# OPINION DIAGNOSIS AND TREATMENT: A HUMAN RIGHTS ISSUE?

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'Mental Illness', 'treatment' and mental health legislation are linked and form most of mental health settings' best practice in Australia, but what are some of the implications this framework have on the human rights of an individual?
Every jurisdiction in Australia has a Mental Health Act (MHA), each slightly nuanced with the core principles of a framework that permits facilitating forced treatment on individuals diagnosed with a 'mental illness'. The MHA require 'treatment' of specific conditions and the availability of effective treatments. A diagnosis or primarily pharmaceutical-led 'treatments' may not appear overtly to impinge on the human rights of a person, but the validity of the diagnostic construct and the primary 'treatment' (medication) approach may be less reliable than is generally accepted.

Many authors provide a narrative about the different perspectives on the diagnostic (Johnstone, L. & Boyle, M.,2018). The Diagnostic Statistical Manual of Disorders (DSM) and International Classification of Disorders (ICD) are primarily opinion-based perspectives on so-called 'diseases' of the brain or 'mental illness'. While they provide a framework of sorts, they have never provided a clearly defined evidence based on the aetiology of such 'diseases'. The origins of the DSM, lack scientific validity with its original version demonstrating a somewhat laissez-faire approach to accepting the opinion of a few psychiatrists, and it has become more far-reaching and reactive in the fashion of time (Davies, 2013).

In recent years, the DSM IV editor has expressed concerns around the limited validity of the DSM and the ever-increasing number of disorders that categorized and appear to fit the requirements of a moment in time, rather than offering a robust diagnostic process to understand a person with mental health needs (Frances, 2013).

The older language of chemical imbalance theories continues to saturate in the modern paradigm, despite leading psychiatrists identifying that the chemical imbalance hypothesis is not, and never was plausible (Pies, 2011). To this end, the uncomfortable relationship between the DSM, Psychiatry and drug companies is well-reported and cannot be ignored when considering legal orders based on a diagnostic and pharmaceutical led paradigm of mental health systems.

The system of disorders (DSM) is the heart of the current picture in mental health services across Australia. This model could be considered impinging on the human rights of a person in distress, with high rates of prescriptions for psychotropic medications (ATLAS, 2015) and ECT still the focus of treating the so-called 'diseases'. This scenario is of specific concern when administered compulsorily, painting a problematic human rights picture, especially given the number of people accessing mental health services and being diagnosed is on the rise, despite the so-called evidence-based treatment paradigm.

To date, we still cannot demonstrate with any certainty that the experiences people have are diseases. However, we can demonstrate that powerful and often harmful medications contribute, for many, to an increase in significant health issues including suicidal experiences, longer-term physical health concerns, increased metabolic and other chronic health concerns that reduce the quality of life and an increasingly reduced life expectancy in individuals with long-term mental health difficulties Ilyas (A, 2017).

Whether delivered compulsorily or not, diagnosis and treatment in tertiary services should be delivered consistent with the relevant MHA; and that currently is based on heuristic decisions of a single profession (Gelletly, 2016), rather than a scientifically validated construct.

A significant common factor known to be present in the experience of many people with ongoing mental health problems is adversity and trauma and the myriad ways a person experiences adversity including cultural meaning and the denial of spiritual or cultural perspectives of an experience. The ACE study (Felitti, 1998) demonstrate a clear dose response in relation to trauma and adversity on chronic health issues, including mental health. Failing to understand the impact of trauma and adversity, and/or disregarding experiences of spiritual or cultural meaning in relation to a person's distress, is likely to re-traumatise a person who has experienced trauma. There are significant human rights implications when forcing treatment on individuals under the notion that there is a demonstrated 'mental illness' and related identified treatment, when in fact a more grounded primary consideration would be to acknowledge the likely trauma and adversity present in the person's life and/or their life history. A more compassionate and dignified approach might be to ask what has happened not, what is wrong with a person. The result of this question for MH Nurses and other professionals is the need to facilitate a trauma-informed and compassionate response and not enact the rhetoric an out of date construct previously discussed.

Even without compulsory interventions and repeated hospital admissions, the many implications and impacts on a person's life of the current dominant diagnosis and treatment could be seen to impact on the rights of the person.

There is also a parallel process that occurs within the professional workforce; as the dominant medicalized diagnostic framework pervades, any professional that seeks to question the status quo is labeled as 'anti-psychiatry' or 'radical', such that their professional integrity is threatened, when they were simply seeking to offer thoughtful discussion on the validity of what mental health services offer and provide to people in need. The risk of this is that it could lead to a shutting down of proactive reflection on the human rights and ethical implications of what we do, why we do it and how medicalization of the human experience might impact on the people it purports to serve.

Human rights issues in mental health are many and varied, but shining the light on the difficulties with the diagnostic and pharmaceutical led mental health system in Australia is vital if we are to see a move towards the statement by the UN Special Rapporteur on the right to health:

> *'Coercion, medicalisation and exclusion, which are vestiges of traditional psychiatric care relationships, must be replaced with a modern understanding of recovery and evidence-based services that restore dignity and return rights holders to their families and communities' Puras – 2017*

Providing more humane and person-centered approaches that place the power back in the hands and hearts of individuals and communities means we must also consider the thorny issue of compulsory treatment. This, of course, means challenging legislators, the dominant medical profession and the other professions that maintain the current model, and examining the powerful role of the pharmaceutical industry. It is not a human right to be a clinical professional, but it the responsibility of the clinical or other professionals to ethically uphold the human rights of the person in mental distress. More needs to happen to question whether clinical professionals and legislators are upholding their responsibilities given the lack of validity of the models that are delivered as compulsory and non-compulsory 'treatment' under a MHA. Listening, accepting and witnessing a person making sense of their valid experience may be the best way to ensure the human right of any individual is upheld.

*References available upon request*

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