

CHAPTER 25

Ethical framework for community mental health

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Introduction

Community mental health services have been developing in the last few decades and in the process a number of ethical issues have arisen. Some of these deserve special attention as they are relatively distinct from ethical issues related to hospital mental health services. Application of established ethical approaches in the context of community mental health services may require revision of these approaches or alternatives to them. The aim of this chapter is to review key ethics concepts, to discuss ethical issues in community mental health services, and to provide a basis for an ethical framework for community mental health.

We will present definitions and central theories in ethics, an overview of bioethics, ethical issues related to community mental health services, addressing generic as well as distinctive problems. We will consider conservative and radical approaches (the latter partly based on community psychology research and practice), and challenges arising from an ethics of community mental health services (such as the view that social justice as in 'social inclusion' goes beyond fair resource allocation).

Definitions and central theories in ethics

Ethics addresses moral problems, sometimes termed ethical problems or dilemmas. In health care, ethical problems are commonly viewed as the tension between two or more morally defensible alternative actions, including inaction (Beauchamp and Childress, 2009). Ethical theories suggest various ways of addressing and resolving such ethical problems. The most veteran and well-established ethical theories are 'utilitarianism' (or more generally 'consequentialism'), which considers outcomes; 'deontology', which considers duties; and 'virtue ethics', which considers intentions. More novel ethical theories include 'rights-based theory' and 'care ethics' (Rudnick, 2001), among others.

Consequentialism and deontology are arguably the broadest in scope and the most influential ethical theories in contemporary health care and probably in contemporary life in general—at least in the Western world. For example, the notion of human rights, a

mainstay of contemporary attitudes to life in the Western world, can be argued to derive from deontology, since duties to others entail rights of those others and vice versa, and as the notion of duties precedes the notion of rights, at least historically. Both consequentialism and deontology are also considered self-sufficient (unlike most other ethical theories such as virtue ethics). And both may have particular relevance to community mental health, especially in relation to consideration of populations as well as individuals.

Consequentialism is based on the argument that consequences or outcomes of actions (and of inactions) determine whether an action (or an inaction) with ethical implications is moral or immoral. In its simplest form, that of hedonistic-like utilitarianism, consequentialism considers pleasure or happiness and pain or suffering as the outcomes of importance, and determines the morality or immorality of an action (or inaction) based on whether it produces more pleasure or happiness than pain or suffering, either of an individual or counted over a number of individuals if more than one individual is affected by the action (or inaction). Two general types of utilitarianism have been described: act utilitarianism, which maintains that the morality of each action is to be determined in relation to the favourable or unfavourable consequences that emerge from that action; and rule utilitarianism, which maintains that a behavioural code or rule is morally right if the consequences of adopting that rule are more favourable than unfavourable to everyone (Dershowitz, 2004: p. 242). Arguably, rule utilitarianism is conceptually more similar to deontology than act utilitarianism is.

Deontology is based on the argument that moral duties or obligations determine whether an action (or an inaction) is moral or immoral. Deontology was first developed systematically by Kant in the 18th century (MacIntyre, 1998), and since then it has been further developed and diversified. In its simplest form, deontology considers universal obligations as the duties of importance, and determines the morality or immorality of an action (or inaction) based on whether it upholds a universal obligation; famously, Kant argued that there is a universal obligation to tell

the truth, even if that means disclosing the location of a potential victim to a person known to plan that victim's murder. More generally, Kant formulated the 'categorical imperative', which is an impartiality—applicable to all people—condition, stating that an action (or inaction) is ethically acceptable if it holds for any person who could hypothetically be involved in the particular circumstances, including the person(s) conducting the action (or inaction) if he were to be at the receiving end of the action (or inaction). A neo-Kantian version of this requirement, developed by John Rawls, is that ethical decision-making should be conducted behind a 'veil of ignorance' (which can be formulated as not knowing whether the person will be the instigator or recipient of the action), which strips the ethical decision-maker of any personal considerations that may disrupt impartiality. A variant of Kant's formulation is that persons should be considered ends in themselves, rather than merely the means for other ends. The question who constitutes a 'person' is still open for discussion, and is particularly relevant in bioethics, e.g. in relation to obligations towards disabled human fetuses and embryos, as mentioned below (Kant claimed that only rational beings are full-fledged persons, hence he declined full-fledged personhood to animals and to human children). Also subject to such considerations are human adults who lack decision-making capacity, such as due to disruptive psychosis (Kant declined full-fledged personhood to such psychotic human adults too).

Overview of bioethics

Health care ethics, or bioethics (as it has been termed since the last few decades), has a history of thousands of years, both in the Western world and elsewhere (Jonsen, 2000). Most well known in relation to ancient health care ethics is the Hippocratic oath. Although partly dated, for example, in its consideration of physician duties to slaves, it has universally applicable components, e.g. its requirements to do no (intentional) harm and to maintain confidentiality (Lloyd, 1983). Admittedly, these Hippocratic requirements are not considered absolute now; sometimes harm may be necessary for benefit (e.g. in relation to chemotherapy for cancer) and sometimes confidentiality may have to be breached (e.g. in order to protect third parties who are at risk due to a patient's illness). However, they are still central considerations in health care ethics. Importantly, self-determination or autonomy, specifically patients' choice in relation to their health care, is not addressed in the Hippocratic oath; it is only since the advent of bioethics, a few decades ago, that it has been widely considered a key component of health care ethics, particularly in the Western world (Jonsen, 1998).

Contemporary bioethics includes various, sometimes conflicting approaches. The most well-known is principlism. Four main moral principles that drive moral action are identified. These may come into conflict with each other (or conflict can occur within one principle), with such conflict resulting in a bioethical problem. These principles are: 1) respect for autonomy or self-determination (sometimes termed respect for persons or their choices), 2) beneficence (i.e. benefiting the person(s) directly involved), 3) non-maleficence (i.e. doing no/least harm, which is sometimes combined with beneficence as a balance of most benefit and least harm), 4) justice (fairness, particularly to third parties or others involved or affected, as in resource allocation) (Beauchamp and Childress, 2009). These principles are considered to ground key tenets of

bioethics, such as confidentiality of personal health information in most circumstances. An example of an alternative approach is care ethics, largely based on virtue ethics and casuistry (context-specific considerations) (Rudnick, 2001). Another example is 'dialogical bioethics', which replaces predetermined principles with reasoned communication, but appears to require the principle of justice as fairness (Rudnick 2002, 2007). Note that contemporary bioethics addresses areas of health care beyond clinical practice, such as health related research, administration, and policy.

Some of the major areas of concern for bioethics to date have addressed end-of-life situations, beginning-of-life situations, and risk/benefit-to-others situations. In these, a bioethical problem is involved, requiring reasoned resolution in order to decide on an acceptable health-related action (or inaction). End-of-life situations address euthanasia (mercy killing), physician-assisted death, withholding or withdrawing life support, and other potential and actual health care procedures that either shorten or do not prolong the life of a person who is terminally ill, irreversibly unconscious, or incurably suffering. Beginning-of-life situations address abortion, artificial insemination, and other potential and actual health care procedures that curtail or alternatively enable the continuation of life of a human fetus, embryo, or newborn.

Risk/benefit-to-others situations address the impact of health, ill health, and health care-related procedures involving one or more individuals on other people. A paradigmatic example of a benefit-to-others situation is that of health-related human research, where persons are invited to participate in health-related research which is not necessarily expected to benefit (and may indeed harm) them, but which is expected to benefit others such as future patients. The need to protect human research participants and to obtain and respect their voluntary informed consent (or refusal) to participate in research was highlighted by the exposure of the Nazi medical experiments in the Doctors' Trial at the Nuremberg Tribunal in 1947, and the resulting 10 principles of human research known as the Nuremberg Code (Jonsen, 2000: pp. 100–2). A paradigmatic psychiatric example of a risk-to-others situation is that of the Tarasoff decisions, whereupon it was determined in the California court system that health care providers are obliged to warn and to protect third parties in relation to identified physical risk posed to these third parties by mentally ill individuals, where the risk is caused by their mental illness (Roberts and Dyer, 2004: p. 104). Such obligations may breach confidentiality of mentally ill individuals, on which see the discussion below.

The context of community psychiatry and related ethical challenges

Community psychiatry involves a change in locus of care (from hospital to community), funding arrangements, and treatment techniques. It establishes a network of services offering crisis intervention, continuing care, accommodation, occupation, and social support which together help people with mental health problems to retain or recover valued social roles (or to promote 'social inclusion'). Usually the focus of services has been on those with severe mental illness. To understand the context of community psychiatry it is important to consider both psychiatric care of **individuals** in the community and psychiatric care in relation to **community**. If the goal of treatment is 'social inclusion' then both aspects require careful consideration.

Mental health care of individuals in the community

To ensure that patients in the community receive the benefits of the range of services that they may require, widespread practice of 'case management' or its variants has been adopted. The aims are to ensure continuity of care, accessibility to often fragmented and independently managed services, accountability, and efficiency. A more intensive model of case management is commonly adopted for people with persistent symptoms who are difficult to engage in treatment—Assertive Community Treatment (ACT). ACT aims to prevent the service user from dropping out of treatment and brings treatment to the patient. If he or she defaults from treatment, the community team may actively seek out the patient to re-establish contact.

Patients with severe mental illness have a diverse range of needs that can often only be met by an array of services and agencies. Access to these may require a substantial flow of relevant personal information between care providers concerning the service user. The nature of the therapeutic relationships between staff and service user also change in community-based treatment. The key-worker or other members of the interdisciplinary team provide a broad range of interventions. As well as medication and standard psychological treatments, they may work with the patient in their ordinary community settings to rehabilitate basic living skills. This special relationship may be used to encourage the service user to adhere to treatment.

The role of the community itself is crucial to 'community care'. Public fears that care in the community for persons with mental illness will be a failure are common. Responses to these fears by government, public agencies, and community members may greatly affect practice. 'Risk thinking' leads to attempts at its management, control, or surveillance through classifications of risky persons, registers, databases, regulatory mechanisms, and so on. Risk may become a professional responsibility with new forms of regulation and governance of professional judgement and actions (Rose, 1998). Thus clinical practice in some areas has moved in the direction of greater social control at the expense of autonomy (Holloway, 1996). At the same time, in many places, there has been a move towards more person-centred and recovery-oriented care that encourages the development and use of autonomy, such as in supported (rather than sheltered) programmes (Roberts, et al., 2006).

Key dilemmas in clinical practice in the community

These can be grouped under four headings: privacy, confidentiality, coercion, and conflicts of duty.

1 Privacy

Assertive treatment programmes bring treatment to service users, often in their residence, whether it be home, hostel, or boarding house. Visits may be made by mental health professionals even when uninvited. Indeed, visits may continue even when the patient's explicit desire is that they cease.

Since much treatment occurs in the community, there is also an increased likelihood that it becomes public. The curiosity of neighbours may be aroused, particularly with repeated visits, and especially if attempts to gain entry are rebuffed by the patient. Neighbours may deduce that the person being visited is a service user.

Furthermore, as treatment becomes more visible to the public, new expectations may be generated that a CMHT can be called to deal with a difficult person suspected to be a patient. Even if a public assessment is not carried out, an acknowledgement by the team that they may have a role may reveal to bystanders that the person is a psychiatric patient (if already so) or label them as one (if not).

If the patient assessed as representing a risk defaults from treatment, the team may be expected to make every effort to re-establish contact. The team may inform the police if the person could pose a significant risk to self or others. The nature of the relationship between clinician and service user may shift from care to supervision. In some cases, assertive treatment, instead of ensuring that service users receive the care they need, may lead them to being labelled as 'dangerous' leading to exclusion from community services or amenities, including housing.

2 Confidentiality

In medicine, information obtained from a patient will not be disclosed to others without the patient's consent. In community mental health services, where the patient is commonly treated by an interdisciplinary team, sharing of information is common. Service users may not know that this is to be expected. More complex is the sharing of information between agencies—health, social, voluntary, housing, and so on. Very needy patients' access to benefits and other goods may depend on information about them being revealed to those in a position to supply them. Since information may flow frequently, confidentiality may receive less emphasis. There may develop an attitude that 'the patient has less to lose by certain breaches of confidentiality than other kinds of patients do' (Diamond and Wikler, 1985).

Confidentiality may be breached ostensibly in the interests of the patient as above, or for the protection of others. The latter is considered below, including the interests of family and carers.

3 Treatment pressures and 'coercion'

A range of pressures may be exerted by community mental health teams to gain the patient's cooperation with treatment. These can be placed on a hierarchy—persuasion, interpersonal leverage, inducements (or offers), threats ('coercion' proper), and compulsion. These 'treatment pressures', are described in detail by Szmukler and Appelbaum (2008) and in Chapter 27 in this volume, and will not be further discussed here.

4 Conflict of duty to patient versus others

Risk of harm to others

As previously discussed, the negative climate in which community mental health services may operate often provokes the question of the degree to which a mental health professional has a duty to protect others. If a specific risk to an identified person is established, the clinician's duty to protect that person is usually reasonably clear. When the risk to others is general, judgements are more problematic.

Expectations of the public about what mental health services should do to control disturbed behaviour may change with a growing emphasis on community care. For example, the mental health team may be asked to intervene by neighbours or shopkeepers, when they are disturbed by a service user's behaviour. A further aspect may be the possibility that if the team does not act, prejudice against the service user will increase and his or her

community tenure be threatened. The balance between the duty of care to the patient and to the local community may be difficult to strike.

Mental health professionals are expected to be competent in assessing risk to others as well as to patients themselves. This often requires information from a range of informants, particularly concerning previous incidents of violence and risk factors such as substance abuse. On occasion, the mere seeking of information concerning the service user's past behaviour may reveal that the person is being treated by a mental health team. It may even raise unwarranted anxieties in others' minds.

Informal carers

Informal carers, usually family, are often central to effective community care. However, the extent to which carers' own needs should be met is often quite uncertain. Where there is a danger of serious physical harm to the carer, the clinician's responsibility is usually straightforward. Far more common are less grave threats to a carer's well-being which nevertheless have serious effects on well-being. Carers may experience difficulty in coping with burdensome behaviours, lack critical knowledge about their relative's illness, and may not know to whom to turn for support, or what support they might expect or be entitled to. The patient may prohibit any contact with the family. It may be unclear then to what extent the mental health team owes a duty of care to the family (Szmukler and Bloch, 1998).

Approaches to addressing the ethical challenges

Acting in the health interests of the service user

Szmukler and Appelbaum (2008) and in Chapter 27 in this volume discuss two approaches to ethical decision-making based on forms of 'paternalism'. These are a 'capacity-best interests' framework and a 'paternalism' framework. It is argued there that these frameworks can be applied to the full range of ethical dilemmas described above. Note that paternalism may not be fully independent from some principlist considerations, particularly from the consideration of beneficence. The reader is referred to the above-mentioned references for a fuller discussion of these approaches. An alternative approach is that of 'dialogical bioethics', where even incapable service users are engaged in dialogue in order to enhance their participation in ethical decision-making as much as possible and to obtain their input and enrich it (as well as others'), including obtaining their assent (incapable agreement) or dissent (incapable disagreement), as the case may be. Even in situations where grave risk is expected for the person or for others, this approach may be sufficient, considering it involves dialogue and input from all stakeholders involved (although it may not be fully independent from some principlist considerations, particularly from the consideration of justice). For a fuller discussion of this approach, the reader is referred to previous publications by Rudnick (2002; 2007).

Preventing harm to others

Szmukler and Appelbaum elsewhere in this volume discuss the difficulties in deciding when to intervene in a 'coercive' manner for the protection of others. They argue that there is an important conceptual distinction between interventions serving the health

interests of service users versus those for the protection of others. The latter may result—through the agency of mental health legislation—in 'preventive detention' or preventive coercive measures that discriminate against people with mental disorders since people not suffering from a mental disorder but who are equally risky cannot be dealt with in such a manner unless they have first committed an offence. Clinical ethical dilemmas in this area are important (see Szmukler and Appelbaum, Chapter 27 in this volume for further discussion of this matter).

Psychiatric care in relation to community: the context

Individual patient goals of social inclusion and community integration imply the need for a receptive community. Considerations include issues of stigma and discrimination, organization of mental health services, and access to social determinants of health. These issues speak to justice, among other moral and ethical considerations.

Oppression, stigma, and discrimination are major issues that impede community integration of individuals with mental illness and perpetuate health disparities (Thornicroft, 2006). People with mental illnesses have been identified to be the most devalued of all people with disabilities (Lyons and Ziviani, 1995). They face negative attitudes and discriminating behaviours, frequently from family members, co-workers, the communities they live in (Schulze and Angermeyer, 2003), and even health care providers (Drake et al., 1999; Geller, 2001). Negative perceptions include beliefs that sufferers are incompetent, unpredictable, violent, hard to talk with, less intelligent, less trustworthy, and less likely to have valuable things to say (Crisp et al., 2000; Overton and Medina, 2008). Fear of this experience is sufficient to prevent some people from seeking help, and is a factor in premature treatment discontinuation (Sirey et al., 2001). Discrimination and stigma play a role in access to social determinants of health such as access to housing (Forchuk et al., 2006a,b), employment (Baldwin and Marcus, 2006; Shied, 2005), and friends (Alexander and Link, 2003).

Other community factors also affect the potential for community integration. Availability and organization of mental health services is important. For example, people in rural areas may relocate to unfamiliar and undesired urban areas solely for accessing mental health services and at times with entire families (Forchuk et al., in press). Unavailability of public transportation can also impede access to services (Forchuk et al., 2006a, in press). These are but a few examples of community level issues that affect the individual.

Discrimination and stigma also play a role in relation to public policy and the priority given (or not given) to people diagnosed with a mental illness. Public policy can have a dramatic effect on the potential for social inclusion. Forchuk, Joplin, and others (2007) described and analysed how the lack of connection between policy changes within the mental health field, housing and income support created a situation which dramatically increased the number of people with mental illnesses who have become homeless. In contrast, using a strategy to explicitly reconnect and partner mental health services with providers of housing and of income support dramatically reduced the number of people discharged from psychiatric wards to homelessness (Forchuk et al., 2008).

When problems with social inclusion occur one cannot assume that the problem is with the individual patient. A conclusion that

the underlying problem is either the patient or the community will lead to very different responses and proposed interventions. Thus community level issues have significant ethical implications.

Key dilemmas in community level psychiatry

There is a myriad of potential ethical issues at the community level. Some key dilemmas include: 1) beneficence—doing good for whom?; 2) social justice and basic human rights; 3) the obligation to advocate or to ‘whistle-blow’, and 4) understanding ethics within legal frameworks.

1 Beneficence—doing good for whom?

When working with individual patients, it is usually clear who the identified ‘patient’ is. However, with a community focus this is often unclear. There may be multiple vulnerable subgroups and prioritizing the needs of one group will often disadvantage another. For example, the common focus and priority given to people with serious and persistent mental illnesses can mean that people with moderate mental health problems are unable to get services unless they deteriorate sufficiently to ‘qualify’. In Ontario, Canada, a priority group for public housing has been people fleeing domestic violence. This group is almost always female and does often include people with mental illness. This seems to be a good policy and practice. However, with the current shortage of public housing, this has made it extremely difficult in many communities for others (such as men with mental illness, or intact families) to get public housing.

2 Social justice and basic human rights

Concerns about ‘doing good for whom?’ relate to resource allocation within a system with insufficient resources for all. This leads to issues related to social justice and basic human rights. Social justice is based on the ideal of fair distribution (Morris 2002). Essential questions to be addressed include ‘which inequalities matter most’ (Powers and Faden 2006) and ‘is our society just?’ (Davison et al., 2006). When people with mental illness are in a community without adequate food and shelter their basic human rights are arguably not being addressed (Forchuk et al., 2006b). Health care providers can contribute to this denial of basic human rights by not looking at the societal context of services. For example, discharging people from psychiatric wards to no fixed addresses has resulted in people, with no previous history of homelessness, being still homeless 6 months later or joining the sex trade to avoid homelessness (Forchuk et al., 2006c).

3 The obligation to advocate or to whistle-blow

If health care professionals witness the denial of basic human rights and other systematic concerns, do obligations follow? In some cases, this will be a part of professional codes of ethics or standards. Some workplaces put restrictions on employees regarding taking information from the workplace to a public forum. To counter this, some jurisdictions have legislation that protects ‘whistle-blowers’ who bring to light serious problems involving their workplace. Solutions in these situations often involve developing alliances with other groups and individuals to carry forward concerns to the political and public arenas. However, large community issues facing community psychiatric patients, such as homelessness, poverty, and lack of services, will take great efforts and time to overcome.

4 Understanding ethics within legal frameworks

Legal frameworks as well as ethical frameworks require consideration. Legal frameworks underpinning mental health acts, hospital acts, community treatment orders, health professional practices, and privacy can vary considerably, yet they form part of the context of community care. There can be tension between legal and ethical frameworks, which should be identified and addressed as best possible, including implementing legislation changes when possible and appropriate. Many people with mental illness are now entangled with the criminal justice system in myriad ways and are in the community under various conditions of parole, probation, conditional discharge, and so on. The legal system often requests various kinds of reports. Hence coercion, confidentiality and other ethical issues arise. The demands of the legal system should be weighed in relation to the patient’s interests. When there is conflict between such demands and such interests, judicial demands may have to take precedence in the short-term, but if deliberation reveals that these judicial demands are ethically unsound, advocacy for legislative and other legal change as well as for related cultural change may be required.

An example of the relation between ethics and law relates to sex offenders, who in many places are now discharged from prison and remanded to mental health care. Mental health care providers may feel unprepared to provide care for these patients, may fear for the safety of community members and may be intimidated by the frequent media accounts of the horrific offences sometimes perpetrated by such patients, while recognizing their fiduciary duty to these patients. To address this set of challenges, mental health care providers and their administrators can champion wide stakeholder collaboration, such as with the police, to try to ensure public safety while keeping confidentiality breaches to the necessary minimum, and with health policy decision-makers and regulators, to try to secure and use adequate specialized resources to provide best care for these patients within legal constraints.

Conclusion

Ethics in relation to community mental health is important and complicated. Such ethics involves knowledge of general ethical approaches, such as the well-established consequentialism, deontology and virtue ethics, as well as more novel approaches, such as care ethics. Skills in bioethics are also required, such as application of principlism, as well as awareness of other bioethical approaches such as dialogical bioethics and—somewhat in contrast—benevolent paternalism. The ethical problems involved in community mental health, in relation to which these approaches can be addressed, range from relatively traditional problems, such as those of coercion, to relatively novel problems, such as those of the community as a unit of ethical analysis. Further discussion and research is required in relation to these and other relevant ethical problems, including some that have not been noted here, in order to address the rapid development of services and policies in relation to community mental health. Community mental health care providers, who may be regularly confronted with ethical problems such as those described here and who may want to seek ethical guidance in relation to these problems, can access written resources, as illustrated in the reference list of this chapter, as well as engage in multidisciplinary team discussions and in consultations by ethicists and ethics committees that are available now in some community

mental health settings. Further development of such consultation and capacity building resources in the area of community mental health may be in order.

Table of summary

- ◆ In health care, ethical problems are commonly viewed as the tension between two or more morally defensible alternative actions, including inaction, and ethical theories such as consequentialism/utilitarianism, deontology and virtue ethics, suggest various ways of addressing and resolving such ethical problems.
- ◆ Bioethics involves ethics of health related matters, both clinical and other, such as in relation to health policy and research. Principlism, which is a widely used bioethical approach, consists of considerations of autonomy, beneficence, non-maleficence, and justice, in addition to context. Alternatives to principlism, such as dialogical bioethics and—somewhat in contrast—benevolent paternalism, may be helpful in bioethical decision-making, although they may not be fully independent from some principlist considerations (such as justice and beneficence, respectively).
- ◆ In community mental health, consideration needs to be given to both the individual person/patient as well as to the community as a unit of analysis. Issues of community integration could be related to the person/patient and/or to the broader community as a whole.
- ◆ Privacy, confidentiality, coercion, and conflicts of duty are key sets of dilemmas in the practice of mental health care in the community.
- ◆ Community level considerations include: 1) beneficence—doing good for whom?; 2) social justice and basic human rights; 3) the obligation to advocate or to ‘whistle-blow’, and 4) understanding ethics within legal frameworks.

Further reading

- Backlar, P. and Cutler, D.L. (eds). (2002). *Ethics in Community Mental Health Care: Commonplace Concerns*. New York: Kluwer/Plenum.
- Blackburn, S. (2001). *Ethics: A Very Short Introduction*. Oxford: Oxford University Press.

References

- Alexander, L.A. and Link, B.G. (2003). The impact of contact stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, **12**, 271–89.
- Baldwin, M.L. and Marcus, S.C. (2006). Perceived and measured stigma among workers with serious mental illness. *Psychiatric Services*, **57**, 388–92.
- Beauchamp, T.L. and Childress, J.F. (2009). *Principles of Biomedical Ethics*, 6th edn. New York: Oxford University Press.
- Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H., and Rowlands, O. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, **177**, 4–7.
- Davison, C., Edwards, N., Robinson, S. (2006). *Social justice: a means to an end, an end in itself*. Ottawa: Canadian Nurses Association. Available at: http://www.cna-nurses.ca/CNA/documents/pdf/publications/Social_Justice_e.pdf (accessed 29 August 2009).
- Dershowitz, A. (2004). *Rights from Wrongs: A Secular Theory of the Origins of Rights*. New York: Basic Books.
- Diamond, R.J. and Wikler, D. (1985). Ethical problems in the community treatment of the chronically mentally ill. In: Stein, L.I. and Test, M.A. (eds.) *Training in community living model: a decade of experience*, pp. 169–96. San Francisco, CA: Josey-Bass.
- Drake, R.E., McHugo, G.J., Bedout, R.R., Becker, D.R., Marris, M., Bond, G.R., et al. (1999). A randomized clinical trial of supported employment for inner-city patients with severe mental disorders. *Archives of General Psychiatry*, **56**, 62.
- Forchuk, C., Nelson, G., and Hall, G.B. (2006a). It's important to be proud of the place you live in: Housing problems and preferences of psychiatric survivors. *Perspectives in Psychiatric Care*, **42**, 42–52.
- Forchuk, C., Ward-Griffin, C., Csiernik, R., and Turner, K. (2006b). Surviving the tornado of mental illness: Psychiatric survivors' experiences of getting, losing, and keeping housing. *Psychiatric Services*, **57**, 558–62.
- Forchuk, C., Russell, G., Kingston-Macclure, S., Turner, S., and Dill, S. (2006c). From psychiatric ward to the streets and shelters. *Journal of Psychiatric and Mental Health Nursing*, **13**, 301–8.
- Forchuk, C., Joplin, L., Schofield, R., Csiernik, R., Gorlick, C., and Turner, K. (2007). Housing, income support and mental health: Points of disconnection. *Health Research Policy Systems*, **5**, 14.
- Forchuk, C., Macclure, S.K., Van Beers, M., Smith, C., Csiernik, R., Hoch, J., et al. (2008). Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'No Fixed Address'. *Journal of Psychiatric and Mental Health Nursing*, **15**, 569–75.
- Forchuk, C., Montgomery, P., Berman, H., Ward-Griffin, C., Csiernik, R., Gorlick, C., et al. (2010). Gaining Ground, Losing Ground: The Paradoxes of Rural Homelessness. *Canadian Journal of Nursing Research* **42**(2), 138–152.
- Geller, J.L. (2001). Taking issue: Ain't no such thing as a schizophrenic. *Psychiatric Services*, **52**, 715.
- Holloway, F. (1996). Community psychiatric care: from libertarianism to coercion. Moral panic and mental health policy in Britain. *Health Care Analysis*, **4**, 235–43.
- Jonsen, A.R. (1998). *The Birth of Bioethics*. New York: Oxford University Press.
- Jonsen, A.R. (2000). *A Short History of Medical Ethics*. New York: Oxford University Press.
- Lloyd, G.E.R. (ed). (1983). *Hippocratic Writings*. London: Penguin.
- Lyons, M. and Ziviani, J. (1995). Stereotypes, stigma and mental illness: Learning from fieldwork experiences. *American Journal of Occupational Therapy*, **49**, 1002–8.
- MacIntyre, A.A. (1998). *Short History of Ethics: A History of Moral Philosophy from the Homeric Age to the Twentieth Century*, 2nd edn. London: Routledge.
- Morris, P. (2002). The capabilities perspective. A framework for social justice. *Families in Society*, **83**, 365–73.
- Overton, S.L. and Medina, S.L. (2008). The stigma of mental illness. *Journal of Counseling and Development*, **86**, 143–51.
- Powers, M. and Faden, R. (2006). *Social justice: the moral foundations of public health and health policy*. New York: Oxford University Press.
- Roberts, G., Davenport, S., Holloway, F., and Tattan, T. (eds.) (2006). *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry*. London: Gaskell.
- Roberts, L.W. and Dyer, A.R. (2004). *Concise Guide to Ethics in Mental Health Care*. Washington, DC: American Psychiatric Publishing.
- Rose, N. (1998). Governing risky individuals: the role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law*, **5**, 177–95.
- Rudnick, A. (2001). A meta-ethical critique of care ethics. *Theoretical Medicine*, **22**, 505–17.
- Rudnick, A. (2002). The ground of dialogical bioethics. *Health Care Analysis*, **10**, 391–402.
- Rudnick, A. (2007). Processes and pitfalls of dialogical bioethics. *Health Care Analysis*, **15**, 123–35.

- Schulze, B. and Angermeyer, M. (2003). Subjective experiences of stigma: schizophrenic patients, their relatives and mental health professionals. *Social Science & Medicine*, 56, 299–312.
- Shied, T. L. (2005). Stigma as a barrier to employment: Mental disability and the Americans with Disabilities Act. *International Journal of Law and Psychiatry*, 28, 670–90.
- Sirey, J.A., Bruce, M.L., Alexopoulos, G.S., Perlick, D.A., Raue, P., Friedman, S.J., et al. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry*, 158, 479–81.
- Szmukler, G. and Appelbaum, P. (2008). Treatment pressures, leverage, coercion and compulsion in mental health care. *Journal of Mental Health*, 17, 233–44.
- Szmukler, G. and Bloch, S. (1998) Family involvement in the care of people with psychoses: an ethical argument. *British Journal of Psychiatry*, 171, 401–5.
- Thornicroft, G. (2006). *Shunned: discrimination against people with mental illness*. New York: Oxford University Press.