

## **Ethical Peril, Violence, and “Dirty Hands”: Ethical Consequences of Mental Health Laws**

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### **Abstract**

This conceptual paper has two aims. The first is to examine the ethical situations of people governed by mental health laws, and of clinicians working under mental health laws. I argue that mental health laws are unethical because they are discriminatory and a form of structural violence. Once subject to such laws, people are exposed to ethical losses and other violence in the form of assaults on autonomy and bodily integrity. Material and other violence flow from these losses. At the same time, this violence might not be evident to the person subjugated by such laws because of a range of broader socio-political factors. The second aim is therefore to analyse and put language to ‘harder to see’ forms of violence experienced by people subject to mental health laws, and explore the potential consequences of those harder to see forms of violence.

**Keywords:** mental health laws, service-user, violence, ethics, autonomy, bodily integrity

### **Introduction**

During the thirteen-year period that I was annually subject to mental health laws (MHL), hospitalization consisted of violent administration of treatments against my will, regular ‘take-downs’, and seclusion. I was scandalized by the physical violence of that first hospital stay. I remember thinking: “wait till they hear about this on the outside”. But I found ‘on the outside’ that others were not horrified. My family felt relieved that I was where I should be, off the streets and where the genetic

disease of 'mental illness' that I'd inherited could be treated. My family's interpretation of my experiences mirrored predominant social/cultural understandings, also shared by friends and colleagues. Under this paradigm, administration of treatment against a person's will is viewed as an unsung, heroic, life-saving act. The violence of such administrations is likely to be erased, disappearing as though it was never there, or if violence is acknowledged, it might be dismissed as necessary. Either way, the violence, its consequences, and addressing the question of what should be done remain unexamined. These are ethical concerns.

In this paper, I explore the ethical situation of people subject to MHL and clinicians who work within their constraints. I argue once subject to MHL, people are exposed to assaults on autonomy and bodily integrity and material and other violence flow from these losses. At the same time, the violence might be hidden from the person or re-interpreted by others, making it difficult to see the violence for what it is.

In the background section I explore the role of MHL and attendant critiques before arguing that MHL are ethically wrong 'in principle' because they operate only on a category of people – those with psychiatric diagnoses - and are thus discriminatory and a form of 'structural violence' (Galtung, 1969). I then explore traditional Western ideas about the intrinsic value of autonomy and introduce two conceptions of bodily integrity. Using these two conceptions as frames I: first, examine the *ethical* losses and onslaughts generated by exposure to MHL; second, examine *material* violence on individual bodies and; third, examine assaults on people's sense of self. Next, I explore ways that violence associated with MHL is effaced, making the point that effacement itself can be regarded as a further form of violence with additional negative consequences for people. In considering the ethical consequences for clinicians working under MHL, I turn to philosopher Michael Stocker (1990), who extends Aristotle's thinking about "dirty hands" situations. For Stocker, "dirty hands" acts are "justified, even obligatory, but none the less wrong and shameful" (1990, p. 9). I draw on Stocker's thinking to make the point that, leaving aside the question of whether or not compulsory treatment can be justified, it is ethically necessary to account for violations of autonomy and bodily integrity. The shameful, dirty aspects of such violations cannot be swept under the carpet, they are grave and in Stocker's words, need to be "noted" and "regretted" (1990, p. 13).

## Background

### *Mental health laws*

MHL exist in most western countries, with powers to compel psychiatric treatment within inpatient mental health services and in the community. MHL vary across and within jurisdictions, but their intention is generally to ensure people governed by them comply with recommended treatments and/or can be hospitalized if this is deemed necessary. The stated purpose of most MHL is twofold: to protect the person from harm or deterioration of their condition, and to protect the community from harm.

MHL are the subject of considerable debate internationally for a number of reasons. These include: whether Acts should function to protect the community, or should solely focus on a person's wellbeing (Large et al., 2008; Ryan, 2011); the legal and ethical position of people treated involuntarily under mental health laws who are deemed legally competent (Molodynski et al., 2010; Dawson & Szmukler, 2006; Richardson, 2006; Fennel, 2010); and that MHL attack human rights, perpetuate prejudice and stigma, reify the association of mental illness with dangerousness, and marginalise people with mental illness (Dawson, 2008; Dawson & Szmukler, 2006; Ryan, 2011). It has also been argued that having separate MHL is a form of institutional discrimination (Campbell, 1994).

Globally, legal scholars/consumer/survivors are engaged in campaigns for the abolition of MHL (Minkowitz, 2010). Countries with MHL *in effect* condone the discrimination posed by these laws and the violence occurring as a direct consequence of their operations. Thinking solely in terms of healthcare systems, MHL are discriminatory because they create different decision-making processes for medical and mental health treatment. It is generally possible, for instance, to refuse treatment in medical decision-making even if to do so would be life-threatening, whereas MHL function to over-ride treatment refusal and legally allow the administration of treatment without consent. Autonomy, valued so highly in the context of medical decision-making and often put forward as the over-riding principle against which all other values must be weighed does not have the same salience under MHL (Richardson, 2006). Relatedly, under MHL psychiatrists tend to base treatments on what is considered medically best rather than on the person's treatment preferences (Donnelly, 2008). These in-built ethical flaws result in a situation of 'ethical peril' for those governed by MHL where people's autonomy and bodily integrity are violated and freedom of movement may be curtailed.

## Discussion

### ***Structural violence***

Societies that feature separate laws permitting involuntary psychiatric treatment are engaged in 'in-principle' ethical violence. MHL are unethical *in principle* because they operate selectively and with negative consequences only on a particular group, that class/category of people with a psychiatric diagnosis. MHL constitute a form of "structural violence" (Galtung, 1969) because they involve: "avoidable insults to basic human needs, and more generally to life, lowering the real level of needs satisfaction below what is potentially possible" (Galtung, 1990, p. 292). MHL do this through onslaughts on human needs for security of person, inviolability of the body, and sense of self. These violations occur under the guise of protecting health. Autonomy and bodily integrity are at stake when people are subject to MHL. They are placed in situations of ethical peril: they cannot refuse treatments, unwanted treatments can be administered violently on their bodies, and their freedom of movement can be curtailed.

### ***What is autonomy and why is it valuable?***

Feminist, Disability, Postcolonial, and Mad scholarship has advanced an important agenda around 'relational autonomy,' responding to realities that people are not 'islands unto themselves' and, rather, exercise agency in relationship to others. Adopting relational conceptions of autonomy provides radical and creative ways to critique MHL because it makes it impossible to focus on individual bodies as either the site of the problem or the legal/medical intervention. However, theories of autonomy focusing on the individual are chosen for this paper in order to demonstrate what is currently, ethically at stake under legal regimes operating upon individual bodies.

Traditional Western theories of individual autonomy centre the value of making our own self-determined choices, constitutive of satisfaction, dignity, and self-esteem. Autonomy is connected to the meaning and worth our life has and what makes life worth living for us (Harris, 1985). Coggon argues that "Autonomous choice is what enables us to be held to account for what we do, and what enables us to take, for example, credit for or pride in our actions. This is central to the importance of

exercising and acknowledging free will” (Coggon, 2007, p. 243). Human capacities for choice, deliberation, and reflection mean it is possible for people to decide what is good and to become the people they wish to be (Buchanan and Brock, 1989, p. 38). Harris (1985) notes that “demonstrating respect for persons” is the starting point of morality: “It is the starting point because it involves recognizing that other people matter and so how they live their lives, and the quality of their lives, matters as well” (p. 193). Any interference with autonomy is a serious matter because it is in respecting others’ decisions that we demonstrate respect for them as persons.

### ***Bodily integrity and why it is valuable – two concepts***

#### *Bodily integrity - individual bodies*

Patosalmi (2009) offers two conceptions of bodily integrity. The first is a human rights framework, based on the work of Martha Nussbaum (2000), where bodily integrity can be thought of as having the right to freedom of movement and security of the person. This is “the straightforward idea that a person is in control of her or his own body and should be the sole authority in making decisions about the body” (Patosalmi, 2009, p. 128). This is the usual way of thinking about our bodies/our physical selves. Under this conceptualization, it is easy to see how, for example, being locked in a hospital, or being given an unwanted injection, would each constitute infringements of bodily integrity.

#### *Mental health legislation - onslaughts on individual bodies*

As compulsory patients, people subject to MHL are unlikely to be able to freely come and go from mental health hospitals and can be subjected to unwanted treatments administered violently against their will. Our skin can be perforated by injections we cannot refuse by law and our brains changed by treatments like electro-convulsive therapy or neuroleptic medication. Psychiatric pharmacological treatments are not benign. For example, modern neuroleptics are associated with weight gain, leading to metabolic syndrome, heightening risks of early death through cancers, stroke, and cardiac problems (Bhuvanewar et al., 2009; De Hert et al., 2009).

In hospitals, we can be exposed to ‘sanctuary harm’ (Robins et al., 2005) through either witnessing or being subject to people holding us down, seclusion, and restraint, and being physically

prevented from leaving, with the expected associated physical and psychological trauma. In less obvious ways, we can be ‘frightened’ into states of submission. For example, Fennell (2010) writes about the ‘shadow of compulsion’ structuring what happens in hospitals:

“Detention, forcible treatment without consent, seclusion and restraint are the ultimate mechanisms of clinical power. A person may consent to treatment or to remain in hospital if they know that they will be compelled in the event of refusal. Compliance in the shadow of compulsion is an important feature of the psychiatric system” (Fennell, 2010, p. 24).

Fennell’s description of clinical power is illuminating because as the word ‘shadow’ implies, the person may or may not entirely see where the power is coming from or when or how it might be applied, but has a sense of its constant presence. In addition, there is the onslaught of constant surveillance, the monitoring, scrupulous assessing and documenting of our bodies, what they are doing, if they are ‘settled’ or not, and so on. In a Foucauldian sense, we may come to surveil ourselves into compliance (Foucault, 1977) through internalized fear of incurring violent responses to infractions of institutional rules. We learn what may happen if we yell, say no, attempt to leave, just as we learn we may be able to get out if we are ‘good’ (compliant, docile).

In summary, MHL transgress taken-for-granted expectations about rights: the right to make decisions about our own bodies, and cause us to lose the ability to protect the security of our bodies. Additionally, we are exposed to physical violence, for instance in the administration of unwanted treatment. Even if we are not directly governed by MHL, the shadow of compulsion structures our responses and we become sensitized to what might enable/hinder our further freedoms.

### *Bodily integrity – sense of self*

The second conception of bodily integrity is based on the work of feminist writer Drucilla Cornell (1995), who incorporates psychoanalytic ideas about personality into her thinking: “The personality is a process that is never finished, and bodily integrity means not just the idea of physical inviolability, but refers to the person’s imaginings and understandings of her or his body, its limits and characteristics... Bodily integrity is not something that the person possesses, but a process that needs protection and recognition from others, including the state and the legal system” (in Patosalmi, 2009, p. 126). Here, Cornell embraces a heightened depiction of bodily integrity – where the person’s own

imaginings, their psyche, and their personality cannot be disengaged from thinking about the physical body or separated from the confirmatory actions of others. Bodily integrity is continually produced through a process whereby others recognize and show respect for the integrity of the person. Showing respect for bodily integrity would mean having consideration for what animates the minds of others, what others imagine for themselves, and what gives their life meaning.

*Mental health legislation - onslaughts on sense of self*

Dominant expectations and experiences of the State and the rule of law are that it will protect us from harms. Adopting Cornell's conceptualisation of bodily integrity, a person's imaginings and understandings of who they are and who they might become, is a process that needs protection and recognition from others, including the state and the legal system. MHL interfere with such processes, as people are both abandoned by ordinary protections of the law and subject to violence engendered by MHL. I turn now to Miranda Fricker's (2007) concept of 'testimonial injustice' to articulate violence done to one's sense of self as a negative consequence of being subject to MHL.

Ethically, having credence as a knower and teller is essential to human value (Fricker, 2007). In Mad Studies scholarship, Liegghio (2013) employs Spivak's account of 'epistemic violence' from the field of Postcolonial Studies to explain the structural level de-legitimation of "psychiatrized people" as knowers, whose identities are pathologised and whose humanity is denied (Liegghio, 2013, p. 123). As an example, people subject to MHL may be viewed through a lens of dangerousness and incompetence (Liegghio, 2013). 'Testimonial injustice' (Fricker, 2007) describes a similar mechanism on an interpersonal level, where prejudice on the part of a hearer has the effect of downgrading or discrediting the speaker's words, constructing us as unreliable in our testimony, manipulative, lying, mistaken, or not to be trusted and so our status as knowers and tellers is discounted (Hamilton & Roper, 2006).

Roessler (2015) argues that testimonial injustice affects the autonomy of an individual by damaging and unsettling a person's relation to themselves, their self-worth, and their self-knowledge. To an imagined extremity, in the context of a person subject to MHL, such a process might unfold like this: if my treatment objections, my opinions, and my preferences are not given credence, then I am not treated as an individual. My testimony is doubted. I may cease to trust myself, my own insights

and testimony. I no longer know who I am. I am susceptible to a loss of self-respect. I can no longer trust in what I know, or even trust if I *can* know anything.

Basing her insights on published accounts by user/survivors of psychiatry, Beaupert (2018) describes how institutional psychiatry engages in a form of symbolic violence, where people's own ways of making meaning and understanding their experiences is re-oriented:

The notion that an institution or worldview can radically alter someone's identity implies that there is a reprogramming of thoughts and opinions about one's self and one's place in the world. The symbolic violence of psychiatry and the mental health paradigm can stifle thoughts, foreclosing possibilities for understanding and conceptualising one's own experiences. This process can preclude the forming and expressing of other opinions and understandings about what is happening, understandings that may be vital for a person to make sense of, work through, or embrace their experiences (Beaupert, 2018, p.8)

The impacts of subtle or harder to see forms of violence associated with MHL include assaults on trust in one's self, one's experience and knowledge, who one *is*. Such impacts are no less ethically consequential than the violence of seclusion and restraint. Each form of violence needs to be understood separately and the impacts understood cumulatively.

### ***How is the violence of MHL effaced and reframed?***

Contained in Fricker's concept of 'epistemic injustice' is 'hermeneutic injustice' which occurs at a stage prior to 'testimonial injustice,' "when a gap in collective interpretive resources puts someone is at an unfair disadvantage when it comes to making sense of their social experience" (Fricker, 2007, p. 1). As an example, how were women to speak about experiences of discrimination and be understood, before the concept of sexism? In these circumstances, people's individual and collective experiences of injustice/oppression are difficult to convey because there is no pre-existing vocabulary to mark these experiences within the larger cultural order.

Exploring this idea further, a reason the ethical peril and violence of MHL often go unnoticed is the dominance of medical explanations for distress, to the exclusion of other ways of understanding. From a medical perspective, MHL seem a logical response to protecting 'vulnerable people' who do

not know their own minds, by obtaining 'beneficial' and 'necessary' psychiatric treatment for them. Under this medical narrative, ethical losses and other violence become invisible and are effaced.

Most powerfully, MHL categorize according to dangerousness to self and/or others, based on 'mental illness' (along diagnostic or epidemiological lines). However, another way to view this is that what people subject to MHL actually have in common, is not 'mental illness', but the breaches of autonomy and bodily integrity they are exposed to. These breaches enable violence and can also lead to situations where those exposed to them are regarded by others as having lost ethical substance as persons worthy of respect and dignity. The impacts of uncertain citizenship status, being subject to legal, ethical, social, and human rights violence are all critical content areas to be investigated and understood; however, under 'illness categorization' their salience is dislodged.

### **Effacement as a further form of violence**

#### *Ethical Peril*

MHL are designed to legally displace autonomy and bodily integrity in favour of securing lawful intervention on bodies. The ethical gravity of these routine, everyday failures to demonstrate respect for persons under MHL is poorly recognised. That these failures are, simultaneously, forms of violence enacted on people subject to MHL, is similarly poorly understood. The operations of MHL interfere with the *basic human needs* of a particular category of people, including self-expression, choice, dignity, physical freedom, and self-determination. None of these ethical concerns can be morally dismissed as trivial and all are grave. If experiencing interference with any *one* of these basic human needs could cause degraded internal conditions to exercise agency, then experiencing a number of these ethical wrongs combined could cause a 'perfect storm' that disrupts agency not just in the present moment (while subject to MHL), but for that person's decision-making and sense of self into the future. It should be noted this position is a reversal of standard medical ethics justifications for paternalistic action: that interfering with current autonomy can preserve future autonomy (Young, 1986, p. 76).

The concept of "ethical loneliness" (Stauffer, 2015) has resonance for articulating the impact of experiences where oppression/discrimination/injustice are not seen and understood for what they

are by the “surrounding world”. Stauffer draws on the writings of Jean Améry, survivor of a concentration camp, to develop her concept of ethical loneliness. It is:

the isolation one feels when one, as a violated person or as one member of a persecuted group, has been abandoned by humanity, or by those who have power over one’s life possibilities. It is a condition undergone by persons who have been unjustly treated and dehumanized by human beings and political structures, who emerge from that injustice only to find that the surrounding world will not listen to or cannot properly hear their testimony (Stauffer, 2015, p. 1).

In our case, the “political structures” are MHL, and they are *designed* to “have power” over our “life possibilities”. That power is in place to authorize a medical response to our distress in situations where we have not agreed, either with the assessment of what is wrong, what to do about it, or both. The medical response means our bodies are violated and we cannot effect our own power to say no and have it respected. Under this process, other ways of being and knowing are disqualified. This is likely to leave us feeling “dehumanized by human beings”, alienated, set apart from humanity.

If people are told that the treatment they are forced to have is necessary and for their own good, violence is effaced and re-packaged as health. But the violence has not gone away. The person may blame themselves for the violence, or re-interpret violence as ‘care’.

Such double messages may be experienced as mad-making, may become internalized, creating more layers of violence, to people’s sense of self, or sense of what is real. That the violence experienced by people subject to MHL is authorised by the State and condoned by society is likely to set up conditions where it is even harder to correctly attribute where the problem lies. It is difficult to locate ourselves as valuable, wanted persons in contexts where violence exercised against us has been sanctioned by the state and, further, is not recognized as violence.

In order to address this ‘gap in collective resources’ (hermeneutic injustice) and shift the site of analysis of my troubles from the personal to the political, I would need cultural/social resources that do not yet exist. In order to have a platform from which to speak and take political action I would first need to: a) offset the individualized, malady-based dominant narrative, b) believe that an alternative narrative could be legitimate c) correctly pinpoint MHL as one of the structures under which I am exposed to violence d) find the language to articulate all the different ways that MHL causes violence,

e) understand and articulate the negative consequences of that violence f) recognize that I am in a category, ('people subject to MHL') g) recognize that the violence I experience is effaced and not likely to be registered by others. Finally, I would need to be able to maintain these insights in the face of the threat that psychiatric powers pose to my autonomy, bodily integrity, and worldview.

I have outlined ethical peril and forms of violence that people subject to MHL are exposed to and laid out ways that ethical losses and other violence of MHL are hidden or effaced which adds a further dimension of violence. Clinicians too, working under MHL, are implicated in ethical trouble, through having "power" over our "life possibilities", a point that I take up next.

### ***The ethical situation of clinicians: "dirty hands"***

Moral responsibility for violations of autonomy and bodily integrity under MHL may be denied by those practicing under it. To explore what is at stake when a moral issue is not recognized by those involved as a moral problem, I turn to philosopher Michael Stocker's work on "dirty hands" to elaborate.

"Dirty hands" are "acts that are justified, even obligatory, but none-the-less wrong and shameful" (Stocker, 1990, p. 9). Stocker draws on Walzer's (1973) well-known ethical dilemma to make his own point about "dirty hands" situations. The ethical example Walzer uses is whether an official should sanction torture in order to force a prisoner to tell where a time bomb threatening the lives of many innocent people is hidden. Can the torture be ethically justified? Intuitively we might think: "Yes, we must do whatever is needed in order to save innocent lives – this will be our justification for the sanctioning of torture." However, for Stocker, the ethical question becomes: if it is justifiable, even obligatory for the official to torture the prisoner, can it nevertheless *also* be wrong and shameful, because even if the torture is justified, it nevertheless stains both the act and the doer of the act?

What makes this a kind of 'catch 22' "dirty hands" situation is that no matter which decision the official makes, there is an ethical wrong involved. The official could refrain from ordering that the prisoner be tortured (because torture is wrong) but then innocent people might die (which would also be wrong). And because each choice contains an ethical wrong, either act is cause for both a great moral moment and for extreme regret (Stocker, 1990, p. 12). The act is to be done despite the dirty feature, and because of the dirty feature, the act is regrettable. This means that there is no ethically

'clean' choice. The 'dirty features' of "dirty hands" situations are serious because with "... people being wronged, they and their trust, integrity and status as ends are violated, dishonoured, betrayed" (Stocker, 1990, p. 17).

To me, what is revolutionary about Stocker's thinking is that he maintains that the "dirty feature" of an act *has to be counted* – that it does not simply disappear on grounds that it is part of a morally justifiable act. This means that if the official sanctions the torture of the prisoner, the "dirty feature" of the act of torture must still be counted. That lives have been saved does not cancel out the torture or make it go away. For Stocker, these "dirty features" are disvalues and they must be taken account of and regretted, not swept under the carpet: "The dirty feature does not merely make a negative contribution to the dirty act. It remains as a disvalue even within that justified, perhaps obligatory, whole – a disvalue which is still there to be noted and regretted (Stocker, 1990, p. 13).

I draw on Stocker's work to make the point that MHL are an immoral structure which create a "dirty hands" situation under which people's "moral autonomy and selfhood" (Stocker, 1990, p. 20) as well as their bodily integrity are violated. The rationale in support of MHL permitting compulsory treatment include that the treatment is necessary and will benefit the person. However, that the person may benefit from compulsory treatment is not the issue in "dirty hands" cases – the point is that any benefit does not remove the moral need to a) "note" and "regret" violations to autonomy and bodily integrity and b) does not remove the moral obligation to attend to the development and renewal of autonomy. Acts interfering with a person's autonomy or bodily integrity *are* "dirty hands" acts. In "dirty hands" cases the agent of the act is morally compromised, *even if* the act can be morally justified.

For my purposes Stocker's account of "dirty hands" is useful as it provides a way of seeing that under MHL, clinicians are ethically endangered. Although those providing care under MHL would most likely regard their treatment decisions as morally justifiable, the concept of "dirty hands" requires more of the agent. It requires that they also attend to the moral wrong engendered by the act: removal of the person's autonomy. It requires of the agent that they "notice", "count", and "regret" the "dirty features" of acts and not discount them. This is a moral obligation.

To provide a clinical example, when clinicians go against a person's wishes by administering unwanted medication to them, they likely do so in the belief that what they are doing is morally justified, but the "dirty features" of violations to autonomy and bodily integrity inherent in this act do not go away.

Whichever helpful acts clinicians choose to do will also be “stained” acts as they are morally compromising acts. Paternalistic justification for interfering with patient’s autonomy under MHL is based on the idea that the treatment is necessary for the health and safety of the person. But whenever an agent acts in such a way as to limit or undermine the autonomy of someone else, they are acting in a way that infringes on ethical values.

There is an urgent need to identify, articulate, face, and redress ethical peril and its consequences *for clinicians*. Clinicians are caught up in contradictory requirements where policies and even legislation instruct regard for people’s autonomy but in a context where people’s rights to refuse treatment are breached. The ethical significance of loss of people’s autonomy under MHL may be glossed over. There are usually no clinical guidelines for staff in reducing distress surrounding compulsory treatment (Szmukler, 2008), nor are there opportunities for clinicians to safely face their anxieties (Lakeman, 2006). If providers’ fears and anxieties are not acknowledged and dealt with, there is a danger of loss of empathy and becoming ‘hard hearted’ (Cutler et al., 2009; Shapiro, 2008). However, institutional supports are needed, including regular opportunities for clinicians to take honest responsibility for their part in the “dirty” acts of eroding people’s autonomy and violating bodily integrity in order to begin the work of ameliorating the negative consequences that result. These are conceptual and practical means through which ethical peril may cease to be hidden from view, may be confronted, and taken seriously.

### **We can do better**

In policy, law, and society more generally, the various ways in which MHL discriminate and place people subject to them in ethical peril and expose them to violence must be acknowledged. If the terrible potential for ethical loneliness is to be avoided, a collective social engagement with naming, better understanding, and owning up to the violence posed by MHL is required. Crucially, Mad scholarship offers paths forward in articulating what is at stake, and forming the basis for action. Public actions for counting, regretting, and repairing personal violence caused by MHL will be an important lead-in process to any eventual elimination of MHL. In the mean-time, institutions must provide clinicians with regular access to safe spaces in which to take seriously, note, regret, and ameliorate the effects of ‘dirty hands’ situations.

**References**

- Beaupert, F. (2018). Freedom of opinion and expression: From the perspective of psychosocial disability and madness. *Laws*, 7(3), 1-26. doi: 10.3390/laws7010003
- Bhuvaneshwar, C. J., Baldessarini, R. J., Harsh, V. L., & Alpert, J. E. (2009). Adverse endocrine and metabolic effects of psychotropic drugs. *CNS Drugs*, 23(12), 1003-1013.
- Buchanan, A. E., & Brock, D. W. (1989). *Deciding for others: The ethics of surrogate decision making*. New York: Cambridge University Press.
- Campbell, T. D. (1994). Mental health law: Institutionalised discrimination. *The Australian and New Zealand Journal of Psychiatry*, 28(4), 554-559.
- Coggon, J. (2007). Varied and principled understandings of autonomy in English law: Justifiable inconsistency or blinkered moralism? *Health Care Analysis*, 15(3), 235-255.
- Cornell, D. (1995). *The imaginary domain: Abortion, pornography and sexual harassment*. New York: Routledge.
- Cutler, J. L., Harding, K. J., Mozian, S. A., Wright, L. L., Pica, A. G., Masters, S. R., Graham, M. J. (2009). Discrediting the notion “working with ‘crazies’ will make you ‘crazy’”: Addressing stigma and enhancing empathy in medical student education. *Advances in Health Sciences Education, Theory and Practice*, 14(4), 487-502.
- Dawson, J. (2008). Community Treatment Orders and human rights. *Law in Context*, 26(2), 148-159.
- Dawson, J., & Szmukler, G. (2006). Fusion of mental health and incapacity legislation. *The British Journal of Psychiatry*, 188(6), 504-509.
- De Hert, M., Schreurs, V., Vancampfort, D., & Van Winkel, R. (2009). Metabolic syndrome in people with schizophrenia: A review. *World Psychiatry*, 8(1), 15-22.
- Donnelly, M. (2008). Autonomy to dignity: Treatment for mental disorders and the focus for patient rights. *Law in Context*, 26(2), 37-61.
- Fennell, P. (2010). Institutionalising the community: The codification of clinical authority and the

limits of rights-based approaches. In McSherry, B., & Weller, P., (Eds.), *Rethinking rights-based mental health laws* (pp. 15-49). Oxford, UK: Hart Publishing.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. Middlesex, England: Penguin Books.

Fricke, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press

Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research*, 6(3), 167-191.

Galtung, J. (1990). Cultural violence. *Journal of Peace Research*, 27(3), 291-305.

Hamilton, B., & Roper, C. (2006). Troubling 'insight': Power and possibilities in mental health care. *Journal of Psychiatric and Mental Health Nursing*, 13(4), 416-422.

Harris, J. (1985). Respect for Persons. In *The value of life: An introduction to medical ethics* (pp. 192-205). London: Routledge and Kegan Paul.

Lakeman, R. (2006). An anxious profession in an age of fear. *Journal of Psychiatric and Mental Health Nursing*, 13, 395-400.

Large, M. M., Ryan, C. J., Niessen, O. B., & Hayes, R. A. (2008). The danger of dangerousness: Why we must remove the dangerousness criterion from our mental health acts. *Journal of Medical Ethics*, 34(12), 877-881.

Liegghio, M. (2013). A denial of being: Psychiatrisation as epistemic violence. In B. A. LeFrançois, R. Menzies, & G. Reaume, (Eds.), *Mad matters: A critical reader in Canadian Mad Studies*. Toronto: Canadian Scholars' Press Inc.

Minkowitz, T. (2010). Abolishing mental health laws to comply with the Convention on the Rights of Persons with Disabilities. In B. McSherry, & P. Weller (Eds.), *Rethinking rights-based mental health laws* (pp. 151-177). Oxford: Hart Publishing.

Molodynski, A., Rugkasa, J., & Burns, T. (2010). Coercion and compulsion in community mental health care. *British Medical Bulletin*, 95, 105-119.

Nussbaum, M. C. (2000). *Women and human development: The capabilities approach*. Cambridge,

UK: The Press Syndicate of the University of Cambridge.

Patosalmi, M. (2009). Bodily integrity and conceptions of subjectivity. *Hypatia*, 24(2), 125-141.

Richardson, G. (2006). Balancing autonomy and risk: A failure of nerve in England and Wales? *International Journal of Law & Psychiatry*, 30, 71-80.

Robins, C. S., Sauvageot, J. A., Cusac, K. J., Suffoletta-Maierle, S., & Freuh, B. C. (2005). Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. *Psychiatric Services*, 56(9), 1134-1138.

Roessler, B. (2015). Autonomy, self-knowledge, and oppression. In Oshana, M.A.L (Ed.), *Personal autonomy and social oppression: Philosophical perspectives*. New York: Routledge.

Roper, C. E., & Edan, V. (2011). Autonomy in jeopardy: Contrasting participatory health models with patient decision making under mental health law. *Journal of Participatory Medicine*, 3. Open access available at: <http://www.jopm.org/evidence/case-studies/2011/09/12/autonomy-in-jeopardy-contrasting-participatory-health-models-with-patient-decision-making-under-mental-health-law/>

Ryan, C. (2011). One flu over the cuckoo's nest: Comparing legislated coercive treatment for mental illness with that for other illness. *Journal of Bioethical Inquiry*, 8(1), 87-93.

Shapiro, J. (2008). Walking a mile in their patients' shoes: Empathy and othering in medical students' education. *Philosophy, Ethics, and Humanities in Medicine*, 3(10), 1-11.

Stauffer, J. (2015). *Ethical loneliness: The injustice of not being heard*. New York: Columbia University Press.

Stocker, M. (1990). *Plural and conflicting values*. Oxford, UK: Clarendon Press.

Szmukler, G. (2008). Treatment pressures, coercion and compulsion in mental health care. *Journal of Mental Health*, 17(3), 229-231.

Walzer, M. (1973). Political Action: The problem of dirty hands. *Philosophy and Public Affairs*, 2, 160-180.

Young, R. (1986). *Personal autonomy: Beyond negative and positive liberty (International series of*

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