



MOVEMENT TOWARDS A HUMAN RIGHTS PARADIGM

Submission to the review of the
Mental Health Act 1986 (Vic)

Vanaheim Group Pty Ltd

ACN 111 717 429

www.vanaheimgroup.com

EXECUTIVE SUMMARY

Part I – Suggested amendments

The following suggested amendments would provide real choice to those who are subject to the mental illness sector, and would further shift Victorian law towards a human rights paradigm:

- 1) Repeal the Part 4, Part 5 and related involuntary treatment provisions;
- 2) Repeal the Part 5 (Division 2) involuntary electroshock provisions; and
- 3) Amend the definition of section 53B informed consent to require a wider more fully informed consent to all invasive psychiatric treatments, based on the Model Consent forms in Appendix I.

Part II – Policy direction

In line with the Victorian government's policies and the Human Rights Charters, funding less restrictive prevention and treatment/recovery programs for those diagnosed with a mental illness is better and cheaper than the status quo, and shifts towards a human rights paradigm in mental health.

We are concerned that should the amendments suggested in our submission not be incorporated into the new Mental Health Act, that Act may continue to contain serious limitations on the human rights of Victorians.

Vanaheim Group therefore calls for the Mental Health Act Review to be halted and handed over to the Law Reform Commission for a review compliant with Victoria's democratic obligations under the Charter of Human Rights and Responsibilities Act 2006 (Vic).

PART I – Suggested amendments

The following suggested amendments would provide real choice to those who are subject, or may become subject, to the mental illness sector:

- 1) Repeal the Part 4, Part 5 and related involuntary treatment provisions with a view to administering cognitively impaired individuals through the *Guardianship and Administration Act 1986* (Vic);
- 2) Repeal the Part 5 (Division 2) involuntary electroshock provisions and replace with a prohibition on involuntary electroshock (that is, electroshock performed on a person who is not a fully informed, legally competent adult); and
- 3) Amend the definition of section 53B informed consent to require a wider more fully informed consent to all invasive psychiatric treatments based on the Model Consent forms in Appendix I.

Why repeal the involuntary treatment provisions?

Involuntary treatment is increasingly viewed as a human rights violation.¹ Repealing the involuntary treatment provisions would put Victoria at the forefront of the human rights and recovery paradigm that is currently being rolled out in New Zealand and other parts of the world.

There is some weight behind the argument that involuntary incarceration (*not* treatment), where no crime has been committed, may be appropriate for the protection of the community. For example, it is statistically more likely that intoxicated young men will commit acts of violence. However, this may be more appropriately legislated within the criminal law framework.

Similarly, cognitively impaired individuals who are unable to make decisions in respect of their activities of daily living and treatment options can be administered under the provisions of the *Guardianship and Administration Act 1986* (Vic).²

¹ See, for example, The UN Special Rapporteur on Torture (<http://www2.ohchr.org/english/issues/disability/torture.htm>); the Office of the High Commissioner for Human Rights (<http://www.ohchr.org/EN/UDHR/Pages/DetaineesWeekInitiative.aspx>).

² See, for example, Goonan G, Healy B, Moynihan P. "The death of the subject: Human rights, due process and psychiatry". *International Journal of Law and Psychiatry*. 23: 23-41, 2000; Szmukler G, Holloway F. "Mental health legislation is now a harmful anachronism". *Psychiatric Bulletin*. 22, 662-665, 1998; Szmukler G, Holloway F. "Reform of the mental health act". *British Journal of Psychiatry*. 177, 96-200, 2000.

The treatment of minors should be subject to the fully informed consent of their legally competent parent/guardian, or the relevant provisions of the *Children, Youth and Families Act 2005* (Vic).

Repealing the involuntary treatment provisions would mean that subject to a contrary order under the *Guardianship and Administration Act* or *Children, Youth and Families Act*, no invasive psychiatric treatments or methods (including restraint or seclusion) could be used except by the fully informed consent of a legally competent adult.

Why repeal the electroshock provisions?

An intervention like electroshock should only ever be provided at the voluntary request of a fully informed, legally competent adult. This means that electroshock should never be performed upon minors or cognitively impaired individuals.

Evidence that electroshock irreversibly damages the brain is conclusive.³ The reason that electroshock in any form has continued is because the brain damage is thought to be outweighed by the therapeutic benefits, despite the lack of evidence to support this thought.

Without conclusive proof of therapeutic and personal benefit from the perspective of people who have experienced involuntary electroshock, the provision of involuntary electroshock cannot be justified.

Why amend the informed consent provisions?

At present, doctors are not required to explain treatment effects to involuntary patients. Further, the informed consent provisions do not effectively require doctors to provide full and frank information to voluntary patients or the parents/guardians of minors.

The first line in psychiatric treatment is almost always pharmacological intervention.

One example of pharmacological intervention is the provision of neuroleptic drugs. Neuroleptic drugs are second only to chemotherapy in their toxicity, and can cause conditions like tardive dyskinesia, neuroleptic malignant syndrome and akathisia. Studies have proven that the brain atrophy increases each year that a person continues to consume neuroleptic drugs,⁴ as do the risks of

³ See, for example, Sackeim HA, Prudic J, Fuller R, Keilp J, Lavori PW, Olfson M. "The cognitive effects of electroshock in community settings". *Neuropsychopharmacology*. 32(1):244-54, Jan. 2007.

⁴ See, for example, Raquel Gur, et. al. "A follow-up of magnetic resonance imaging study of schizophrenia". *Archives of General Psychiatry*. 55, 145-151, 1998; Al Madsen. "Neuroleptics

diabetes, heart disease and death.⁵ In practice, current informed consent procedures do not effectively mandate the provision of such information to patients.

Genuinely informed consent would allow a patient or the patient's legal guardian to assess the real potential risks and benefits of all treatment options. Two such informed consent forms are included in Appendix 1—one for pharmacological intervention, and one for electroshock.

Further, an even more genuinely informed consent could be made if patients were offered a range of less restrictive alternatives—alternatives that do not currently exist in Victoria.

PART II - Policy direction

This Review brings with it a great opportunity to evaluate Victoria's Mental Health Act and discover evidence-based treatment/recovery methods that may be overlooked under the current Act's paradigm. In line with the Victorian government's policies and the Human Rights Charters, funding less restrictive prevention and treatment/recovery programs for those diagnosed with a mental illness could prove more effective and cheaper than involuntary treatments—particularly in the long term.

The Victorian government currently fails to encourage and support alternatives for individuals who do not wish to be treated within the mental health system or dislike using pharmacological intervention. Similarly, federal government programs like *MindMatters* and *headspace* endorse one particular point of view—that people who are diagnosed with a mental illness will most likely be reliant on psychoactive drugs for the rest of their lives.⁶

This state of affairs directly impacts upon anyone who is unable to cope with problems that arise in their lives: should they dispute their treatment or diagnosis there is no real alternative to involuntary and/or drug treatment. On a practical level, this means that the people who search for alternatives are mostly disappointed—and are forced to source help from professionals who seek to convince them that the answer lies in embracing their diagnosis and/or

in progressive structural brain abnormalities in psychiatric illness". *The Lancet*. 352, 784-785. Sept. 5, 1998; Breggin, P. "Brain damage, dementia and persistent cognitive dysfunction associated with neuroleptic drugs: Evidence, etiology, implications". *The Journal of Mind and Behavior*. 11(3-4), 425-464, 1990.

⁵ See, for example, Grace Jackson (2005) *Rethinking Psychiatric Drugs: A Guide to Informed Consent*, Author House. Indiana; Peter Breggin (1997) *Brain-Disabling Treatments In Psychiatry*. Springer Publishing, New York.

⁶ See for example, *Consequences of financial interests in the leading theory of mental illness*, Working Paper, 2008, Vanaheim Group Pty Ltd.



psychoactive drugs. Others do not even seek help for fear of involuntary and/or drug treatment.

Over the past few decades, there have been a number of well-documented but little known alternatives that have almost invariably initially thrived then perished for lack of funding and publicity. Examples of alternatives around the world that currently exist include the Sequoia Psychotherapy Center in California, the Freedom Center in Massachusetts, Runaway House in Germany and Soteria Bern in Switzerland. These alternatives can be narrowed into three categories: drug-free professional services model, non-professional services model and ex-patient separatist model.

Drug-free professional services model

The drug-free professional services model is generally for-profit, non-coercive psychotherapy. For example, the Sequoia Psychotherapy Center (SPC), based in Fresno, California, is a community based treatment facility. Services include a comprehensive day treatment program that provides an alternative to hospitalisation. Traditional outpatient services are also available. SPC does not rely on psychiatry's principles. It is one of a handful of facilities that specialises in medication-free treatment.⁷

On a practical level, this model is the most likely to succeed because its for-profit structure allows some independence from the government, although in practice there are financial problems stemming from poor marketing strategies—generally SPC relies on word-of-mouth “advertising”, and certainly does not have the budget or the marketing capabilities of the allies of psychiatry.

Non-professional services model

In contrast, the non-professional services model generally fails when government funding is pulled. For example, Soteria House. This house was set up as an experiment funded by the National Institute of Mental Health in the US. The Soteria Project was a study of people newly diagnosed as having schizophrenia and deemed in need of hospitalisation. Soteria House used interpersonal phenomenological interventions by a non-professional staff, usually without antipsychotic drugs, in the context of a small, homelike, quiet, supportive, protective, and tolerant social environment. This environment was compared with usual general hospital and psychiatric ward interventions. The results of the study, confirmed in replicated studies and critical evaluations, confirmed that around 85-90% of acute and long term patients deemed in need of acute hospitalisation can be returned to the community without conventional

⁷ The web page for SPC can be found at: <http://www.medsfree.com>. Similar centres include Full Spectrum in San Francisco and Associated Psychological Health Services in Wisconsin.

hospital treatment and without antipsychotic drug treatment. In fact the study found that the Soteria drug-free environment was as successful as drug treatment in reducing psychotic symptoms in 6 weeks. In the long term, many more people recovered completely compared with those reliant upon the standard treatment principles. Further, the clients were treated at a considerably lower cost.⁸ Unfortunately, Soteria House and its later cousin Emanon ran out of funding. There is currently Soteria Bern in Switzerland, and another one starting up in Alaska.

It is important to note that Soteria House should not be confused with existing programs such as ORYGEN Youth Health. Such programs are run by professional mental health workers, rather than the students and other non-professional staff who formed such an integral part of the recovery process at Soteria. Similarly, such programs do not have a psychiatric drug-free philosophy.

Ex-patient separatist model

Both the professional and non-professional alternatives, however, do not necessarily offer what many ex-patients call for: a safe place to go and just hang out with people who are not going to see them as a problem to be solved and who are not going to try to change them or the way they live. Often the people who need the support of other ex-patients have been scarred—both spiritually and physically—by involuntary psychiatric practices. Thus, Judi Chamberlin in *On Our Own* advocates such organisations being completely separate from the mental health professions, including any form of hierarchy. The Freedom Center in Northampton, Massachusetts is one example of such an organisation, as their web page attests—

If you are labelled with ‘mental illness,’ are a psychiatric abuse survivor, or go through extreme mental and emotional states, we invite you to join us. Allies and supporters willing to share their personal experiences are also welcome (mental health staff allies are welcome but should contact us first). We alert people to the serious dangers of psychiatric drugs so that they can make truly informed decisions, and we oppose how the system pushes drugs on people, but we support everyone’s choice in their own recovery as they define it for themselves. We don’t judge people. **Whether you take psychiatric drugs or you don’t take psychiatric drugs, you are welcome at the Freedom Center.** We respect self-determination and choice, and approach all drug use and lifestyle choices from a harm reduction philosophy.⁹ (emphasis in original)

⁸ Loren R Mosher ‘Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review’ (1999) 187 *The Journal of Nervous and Mental Disease* 142. See also, Loren R Mosher and Joyce Hendrix (2004) *Soteria: through madness to deliverance*, Xlibris Corporation, USA.

⁹ <http://www.freedom-center.org>



The Center provides free acupuncture two days a week, free yoga classes once per week, has weekly meetings chaired by whoever wants to chair them, provides lectures on legal rights, and is compiling first person oral histories for those whose stories would otherwise be side-lined. Similar organisations seem to be appearing around the US.

The largest problem for most of these alternatives is the lack of funding. Generally, in Australia, those who would benefit from such alternatives are not wealthy—subsisting on Centrelink payments—and closely monitored by a team of mental health workers, making the logistics of organising such a group difficult.

Australian Alternatives

In Australia, any alternatives are few and far between—and are not found on government-sponsored web sites. In fact the only alternatives located by Vanaheim Group to date are Eagle’s Wings and Teen Challenge—both Christian rehabilitation programs aimed primarily at young people experiencing problems with living, in particular over-use of drugs—and the Schizophrenia Drug-free Crisis Centre & Helpline in Adelaide. There are also two CCHR¹⁰ chapters—one in Perth and one in Sydney, who disseminate material critical of psychiatry. Individual psychotherapists and psychiatrists who disagree with the current mainstay are difficult to locate and generally ostracised by their peers.

Should the Victorian government fund true alternatives such as Soteria House and the Freedom Center there would be no need for the current involuntary treatment provisions, electroshock and psychosurgery would be redundant, and a movement towards the human rights paradigm would be a natural progression.

Vanaheim Group Pty Ltd

ACN 111 717 429

www.vanaheimgroup.com

Vanaheim Group’s mission is to inspire real choice in the mental illness sector.

Since its establishment in 2004, Vanaheim Group has offered an Australian port of call for referrals for Australian psychiatric survivors from the American psychiatric survivor networks.

¹⁰ The Citizen’s Commission for Human Rights was founded by Professor Szasz and the Church of Scientology to campaign against psychiatry’s philosophy and practices.



APPENDIX I

A Model Consent Form for Psychiatric Drug Treatment

By David Cohen, Ph.D., and David Jacobs, Ph.D.

I, the undersigned, understand that I am about to be prescribed one or more drugs by Dr. _____.

The drug(s) I am to be prescribed is (are) the following:

_____.

I understand that a DSM-IV diagnostic label has been assigned to me, based on my doctor's (and perhaps also on other people's) subjective judgment of my speech, manner, and behavior during our meeting, which lasted approximately _____ minutes. I am aware that I will never be able to remove this diagnosis, or any other that will be added in the future, from my medical record.

I understand that although my doctor says that I am sick or that I have a treatable illness or disease, he or she is just using a figure of speech and cannot establish, with any test or procedure known to medical science that I in fact "have" the "illness" implied by the diagnostic label.

Indeed, I am aware that although medical opinion may now hold that a "chemical imbalance," a "brain abnormality," or some physical problem "underlies" or "produces" my distress or suffering, no objective information (through lab tests, scans, etc.) concerning the state of my body has been obtained in order to arrive at a DSM-IV diagnosis. If, by chance, such information has been obtained for that purpose, I understand that this information plays no role whatsoever in fulfilling any criteria for any DSM-IV diagnosis or diagnoses that I have been given by my physician except perhaps for diagnoses related to drug-induced disorders such as tardive dyskinesia.

I have been informed that the drug or drugs which my doctor is prescribing cannot cure whatever "illness" or "chemical imbalance" medical opinion might believe I have but can only affect symptoms of my distress or suffering.

I understand that the drug I am about to take cannot restore any of my physical or psychological functions "back to normal." Rather, the drug is expected to produce many new mental and physical symptoms, which might help make my original complaints seem less disturbing for a while.

I understand that it is exceedingly difficult to determine what is brought about (both desired and unwanted) by a psychoactive drug which has wide and diverse effects on the brain and other organ systems. I further understand that the problem of how to accomplish this adequately is a controversial issue within psychiatry and the Food and Drug Administration (FDA).

I realize that FDA approval of the drug I am about to take is based upon very short-term studies (usually 6 to 8 weeks) which are designed, paid for, and supervised by the drug's manufacturer. I further realize that the FDA does not require or expect that a drug's full range of adverse effects will be known prior to marketing and prior to lengthy exposure of ordinary patients to that drug.

I am also aware that the FDA's knowledge about the drug's adverse effects after marketing comes



mostly from spontaneous physician reports, the FDA itself recognizes that these reports are just "the tip of the iceberg" of the probable true frequency of adverse effects. I know that wording in the package insert and in the Physician's Desk Reference is the outcome of a complex negotiation between the manufacturer and the FDA. I also realize that it sometimes occurs that the FDA belatedly learns that the manufacturer has not fully disclosed to the FDA what it actually knows about a drug's adverse effects. Finally, I understand that despite FDA approval for psychiatric drugs being granted on the basis of short-term studies, the longer-range consequences of continuing drug use are not systematically studied by any responsible organization or government agency.

If I am consenting to take the drug as part of a research study, I understand that the researcher's primary interest and loyalty is not to me as a patient and not to my personal interests or welfare. I understand that the "needs of the research project" come before and have priority over my own personal needs.

I understand that the drug will have a wide range of effects on my brain, body, consciousness, emotions, and actions. My sleep, my memory, my judgment, my coordination, my stamina, my sexuality are likely to be affected.

I understand in particular that the effects of a psychoactive drug may undermine my ability to accurately monitor and report upon just how the drug has affected me, even impaired me, perhaps in a dangerous direction (judgment, social perception, impulse control, etc.). I further understand that what to do to protect me, as a patient or subject, against this possibility is a basically unanswered problem in psychiatric drug treatment and research.

I understand that effects that have a 1 in a 100 chance of occurring are actually considered "frequent" effects that should be mentioned to an adult, competent, prospective patient like myself. My doctor (or the researcher) has specifically advised me that the following toxic or adverse reactions may occur, and has provided these estimates of the frequency of their occurrence in patients like me:

_____.

I understand that I may experience an adverse effect which might then disappear after a few days or weeks. This disappearance will usually mean that my body has developed a tolerance to the drug's presence, not that the effect will never bother me again in the future.

I understand that if I inform my doctor of the occurrence of adverse effects, he or she will have five basic options: (a) cease the drug, (b) decrease the dose, (c) increase the dose, (d) switch to another drug, or (e) add another drug. I understand that no rules exist to determine which option is best to follow in individual cases, and it is likely that several options will be followed simultaneously. I also understand that most doctors are not likely to report to the FDA any adverse effect they suspect or have observed, contributing to the generally inadequate picture of a drug's true impact on patients like me.

I have been informed, if I am prescribed a neuroleptic drug such as Haldol or Risperdal and if I take it regularly for a few years, that I have at least a 30% chance over the next 5 years of developing tardive dyskinesia, a possibly irreversible disorder characterized by abnormal involuntary movements of my face or other body parts. I have been informed that I may also suffer from other acute or chronic movement problems, such as parkinsonism, akathisia, and dystonia, and their associated unpleasant mental states.



I have been informed, if I am prescribed a tranquilizer like Xanax or Klonopin and I take it regularly for more than three or four weeks, that I run the risk of becoming physically dependent on it. I will then have a good chance of experiencing "rebound" insomnia and anxiety, and many other unpleasant sensations, when I try stopping the drug, or even while I continue to take it. I understand that these drugs are not effective antianxiety or sleep-inducing agents after a few weeks of use. I realize that some people are unable to withdraw and must therefore permanently endure the consequences of daily use.

I have been informed that if I am prescribed lithium, I do not have a "lack" of lithium in my body, nor can such a "lack" be demonstrated by any existing test. I understand that the blood tests that I will undergo regularly will be for the sole purpose of determining just how much lithium has been introduced into my bloodstream and whether this could produce toxic symptoms, since, as a result of the mental dullness that lithium is expected to produce, I will be in no position to recognize some of these toxic symptoms.

I understand that the drug is likely to provoke various unpleasant effects when I stop taking it, especially if I stop too suddenly. I understand that although withdrawal reactions are systematically ignored in psychiatric drug treatment or research, they might represent the worst part of my whole drug-taking episode. I further understand that these reactions will often closely resemble the original symptoms for which the drug was prescribed to me, and are likely to be taken for a return of these symptoms (a "relapse"), rather than for withdrawal effects. I realize that my doctor or the researcher is likely to interpret these reactions as a sign that my "illness" is chronic and that my drug is "effective."

I also understand that once I have been taking drugs for months or years, I will have much difficulty to find a health professional to assist me in withdrawing prudently and safely from the drugs, if I so wish.

Having understood the above, I realize that the drug treatment may cause severe pain or discomfort, worsen my existing problem significantly, or even damage me permanently. However, most doctors or experts will never formally or informally acknowledge that the drug harmed to me in this manner. I will have practically no chance of proving that the drug caused my damage and obtaining compensation.

I understand that no body of research clearly shows that the problems my diagnosis or diagnoses require or respond more favorably to drug treatment than to one or more forms of nondrug treatment. It is obvious to me that nondrug treatment would enable me to completely avoid whatever dangers or risks are associated with taking the drug or drugs I am agreeing to take. My doctor (or the researcher) has made it clear to me that existing evidence does not indicate that it is in my best interest to choose drug treatment as a first recourse.

I am choosing to be treated with (write in the name of the drug or drugs) for the following reasons: (provide ample space; this section must be filled in by the patient or subject):

Signed: _____.



AN INFORMED CONSENT FORM FOR ELECTRO CONVULSIVE THERAPY (ECT)

by Dr Bob Johnson, Consultant Psychiatrist

Informed Consent Form for ECT

To the patient – this is an important document. By signing it, you are giving your consent to receive Electro Convulsive Therapy (ECT). There are 6 points in all. Read each point carefully in turn. It is important that you understand each point. If there is anything you do not understand, ask for an explanation. And do not sign until you have understood, agreed to, and ticked, every point.

Point 1

The scientific evidence proving that ECT helps with depression and with suicide has always been either weak or seriously flawed.

I have had this point carefully explained to me, and I clearly understand its full implications for me. Yes No

Point 2

ECT is still controversial, medical opinion has always been divided – some doctors being strongly in favour, others strongly against, then as now.

I have had this point carefully explained to me, and I clearly understand its full implications for me. Yes No .

Point 3

ECT can be fatal, with one estimate being as high as 1 death in every 2000 patients.

I have had this point carefully explained to me, and I clearly understand its full implications for me. Yes No .

Point 4

ECT always disrupts the memory, sometimes briefly, sometimes permanently.

I have had this point carefully explained to me, and I clearly understand its full implications for me. Yes No .

Point 5

ECT always causes mental confusion, known as ‘cognitive impairment’. This means that normal mental activities such as reading, calculating, planning, learning something new, telling the time, telling who you are – any or all of these can become hard or impossible to do, following ECT. Sometimes this impairment is brief, sometimes it is permanent. In its first 20 years, this was commonly used to justify the use of ECT.

I have had this point carefully explained to me, and I clearly understand its full implications for me. Yes No .

Point 6

ECT always damages brain cells, as animal studies amply prove. Again, in the early decades, this was regarded by some as justification for using it (cf lobotomy).

I have had this point carefully explained to me, and I clearly understand its full implications for me. Yes No .