Other disciplines have questioned the role of involuntary treatment in mental health, such as sociology (Pilgrim & McCranie, 2013), psychology (Coles, Keenan, & Diamond, 2013), law (McSherry & Weller, 2010) and psychiatry (Callaghan & Ryan, 2014). Social work has rarely engaged with this debate; instead uncritically accepting the need for involuntary treatment, and seeking to work within existing frameworks (see, e.g. (Courtney & Moulding, 2014; Davidson, Brophy, & Campbell, 2016; Bland, Renouf, & Tullgen, 2015; Kendall & Hugman, 2016). As Renouf (2016, p. 131) writes, ‘Almost all mental-health social work involves actual or potential use of statutory authority,’ and the IFSW (2012) accepts that ‘social workers function as both helpers and controllers’.

This may be because while other disciplines can rely on rights based idealism (law), or positivist data (psychiatry) to motivate reform agendas, social work is grounded in the practice reality of mental health social work. This has lead social workers to take a pragmatic approach, with an acknowledgment that ‘there may be no choice about the fact of involuntary treatment’ (Renouf, 2016, p. 132). Without clear alternatives to involuntary practice, social workers are confounded by its seeming inevitability. This chapter briefly outlines the arguments against involuntary practice in mental health social work, then presents a range of alternatives which social workers can consider for practical implementation of mental health services which do not rely on involuntary practice. In doing so, the author seeks to demonstrate that the contemporary reliance on involuntary practice is not a regrettable necessity, but an historical relic with no place in the future of social work practice.

The first section of this chapter illustrates how involuntary treatment is discriminatory and contrary to human rights, inconsistent with international law, denies citizenship, and is inconsistent with the recovery model. The second section challenges the assumptions around risk which underpin involuntary treatment, and that involuntary mental health treatment provides a successful way to manage that risk. Finally, alternatives to involuntary treatment are presented, at micro, meso and macro levels.
Arguments Against

Despite social work's tacit acceptance of involuntary treatment, it is well positioned to take a stand against it. As the IFSW indicates:

*Social workers should respect and promote people's right to make their own choices and decisions, irrespective of their values and life choices, provided this does not threaten the rights and legitimate interests of others.* (IFSW, 2012)

Should this not be enough, consumer opposition to involuntary mental health treatment is older than white colonisation of Australia. In his 'One More Proof of the Iniquitous Abuse of Private Madhouses', Samuel Bruckshaw rails against the English magistrates who:

...drag the wretched victim of their despotism violence from his business, confine him in a goal, load him with irons, and are not ashamed to call in the aid of a Keeper of Private Mad-house: in which..., they prolong his confinement for near a year, to the total ruin of his fortune and of his character. (Bruckshaw, 1774)

These words, written over two centuries ago, would resonate with many people who find themselves subject to involuntary treatment today. In the early 20th century, Clifford Beers, in his seminal autobiography, 'A Mind that Found Itself', again brought light to the injustices of his own involuntary treatment in the United States. In hindsight, he was later able to see how the nature of involuntary treatment corrupted the people who enforced it:

...were they not victims of the same vicious system of treatment to which I was subjected? In every institution where the discredited principles of "Restraint" are used or tolerated, the very atmosphere is brutalizing. Place a bludgeon in the hand of any man, with instructions to use it when necessary, and the gentler and more humane methods of persuasion will naturally be forgotten or deliberately abandoned. (Beers, 1908, p. 122)

The use of involuntary treatment as a bludgeon continues today (Floyd, 2013; O'Hagan, 2004; Lawn, Delany, Pulvirenti, Smith, & McMillan, 2016). Social workers, so used to the bludgeon of involuntary treatment, must find 'gentler and more humane methods'. In addition to the simple premise that people subjected to involuntary treatment do not want it, a number of other arguments against are presented here.

Discrimination and Human Rights

Australian social workers are bound by their code of ethics to eliminate all violations of human rights (AASW, 2013), yet social workers in mental health routinely support the violation of the rights to bodily integrity, autonomy and freedom of movement. The very nature of involuntary treatment on grounds of mental health diagnosis takes away a basic right to bodily integrity enjoyed by the majority of the population. In general, all adults must give informed consent to treatment, a right well established in common law and statute (Weller, 2013). Australian courts have maintained a person's right to refuse treatment, even up to the point of death. Take, for example; a Jehovah's Witness who refused a blood transfusion in Hunter & New England Area Health Service v. A (2009); a man with profound physical impairment who was allowed to starve himself to death in Brightwater Care Group (Inc) v. Rossiter (2009); or where the High Court maintained that the police had no power to detain a man who ultimately committed suicide in Stuart v Kirkland-Veenstra (2009), on the basis that he didn't have a mental illness.

Granting the right to refuse treatment to the majority of the population, and with holding it from people on the grounds of their diagnosis is clearly discriminatory. This might be mitigated if the decision was made on the basis of their capacity to give informed consent to treatment, but in Australia, only some states, such as Tasmania and Western Australia, make this distinction. In Victoria or New South Wales, for example, a person can be forced to receive treatment even while completely free of any symptoms, so long as they have a diagnosed mental illness.

It seems fundamentally oppositional to social work values that social workers would be expected to maintain a system which seeks to deny perfectly sane people of their right to make their own choices, merely on the basis of their diagnosis.
Inconsistency with International Law

This is not to suggest that people who are assessed as not having the capacity to consent to treatment should be involuntarily treated, either. The United Nations Convention on the Rights of Persons with Disabilities (2007) (the ‘Convention’) casts a long shadow over involuntary treatment and detention of people with a diagnosis of mental illness, with many reading the Convention to prohibit such action (Minkowitz, 2010). Since the ratification of the Convention in 2007, all Australian states and territories have amended or renewed their mental health legislation in attempts to comply, however all still allow for involuntary treatment and detention.

Article 17 of the Convention allows for ‘[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.’ As Waddington and McSherry (2016, p. 283) write, ‘[a]n individual’s integrity is violated when he or she is subject to enforced treatment.’ Detention on treatment on the basis of disability is explicitly prohibited, under article 14(1)(b). Article 18 upholds liberty of movement, and art 19 maintains the right to live independently. Bringing these together, the United Nations Committee on the Rights of Persons with Disabilities (2015, p.2) has demanded ‘an absolute prohibition of detention on the basis of impairment’, requiring that ‘the provision of health services, including mental health services, are based on free and informed consent of the person concerned’.

Following the Convention, more attention has been paid to notions of supported, rather than substituted, decision making. This is based on a distinction between legal capacity, which is the ability to hold and exercise rights and duties, and mental capacity, the ability of a person to make decisions. Under the Convention, the two concepts of capacity must be de-linked—a person cannot have their legal capacity, including their right to refuse treatment, denied on the basis of their mental capacity. This means that people in mental distress must be supported to make decisions, not have the right to make decisions taken away from them (Series, 2015). Article 12 requires Australia, as a signatory of the Convention, to ‘take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity’.

The right to refuse treatment, McSherry and Wilson (2015) argue, should be read in conjunction with the right to treatment, found in article 25 of the Convention which upholds the right to quality care and support – on the basis of free and informed consent. Together, these rights can be conceived of a right to choose treatment – a right afforded to the majority of the population, and consistently denied in mental health care, where the system remains funded beneath the required standard (Burns & Molodynski, 2014; McSherry, 2014). A reduction in voluntary treatment must be met with an increase in voluntary services which support decision making and allow people to choose support and treatment that suits their needs.

This point also addresses claims that involuntary treatment can be used to prevent people from becoming unwell – poorly resourced services should not be used as a justification for involuntary treatment when properly resourced voluntary services could perform the same function. An end to involuntary treatment would mean services would have to work a lot harder to engage with people, providing appealing services, rather than dictating terms of treatment to people receiving it. This would address the power imbalance in mental health care, and end the antagonistic relationship many people have with involuntary services.

Social workers are uniquely placed to support people in their decision making, with a skills and values base focused on empowering people. This can only occur if social workers are not also complicit in disempowering them through involuntary treatment, which inevitably leads to a denial of citizenship.

A Denial of Citizenship

Involuntary treatment denies people their basic human rights, and the detention of people for the purpose of treatment prevents them from participating in society. The combination of these forces strips people of their citizenship, both their liberal citizenship, which includes civil and political rights, but also their social citizenship, which extends to the right to participate in the community (Rogers & Pilgrim, 1989; Marshall, 1963). Social citizenship ‘…includes the right of every individual to protection from exclusionary laws and social practices which may lead to segregation or
discrimination of any kind.' (Prior, 2007) Especially when working with people in mental distress, in cases where their decision making capacity is in doubt, social workers must strive to maintain social citizenship. MHPOD, the national mental health training resource for Australian clinicians, emphasises how important citizenship is for recovery, requiring clinicians to work:

...with the person to re-claim lost citizenship... as a recovery priority and services need to support practitioners to incorporate work that recognises and supports citizenship. This includes first and foremost upholding and facilitating full reclamation of the person's rights - supporting the person's capacity to make decisions for themselves and respecting the individual's physical and mental integrity... (Cadre, 2014)

It is oxymoronic to attempt to restore a person’s rights while taking them away. If social workers are serious about maintaining social citizenship, they must first reject involuntary treatment. This is particularly important when working within a recovery model, which essentially aims to assist people to claim and maintain their social citizenship.

Reclaiming Recovery
The concept of recovery has been a major feature of the Australian mental health landscape in recent years, with policy initiatives such as the National Framework for Recovery-Oriented Mental Health Services attempting to introduce recovery principles into all aspects of mental health practice (AHMAC, 2013). Despite its rise in popularity, recovery itself is an ambiguous and contested notion. However, some key components are consistent across the various notions of recovery; choice, working together, hope, humanism, an appreciation of a personal narrative and support of individual meaning (Morgan & Felton, 2013). For social workers, this requires a reconceptualisation of services as received, rather than a focus on how they are delivered.

Even people subject to involuntary treatment have highlighted how it is inconsistent with the recovery model (Brophy, Roper, Hamilton, Tellez, & McSherry, 2016), but social workers have mainly attempted to introduce recovery principles into involuntary treatment contexts (see e.g. (Davidson, Brophy, & Campbell, 2016; Renouf, 2016), stopping short of viewing the two as discordant. While reducing the negative impacts of involuntary treatment is important, it is clear that reducing discrimination, central to recovery, is fundamentally incompatible with taking a person’s choice away from them on the basis of their diagnosis (O’Hagan, 2012a). For social workers, actually adopting a recovery approach will require a rejection of involuntary treatment. This requires an examination of the assumptions which underpin it.

Rejecting Risk
Few commentators actively oppose the points raised above, instead suggesting that discrimination based on mental illness is an appropriate response given the risk that people with a mental illness pose to themselves and to others. This is certainly the position of most policymakers in the sector, reflecting the rise of risk management in the contemporary Australian public policy. The Australian national mental health training resource, MHPOD, describes involuntary treatment as ‘regrettable’ but ‘justifiable’ (Cadre, 2014). Similarly, the Victorian Mental Health Act 2014 (s 5), restricts involuntary treatment to people who, because of their mental illness, require immediate treatment to prevent a ‘serious deterioration’ in their mental or physical health, or ‘serious harm’ to the themselves or someone else. Rather than reject involuntary treatment outright, policy makers, like social workers, have instead endeavoured to minimiseiatrogenic harm.

Davidson, Brophy, and Campbell (2016, p. 159) have suggested that that mental health social work has embraced the professional status that assessing risk bestows while also being criticised for its inability to accurately predict the future and so prevent all harm.’ The problem with this position is that it is based on assumptions which are ungrounded - this ‘myth of dangerousness’ is broadly condemned by experts in the field (Friedman, 2006; Walsh & Fahy, 2002; Freckelton, 2010; Gostin & Gable, 2008; Large, Ryan, Niesssen, & Hayes, 2008; Lord & Stein, 2013). This section examines the problem with using involuntary mental health as a way of managing risk.
Some people with a mental illness are at greater risk of harming themselves than others. For example, the lifetime risk of suicide for people diagnosed with schizophrenia is around 5-10% (Hor & Taylor, 2010). While this is much higher than for the mainstream population, just 35 people died last year in Australia where an underlying cause was recorded as schizophrenia (ABS, 2015). Each of these deaths is a tragic occurrence, and society in general and social workers in particular have a responsibility to try and reduce this number. Psychiatric risk assessment, however, is not a reliable method for doing so.

Mulder (2011), Undrill (2007), Large et al. (2011) and Ryan et al. (2010), all discount the ability of psychiatrists to accurately predict suicide. Large et al. (2011) wrote that ‘risk categorization is of no value in attempts to decrease the numbers of patients who will commit suicide after discharge’, with only 3% of people in the high risk category committing suicide in the year after discharge, and 60% of suicides occurring in groups of people assessed as low risk. Responding to this study, Goldney (2012) argued that 3% risk should be considered relevant for treatment purposes. This may be a valid point for clinical considerations, but the remaining 97% of people should not be subject to involuntary treatment on that basis.

People who have been diagnosed with a mental illness are subject to discrimination on the basis of risk beyond that of other ‘high risk’ groups in society. People who risk their health by smoking or consumer dangerous amounts of alcohol are not forcibly prevented from doing so, although social workers and policy makers might do their best to assist them to reduce the risk of harm.

Similarly, preventing risk to others is problematic. People accused of breaking the law must have their crime proven beyond a reasonable doubt — a higher bar than ‘needing treatment to prevent serious harm’, and a retrospective test based on an actual act, not predicted behaviour. This points to the troubling conclusion that society affords more rights to people who break the law than to people with a diagnosis of mental illness.

Many studies have explored the link between violence and mental illness, but it is still poorly understood, with only a ‘contradictory and ambiguous’ link able to be established (Morgan & Felton, 2013, p. 63). Mechanic, McAlpine and Rochefort (2014) examined a number of studies, finding that while some factors might increase risk, such as positive symptoms of schizophrenia, negative symptoms had the opposite effect, although other studies found the exact opposite was true (Fazel, Buxrud, Ruchkin, & Martin, 2010; Appelbaum, Robbins, & Monahan, 2000). What is clear is that the same factors which indicate violence in the broader community — youth, gender, socioeconomic status, presence of law enforcement, weapon availability and drug and alcohol use, are also correlated with violence committed by people with a mental illness diagnosis (Golenkov, Tsybalova, Large, & Nielssen, 2011; Large, Smith, & Nielssen, 2009; Wootton, et al., 2008). Mental illness diagnosis is not a static causal factor, and at most plays an exacerbating role when other causal factors are present. Ultimately, ‘most people with mental health problems do not commit violent acts, and most violent acts are not committed by people with diagnosed mental disorders’ (Gled & Frank, 2014). This makes predicting risk on the basis of mental health diagnosis problematic, if not impossible.

The increasing use of Community Treatment Orders are also problematic, where people can be forcibly treated in the community. Despite an overwhelmingly negative response from people subjected to them, a systematic review of 72 studies found that ‘is not possible to state whether community treatments orders (CTOs) are beneficial or harmful to patients’ (Churchill, Owen, Singh, & Hotopf, 2007, p. 7), while another study concluded that that ‘no systematic review or meta-analysis has identified any clear clinical advantage to CTOs’ (Rugkauša, Dawson, & Burns, 2014, p. 1868).

Taken together, the actual evidence for detaining and involuntarily treating people on the basis of preventing harm to themselves or others does not hold up. This is not to suggest that people in mental distress should be left alone, unsupported — ‘dying with their rights on’, as some have claimed (d’Abrera, 2015; Treffert, 1973). Social workers are well positioned, well trained and ethically guided to support people in mental distress, just not by forcing them to receive treatment, or detaining them for
the purpose of doing so. Instead, they should concentrate on ‘...challenging the social structures that create social disadvantage and risk, and championing the rights of marginalised groups, rather than trying to measure their potential to be harmed.’ (Morley 2015, 167)

The remainder of this chapter will detail how social workers might address this, by developing and implementing ways in which people can be well supported voluntarily, without coercion or duress.

**Practice Alternatives**

Maintaining citizenship for vulnerable people is social work’s core business, but readers will no doubt be concerned about the practice realities of such an approach. The answer requires what Glen (2012) describes as a paradigm shift, where social workers engage entirely differently with people in mental distress, across macro, meso and micro fields of practice. Potential alternatives are explored in this section.

**Macro**

At the highest level, alternatives to involuntary treatment in mental health social work require a fundamental shift in the way society in general relates to mental illness. Some will bemoan this blue sky thinking as naïve and disconnected from the realities of mental health social work – they would do well to remember that exactly this kind of paradigm shift has occurred before, in the era of deinstitutionalisation. US Judge Kristin Booth Glen describes how during that paradigm shift many:

> ...were convinced that the prior statutory schemes better protected people who lacked capacity; that increased procedural protections would dramatically increase the cost of, and time necessary for, protective proceedings; that those protections would cause undue hardship to families seeking only to “do right” by their incapacitated relatives; and that the virtually unlimited power previously given to judges was appropriate because of their experience and belief that they “knew best.” (Glen, 2012, p. 110)

We are again at such a tipping point in the way society responds to people with a diagnosis of mental illness, with the United Nations calling on Australia to abolish involuntary treatment (Committee on the Rights of Persons with Disabilities, 2013). One way in which this can be conceived is of a social model of disability, the model adopted by the Convention, which states that ‘disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’. From this perspective, involuntary treatment actively works to disable people, despite the intentions of those who seek to embed it in a best interest framework.

Radical change at this level requires the problematisation of the medical model, which is largely biological. Many have critiqued this singular biological cause theory (Szasz, 1961; Szasz, 1998; Cromby & Harper, 2013; Boyle, 2013; Bland, Renouf, & Tullgen, 2015), with a growing acceptance of the need to appreciate a plurality of causal factors. Once a solely biological disease model of mental distress is rejected, it can be understood to be a normal reaction to abnormal circumstances (Boyle, 2013), or related to issues of sex and gender, race, trauma, employment (Macfarlane, 2007).

Theoretical alternatives to conceptualising the relevant issues can also be useful. For example, Lord and Stein (2013, p. 33) problematize the ‘myth of the autonomous actor’, an Aristotelian and Kantian notion of ‘a self-realising individual who directs his efforts towards maximising his personal gains’. As this concept of capacity is central to what it means to be a citizen, society can strip citizenship from those who are deemed not to possess it. Instead, they propose feminist and communitarian approaches, which appreciate the importance of connections between individuals – a position social workers should find appealingly compatible.

There are more theoretical alternatives than can be listed here, including the recovery model mentioned above, however some that would be of use to social workers include social role valorisation (Double, 2006), voice hearing de-stigmatisation (Romme & Morris, 2013), accepting the importance and dignity of risk (Stanford, 2008) and spiritual and cultural approaches. While they are in abundance, theoretical alternatives are only as useful as their capacity to be implemented and reflect actual change for people who use services. Community and organisational level responses
hold the key to transferring theory into practice and generating real social change.

Meso

At the community and organisational level, opportunities for implementing alternatives to involuntary practice also abound and are included here as practice examples for future development.

An alternative model of community organisation which reflects some of these shifts has already been implemented, intensively evaluated, and proved successful for over 700 years. In Geel, a village in northern Belgium, a tradition of voluntary community support and treatment has been ongoing since the 15th century (Goldstein & Godemont, 2003). Beginning as a place of pilgrimage to St Dymphna, the patron saint of the mentally ill, ‘possessed’ pilgrims would board with local villagers while receiving treatment for their ‘affliction’. Over time, this evolved into a more formal arrangement, now known as the Family Care Program, where today people with a diagnosis of mental illness are billeted to local families, and participate fully in the community. In 2003, 516 boarders lived with 423 ‘foster families’, although the number of boarders peaked at 3,800 in 1938 (Goldstein & Godemont, 2003).

Around a third of the boarders have a diagnosis of schizophrenia, yet violence is extremely rare, with only one murder committed by a boarder in the entire 20th century, and no difference in rates of violence between the boarders and the rest of the population (Goldstein, Godemont, & Crabb, 2000). In 1902, the International Congress of Psychiatry proclaimed Geel ‘as best practice to be reproduced wherever and whenever possible’ (Roosens & Walle, 2007, p. 13), yet the lessons it holds have not been absorbed into the biomedical hegemony of 20th century psychiatry.

Boarders generally work, often on farms, with their foster families, are supported in social clubs, can access clinical care as required, and are actively incorporated into the broader community. As the number of farming families has declined in the age of industrialisation of agriculture, so too have the number of boarders. Despite this, this model clearly demonstrates the potential for community reorganisation to better support people in mental distress, and is a model social workers can work towards.

A smaller scale approach, the Soteria House model was developed in the 1970’s, as a kind of voluntary therapeutic residence, based on certain principles:

...the provision of a small, community-based therapeutic milieu with significant lay person staffing, preservation of personal power, social networks, and communal responsibilities, a “phenomenological” relational style which aims to give meaning to the person’s subjective experience of psychosis by developing an understanding of it by “being with” and “doing with” the clients, and no or low-dose antipsychotic medication (with all psychotropic medications being taken from a position of choice and without coercion). (Calton, Ferriter, Huband, & Spandler, 2008, p. 181)

Unfortunately, the Soteria model has not been studied sufficiently to demonstrate success, but does provide a model for the development of future services. An even less clinical model, Kingsley Hall, run by maverick psychiatrist RD Laing was by all accounts a fairly unstructured therapeutic environment, an asylum in the original sense of the word—a safe space for people in mental distress (O’Hagan, 2012b). This approach, of allowing people to work through their distress in an unstructured space, is not popular with the medical establishment, but holds lessons for those seeking ways to support people voluntarily. The same principles have been used to divert people away from emergency departments, into ‘warm rooms’, or a ‘community-based, recovery-oriented, alternative crisis intervention treatment environment’ (Shattell, et al., 2014, p. 5). These are services which are usually staffed by clinicians as well as by people with a lived experience of receiving mental health services, who are able to provide practical, compassionate responses to mental distress.

Many alternate models have been developed using coproduction, described as:

A relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have
vital contributions to make in order to improve quality of life for people and communities. (Slay & Stephens, 2013, p. 3)

Coproduced approaches are many and varied, including, supported decision making models (Roper, Hopkins, & Houghton, 2014), inpatient units and hostels (Hyde & Davies, 2004), community time banks (Reed, 2008; Cahn, 2004), and research and evaluation (Petrakis et al., 2014).

Coproduction is based on six principles (Slay & Stephens, 2013):

* Taking an assets-based approach
* Building on people’s existing capabilities
* Reciprocity and mutuality
* Peer support networks
* Blurring distinctions
* Facilitating rather than delivering

* Coproduction is used elsewhere in social work practice (see e.g. (Lavalette & Moran, 2016), and provides a pragmatic next step for social work practice models.

Most revolutionary, in that they literally require letting ‘the inmates run the asylum’ are consumer-operated services. Studies have shown ‘that people who accessed consumer-operated services experienced improved levels of empowerment, social inclusion, well-being, housing, employment, hope and program satisfaction, than those who accessed only traditional services’ (Grey & O’Hagan, 2015). These survivor led services commonly incorporate social work theories such as anti-oppressive practice (Venner and Noad 2013). We may be seeing a shift towards this model in Australia, as the National Disability Insurance Scheme (NDIS) attempts to put power in the hands of consumers (Laragy, et al. 2015), but a more fundamental change is required, in the very fabric of the way social workers interact with people in mental distress. This is best examined at the individual level, in direct social work practice.

**Micro**

Of course, the best way social workers can reject involuntary treatment is by demonstrating that it is unnecessary, and working with people in ways that ease their mental distress without a perceived need for coercive intervention. People receiving services are clear about the supports they want; supportive advocates who act as motivators, encouragers and coaches, assistance with health, economic and financial support, social connectivity, housing and assistance with maintaining intimate and family relationships (Brophy, Bruxner, Wilson, Cocks, & Stylianou, 2015). This is just good social work, but requires understanding services as received rather than delivered. Healy (2005, p. 73) describes this consumer rights discourse as characterised by ‘the needs of service users as the need for ‘community’ rather than for ‘cure’. Healy writes;

*Consumer rights discourse is highly consistent with some of the key values asserted in social work and human services fields. Consumer rights discourse is built on themes of empowerment, self-determination and social justice, and offers practical strategies for consumers to insist on their rights to participate in determining their needs and choosing how these needs will be met. (Healy, 2005, p. 78)*

This is, of course, all about sharing power. Fook (2016) suggest that social workers are often ambivalent about their power, and perceive themselves as powerless, which can make it hard for them to participate in their own disempowerment. Fook recommends deconstruction and reconstruction as a form of critical reflection, as a way to develop more empowering practices. For example, a realisation of the point raised by Beers (1908) above; that involuntary treatment is used as a bludgeon, and that they must find ‘gentler and more humane methods of persuasion’. This process must be ongoing, to ensure that social workers do not fall into some other form of coercive practice, resorting instead to resource control or manipulation. Instead, the paradigm of supported decision making, in coproduced or consumer led recovery-oriented services, provides a workable alternative to involuntary treatment at the micro level.

There are also more specific tasks social workers can undertake, for example assisting people to complete psychiatric advance directives (Weller, 2012), or representation agreements. Psychiatric advance directives, also referred to as Ulysses agreements or advance statements, give people an
opportunity to make clear their treatment preferences in advance. While some Australian jurisdictions, such as Victoria, allow for non-binding advance statements, they can be overridden by a psychiatrist if ‘clinically appropriate’ (Mental Health Act 2014 (Vic) s 73). Similarly, the Victorian Mental Health Act 2014 allows for people to nominate a person to represent their interests. Unlike enduring medical powers of attorney, which give appointees the power to refuse treatment, the wishes of nominated persons can be overridden (Medical Treatment Act 1988 (Vic) s 5B). Despite this, social workers can play a role in both advocating for legal reform to reduce discrimination, and in supporting people to access what protections are currently available.

Similarly, Laragy et al. (2015) highlights the important role social workers can play in other areas, such as with the implementation of the NDIS, as advocates, supporting decision making, providing information and building community connections. Even within otherwise traditional organisations, social workers can implement and maintain mutual support groups, using models and networking with the broader Hearing Voices movement (Longden, Corstens, & Dillon, 2013) or the Paranoia network (Cromby & Harper, 2013).

These micro level interventions will not by themselves bring an end to involuntary treatment, but form a vital part in the process, filling the vacuum left behind. Conversely, support for people in mental distress can be developed to the point at which involuntary treatment is no longer required, or at least significantly reduced. Social workers must be at the forefront of this process, lest the wholesale abandonment of people post-deinstitutionalisation is to be repeated.

**Conclusion**

The days of involuntary mental health treatment in Australia are numbered, with disciplines of law and psychiatry leading the way. Social work has so far dragged its feet, attempting to practise social work ethically in an inherently unethical environment. Involuntary treatment is discriminatory, contrary to human rights, inconsistent with international law, denies citizenship and is incompatible with the recovery movement. Justifications of risk management are based on unfounded assumptions, and what risk there actually is cannot, and should not, be managed through further depredation of a person’s rights. Furthermore, involuntary treatment is not therapeutically necessary, as alternatives exist at the macro, meso and micro levels of social work practice. Social workers should reject involuntary mental health treatment, and instead focus on promoting ‘social change and development, social cohesion, and the empowerment and liberation of people.’ (IFSW, 2014) Until then, as Beers (1908, p. 122) warns, we will remain the ‘victims of the same vicious system of treatment’ that we are complicit in imposing.

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