospital – should have been honoured. In both cases though, this approach was notably absent. Rather, the apparent acceptability or unacceptability of the particular deaths provided the setting and the starting point for presumptions about autonomy and vulnerability. The implications of the decision in *Rabone* in particular, were that where there is a risk of suicide in a vulnerable person (as all psychiatric inpatients are presumed to be) coercive powers under mental health laws *should* be used to detain them. This suggests, therefore, that what is important is not simply a person’s capacity to make autonomous decisions, but a person’s vulnerability. We therefore need to understand how judgements about vulnerability are made and why vulnerable people have less claim to autonomy.

2.2 ‘Vulnerability’ as an alternative to autonomy

In addition to the possibility that we should simply create an exception to autonomy for suicide – a type of ‘outcomes’ approach – a separate justification for preventative detention arises out of the notion of ‘vulnerability’. This might be expressed in a variety of ways, but essentially, an argument may be run that some persons, either because of internal or external circumstances, are unusually susceptible to harm and/or are unusually unable to protect themselves from it. In those circumstances, regardless of formal decision-making capacity, such persons should be protected by law.

In English and Australian law, courts have a well established power to intervene to reverse contractual decisions made where one party has taken advantage of another person’s ‘special disability’. ‘Special disability’ is not defined in law, but it extends beyond a lack of capacity to enter into the arrangement. The disability might only occur within the relationship between the parties. For example it may be a relative disability of the weaker party compared to the stronger party. It has been held to include age, illiteracy, lack of education, poor English speaking, emotional dependence, infatuation, or a combination of factors.

More recently in a line of legal decisions in England, this type of approach has been broadened beyond situations where a person is has been “taken advantage of”, to those in which a person requires protection more generally. In the leading case of *Re SA (Vulnerable Adult with capacity: Marriage)* Munby J said that in order to exercise the court’s inherent jurisdiction:

“I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb, or who is substantially handicapped by illness, injury or congenital deformity.”⁴⁴

⁴⁴ [2005] EWHC 2942 (Fam) at [82]

However a vulnerability standard remains problematic for a number of reasons. Donnelly identifies the key issues as follows: First, because vulnerability appears to be tied to a person's physical, mental, social or economic circumstances, it has the potential to be very wide in scope. Second, an approach to state interference based on vulnerability "reawakens the ghost" of status-based capacity assessment in which members of a particular class – say of disabled persons – is presumptively deprived of the right to make personal decisions. Third, quoting Dunn *et al*, a power to intervene to override the wishes of persons deemed vulnerable [raises] the possibility that a judgement that a person has the capacity to make an autonomous decision will be considered an 'inconvenient truth' which may be ignored as the focus for discussion shifts to other matters" (Donnelly, 2010 p 224).

The *Rabone* and *Nicklinson* cases illustrate clearly how the particular circumstances of the people involved, their particular vulnerability, and the particular outcome – suicide – overwhelmed both respect for the principle of autonomy and considered assessment of capacity. Vivid narrative accounts of suffering seemed to pre-empt the issues of capacity and vulnerability, and further interrogation of circumstance based conclusions did not seem to have been considered necessary by the court. Tony Nicklinson was, in his own words "*not vulnerable, I do not need help or protection from death or those who would help me*".⁴⁵ He was not vulnerable, he said, because vulnerable people are "*those who cannot make decisions for themselves*" and that group of people, he said "*just don't include me*".⁴⁶ The Court did not quibble with any of these assertions. It presumed that Mr Nicklinson had capacity, and no further issue was taken with whether he might be vulnerable – notwithstanding his extreme disability, with all that that might psychologically, physically and existentially entail.

Conversely, it was Melanie Rabone's *lack* of capacity – and state of vulnerability – that was presumed by the Court. In distinguishing her situation from that of other hospital patients whose choices must be honoured regardless of the risk to life, Hale LJ simply noted that:

"A patient receiving treatment in hospital for a physical illness or injury is in a quite different position. She has made an informed and autonomous choice to be in hospital and to receive the treatment in question."⁴⁷

Hale LJ did not appear to consider that some patients "in hospital for a physical illness" do, in fact, lack decision-making capacity, or that Melanie Rabone, a voluntary patient, may have made "an informed and autonomous choice to be in hospital" and might, with the request for leave, have made a "an informed and autonomous choice" to go home. Instead Ms Rabone was placed into a class of patients whose decision-making capacity was presumptively absent. According to Dyson LJ:

"In the case of the suicide of a psychiatric patient, the likelihood is that, given the patient's mental disorder, her capacity to make a rational decision to end her life will be to some degree impaired."⁴⁸ [emphasis added]

Similarly, Hale LJ opined:

⁴⁵ *Nicklinson* [2012] EWHC 304 (QB), [3].

⁴⁶ *Nicklinson* [2012] EWHC 304 (QB), [3].

⁴⁷ *Rabone* [2012] UKSC 2, [106] (Hale LJ).

⁴⁸ *Rabone* [2012] UKSC 2, [30] (Dyson LJ).

“[Melanie’s] mental disorder meant that she might well lack the capacity to make an autonomous decision to take her own life”⁴⁹
[emphasis added]

There was no further discussion about whether or not Melanie Rabone *did* have capacity to make the decision to leave hospital from which the state was apparently compelled to protect her lest she put herself in harm’s way. Rather, she belonged to a class of vulnerable people, whose risk of harm will be the primary consideration in determining whether or not their wishes should be respected.

It may seem perverse with the benefit of hindsight, to assert that Melanie Rabone should perhaps not have been thought to be vulnerable. But decisions made about what to do about a person who refuses treatment are prospective – and the precedent in the *Rabone* case implies that in order to meet human rights obligations, all people who have a mental illness are presumptively vulnerable and if they are thought to be at risk of suicide they should be preventatively detained in hospital using coercive powers if necessary. We suggest that this is unreasonable, prejudiced and unjust. Certainly the idea that a physically robust 24 year-old woman who may have had decision-making capacity is necessarily vulnerable, when a 58 year-old man who is completely paralysed and facing his own slow death, is not, strains the concept of vulnerability beyond breaking.

None of this should be taken to imply that Melanie should not have been prevented from leaving hospital. Perhaps she should have been detained. But, a decision to detain her should not have been based on an assessment that she was a vulnerable person whose wishes do not count. Rather her decision to request leave should have been thoroughly examined. If it were thought that the circumstances around her decision might have placed her in peril and provided grounds for her doctors to doubt her capacity, her capacity to make that decision ought to have been assessed. If she had decision-making capacity her request for leave ought to have been honoured. Only if she lacked such capacity, should denial of her request been contemplated.

3. The price of protection – what compromising autonomy means for people with mental illness

Despite the normative weaknesses we have highlighted, the community may simply demand that we should have some mechanism for preventing suicides, particularly of physically healthy people, where we suspect that detention and treatment for mental illness might make them feel differently about that decision. However, even if we were to put aside the objections highlighted in the preceding sections, such an approach would still need to be justified on the basis that such measures (which clearly involve a loss of ordinary rights) would be effective in achieving their purpose and would not be unacceptably burdensome on the community as a whole.

In terms of effectiveness, it is not actually the case that simply admitting a person to a psychiatric unit negates the possibility that a person might suicide. Psychiatric inpatients often suicide despite admission to an inpatient unit (Morgan & Stanton, 1997; NSW Mental Health Sentinel Events Review Committee, 2008; Pirkola, Sohlman, & Wahlbeck, 2005; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2010).

⁴⁹ *Rabone* [2012] UKSC 2, [106] (Hale LJ).

However, even if we are to allow that a short stay in hospital under observation might prevent at least *some* suicides, the burden on the community still needs to be considered.

3.1 The magnitude of the burden

As only a proportion of the class of persons thought to be at risk of suicide will actually go on to suicide, we need to consider the magnitude of the burden placed on the rest of that class, and the population of mentally ill people in general, when evaluating the use of coercive psychiatric treatment as a tool for suicide prevention. When considering this issue in relation to the granting of leave from a psychiatric hospital, for example, the first issue to be addressed is an empirical one: how many persons at high-risk of suicide need to be detained in hospital in order to save the life of one such person, who if granted leave will go on to suicide?

The eventual number arrived at will depend crucially upon the following factors: the base rate of suicide among all inpatients; and the sensitivity and the specificity of the method used to categorise the inpatients into high and low risk. Sensitivity refers to the probability that a person who will go on to suicide will be classed as 'high risk'. A person classed as high risk who did not go onto suicide would be a false positive. Specificity refers to the probability that a person who would not go on to suicide would be classed as 'low risk'. A person classed as low risk who did go onto suicide would be a false negative. The base rate of suicide in this case, would be the percentage of all inpatients who eventually go on to suicide. The biggest problem in categorising psychiatric patients into those at high and low risk for suicide is that, thankfully, suicide is an extremely rare event. This means that even for methods of categorisation that have high sensitivity and specificity, there will still be large numbers of false positives and negatives.

A recent study by Madsen *et al* allows us make this sort of calculation using real data. They analysed data from all 126,382 psychiatric inpatients admitted in Denmark between 1997 and 2006 to determine the risk factors for inpatient suicide among the 279 inpatients who died by their own hand (Madsen, Agerbo, Mortensen, & Nordentoft, 2012). They identified a number of risk factors that were associated with inpatient suicide (which includes suicide whilst on leave from hospital). Patients were designated as 'high-risk' if they had three or more such risk factors. High-risk patients were indeed at higher risk and were 2.7 times more likely to suicide than 'low-risk' patients. This categorisation had a specificity of 93%. Nonetheless, only 1.41 per 1000 of these high-risk patients would have actually gone on to suicide. If we again assume, for the sake of argument, that in Danish hospitals inpatients only ever suicided while on leave and that deprivation of leave prevented all suicides, these figures mean that in order to prevent one suicide of a patient whilst on leave, 709 patients would need to be prevented from taking leave who would never have committed suicide. Notably too, while the specificity of the categorisation was high, the sensitivity was low, only 12%. As a consequence 88% of people who would have eventually gone on to suicide would have been classified as 'low-risk' and allowed leave anyway (Madsen & Nordentoft, 2012).

Of course the calculations for this sort of exercise will vary according the population studied and according to the method used to determine which patients are at high risk. However, no matter what the population or the method, the low base rate of suicide and our poor ability to identify patients who will actually go on to suicide, will inevitably mean that the number of false positives will be very high.

3.2 Balancing false positives and false negatives

The epistemological uncertainty in predicting suicides gives rise to a further normative concern. If we cannot know exactly who will go on to suicide, and those who are falsely identified as being at risk will have to bear the burden of loss of autonomy to avoid the risk of some deaths, how many persons at high-risk of suicide would we be *justified* in detaining in order to save the life of one such person?

As it happens, the legal system has had a great deal of experience in balancing false positive (finding a person is liable/guilty/mentally ill when in fact they are not) and false negative (finding a person is not liable/guilty/mentally ill when in fact they are) decision errors when risking a loss of ordinary rights.

Traditionally it has erred strongly on the side of allowing false negatives. The most well-known example is Blackstone's dictum that it is "better that ten guilty persons escape than that one innocent suffer" – indicating a preference for false negatives (erroneous acquittal) over false positives (erroneous conviction) in a ratio of 1:10 in criminal liability (Blackstone, 1765-1769). This preference has been repeated by jurists in countless variations from 1:5 to 1:1000, with the 'innocent' facing a variety of fates from execution, to imprisonment, to being confined to a mental institution, to ordinary 'suffering' which is otherwise undefined (Volokh, 1997). This is an interesting starting point if, when considering the use of coercive treatment laws to prevent risk of suicide, we are considering a reverse ratio favouring false positives (the detention of those at risk of suicide who will not go on to suicide), using our example above, of 700:1.

However even in the criminal context the preference for false negatives has not been without its critics. Volokh relates the story of the fabled Chinese law professor, who, after being told about the Blackstonian maxim, responded simply, "Better for whom?" (Volokh, 1997, p. 211). In the context of involuntary treatment for mental illness, where there is a suicide risk, that question becomes biting relevant. Indeed, while Blackstone's maxim *has* been applied in courts in relation to involuntary detention in a psychiatric hospital,⁵⁰ and the loss of liberty involved in civil detention is essentially the same as imprisonment, being detained for medical treatment is obviously not *exactly* the same as being gaoled for an offence. Treatment is not, after all, supposed to be a punishment – but rather, at least in principle, it is a means of delivering some kind of benefit. Well may we ask which is the lesser of the harms facing the person with mental illness – or the person who *may* have mental illness – when one is their desire to go about their lives as they choose, and the other, the chance that without treatment for mental illness, they may go on to suicide?

In this respect, Chief Justice Warren Burger of the United States Supreme Court found that although civil commitment constituted a significant deprivation of liberty that was worthy of protection by due process, civil commitment for mental illness was sufficiently different to criminal prosecution that requiring proof of the conditions for commitment 'beyond reasonable doubt' would be inappropriate. He wrote apropos of Blackstone's dictum that "The full force of that idea does not apply to civil commitment" and that while "It may be true that erroneous commitment is sometimes as undesirable as erroneous conviction... it is not true that the release of a genuinely mentally ill person is no worse for the individual

⁵⁰*Goetz v. Crosson*, 967 F. 2d 29 (2d Cir. 1992), 39 (Newman J, concurring): "If ten to one is appropriate in the criminal context, then perhaps one could plausibly say that it is better that five or perhaps three mentally ill persons be released than that one mentally sound person be confined."

than the failure to convict the guilty. One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma. . . . It cannot be said, therefore, that it is much better for a mentally ill person to 'go free' than for a mentally normal person to be committed."⁵¹

It is troubling, of course, that Berger J erroneously equates mental illness with incapacity.⁵² Not all mental illness is "debilitating" in terms of decision-making capacity – even less so where proper decision-making support is provided – and in any case not to the point where people with mental illness can generally be considered not to be "wholly at liberty" to have a preference about whether or how they obtain psychiatric treatment. This much at least is now established in law.⁵³

However it would appear that any preference for erring on the side of detention over release of persons with mental illness ultimately depends on values – and the extent to which, in Berger J's terms, policy makers believe that detaining a person with mental illness and who wishes to go home, is a serious harm. Those who favour protective detention of people, who are thought to be at risk of suicide, may simply believe that there is insufficient downside to detaining persons with mental illness to warrant release of competent persons who are thought to be at risk of suicide.

Indeed, there would appear to be a pervasive scepticism about the idea that compulsory treatment for a person who has mental illness can ever be truly harmful, or if, when medically sanctioned, it really compromises human rights. If treatment for mental illness is thought to be basically beneficial, then detention and coercive treatment might be thought to be more acceptable, because for a mentally ill person, the stakes are apparently low.

In his careful analysis of human rights cases, Bartlett notes a general "reluctance in the courts to acknowledge that compulsory treatment actually raises human rights concerns" where medical opinion is in favour of treatment (Bartlett, 2011, p. 4). In a similar vein, the importance of loss of autonomy in people with mental illness is often downplayed by persons interested in the rights of persons with mental illness, by comparison to the loss of opportunities for treatment. As one senior New South Wales government psychiatrist recently wrote:

"Does it truly empower patients when they make a 'competent choice' to cease treatment...only to be spun through the revolving door of relapse and remission; discharge and admission?... Patients and carers complain about the failure of mental health services to provide access to effective treatment, far more than the violation of human rights associated with [involuntary treatment]" (Keller, 2012, p. 3).

But many patients *do* complain in very serious terms about rights violations in involuntary treatment even where treatment is apparently indicated – that is, where the person has mental illness and a consulting clinician thinks treatment is appropriate. Minkowitz has written that, the medical perspective aside, there is "a need to... examine the serious nature and consequences of forced psychiatric interventions as a violent assault... affecting every

⁵¹ *Addington v. Texas*, 441 US. 418 (1979) at 429

⁵² This is part of a long tradition in law: Minkowitz (2007 p 408) "All laws directed at restricting [disabled persons'] freedom and self-determination are premised on an equation of psychosocial disability with legal incapacity, and legal incapacitation is the primary way that the law deals with persons with psychosocial disabilities."

⁵³ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819

aspect of a person's life: the body, the mind, the personality, the social relationships, and the spiritual values or higher meaning" (Minkowitz, 2007, p. 405). This deeply personal perspective from the point of view of the patient, and the experience of violation in being forced, is entirely missing from views that focus on managing physical risks, responding to pathologised behaviours and in prescriptions for invasive treatment that is supposed to be in a person's best interests, wherever such prescriptions do not prioritise the preferences of the person to whom they apply.

Another potential justification for coerced treatment is the 'thank-you theory' – that patients will ultimately be grateful for coerced treatment once the crisis is over (Stone & Stromberg, 1976). However there is reason to be suspicious of this rationalisation – mainly because of a lack of empirical evidence that patients do actually appreciate these interventions even when returned to health (Katsakou & Priebe, 2006). Although one UK study has shown that a high proportion of patients who regain capacity give retrospective approval for involuntary treatment (Owen, et al., 2009) other studies indicate that many patients do not later regard coercive treatment as justified (Katsakou & Priebe, 2006; Priebe, et al., 2009) and even where patients acknowledge that past coercive treatment was justified, they are not necessarily grateful for it (Gardner, et al., 1999). Aside from Owen et al., no other study makes a distinction between patients who were competent at the time of coercive treatment and those who were not, so it is not clear how much of an impact this might have on attitudes towards coercive treatment.

Indeed, notwithstanding the beneficial effects of good psychiatric treatment, the non-therapeutic impacts of psychiatric medications are significant and it is not difficult to imagine that some patients may feel resentful about forced treatment even where the benefits are there. Many psychotropic medications cause sedation, weight gain and sexual dysfunction (McKnight, et al., 2012; Serretti & Chiesa, 2011; Serretti & Mandelli, 2010; Taylor & McAskill, 2000). Lithium is linked with hypothyroidism (McKnight, et al., 2012), and antipsychotic medication with diabetes (De Hert, Detraux, van Winkel, Yu, & Correll, 2012), tremors, muscle spasm, and tardive dyskinesia which in some cases is permanent (Correll & Schenk, 2008), life-threatening blood abnormalities, heart disease and deep vein thrombosis (Hall, Smith, & Edwards, 2003; Layland, Liew, & Prior, 2009; Paciullo, 2008). While it is one thing for a patient to accept these risks themselves in consenting to a course of medical treatment, it is quite another to impose them on an objecting patient – and it is more serious still to impose them on an objecting patient who retains decision-making capacity.

These kinds of impacts were taken into account in the 2008 Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Report noted, using psychosurgery as an example, that:

"The more intrusive and irreversible the treatment, the greater the obligation on States to ensure that health professionals provide care to persons with disabilities only on the basis of their free and informed consent... Otherwise, the Special Rapporteur notes that such treatments may constitute torture, or cruel, inhuman or degrading treatment." ("Torture and other cruel, inhuman or degrading treatment or punishment," 2008, para. 59)

The Report makes similar comments about the use of electroconvulsive therapy (para. 61) and then goes on to point out specifically that "[d]epending on the circumstances of the case, the suffering inflicted [by psychiatric drugs] and the effects upon the individual's health may constitute a form of torture or ill-treatment' (para. 63) and that "[i]n certain

cases, arbitrary or unlawful deprivation of liberty based on the existence of a disability might also inflict severe pain or suffering on the individual, thus falling under the scope of the Convention against Torture.” (para. 65).

While we do not mean to overstate the negative impacts of psychiatric treatment at the expense of the benefits such treatments often bring, it is worth acknowledging that psychiatric treatment is a serious undertaking and the disbenefits, particularly when imposed on an unwilling person, warrant careful consideration.

4. Competence based treatment – a better alternative?

Policy makers must be realistic about the limits of the ability of medical practitioners to predict suicide, the magnitude of the impact on persons who will not actually suicide if presence of perceived risk factors alone is used at the basis for involuntary treatment, and the true costs of detaining competent people who do not wish to have treatment for a psychiatric illness, in terms of loss of ordinary rights.

On balance, we suggest that persons who retain decision making should be able to refuse coercive treatment for mental illness, and that a perceived relative increase in suicide risk should not be used to override that refusal. This is not only because the law allows competent non-psychiatrically ill people to make decisions not to have medical treatment even if there is a risk of harm or even death; or because domestic and international law says all persons should be treated equally; or because the Convention on the Rights of Persons with Disabilities now requires that persons with disabilities are entitled to enjoy legal capacity on an equal basis with others. Although any of these reasons might be reason enough.

It is also because, even if we simply cannot abide some death-decisions, competent or otherwise, and we just want to prevent suicide, there is no evidence to suggest, nor reason to suspect, that coercive treatment on the basis of perceived risk will achieve that. And it will certainly lead to a serious loss of very basic rights that most of us take for granted for the very many patients who will not in fact go on to suicide. In addition, because under this sort of legislation, all persons with mental illness can be compelled to take whatever treatment is demanded of them, there is little need for clinicians to take the time to negotiate treatment options with patients. It is likely that this power imbalance imposes a corrupting influence on the clinician-patient relationship.

We, and others, have suggested that legislated coercive psychiatric treatment should not be triggered by an assessment of the likelihood of harm, whether because certain types of harms are thought to be too important or because persons should be considered vulnerable, but should be available only where a person is found to lack capacity to make their own decisions about their own health risks, after appropriate support has been given. While this has found considerable favour among academic commentators and among some lawmakers, others remain sceptical. Our analysis suggests that reluctance to embrace this approach may find its origin in a number factors including: ambivalence about extending the right to refuse medical treatment where there is a perceived risk of suicide; uncertainties about the idea of vulnerability and its relationship to capacity; over-confidence in the predictive value of psychiatric risk assessment; and a tendency to minimise the real costs of psychiatric treatment, relative to benefits.

None of these factors, we maintain provide grounds for rejecting an approach to coercive psychiatric treatment that protects human rights. Nonetheless, these are all factors that must be overcome by those interested in seeing legislative reform take hold.

References

- Appelbaum, P., & Grisso, T. (1995). The MacArthur Treatment Competence Study. I: Mental illness and competence to consent to treatment. *Law and Human Behavior; Law and Human Behavior*, 19, 105.
- Appelbaum, P. S. (2010). Harnessing the power of fusion? A valiant but flawed effort to obviate the need for a distinct mental health law. *Journal of Mental Health Law*, 25-33.
- Bartlett, P. (2011). 'The necessity must be convincingly shown to exist': standards for compulsory treatment for mental disorder under the Mental Health Act 1983. *Medical Law Review*, 19, 514-547.
- Blackstone, W. (1765-1769). *Commentaries on the Laws of England*. (Vol. 4).
- Blais, A., Massicotte, L., & Yoshinaka, A. (2001). Deciding who has the right to vote: a comparative analysis of election laws. *Electoral Studies*, 20, 41-62.
- Boettcher, B. (1992). Inquiries into psychiatry: Chelmsford and Townsville. *Medical Journal of Australia*, 156, 222.
- Burt, R. A. (2004). *Death is That Man Taking Names*. California: Milbank Books.
- Correll, C. U., & Schenk, E. M. (2008). Tardive dyskinesia and new antipsychotics. *Current Opinion in Psychiatry*, 21, 151-156.
- Council of Europe. (1950). Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No. 11 with Protocol Nos. 1, 4, 6, 7, 12 and 13. In: Registry of the European Court of Human Rights.
- De Hert, M., Detraux, J., van Winkel, R., Yu, W., & Correll, C. U. (2012). Metabolic and cardiovascular adverse effects associated with antipsychotic drugs. *Nature Reviews Endocrinology*, 8, 114-126.
- Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19, 91-102.
- Donnelly, M. (2010). *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Vol. 12): Cambridge University Press.
- Dworkin, R. (2011). *Life's dominion: An argument about abortion, euthanasia, and individual freedom*: Vintage.
- Fennell, P. (1986). Law and Psychiatry: The Legal Constitution of the Psychiatric System. *Journal of Law and Society*, 13, 35.
- Gardner, W., Lidz, C. W., Hoge, S. K., Monahan, J., Eisenberg, M. M., Bennett, N. S., Mulvey, E. P., & Roth, L. H. (1999). Patients' revisions of their beliefs about the need for hospitalization. *American Journal of Psychiatry*, 156, 1385-1391.
- Gillon, R. (2003). Ethics needs principles—four can encompass the rest—and respect for autonomy should be “first among equals”. *Journal of Medical Ethics*, 29, 307-312.
- Hall, R. L., Smith, A. G., & Edwards, J. G. (2003). Haematological safety of antipsychotic drugs. *Expert Opinion in Drug Safety*, 2, 395-399.
- Katsakou, C., & Priebe, S. (2006). Outcomes of involuntary hospital admission—a review. *Acta Psychiatrica Scandinavica*, 114, 232-241.
- Keller, A. (2012). If it ain't broke - don't fix it. In *Psychiatry Update* (pp. 3).
- Layland, J. J., Liew, D., & Prior, D. L. (2009). Clozapine-induced cardiotoxicity; a clinical update. *Medical Journal of Australia*, 190, 190-192.
- Leonard, K. (2012). Keeping the mentally incompetent from voting. In *The Atlantic*.

- Mackenzie, C., & Stoljar, N. (2000). *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self*: Oxford University Press on Demand.
- Madsen, T., Agerbo, E., Mortensen, P. B., & Nordentoft, M. (2012). Predictors of psychiatric inpatient suicide: a national prospective register-based study. *Journal of Clinical Psychiatry, 73*, 144-151.
- Madsen, T., & Nordentoft, M. (2012). Drs Madsen and Nordentoft reply. *Journal of Clinical Psychiatry, 73*, 1034-1035.
- McKinnon, C. A. (1987). *Feminism unmodified: Discourses on life and law*: Harvard University Press.
- McKnight, R. F., Adida, M., Budge, K., Stockton, S., Goodwin, G. M., & Geddes, J. R. (2012). Lithium toxicity profile: a systematic review and meta-analysis. *Lancet, 379*, 721-728.
- Mill, J. S. (2006). On Liberty (1859). In A. Ryan (Ed.), *On Liberty and The Subjugation of Women*. London: Penguin.
- Minkowitz, T. (2007). The United Nations Convention of the Rights of Persons with Disabilities and the right to be free from non-consensual psychiatric interventions. *Syracuse Journal of International Law and Commerce, 34*, 405-428.
- Morgan, H. G., & Stanton, R. (1997). Suicide among psychiatric in-patients in a changing clinical scene. Suicidal ideation as a paramount index of short-term risk. *British Journal of Psychiatry, 171*, 561-563.
- Mulhall, S., & Swift, A. (1992). *Liberals and communitarians*: Cambridge Univ Press.
- New South Wales Law Reform Commission. (2008). Young people and consent to health care. In. Sydney.
- New South Wales Legislative Council's Standing Committee on Social Issues. (2010). Substitute decision-making for people lacking capacity. In. Sydney: New South Wales Legislative Council.
- NSW Mental Health Sentinel Events Review Committee. (2008). Tracking tragedy. A systemic look at homicide and non-fatal serious injury by mental health patients, and suicide death of mental health inpatients. Fourth report of the Committee. In.
- Nussbaum, M. C. (1998). *Sex and social justice*: Oxford University Press, USA.
- Okai, D., Owen, G., McGuire, H., Singh, S., Churchill, R., & Hotopf, M. (2007). Mental capacity in psychiatric patients: systematic review. *The British Journal of Psychiatry, 191*, 291.
- Owen, G. S., David, A. S., Hayward, P., Richardson, G., Szmukler, G., & Hotopf, M. (2009). Retrospective views of psychiatric in-patients regaining mental capacity. *British Journal of Psychiatry, 195*, 403-407.
- Owen, G. S., Richardson, G., David, A. S., Szmukler, G., Haywood, P., & Hotopf, M. (2008). Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *British Medical Journal, 337*, 448.
- Paciullo, C. A. (2008). Evaluating the association between clozapine and venous thromboembolism. *American Journal of Health-System Pharmacy, 65*, 1825-1829.
- Pirkola, S., Sohlman, B., & Wahlbeck, K. (2005). The characteristics of suicides within a week of discharge after psychiatric hospitalisation - a nationwide register study. *BMC psychiatry, 5*, 32.
- Powell, P. (2003). The Origins and Development of the Protective Jurisdiction of the Supreme Court of New South Wales. In F. F. S. f. A. L. History (Ed.): Francis Forbes Society for Australian Legal History.
- Priebe, S., Katsahou, C., Amos, T., Leese, M., Moriss, R., Rose, D., Wykes, T., & Yeeles, K. (2009). Patients' views and readmissions 1 year after involuntary hospitalisation. *British Journal of Psychiatry, 194*, 49-54.
- Quinn, G. (2010). Personhood & legal capacity. Perspectives on the paradigm shift of Article 12 CRPD. In *HPOD Conference, Harvard Law School* (Vol. 20).
- Russell, W. O., & Turner, J. C. (1958). *Russell on Crime* (Vol. 1). London: Stevens.

- Serretti, A., & Chiesa, A. (2011). Sexual side effects of pharmacological treatment of psychiatric diseases. *Clin Pharmacol Ther*, 89, 142-147.
- Serretti, A., & Mandelli, L. (2010). Antidepressants and body weight: a comprehensive review and meta-analysis. *Journal of Clinical Psychiatry*, 71, 1259-1272.
- Skipworth, J. J., Dawson, J., & Ellis, P. M. (2013). Capacity of forensic patients to consent to treatment. *Australian and New Zealand Journal of Psychiatry*, 47, 443-450.
- Stewart, C. (2001). Public interests and the right to die: compelling reasons for overriding the right to refuse treatment. *Australian Institute of Health Law and Ethics Issues Papers*, 14, 1-12.
- Stewart, C., & Biegler, P. (2004). A primer on the law of competence to refuse medical treatment. *Australian Law Journal*, 78, 325-342.
- Stone, A. A., & Stromberg, C. D. (1976). *Mental health and law: A system in transition*: J. Aronson New York.
- Taylor, D. M., & McAskill, R. (2000). Atypical antipsychotics and weight gain - a systemic review. *Acta Psychiatrica Scandinavica*, 101, 416-432.
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (2010). Annual Report: England and Wales. In. Manchester: University of Manchester.
- Torture and other cruel, inhuman or degrading treatment or punishment. In. (2008). United Nations. (2006). Convention on the Rights of Persons with Disabilities. In.
- Valenstein, E. S. (1986). *Great and desperate cures: the rise and decline of psychosurgery and other related radical treatments for mental illness*: Basic Books.
- Volokh, A. (1997). n Guilty Men. *University of Pennsylvania Law Review*, 146, 173-216.