



Review of the **Mental Health Act 1996**  
and **Criminal Law (Mentally Impaired Defendants) Act 1996**

**Submission regarding the Mental Health Act (MHA) 1996**

**Our Details**

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Closing Date**

The closing date for submissions is **Friday 28 March 2003**. Please send your submission to:

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This Review is about the operations and effectiveness of the existing Act and not about writing a new Act. Therefore you do not need to re-write sections of the Act, this will occur after the Review has been completed and is the responsibility of the Parliamentary Counsel's Office.

Please address those areas that are of concern and how you think the Act may be altered. The following is not a comprehensive list of all aspects of the Act. You do not need to comment on all areas. Please use the space available or add pages to include other areas of importance.

# INTRODUCTION

The Citizens Committee on Human Rights Inc, (CCHR) is the local chapter of the international organisation, the Citizens Commission on Human Rights. CCHR was founded in 1969 by the Church of Scientology and Dr Thomas Szasz, Professor of Psychiatry, as an independent body to investigate and expose psychiatric violations of human rights and to clean up the field of mental healing. There are now more than 130 chapters in 34 countries. For more information, log onto <http://www.cchr.org>

## AREAS OF THE ACT

### Part 1

#### Meaning of mental illness s.4

It can be seen that psychiatrists cannot agree on a definition of mental illness or disorder, emphasised by the fact that internationally almost every mental health law either has a different definition of this mental phenomena or do not define it at all.

The Diagnostic Statistical Manual, DSM (the psychiatric textbook on mental illnesses and disorders) even admits this. In the second edition of DSM, it states of schizophrenia: "Even if it tried, the Committee could not establish agreement about what this disorder is, it could only agree on what to call it." DSM III Disorders tells us, "there is no satisfactory definition that specifies precise boundaries for the concept 'mental disorder'.... For most of DSM III disorders...the etiology (cause) is unknown. And DSM IV, the latest edition, states that the term "mental disorder" continues to appear in the volume "because we have not found an appropriate substitute."

Speaking at a 1994 European psychiatric congress in Denmark, the then president of the World Psychiatric Association, Norman Sartorius, said that psychiatrists should no longer consider that they could *cure* the mentally ill and that in the future, the mentally ill will have to lean to *live* with their illness.

In 1995, psychiatrist Dr. Rex Cowdry, the then director of the National Institute of Mental Health in the United States, gave evidence before a Senate Select Committee Hearing admitting that as for mental illness, "We do not know the causes. We don't have the methods of 'curing' these illnesses yet."

Psychiatrists admit that they cannot predict dangerous behaviour; numerous studies prove the unreliability of psychiatric testimony on insanity. As early as 1959 studies showed this. One study found the agreement rate between psychiatrists of 54 percent in 6,263 cases. A 1973 study estimated that 65 to 95 percent of those judged dangerous by psychiatrists were actually harmless.

Definitions of "mental illness" should not be so broad as to invite interpretation and arbitrary opinion, and must rule out the possibility of a treatable physical condition being the cause of the person's mental disturbance.

Additionally, the United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 4:2 A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.*

*Principle 4:3 Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.*

## **Proposed Amendment**

Consequently the following definition for mental illness is suggested:

“For the purpose of this law only, a person is deemed “mentally ill” where his “condition” does not have a traceable physical cause and where, beyond reasonable doubt, the person is found to be incapable of coping with and controlling routine problems, his rationality is seriously reduced and he is being destructive to himself and requires care.”

In accordance with the above UN Principles, s.4(2) of the Act should reflect engaging in illegal conduct in place of (f) which is too indefinite and broad.

Likewise a person should not be deemed mentally ill by reason only of any of the following:

- a) Behaviour or actions that may cause them financial harm or harm to their reputation or harm to their relationship with another or others.
- b) Epilepsy
- c) Intellectual or developmental disabilities
- d) Brief periods of intoxication caused by substances such as alcohol or drugs or by dependence upon or addiction to those substances.
- e) Juvenile offenses, including school truancy, home truancy, or incorrigibility.

## **Part 2 The Chief Psychiatrist (ss. 8-16)**

Mental health practitioners and staff whom have committed criminal offences should not be protected from the application of the law. Such protection also interferes with patients’ rights to civil legal actions in seeking redress of wrongs committed against them. Mental health staff should be made fully responsible for their actions towards patients who are in a position of vulnerability.

### **Proposed Amendment:**

Accordingly s.14(3) should be deleted from the Act.

## **Part 3 Involuntary Patients**

United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 15:1 Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.*

*Principle 4:4: A background of past treatment or hospitalisation as a patient shall not of itself justify any present or future determination of mental illness.*

Universal Declaration of Human Rights states:

*Article 9. No one shall be subject to arbitrary arrest, detention or exile.*

### Incarceration

Involuntary commitment is an area where CCHR receives an extremely large amount of complaints. It is often reported to CCHR that, “ I went to the hospital voluntarily and when I refused treatment because I didn’t want to take the drugs, I was threatened that if I didn’t, I would be made involuntary.”

One complainant after she had experienced first hand the horror of involuntary commitment with one of her children, stated to CCHR Perth in 2003, "At present psychiatrists are allowed to use unfounded evidence against the client as part of their report, which they produce in a legal court room as evidence to convince and persuade the judges that the client is in fact a danger to himself and the community. Then when the misleading and inaccurate information is disputed and a complaint is made such as mine, it is closed because the complaint lacks substance due to the fact that the information wasn't factual in the first place. Meanwhile someone is detained involuntarily due to misleading and inaccurate information. I find this an extreme abuse of a patient's rights; that a psychiatrist can use words that are not factual in a court of law like a Mental Health Review, against their client, and the client is then locked up. This has to STOP!"

As psychiatrists claim to be medical doctors, then the same provisions for medical doctors should be applied to psychiatrists: no detention and treatment in a hospital without the full and voluntary informed consent of the patient.

If mental health facilities were places of rest, where people did not fear to seek help, knowing they would not be assaulted with drugs and electric shock, but where they could receive real medical help, people would be more approachable about being helped.

Fraudulently or wrongfully detaining a person and/or wrongfully committing them are a criminal matter and should be dealt with as such. It goes beyond medical negligence because the professional is wilfully or maliciously depriving a person of their liberty and detaining them against their will, without their having committed any offence. When this is done, the responsibility for this rests solely with the psychiatrist, mental health worker or staff who has power to involuntarily detain and commit another.

Currently there are little or no protections or recourse for people who are accused of being "mentally ill" - a danger to themselves or others - and being detained against their will by their accusers.

However as can be seen by the well-publicized FBI and police raids on private psychiatric facilities in the U.S., and exposure of the many instances of patients being wrongfully admitted, as well as the rampant fraud and abuse that took place in these facilities (owned at the time by National Medical Enterprises), granting immunity from the law to certain individuals opens the door to widespread disaster. False imprisonment should be treated as false imprisonment, kidnapping as kidnapping and assault as assault; no one should be above the law no matter what their profession.

To curb fraud, criminal abuse of patients, and enormous costs to the state through this fraud and abuse, criminal and civil penalties must be enacted against any mental health professional, staff and any laypersons who may be involved, who are found to have wrongfully caused another to be locked up or held in a psychiatric hospital or facility.

In order to ensure basic human rights and to prevent abuses, persons should have:

1. The right to defend themselves against incarceration in a court of law where full laws of evidence apply, the right to legal representation prior to and throughout any involuntary commitment procedure.
2. The right to a full, physical examination by qualified medical practitioners who can determine whether an underlying and untreated physical problem is causing the mental state and that no involuntary commitment can occur without this.
3. The right not to be medicated or be given electroconvulsive therapy without consent during the detention period.
4. The right to have all consent procedures, especially explanation of them to the patient, video-taped.
5. The right to call witnesses of the person's choice.

6. The right to have an independent medical opinion, which must be paid for by the government, as it is public psychiatrists attempting to have the person involuntarily detained and the onus should be on the psychiatrist to prove their case.
7. The right to appeal any decision made.

A Patients Chart of Rights explaining the above should be on the wall of the admissions ward and other wards in the facility and a copy should also be given the person in their own language.

### Medical screening

Most laws make provision that anyone admitting to a mental health facility has the right to the least restrictive environment. Numerous studies, books and other publications show that frequently people are wrongfully admitted or committed to psychiatric facilities when they actually have an undiagnosed and untreated physical condition. Frequently, physical illnesses and diseases can create or manifest as psychiatric symptoms. Typically, when a person is admitted to a psychiatric facility, a person is only given a cursory physical examination, which is not thorough and does not first eliminate the possibility that the person has an underlying physical problem.

In California where medical screening was implemented there was no net increase or net decrease in the state's combined medical and mental health costs for these patients. Enormous suffering could be avoided by the prompt diagnosis and treatment of organic conditions and disease manifesting as emotional or behavioural disturbances.

### **Proposed Amendment:**

The following procedures are recommended to be incorporated into the Mental Health Act:

**1. (a)** Each person presenting themselves, or being presented for admission to a mental health hospital or facility, either voluntarily or involuntarily must be informed that underlying physical diseases or illnesses may cause behaviour problems or mental illness or disorder, and that in their own interests, and to avoid unnecessary suffering, they should undergo a medical screening test.

**(b)** The person presented for admission to a mental health hospital or facility may be admitted temporarily to undergo the medical screening and shall not be medicated or otherwise treated against their will during the medical screening, including determining the findings of such screening.

**(c)** Any person being given a medical screening must consent to this, and the consent procedure must be videotaped.

**(d)** Any person who chooses or receives this medical screening shall have the right to be thoroughly and competently medically screened by a medical, not psychiatric, physician skilled in physical assessment, medical history taking, neurological examination and laboratory testing.

**(e)** Any person who chooses or receives this medical screening shall have the right to have this procedure videotaped.

**(f)** The laboratory tests in **(d)** should include but are not limited to:

- (1) a complete blood count
- (2) a 23-item chemistry panel (including determinations for glucose, albumin, serum urea nitrogen, creatinine, calcium, phosphate, alkaline phosphatase, aspartate aminotransferase, alanine aminotransferase, gamma-glutamyltransferase, bilirium, iron and electrolytes)
- (3) a serum fluorescent treponal antibody test.
- (4) thyroid tests (a triiodothyronine resin uptake, total serum thyroxine, and a free-thyroxine index)

- (5) serum folate and vitamin B12 levels
- (6) a dipstick urinalysis
- (7) allergy tests
- (8) hormone testing at the physician's discretion
- (9) determination that no other psychiatric drug or medication the person may be taking is causing the manifestation of the psychiatric symptom.

(g) Each test must be in documented form with the results attested to by the practitioner/pathologist performing the tests.

(h) The patient has the right to have a second, independent medical screening done by a doctor/pathologist of their choice and to have the initial tests verified.

(i) If an underlying physical illness or disease is determined after the tests according to point [e] are performed, the person shall not be formally admitted to a mental health hospital or facility but be transferred to a general medical hospital or to a medical doctor of their choice. If no physical illness or disease is found then the person may be admitted to the mental health facility in accordance with the law.

2. If the patient is admitted after being scheduled to the psychiatric facility or having been admitted involuntarily to an institution, the institution or facility is responsible for all costs incurred in the medical screening.

### **Part 3**

#### **Police Assistance**

**(ss.34, 35, 41, 42 also ss. 70, 71, 72, 78, 82-84, 195-200)**

Universal Declaration of Human Rights states:

*Article 9. No one shall be subjected to arbitrary arrest, detention or exile.*

*Article 12. No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor attacks upon his honor and reputation. Everyone has the right to protection of the law against such interference or attacks.*

The police should not be used for this function. It is a violation of human rights as the person has not committed a crime. The police should be involved with controlling criminals and crime, and should not be used to enforce medical appointments for the psychiatric industry. As a comparison, an oncologist cannot force a cancer patient to have surgery to remove a cancerous growth if the patient refuses it, regardless of the doctor's assertions that it is the best chance of prolonging or improving life of the patient. Mental Health Practitioners shouldn't be allowed to employ police power to enforce a mental health appointment.

If the police arrest someone, then that person should be dealt with in the justice system and put into hospital that is under the control of the justice system and not in hospital where the general public are, if they suspect the person is mentally unwell.

The extensive powers granted to police to enter premises and seize property etc. to deal with law-breakers should not be extended to deal with persons only suspected of having a mental illness.

#### **Proposed Amendment:**

The police should not be required to carry out transport orders or any other function under the Mental Health Act. Transport orders should be abolished.

### **Part 3**

## **Releasing a detained patient (ss.52, 54, 55, 56)**

If someone is a suspected criminal or convicted criminal, then they should not be in a public hospital. This situation creates an unsafe environment for unwell people. Criminals should be dealt with by the justice system in police custody.

### **Proposed Amendment:**

Criminals should not be detained within the public health system and their detention should not be part of the Mental Health Act.

### **Part 3**

## **Community Treatment Orders**

Universal Declaration of Human Rights states:

*Article 13. (1) Everyone has the right to freedom of movement and residence within the borders of each state.*

*(2) Everyone has the right to leave any country, including his own, and to return to his country.*

If a person is considered to be in need of involuntary commitment status, this presumes the person must have enforced care because they cannot care for themselves. How then can this be altered to mean the person still needs enforced care but can go home? The justifications for CTO's are very unsound. Either a person requires enforced care, which must therefore take place in a hospital setting, or they do not need enforced care.

All mentioned arguments against involuntary commitment in this submission apply to CTO's. They are both a gross violation of human rights, and a danger to the community.

The following was reported to CCHR Perth in 2002 : "I was receiving depot medication every 4 weeks under the community treatment order. I was not able to reject the medication and was forced to take it, although I was not a risk or harm to others, I did not have a disturbance of thoughts, mood volition, perception orientation or memory that impaired judgement or behaviour to a significant extent and the relevant practitioners could not be satisfied that I have a mental illness under normal circumstances. I did not require treatment for the health and safety of myself or others nor did I need protection from self inflicted harm nor serious damage to property. I do not like to be categorised and stereotyped and I do agree to disagree with the doctor's view that I was mentally ill. "

Some of the drug induced violence committed by persons on psychiatric drugs include: 1) AUSTRALIA: David Hawkins, a 74 year old with no prior history of violence, killed his wife while on antidepressants. In 2001, a judge ruled that the drug was in part responsible; 2) U.S. : Kip Kinkel, 14, killed 2 and injured 22 after opening fire at his Springfield, Oregon high school in 1998. He had undergone psychological "anger management" classes and was on psychiatric drugs; 3) U.S. : In 2001, Andrea Yates filled the bathtub and drowned her 5 children, ages 6 months to 7 years. Medical experts argue that the murderous rage was induced by excessive doses of certain psychiatric drugs, causing "involuntary intoxication"; 4) JAPAN: The same year, Mamoru Takuma, 37, stabbed to death 8 schoolchildren and injured 15 others in a frenzied knife attack while under the influence of psychiatric drugs; 5) U.S. : Jeremy Strohmeier, 18, raped and murdered a 7 year old girl in a Las Vegas casino bathroom after being prescribed psychotropic drugs.

The above is by no means an exhaustive list but merely a sample of cases.

As the CTO states where and when the treatment is to be done/given, it effectively holds a person in the area and they are unable to travel. This is again another huge human rights violation.

### **Proposed Amendment:**

CTO's should be abolished.

## **Part 5 Treatment of Patients Informed consent (ss. 95-98)**

United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 8:2 Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.*

*Principle 11:2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in the form and language understood by the patient on:*

- a) The diagnostic assessment;*
- b) The purpose, method, likely duration and expected benefit of the proposed treatment;*
- c) Alternative modes of treatment, including those less intrusive.*
- d) Possible pain or discomfort, risks and side-effects of the proposed treatment.*

*Principle 12:1 A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.*

CCHR receives complaints constantly from people in Western Australia who did not know what the treatment would do, what the possible side effects of the treatment were etc, and were not given time to consider treatment etc.

### Medication

People admitted to a psychiatric hospital or facility, whether voluntarily or involuntarily are often forced to take or are forcibly given psychiatric drugs that they may not want or even need. This practice is often justified by hospital staff as being an "emergency measure" and is a means by which hospital staff can quieten someone who may be simply protesting being held against their will. The drugs are frequently forced upon a person long before any complete examination has taken place, at which point the side effects of the drugs can mask either a physical problem or a patient's ability to communicate the real problem.

Whereas medical drugs commonly treat, prevent or cure disease or improve health, psychiatric drugs only suppress symptoms - symptoms that return once the drug has worn off. Like illicit drugs, they provide no more than a temporary escape from life's problems. Such drugs can have horrific physical and mental side effects including suicidal thoughts, hostility, spasms, grimacing movements, manic reactions, seizures, sexual dysfunction and much more.

The mother of a patient reported the following to CCHR Perth in 2003: " The side effects that I have seen, after reading documented medical information, that my child has include, stiffness, he's crouched over and stiff and walks like cardboard, he has sloppiness, he has speech dribbling problems, indigestion, nausea and vomiting. His weight changes, he puts it on and loses it. He has slow thinking, headaches, agitation and confusion. As the drug he is on according to some researchers induces more adverse affects, the appropriate testing for the development of tardive

dyskenisia, diabetes or even liver, kidney and heart problems may arise and needs to be tested for at intervals. To date I have seen and been informed of none. It has been three years. The side effects of the medications are adding to the existing problem. Other options should be given by psychiatrists and doctors to the patient that will cause collaboration and shared information for a better regime, because medication alone does not cure nor promote well being. My definition of consent is having the choice to consent to or not consent to, however the present system dictates your consent. This needs to change and alternative choices need to be introduced.”

In another example reported to CCHR Perth in 2002 the patient stated: “I received an injection and medication without me even being asked, if I consent to treatment or not. The lack of information, the denial of choice of treatment are in my eyes a violation of human rights, also the community treatment order is a violation of human rights.”

In the 1990’s researchers admitted that neuroleptics did not control delusions or hallucinations; that two-thirds of the drugged patients had “persistent psychotic symptoms a year after their first psychotic break”; and that 30% of patients didn’t respond to the drugs at all. (Robert Whitaker, *Mad in America : Bad Science, Bad Medicine, and the enduring Mistreatment of the Mentally Ill* – Perseus Publishing, New York, 2002, p.203.)

Tests were run on the newer antipsychotics. One in every 145 patients who entered the clinical trials for four atypical drugs died, yet those deaths were never mentioned in the scientific literature. (*Op. cit.* Whitaker, p.269.) Thirty six patients involved in the clinical trial committed suicide. (*Op. cit.* Whitaker, p. 272-273.) Eighty four patients had experienced a “serious adverse event” of some type which the Food and Drug Administration defined as a life threatening event or one that required hospitalisation; 9% of the patients had to drop out of the clinical trials because of the adverse events, compared to 10% of patients treated with one of the older antipsychotics. (*Op. cit.* p.276.)

In 2001, Professor Ralph Edwards, the head of World health Organisation’s unit monitoring drug side-effects, warned that SSRI’s have produced far more complaints from patients than old-fashioned tranquillisers prescribed by doctors in the 1970’s. He also reports that, “the issue of dependence and withdrawal has become much more serious.” (Robert Mendick, World Health watchdog warns of addiction risk for Prozac users”, *Independent World News*, 29 Apr. 2001.)

In 1995, nine Australian psychiatrists reported that patients had slashed themselves or become preoccupied with violence while taking SSRI’s. “I didn’t want to die, I just felt like tearing my flesh to pieces,” one patient told psychiatrists (David Grounds, et.al., “Antidepressants and Side Effects,” *Australian and New Zealand Journal of Psychiatry*, vol. 29, No.1, 1995.)

In 1996, the National Preferred Medicines Centre Inc. in New Zealand, issued a report on “Acute Drug Withdrawal,” saying that withdrawal from psychoactive drugs can cause 1) rebound effects that exacerbate previous symptoms of a “disease,” and 2) new symptoms unrelated to the condition that had not been previously experienced by the patient. Antidepressants can create “agitation, severe depression, hallucinations, aggressiveness, hypomania [abnormal excitement] and akathisia.” (“Acute Drug Withdrawal,” *PreMec Medicines Information Bulletin*, Aug., 1996, modified 6 Jan. 1997, Internet URL: <http://www.premec.org.nz/profile.htm>, accessed 18 March 1999.

Protection against unwarranted and unnecessary drugging is required.

Another area of major concern is the number of complaints we receive in relation to patients being in hospital voluntarily and not wanting to have their medication. These patients are told that if they do not have it they will be made involuntary. This is definitely an abuse of human rights and threatened punishment. Under these circumstances consent becomes null and void yet it is a crucial issue in any medical field. Informed consent needs to be firmly enshrined into mental health laws **for all patients** with severe penalties for its violation, and avenues for recourse by patients wide open for any instance of abuse of consent resulting in abuse or permanent damage.

### Written and Videotaped Informed Consent.

Patients must have the right to give full, *written* informed consent for all psychiatric treatments. This includes being given *written* information on what their legal and other rights as a patient are and what the treatment they are to be given entails (i.e. procedure, risks, side effects, expected results, whether there is a division of medical opinion about any procedure such as Electroconvulsive therapy, psychoactive medications etc.) In this way, the law can represent the patient's, and not the doctor's interests and overcomes the imbalance of power between a patient and his psychiatrist.

Frequently, people who present to a psychiatric facility are not given a written copy of their rights, are not informed about why they are being involuntarily detained in a psychiatric facility, are not informed about what the drugs or treatments proposed for them can do, nor what their choices and legal options are. This creates a situation where a person does not know that his or her rights **have been** violated or, alternatively, has no way of ensuring his or her rights are not violated.

While the onus for having obtained an "informed consent" rests entirely with the treating psychiatrist and hospital staff, if there are no strict guidelines under the law, the patient or his concerned relative or representative is unable to prove that consent was *not given* or that their rights were not legally applied.

Regulations attached to the law and which clearly describe all side effects, risks etc. of a treatment is one way of overcoming the barrier. Each psychiatric facility should be required to provide a copy of these to patients.

However, even written information does not overcome coercion and wrongful consent, which are both very real threats to any patient entering a psychiatric facility. Wrongful consent includes consent obtained while the person is drugged.

Justice John P. Slattery in the Chelmsford Royal Commission Report of 1990 cites this: "The very appearance of the writing (signature of the patient) shows that the patient was not capable of consent." He said that patient being forced to give consent influenced by the drugs in deep sleep treatment "is worse than there being no consent."

He found: "Some patients were treated contrary to their express wishes. Other patients were treated by stealth and deceit. The signature on some forms was obtained by fraud and deceit. Some were signed by people whose judgment was compromised by drugs. Some patients were woken up from their DST treatment to complete the authorization. Other patients were treated contrary to their express wishes and some were treated despite the fact they had specifically refused the treatment."

"The doctors and the nurses who treated patients without the patient's consent, contrary to the patient's consent, or on the basis of consent obtained by fraud or deceit, committed a trespass to the person of each of these patients and were responsible for an assault on them."

The NSW Health Minister at the time, The Hon. Peter Collins noted that electroshock given outside of the parameters of "consent" is "an act of violence" constituting criminal assault.

The solution for both the patient's protection and the mental health facility is to videotape the patient giving his or her informed consent. The information about the drugs and treatments being proposed—indeed, a complete treatment plan—would be in writing, which the patient could read aloud and then sign. The patient may have a representative of his choice present during the procedure. Patient confidentiality laws would apply to this procedure in the same way that they do the rest of a patient's medical records. The procedure should be mandatory, with criminal penalties for any psychiatrist or other mental health worker who has violated or not carried out this procedure.

The patient has the right to be in an unmedicated state during this and any consent procedure.

The same procedure should apply to all patients regardless of status under the Act.

The patient's rights must include information that states that it is illegal for any provider, including a psychiatrist, nurse or other mental health worker, to make sexual advances towards or to sexually exploit, use or abuse patients.

**Proposed Amendment:**

**1. (a)** Within two hours of a patient entering a psychiatric facility, through either voluntary or involuntary admission, videotaping of their rights being given them, and the obtaining of their informed consent for treatment must have commenced. The patient may not be given psychotropics, neuroleptics or any other kind of psychiatric drug that may impair his thinking, hearing, sight and/or ability to speak prior to or during the videotaping session.

**(b)** The patient has the right to have any person or representative of their choice present during the videotaping as a further witness to the proceedings.

**(c)** The following must be addressed during the videotaping, without exception.

**i.** The person must state their name and address at the beginning of the videotape. The person informing the patient and the person videotaping the interview (if this is an additional person) must also give their name and job title plus the location of the interview and the time and date.

**ii.** If the patient is already on psychiatric drugs they must state this at the commencement of videotaping. The patient then states what the drug or drugs are and the dosages, as well as the name of prescribing physician and that the patient does not object to being under the influence of such drugs during the consent procedure.

**iii.** The person must be told why they have been brought to the facility. They must be given a copy of the patient rights to read aloud. This must be written in clear, layman's terms and in the person's primary language. If the person does not understand something it must be explained to him and he must acknowledge on tape that he now understands it.

If a person cannot read, the information must be read to them by their representative or staff member who is not the treating physician. The person must also be read, or be given a copy of their legal rights and what legal recourse they have open to them.

**iv.** Information on each of the treatment methods must include not only documented benefits, but also full data on all risks, side effects [including the division of medical opinion about such side effects, as in the case of Electroconvulsive therapy, where some psychiatrists say it is effective and others state that it is harmful and can result in memory loss, brain damage and even death] and the expected results of the treatment and whether or not the patient can be cured by it.

**v.** A written list of patient, human rights and legal advocacy organizations and individuals independent of the psychiatric facility must be given to the person. The person must be told that they have the right to call anyone from this list, or anyone of their choice, to obtain further assistance and aid in their case. The patient must verbally reply that they have been provided this list and that they understand what its purpose is.

**vi.** The patient must also be provided with information on the alternatives to these treatments, without bias.

**vii.** The patient must be made aware that should another type of treatment be proposed at any time during his hospitalisation, the consent procedure, as laid out above, must be followed. Informed consent is therefore required for each new drug to be given, therapy tried etc.

**viii.** The patient must be made aware that should he wish to retract his consent, a verbal retraction is sufficient to cease the treatment, after which, the patient's retraction of consent must also be videotaped.

**ix.** Once the above has been carried out, the person must sign the consent form and verbally state on video that he is satisfied with the information about the treatment procedures and understands the information given him. He must give his agreement both verbally and in writing and with the understanding that he may revoke his consent at any time.

**(d)** All videotaping must be carried out in the least restrictive environment, which is not intimidating to the patient.

**(e)** All videos must be kept as a matter of record for the same period that the law requires hospital facilities to maintain patient medical records. The video becomes part of the patient's record and the patient and/or his or her legal counsel/representative may have access to or copy of the video.

Section 97(2) removes patient rights as it enters another's opinion as to what another would need to know about their treatment. This means vital explanation can be missed. Medical doctors, surgeons etc. have to fully explain any procedure and its actual ramifications, so should psychiatrists. This section can bring about a situation where mental health practitioners are not liable for the results of their treatments on patients.

As a patient may have difficulty due to them being unwell, the next of kin or nominated person should also be given a full explanation of the treatment in the event that the patient wishes to confer with another person.

**Proposed Amendment:**

Section 97 (2) should be deleted from the act. Notification of next of kin or nominated person of full explanation of the treatment should be added to the act.

**Part 5  
Treatment of Patients  
Prohibited treatments (s. 99)**

**Proposed Amendment:**

Psychosurgery, electroconvulsive therapy, and the use of restraints should be prohibited treatments.

**Part 5  
Treatment of Patients  
Psychosurgery (ss100- 103)**

Psychosurgery injures healthy brain tissue and can cause memory loss, disorientation, relapses, seizures, irreversible brain damage, suicides, destruction of basic social skills, and post-operative death. Insufficient scientific evidence exists proving that any benefits from this treatment exist outweighing the irreparable harm inherent in it to warrant its use in any circumstances. Something constructive can always be done for the patient. Psychosurgery should be a fully prohibited treatment.

**Proposed Amendment:**

Psychosurgery should be a prohibited treatment.

**Part 5  
Treatment of Patients  
Electroconvulsive Therapy (ss104-107)**

**ECT should not be performed on anyone regardless of their status and regardless of the opinion of another psychiatrist's recommendations.**

**Where ECT is not banned outright it should not be performed on persons under the age of 16 or over the age of 60, or on pregnant women, or on any person whom has not given fully informed consent, or on any person unable to give consent.**

Documented studies show ECT can leave irreversible brain damage, cause permanent loss of memory and may result in death. Psychiatrists tell you openly that they don't know how it "works" or that they have any scientific reasoning for why they think it is a good idea to destroy your brain cells.

ECT is still widely used around the world. Yet a 2001 Colombia University study found ECT is so ineffective at ridding patients of their depression that nearly all of those who receive it relapse within six months of stopping treatment.

Psychiatrists tell the patient that electroshock is like "jump-starting" the brain – just as shock is used to revive a stopped heart. This is a lie. The brain is like a switchboard or a computer. When subjected to electric shock, its capability functions are impaired. This inhibits the display of the person's behaviour or emotions and thus in people who have exhibited "abnormal" behaviour there is the apperency that the person is "better."

However, psychiatrist Lee Coleman says, "The brain, for a while, is so injured that the patient is too confused to know or remember what was troubling him. Unfortunately, when the brain begins to recover somewhat, the problems usually return since electricity has done nothing to solve them." This is why electroshock is given repeatedly to patients over many years.

In the United States, Medicare will cease funding of multiple electroconvulsive therapy, (MECT) as of April 1, 2003. The Department of Health & Human Services, Medicare Coverage Issues Manual, Jan 10, 2003 states:

*"The clinical effectiveness of the multiple-seizure electroconvulsive therapy has not been verified by scientifically controlled studies. In addition, studies have demonstrated an increased risk of adverse effects with multiple seizures. Accordingly MECT cannot be considered reasonable and necessary and is not covered by the Medicare program." (See attachment)*

**Proposed Amendment:**

The practices and procedures for the delivering of ECT (that were put into law in Texas) should be adopted as follows:

**i) (a)** There shall be a standard written consent form to be used when electroconvulsive therapy is considered. The written consent form must clearly and explicitly state:

1) the nature and purpose of the procedure;

2) the nature, degree, duration, and probability of the side effects and significant risks of the treatment commonly known by the medical profession, especially noting the possible degree and duration of memory loss, and the remote possibility of death;

(3) that there is a division of opinion as to the efficacy of the procedure; and

(4) the probable degree and duration of improvement or remission expected with or without the procedure.

**(b)** Before a patient receives each electroconvulsive treatment, the hospital, facility, or physician administering the therapy shall ensure that:

(1) the patient and the patient's guardian of the person, if any, receives a written copy of the consent form that is in the person's primary language, if possible;

(2) the patient and the patient's guardian of the person if any, receives a written supplement that contains related information that pertains to the particular patient being treated;

(3) the contents of the consent form and the written supplement are explained to the patient and the patient's guardian of the person, if any:

(A) orally, in simple, non-technical terms is in the person's primary language, if possible; or

(B) through the use of a means reasonably calculated to communicate with a hearing impaired or visually impaired person if applicable;

(4) the patient or the patient's guardian as appropriate, signs a copy of the consent form stating that the person has read the consent form and the written supplement and understands the information included in the documents; and

(5) the entire informed consent procedure is videotaped in accordance with the earlier amendments and that the videotape of this informed consent and the signed copy are both made a part of the person's medical records.

**(c)** Consent given under this section is not valid unless the person giving the consent understands the information presented and consents voluntarily and without coercion or undue influence.

**(d)** A patient or guardian who consents to the administration of electroconvulsive therapy may revoke the consent for any reason and at any time. Revocation of consent is effective immediately and must also be videotaped in accordance with the procedures outlined in the earlier amendments.

**(e)** A mental hospital or facility administering electroconvulsive therapy, (or psychosurgery) or a physician administering the therapy on an outpatient basis shall submit to the Department of Health quarterly reports relating to the administration of the therapy in the hospital or facility or by the physician.

(a) A report must state for each quarter:

(1) the number of patients who received the therapy including:

(A) the number of persons voluntarily receiving mental health services who consented to the therapy;

(B) the number of involuntary patients who consented to the therapy;

(C) the number of involuntary patients for whom a guardian of the person consented to the therapy;

(2) the age, sex, and race of the persons receiving the therapy;

- (3) the source of the treatment payment;
  - (4) the average number of non-electroconvulsive treatments;
  - (5) the average number of electroconvulsive treatments administered for each complete series of treatments, but not including maintenance treatments;
  - (6) the average number of maintenance electroconvulsive treatments administered per month;
  - (7) the number of fractures, reported memory losses, incidents of apnea, and cardiac arrests without death;
  - (8) autopsy findings if death followed within 14 days after the date of the administration of the therapy; and
  - (9) any other information required by the Department of Health.
- (f) The Department of Health shall use the information received in the above points to analyse, audit, and monitor the use of electroconvulsive therapy, (in addition to psychosurgery) administered to treat mental illness.
- (g) The department shall file annually with the Minister a written report summarizing by facility the information received under the reporting line. If the therapy is administered by a private physician on an outpatient basis, the report must include that information. The department may not directly or indirectly identify in a report issued under this section the patient who received the therapy.

## **Part 5 Treatment of Patients Consent not required (s. 109)**

Universal Declaration of Human Rights states:

*Article 3: Everyone has the right to life, liberty and security of person.*

**No-one should have psychiatric treatment forced upon them regardless of their status.**

Considering the intrusive nature of all psychiatric treatments, the high percentage of unwanted side-effects and physical and mental damage caused by such treatments, no person should be given psychiatric treatments without their fully informed consent.

**Proposed Amendment:**

Fully informed consent should be obtained from everyone, no matter their status.

## **Part 5 Treatment of Patients Second opinions (ss 111, 112, 164)**

In view of the fact a person can be administered treatment very quickly, if the person is dissatisfied with their treatment, their complaint should be acted upon immediately by the relevant authority.

## **Proposed Amendment**

All patients should have the right to an independent medical opinion from a physician of their choosing. All complaints should be dealt with within 24 hours.

### **Part 5 Treatment of Patients Emergency Psychiatric Treatment (ss. 113-115)**

United Nations Principles for the Protection of Persons with Mental illness states:

*Principle 8:2 Every patient shall be protected from harm, including unjustified medication, abuse from other patients, staff or others or other acts causing mental distress or physical discomfort.*

Universal Declaration of Human Rights states:

*Article 5 No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.*

## **Proposed Amendment:**

This section of the Mental Health Act 1996, should be abolished. No patient should be given any psychiatric treatment without fully informed consent as described above.

### **Part 5 Treatment of Patients Mechanical bodily restraint (ss. 121- 124 & Regulations 14-16)**

The United Nations Principles for the Protection of Persons with Mental illness states:

*Principle 1 (2) All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of human person.*

*Principle 2, Protection of Minors, Special care should be given within the purposes of these principles and within the context of domestic law relating to the protection of minors, including if necessary, the appointment of a personal representative other than a family member.*

*Principle 8 Standards of Care (1) Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.*

*Principle 11 (11) Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others... All instances of physical restraint or involuntary seclusion shall be recorded in the patients medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified ,members of the staff...*

## **Proposed Amendment:**

Due to the above, the following amendments should be made:

The use of physical restraints on children and adolescents should be abolished with criminal penalties for its use.

The practice on adults should be as a last resort only and should not be accompanied by the administration of psychotropic or neuroleptic drugs.

The duration of restraint/seclusion would be videotaped to ensure that there is no abuse, mistreatment or complications. The videotape would then form part of the medical records.

### **Criminal penalties**

- a) A person commits an offense if the person intentionally causes, conspires with another to cause or assists another to cause a minor to be physically restrained in a mental health facility.
- b) A person commits an offense if the person intentionally causes, conspires with another to cause, or assists another to physically restrain an adult in a mental health facility in violation of the standards set out above.

Where the restraint of the adult (or illegal restraint of a child) results in harm damage or death, those responsible for causing physical restraint, including the supervising psychiatrist or doctor, shall be held culpable and charged and tried in accordance with criminal law.

## **Part 7 Protection of Patients' Rights Explanation of rights (ss. 156-159 & Regulation 18)**

United Nations Principles for the Protection of Persons with mental illness states:

*Principle 12:2 If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.*

Due to the fact that there is no record of a patient actually being given his rights, it creates a situation if the person has not been given his rights and understood the rights, the person does not know his or her rights have been violated or alternatively has no way of ensuring his or her rights are not violated.

It is also difficult to prove someone has not been given their rights. By videotaping the giving of rights and obtaining written confirmation from the next of kin/nominated person that they also have been given the rights, it protects both the patient and the mental health facility.

Codified rights of persons within psychiatric hostels also need to be defined under the Mental Health Act which should be displayed prominently in psychiatric hostels.

This can be prevented by the following amendment to existing law.

## **Proposed Amendment:**

As per Part 5, Informed Consent.

**Part 7**  
**Protection of Patients' Rights**  
**Access to records (ss. 160, 161)**

161. The patient should be able to nominate who they want their medical records released to. They should be able to nominate *any person* who is helping them, to receive their medical records.

**Part 7**  
**Protection of Patients' Rights**  
**Personal possessions/ letters/ phone calls and visitors (ss. 165-171)**

United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 13(c) Freedom of communication, which includes freedom to communicate with other persons in the facility: freedom to send and receive uncensored private communications: freedom to receive, in private, visits from counsel or personal representative and, at all reasonable times, from other visitors: and freedom to access postal and telephone services and to newspapers, radio and television.*

Universal Declaration of Human Rights states:

*Article 12. No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor attacks upon his honor and reputation. Everyone has the right to protection of the law against such interference or attacks.*

**Proposed Amendment:**

The above principles should be implemented fully as any patient should have the right to receive mail, phone calls and visitors, and no psychiatrist should be able to take away these basic human rights.

**Part 10**  
**Miscellaneous**  
**Capacity to vote (ss. 201- 203)**

United Nations Principles for the Protection of Persons with Mental Illness States:

*Principle 1:4 There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.*

*Principle 1:5 Every person with a mental illness shall have the right to exercise all civil, political, economic, social, and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, The International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body Principles for the protection of all Persons under any form of Detention or Imprisonment.*

Universal Declaration of Human Rights states:

*Article 21. (1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.*

*(2) Everyone has the right of equal access to public service in his country.*

*(3) The will of the people shall be the basis of the authority of the government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.*

Australia is a democratic nation and no psychiatrist should be able to prevent someone from voting for their chosen representatives in government.

## **Proposed Amendment**

Any restrictions on voting should be removed from the Mental Health Act 1996.

## **Mental Health Review Board (Part 6 & schedule 1 & 2) (eg Registrar [ss22-25 and Regulations 8, 9] Establishment, Constitution, Procedure, Reviews, Appeals, Provisions concerning Proceedings)**

United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 17:2 The initial review of the review body, as required by paragraph 2 of Principle 16 above, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.*

This principle needs to be implemented fully as there is no immediate review of the decision to retain someone as an involuntary patient, and subsequent reviews are too far in between, and when requested they take too long to occur.

There should be no authorisation for any psychiatrist to order the incarceration of a person for a period of 6 months. This is way too long and is a gross violation of a person's liberty, even without taking into consideration the fact that psychiatry has not proven the efficacy of its treatments and cannot cure any conditions.

This needs to be considered in line with our justice system which deals with imprisonment. No person other than a Judge or Magistrate has the right to order the imprisonment of a citizen, and such is only done after careful consideration of all contributing factors as provided to the Judge or Magistrate according to the laws of evidence and jurisprudence. Even a person found guilty of committing a crime against another person or the state, is afforded full consideration of all mitigating factors before sentence is passed. In the case of a woman for example, the Judge gives consideration to whom will care for her children, the reasons if any given for having committed the crime and whether the convicted has been co-operative with law enforcement are taken into account upon sentencing. It is recognised in our society that detainment in prison is a serious matter as it is a serious deprivation of liberty, and is not mitigated upon individuals lightly.

However this is not the case in the current Mental Health Law. Incarceration within a mental health facility is in numerous ways effectively imprisonment, as the person is removed from being able to control their life, whether this is caring for their children or running a business or simply enjoying life as a free citizen. And in this instance the person hasn't even committed a crime in the eyes of the law.

The following example reported to CCHR Perth in 2003, illustrates what can occur: A mother went to a Mental Health Review Board for one of her children. To her horror she discovered that her

child's medical records contained totally incorrect sexually explicit information about her and her child. This information was being used in the review and was the basis from which the decisions made by the Board were put into action. There was an attempt to remove the information from the file to no avail. Ms B said, " I believe that information which has been derived from a collection of words between the doctor and the client, that is not classed as actual facts, should not be allowed to be used in a court of law like a Mental Health Review Board by psychiatrists. The incorrect information is then used in the future to determine whether someone is still mentally ill."

Involuntary detainment should be abolished, and where this is not done, such procedures for incarceration should take place in a court of law, any detainment period must be brief and avenues for the person's right to defend themselves in a court of law against such, and at any future time, must be fully catered for.

If psychiatrists through the state want the right to involuntarily incarcerate and thus deprive patients of their liberty and forcibly treat them, then free legal advocacy at the expense of the state must be available at all times to the patients concerned.

A list of groups and individuals independent of the psychiatric facility who could assist or represent them and who have no financial, familial, political or work connections to the facility, its employees or the mental health department needs to be provided to the patients.

**Abolish Involuntary Commitment:** As mentioned it is CCHR's position, however, that all involuntary commitment be abolished. As psychiatrists claim to be medical doctors, then the same provisions for medical doctors should be applied to psychiatrists: no detention and treatment in a hospital without the full and voluntary informed consent of the patient.

**Proposed Amendment:**

Section 141. (1) should be deleted as this simply takes away the patient's right to a review and undermines the process itself.

**Proposed Amendment:**

United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 12:3 A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.*

Section 142. (2) The Board should not be deciding who has a genuine concern for the patient, the patient should have the opportunity to determine who has a genuine concern for them and allow that person to make application on their behalf.

**Proposed Amendment:**

United Nations Principles for the Protection of persons with Mental Illness states:

*Principle 18:5 The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.*

Schedule 2-Provisions Concerning Proceedings Before the Board. 3. (b) A patient should have the right to be represented by any person they deem fit to do so and whom the patient believes has their best interests at heart. "with the leave of the Board" should be deleted and amended to "by counsel or any other person requested by the person.

## **Proposed Amendment:**

Schedule 2-Provisions Concerning Proceedings Before Board, 10. As already mentioned, if psychiatrists through the state are forcibly incarcerating someone, then the state should pay all costs involved in proceedings before the Board.

## **Council of Official Visitors (Part 9 & schedule 3 & Regulation 20) (eg Administrative and Procedural Provisions, Powers and Functions)**

United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 14:2 Each mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with the present principles.*

*Principle 22 States shall ensure that appropriate mechanisms are in force to promote compliance with the present Principles, for inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the right of the patient.*

## **Proposed Amendment**

The Council of Official Visitors should be able to assist every person affected by the Mental Health Act 1996. This would enable persons not involuntary to also obtain assistance. This would include any patient in a private or public mental health service.

The definition of "affected person," should therefore include any person no matter their status, in any private or public hospital, any person who is the subject of a community treatment order, any person in a psychiatric hostel.

The Council of Official Visitors should be given power under the law to enforce the Mental Health Act, issue infringement notices and prosecute those who do not comply with the infringement notices or prosecute without an issued infringement notice if the violation warrants it. If bodies such as Occupational Health and Safety, the Fire Brigade etc can enforce improvements upon other organisations to be compliant with relevant legislation, then the Council of Official Visitors should have the power to enforce the Mental Health Act to protect patients rights. If the Council of Official Visitors does not have the power to ensure that this is done, then there is no governing body to protect patients, just a monitoring and reporting body who can assist, but do not have the power to really improve the mental health system.

## **Part 10 Miscellaneous**

### **Records and information (ss. 204, 205, 212, & Regulations 17, 19)**

There continues to be a situation where medical records are not adequately maintained with sufficient accurate information. A list of the specific categories of information required to be kept needs to be legislated so that this can then be enforced upon the staff and psychiatrists so that evidence exists and serves as a recording of the patients' diagnosis and explanation of such, exact treatment and behaviour during hospitalisation. Penalties should be enacted for breaches of record keeping as this is information required by staff to care for the patient and vital evidence that may be required in court on criminal, civil or coronial matters.

A complainant to CCHR Perth in 2000, made the following statement to CCHR concerning record keeping: "My daughter hung herself in ... psychiatric hospital and died as a result. My daughter told staff twice on the morning of the day that she hung herself that she was suicidal. The staff did not note this in her medical records. On the third occasion they did note it, but as the earlier times were not written the severity was not seen, though the statement, 'I'm suicidal' should be considered the ultimate, obviously. And if this is the case, one on one nursing needs to be observed and adhered to. This seems to be a problem in mental institutions...some staff are not observant or just do not care. More thorough investigations as to the background and stability of mental health staff is essential. Will these staff actually do their job and care for the person and record vital information as part of their job and take action when it is needed."

In October 2000, the Coroner in his findings said that the hospital had to improve their record taking in recording of suicidal ideation. It can be seen that record taking has not improved. The Council of Official Visitors in late 2002 reported that a person was placed in mechanical body restraint and no records were kept of who visited, treated her nor of any medical examinations. (*West Australian Newspaper*).

During the inquest into the death of the daughter of one of CCHR's complainants in 2001, it was revealed that: neither the nurse nor the doctor could tell from the medical records exactly what had occurred with a blood test. They could not tell if it had been done or not. This is an extremely dangerous state of affairs, people's lives could depend on the accuracy of the medical records. Staff should be accountable for their errors. If they were then the errors wouldn't keep occurring again and again.

A patient stated to CCHR Perth in 2002: "I gained access to all the notes under the Freedom of Information Act... I could criticize the content page by page but it would take days to explain where they were biased, generated assumptions and even some statements were made which did not match truth. In short I discovered outright lies, things which I never said."

## **Other areas of concern:**

### **Part 2 Division 3-Psychiatrists and authorized practitioners Register of psychiatrists**

S. 17 (1) The register of psychiatrists should be made available to the public. CCHR requested a copy of the register from the Medical Board in 2002. The Medical Board advised that it was not available in published form and the Mental Health Act 1996 does not provide public with an express legal right to inspect the register.

## **Living Will**

United Nations Principles for the Protection of Persons with Mental Illness states:

*Principle 7:3 Every patient shall have the right to treatment suited to his or her cultural background.*

Universal Declaration of Human Rights states:

*Article 18. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.*

One of the ways a person can protect their rights to receive or not receive certain medical treatments in the event they are unable to make their wishes known is through the "living will."

If a person makes their wishes known through a living will, signed at a time the person is of sound mind, concerning intrusive treatments including psychiatric treatment, then this must be respected by mental health practitioners, and the law amended to reflect this.

**Proposed Amendment:**

A clause be added to the definitions, specifically “meaning of mental illness” stating that no person whom has signed a living will rejecting psychiatric treatments or labels can be brought under this Act or given any treatment thereunder.