Mental Health Accountability and Chemical Restraint

Research Report and Recommendations

March 2015

JUSTICE ACTION

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Mental Health Accountability and Chemical Restraint: Research Report and Recommendations is a Justice Action study into mental health consumer preferences regarding medication and the willingness of authorities to consider collecting this data.

"You win the battle but lose the war, if the goal is to help the person get better. There are many ways to heal."[1] (Aaron Levin)

Exective Summary

Data collection on the use of seclusion in mental health management has resulted in increased awareness of its harmful effects and a dramatic lessening of its use. As a result, however, it has been postulated that the use of medication to sedate consumers against their preference may have increased. In an attempt to establish data collection for consumer (patient) preferences, thirty-five mental health authorities from both Australia and New Zealand were contacted. They were asked to consider altering the required procedural forms to include a question on whether the consumer actually wants the medication that is given to them. Of the thirty-five participants contacted not one person in authority was prepared to discuss the proposed question.

Justice Action, recognising the lack of responses by these individuals, has redirected its research away from this initial 'top down' approach to instead work directly with consumers themselves. Research was conducted recording the consumer's preference to medication of over 100 consumers from Australia and New Zealand across five mental health wards. Consumers responded to their own suggested question, 'Do you find your medication beneficial to you?' The overwhelming response to this question was negative, with 81% of respondents believing that their medication was not beneficial to their treatment. The remaining 19% agreed that the medication was beneficial, but many suggested that their compliance was motivated by a desire to establish goodwill with their psychiatrists and treatment teams to encourage favourable treatment and an early release.

From the evidence complied, the 81% of patients surveyed who do not consider their medication to be beneficial indicated that the majority of consumers would prefer not to receive their medication. It is very concerning that consumer preferences towards their

[1] Aaron Levin, "Covert Drug Administration: `Win Battle, But Lose War'." *Psychiatric News*, 40(10) 10.

own medication is not acknowledged nor seen as important. The absence of official instruments to record the preference of consumers represents a complete absence of consumer agency in the treatment of mental health conditions.

Moreover, the results of eight months of logged contact and discussion with mental heath authorities has unearthed significant issues surrounding the transparency and accountability of the treatment of vulnerable individuals.

Background

'Mental Health Accountability and Chemical Restraint, Research Report and Recommendations' is the culmination of eight months of logged contact and discussions with mental health authorities, initiated after the 9th National Seclusion and Restraint Forum. The report is a response to the concern that forced medication could replace the now significantly reduced use of seclusion for mental health consumers.

The Forum revealed a reluctance to discuss the reality of this important issue. Justice Action's subsequent proposal to include consumer preferences on the National Inpatient Medical Chart (NIMC) exposed the total unwillingness of mental health authorities to commence data collection on consumer preferences to medication. Justice Action contacted thirty-five health professionals and authorities (the participants). These individuals included attendees of the 9th National Seclusion and Restraint Reduction Forum and the Chief Psychiatrists from Australia and New Zealand. The thirty-five participants were emailed a proposal for amendments to medical treatment forms with a section to log consumer preference to receiving their medication. Each of these participants was emailed the proposal and received an average of four follow-up phone calls.

Justice Action received only five responses and of them, four accepted the need for better accountability and measurement of forced medication. However, of all the thirty-five participants contacted, none were prepared to enter into a discussion about the inclusion of a question regarding consumers' preferences. In the face of this poor response, Justice Action conducted research into the extent and level of acceptance of medical treatment in a survey of consumers.

The 2013 report entitled '*Mad in Australia*', [2] published by Justice Action, highlighted the legal and personal implications of forced treatment for mental health patients. This publication emphasised the abuse of forced medication and proposed other responses to mental illness. Justice Action outlined their concerns in this report that 'the therapeutic benefits of involuntary medication can mask, rather than relieve the symptoms of medical illness(es) often with sedative effects, which are used as chemical restraints'.[3] This can result in the use of chemical restraint by psychiatrists as a subsequent by-product of medical administrative practices.

Since the publication of '*Mad in Australia*', reports of forced treatment and sedation investigated by Justice Action suggest nothing has changed and that the use of chemical restraint may even have increased as an alternative to the more thoroughly monitored physical forms/practices of seclusion and restraint (e.g. isolation in rooms for long periods of time, being physically restrained by bindings, etc.). Disturbed by this suspected increase, Justice Action created a proposal for procedural change in the administration of treatment for mental health consumers, identifying the use of forced medication as a possible abuse of trust and authority by professionals.

In its email to the thirty-five participants, Justice Action proposed including a "Yes/No" question on existing medical paperwork regarding the consumer's preference to the medication being administered. This simple question, "Does the medication being administered to you suit your preference?" would allow accurate data to be collected and recorded, as to whether consumer consent is given, in order to assist future mental health policy (Appendix A). Such a step also encourages dialogue, cooperation and compromise between medical professionals and consumers, thus potentially contributing to a break down the 'us' and 'them' mentality.

Data Collection Proposal

Currently, there are no official State, Territory or Federal procedures to record consumer's preference for regular or irregular medication. No official quantitative or qualitative records for consumer preference to treatment exist. Justice Action believes

[2] Justice Action, '*Mad in Australia: The State's Assault on the Mentally Ill*' (2007).
[3] Penelope June Weller, 'Developing Law and Ethics: The Convention on the Rights of Persons with Disabilities' (2010), Cited in 'Mad in Australia', Justice Action (2013) 23.

this inevitably results in biased records that do not reflect patient wishes as well as an overall lack of transparency regarding practitioner's treatment of vulnerable members of the community. Measures should be implemented to formally record whether mental health consumers want their medication in the medical registers, used to guide treatment.

Justice Action proposed that the *Medication Handling in NSW Public Facilities* document[4] be amended to include the question 'Do you want the medication that is given to you?' to ensure that consumer preference to medication, reflecting the wishes of the consumer, is recorded on every individual medical chart in a checkbox format. It was alternatively proposed that this question be asked at the point of prescription, in addition to the form in the *Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists*.[5]

The Justice Action proposal aimed to gather data detailing consumer preference in order to create transparency regarding the scope of forced medication. Accurate data would allow for a comprehensive review of the treatment of mental health consumers, provide the consumers with a greater sense of agency and as such, mental health systems can become more effective, transparent and accountable.

Of the thirty-five participants contacted across nine jurisdictions by Justice Action, only four individuals from NSW, ACT, SA and NZ responded positively, advocating their support for the procedural change proposals to ensure their jurisdiction did not partake in harmful practices. One particular response from a participant demonstrated the disdain with which the proposal was treated, evidenced by the suggestion that the proposal was 'dramatic… over the top… [and] to be disregarded'.

The lack of transparency and accountability of the leading mental health figures and government officials in both Australia and New Zealand gives rise to many concerns including the human rights implications of such procedures. It would appear that the

[4] NSW Government Department of Health, '*Medication Handling in NSW Public Health Facilities'* (2013) <http://tiny.cc/iecomx>.
[5] NSW Government Department of Health, *'Guide to Poisons and Therapeutic goods legislation for Medical, Nurse, and Midwife Practioners and Dentists'* (2007) 3 <http://tiny.cc/uacomx>.

practice of administering involuntary medication is considered to be above reproach or immune from review or discussion.

The lack of discourse on chemical restraint can be considered to be a direct result of the lack of data being collected on coercion of the consumer by the state. The absence of such data was noticeable at the 9th National Seclusion and Restraint Forum, despite multiple presenters alluding to their concern for consumer health and safety[6]. The Forum neglected, and was seemingly reluctant to discuss, the realistic possibility that medication is increasingly being utilised as a form of chemical restraint. The persistent use of coercive medicine nullifies the ultimate goals of the Forum - to increase patients' involvement and improve the mental health system.[7]

Consumer Directed Research

The independent research Justice Action has undertaken has exposed the dynamic of the relationship between the physician and consumer, which cultivates unequal bargaining power and the opportunity for physicians to exploit the vulnerability of the consumer. By disagreeing with medical professionals and opposing their treatment, consumers run the risk of being clinically judged by psychiatrists as possessing a lack of insight. This can then be used to justify further involuntary treatment and even refused release. Given this, it is likely that the anonymous nature of Justice Action's survey allowed it to record responses that may not have been given in a more public, official setting for fear of being perceived as opposing treatment and the potential consequences of this.

Methodology

Following the poor response from authorities to proposed changes, Justice Action went directly to the consumers, using a survey, to collect quantitative data (with opportunity for additional optional qualitative response if desired) on the issue of forced medication. This research was founded on a consumer proposal, and asked whether consumers felt that their medication was beneficial.

[6] Justice Action, *National Forum of Seclusion and Restraint* (2013) <http://tiny.cc/6w4nmx>.
[7] Ibid.

Consumers from Australia and New Zealand across five mental health wards were posed the question, 'Do you find your medication beneficial to you?' (N=100). Respondents recorded their answer as 'Yes' or 'No' and were given the opportunity to expand on the reasons for their response.

Results

Of the 100 consumer participants to the question 'Do you find your medication beneficial to you?':

- 81% of the respondents answered 'No'
- 19% of the respondents answered 'Yes'

Our findings suggest that a significant number of consumers not only objected to their current treatment plan, but also would not actively partake in their medication regime if they did not have to.

It is important to note however, that of those who found medication beneficial and would comply with medication of their own volition, most cited reasons not directly related to their mental well being in justifying their response. Instead, justifications included that medication would help them sleep or because they believed compliance would help them get out of the system and return home sooner.

Previous Research into Consumer Preference

As stated earlier, that no research has been conducted in Australia regarding consumer preferences in medication. However, some research has however been conducted overseas and is outlined below.

In Sweden, Greenberg et al. (1996) interviewed 30 forcibly medicated acute-care in-patients after discharge about their attitudes and experiences of forced medication. Fifty per cent expressed fear of side effects; seventeen per cent feared addiction and objected to others controlling them; forty per cent felt angry; thirteen per cent embarrassed; one third helpless, and one quarter fearful.[8]

[8] Forced Medication in Psychiatric Care: Patient Experiences and Nurse Perceptions, K. Haglund. L. Von Knorring & L. Von Essen, *Journal of Psychiatric and Mental Health Nursing*, 2003, p. 66.

Von Essen & Sjoden (1993) found that a trusting relationship between staff and patients was considered a key element of care for psychiatric patients.[9] Findings by Olofsson et al. (2000) indicated that closeness with and attention from nurses and physicians might reduce patient feelings of discomfort and increase feelings of security when subjected to coercion.[10] The Swedish study by Haglund et al. conducted in five locked wards at department of psychiatry for inpatient care in Sweden found that forcibly medicating a patient was connected with "a violation of patient integrity" and "psychological discomfort", experiencing anger, panic and sadness.[11]

In a study published in the United Kingdom, sixty-nine patients who were diagnosed with schizophrenia were questioned regarding their satisfaction with and subjective experiences of treatment with anti-psychotic medication[12]. Two-thirds indicated that they found the medication to be beneficial, however sixty-four per cent reported that they were experiencing side effects and only fifty-eight per cent said that their healthcare professionals dealt with their side effects effectively[13].

McEvoy and Colleagues (1981) found that forty-seven per cent of a sample of mentally ill patients felt their medication was unnecessary[14]. Allen and Barton (1976) sampled a group of inpatients who were dissatisfied with staff interactions. These patients perceived psychiatric residents and nursing staff as "authoritarian" and said there was not enough informal communication between staff and patients.[15] This indicates that the patients valued "sincere relationships with all levels of treatment personnel"[16]. More generally, patients were unhappy with the lack of information shared about medication effects. (Distefano et al., 1980; Glenn, 1978) The majority of patients expressed displeasure with the use of seclusion techniques to control violent and no-compliant

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[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Gray, R., Rofail, D., Allen, J., Newey, T., 'A survey of patient satisfaction with and subjective experiences of treatment with anti psychotic medication' in *Issues and Innovations in Nursing Practice*, 2005, 52:1, pp. 31-37.
[13] Ibid, 34-35.
[14] Corrigan, P. 'Consumer satisfaction with institutional and community care' in Mental Health Journal, 1990, 26:2, pp. 153.
[15] Ibid.
[16] Ibid, 157.

patients. (Binder et al., 1983) As seen in a study by Soliday (1985) consumers said that these methods of seclusion is too frequently used as a punishment and tends to humiliate people.[17]

Noble and Douglas (2004) found that the single most common request from patients was a desire to make decisions for themselves.[18] Furthermore, there were indications of a relationship between patient's requests and outcomes of care as better outcomes were associated with services meeting patients' requests or acknowledging requests that could not be met.[19]

Gibson, Cartwright and Read (2014) found that patients had predominantly negative views of anti-depressants because they have limited information about the medication or about other treatment options. In the study, patients expressed a preference to psychotherapy rather than medication and generally believed that they had been given insufficient information about medication effects, with 40% saying that they had not been informed about side effects.[20] Some evidence also suggested that physicians had not discussed alternative treatments to anti-depressants.

Discussion

Given these results, it is clear that the current system in Australia and New Zealand, as well as internationally, is not consumer focused. Consumers are either not involved in the decision-making for their treatment or their agreement is frequently coerced or ignored. Consumer preference or objection is regarded as irrelevant and has no official or de facto role in treatment decision-making processes.

This indicates a significant ethical issue not yet addressed within current codes of practice that govern mental heath authorities, despite the Australian Commission on

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[17] Ibid.

[18] Lorraine Mary Noblea and Brian Christopher Douglas 'What users and relatives want from mental health services', (2004) 17(4), *Current Opinion in Psychiatry*, <http://journals.lww.com/co-psychiatry/Abstract/2004/07000/What_users_and_relatives_want_from_mental_health.11.aspx>.

[19] Ibid.

[20] Kerry Gibson, Claire Cartwright and John Read, 'Patient-centred Perspectives on Antidepressant Use' (2014) 43(1) *International Journal of Mental Health* 81-99.

Safety and Quality in Health Care (ACSQHC) emphasising the need for a consumer-centric approach.[21]

Changes should be made to medication recording systems to include a recorded acknowledgement of consumer preference, ensuring that consumer autonomy remains protected and that exploitation does not occur. This could be achieved by incorporating the question proposed by Justice Action to the thirty-five participants, namely 'Do you want the medication that is given to you?'

The medication process will be consistent with the obligation to uphold the rights of consumers as outlined in the Australian Government's National Standards for Mental Health Services (NSMHS).[22] In particular, the inclusion of a clear Yes/No question will meet NSMHS guidelines by ensuring that 'all care delivered is subject to the informed consent of the voluntary consumer'[23] as well as adhering to 'the right of the consumer to be involved in all aspects of their treatment, care and recovery planning'.[24]

The collection of answers to the proposed question by consumers will also help fill what the National Mental Health Consumer and Carer Forum (NMHCCF) said was a gap in 'clear, regular and reliable public reporting' with regard to seclusion and restraint[25]. The NMHCCF also said that 'chemical restraint is unacceptable as a form of involuntary restraint in any circumstances and is 'exceptionally dangerous… for people with mental illness'[26] reinforcing the need for change as asserted by Justice Action.

The NSW Health Policy Directive states that chemical restraints can only be used in 'extreme circumstances when other forms of management of a less restrictive nature have been proven unsuccessful'[27]. However, as indicated in '*Mad in Australia'*, under

[21] Electronic Medication Management Systems- A guide to Same Implementation (EMM) 17(Figure 5.2).
[22] Australian Government, *National Standards for Mental Health Services (NSMHS)*, (November 2014) <.http://tiny.cc/pocomx>.
[23] Ibid, 1.3.
[24] Ibid, 1.10.
[25] Ian Hickle, 'Ending Seclusion and Restraint in Australian Mental Health Services' (paper presented at the National Mental Health Consumer & Carer Forum, 2009) 8 <http://tiny.cc/34comx>.
[26] Ibid, 6.
[27] NSW Government Department of Health, *'Policy Directive: Seclusion Practices in Psychiatric Facilities'* (2007), cited in Justice Action 'MAD in Australia' (research discussion paper, 2013) 16.

the *Mental Health Act 2007* (NSW) the safeguards for patients against non-compliance with this directive are not yet secure enough to ensure patient protection.

More generally, the NMHCCF has said it is their position that involuntary seclusion and restraint 'should be eradicated from use in Australia's mental health services'[28]. Bradley Foxlewin of the NSW Mental Health Commission has advocated against seclusion and restraint, saying that the practice is 're-traumatising' patients.[29]

Emphasizing the need for transparent and open discourse, this paper mirrors the views of the Executive Director of the Brain & Mind Research Institute, Professor Ian Hickie, who stated that 'the frequent requirement to seclude and restrain people with an acute mental illness highlights the ongoing failure of the mental health system to provide high quality care'[30]. The serious disenfranchisement within the current mental health system needs to be addressed through fair and open discussion in order to improve the recognition of patient's (consumer's) fundamental human rights.

The present study is limited in scope. However, the findings provide powerful evidence that warrants further investigation into mental health consumer's wishes and perception of medication compliance from a larger national sample. The findings also provide a clear example of legitimate concerns towards the failings of current medical practice and procedure that needs to be addressed.

Recommendations

The overwhelming desire to reject forced medication, as indicated in the data presented, raises concern that the chemical restraint of mental health consumers may be widespread. Furthermore, those who indicated that they consider their medication to be beneficial only as a method of perceived compliance cannot be said to have given free and voluntary consent. Moreover, in this case medication becomes beneficial only as a means to an end. These results allow for the possibility that the provision of involuntary medication may result in chemical restraints currently being employed on a

[28] Hickle, above n 25, 7.
[29] NSW Mental Health Commission, 'Our People Deputy Commissioner Bradley Foxlewin' <http://tiny.cc/b5domx>.
[30] Hickle, above n 25, 4.

large scale across Australia and New Zealand. As stated by the NMHCCF, 'chemical restraint is unacceptable as a form of involuntary restraint in any circumstance'.[31]

It is recommended that:

- Consumers should be given the opportunity to have their preference to particular medication and treatment recorded.
- This should be recorded in the 'Medication Handling in the NSW Public Facilities' document, posing the question '*Do you find your medication beneficial?'*.
- Alternatively, the question could be posed at the point of prescription, adding it to the provisions in the *Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists*.[32]
- Consumer led research into the issue of consumer preferences for the use of medication should be supported.

Justice Action encourages the implementation of these procedures and advocates for open and honest discourse surrounding seclusion and restraint in order to achieve the best care for at-risk and vulnerable individuals.

Glossary of terms

Consumer: A person who has or has had direct experience of mental illness and has used or is currently using mental health services.[33]

Restraint: When somebody's movements are restricted by the use of straps or belts (physical restraint) or sedation (chemical restraint).[34]

Seclusion: When someone is confined in a specific room from which they cannot freely leave.[35]

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[31] Ibid, 6.
[32] NSW Government Department of Health, above n 5, 3.
[33] Victorian Government Department of Health, *Strengthening Consumer Participation in Victoria's Public Mental Health Services* (2009) 2.
[34] Australian Government National Mental Health Commission '*Glossary; definition of 'restraint'* (2014) <http://tiny.cc/aoeomx>.
[35] Ibid, '*definition of 'seclusion'*.

Appendix A

Combination of two emails sent for survey 12 August 2014

Dear…

Please see Justice Action's linked Report on the 9th National Seclusion and Restraint Reduction Forum.

We have continued our research and ask for your response on the proposal underneath.

Earlier, we proposed the inclusion of a section in local Seclusion and Restraint Registers that would indicate whether an individual consumer wants the medication(s) administered prior, during or immediately after following restraint and/or seclusion. However, it is clear that the greater the focuses on the reduction of Seclusion and Restraint around an incident, the more likely that forced medications cloaked are regular 'treatment' will occur. The culture of the mental health industry has permitted this false division between treatment and sedations. This is a serious fault, primarily in the sense of coercion of consumers, and it being anti-therapeutic.

We would like to direct your attention to a serious issue. As the Report expresses, the Forum raised significant issues involving the reduction and elimination of seclusion and restraint practices in mental health facilities. However, there was an avoidance of the topic of medication, where the Forum failed to present corresponding data from any States on the rates of chemical restraint use. The absence of data and significant reduction in national rates of seclusions encourages the possibility that chemical restraint is being used as an alternative remedy to seclusion.

The administration of medications to mental health consumers against their wishes is equivalent to the overpowering of them by physical force. For too many consumers, it is much worse, with significant side effects; the issue of chemical restraint, however justified, was carefully avoided.

The strident voice of Justice Action and our distribution of 'Mad in Australia', ensured exposure of the issue. It is clear that involuntary medication is as critical an issue as physical restraint, but much more insidious. If the consumer is being overpowered, motivation is irrelevant. The question as to whether the patient wants the medication or not should be recorded; it is dishonest to say that only the psychiatrist's motivation is relevant, if so called treatment is prescribed.

Without data on restraint, there cannot be an accurate reflection of the current state of seclusion and restraint practices, which impedes efforts to improve the mental health system. Further, there are no records of the consumer's preference on the use of regular medication, which in turn gives no regard to the feelings of outrage in the use of restraint and sedation, threats of restraint or sedation, or other inducements to the same effect. It would be unreasonable to reject the premise that a consumer's wish be recorded, especially when viewed in context with the coercive forces of the treating parties, as the 'Mad in Australia' (linked above) report has demonstrated.

To resolve the gap in the date collection of coercion against the consumer, we have found the following opportunities for the question “Do you want the medication that is being provided to you?” to be posed to consumers and recorded.
We have focused on the NSW Health System; however, other states have similar processes and forms. Section 4.8.1 of the Medication Handling in NSW Public Facilities document (PD2013_043) Outlines a list of items to be specified in a medication chart order.

We propose that the question of whether a consumer “wants the medication given to them” be included in these requirements. This will be recorded on the attached National Inpatient Medical Chart (NIMC), in addition to all other required items necessary for all admitted patients. We propose a row to be included after ‘Prescriber Signature’, which would read “Consumer wants medication” followed by a checkbox for ‘Yes’, in a similar format to the ’VTE Risk Assessed’ checkboxes.

A further option is for the question to be asked at the point where a decision is made to prescribe medication. Currently, there is no documentation for the consumers’ response to the doctor about prescription. The question and response should be recorded in the prescription, as an addition to the particulars listed on the Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists (TG12/25, pg. 3), as well as the doctors clinical notes, as referenced on page 18 of the Electronic Medication Management Systems – A Guide to Safe Implementation (EMM). These responses would form part of the patient medical records, and the question may then be asked whether the consumer wants the treatment at the point the decision is made to treat, indicated in the third step of the ‘Inpatient Medication Management in Hospitals’ chart in the EMM document (linked above, pg. 19, Figure 5.3).

We have found that while the Australian Commission on Safety and Quality in Health Care (ACSQHC) emphasises a patient-centered approach in the issuing of medication, it is clear that this is not always the case. The EMM guide (as above) suggests an approach that involves the consumers in all aspects of medication management with the exception of a key component: the decision on treatment. This is evident in Figure 5.2 on page 17 of the EMM guide, in which the consumer forms the center of the diagram, linking to all principles, except the decision on appropriate treatment.

In incorporating this question into these key points, the medication process will be consistent with the obligation to uphold the rights of consumers, as outlined in the Australian Government’s National Standards for Mental Health Services. In particular, it will address the criteria that “all care delivered is subject to the informed consent of the involuntary consumer” (1.3) and for “the right of the consumer to be involved in all aspects of their treatment, care and recovery planning” (1.10). It will also be consistent with ACSQHC’s National Safety and Quality Health Service Standards, which outlines the need for an agreed medication management plan (4.14).

We understand the variety of forms used, and the inertia involved. However, any data collection focusing on coercive care, such as seclusion and restraint, that does not include the use of forced medication is deliberately misleading and not useful in demonstrating the issues at hand. To not record consumers’ views on receipt of medication is disrespectful to not only the consumers themselves, but to a wider society who are concerned with mental health and the meaning of ‘recovery’.

As part of our proposal, we are seeking responses from various State agencies regarding the elimination of unnecessary involuntary medication.
As part of your response, we would appreciate it if our views are presented in any committees or hearings through which you have input, or are able to provide us with an avenue through which may present such views.

Kind Regards
Olivia Richards Hill and the Justice Action Team

Appendix B

Media Release: Friday 28th August

Mental health accountability research

"Research showing the total unwillingness of Australian mental health authorities to be held accountable was launched at the Mental Health Services(TheMHS) conference held in Perth. How can we discuss positive forces for change at the conference when there is such structural concealment, disempowerment and hypocrisy from those being allowed to guide the industry?" said Justice Action Coordinator Brett Collins.

"Following the 9th National Seclusion and Restraint Reduction Forum in Canberra last year, Justice Action contacted all participants and every Chief Psychiatrist in Australia and NZ with a proposal to collect data on the use of involuntary medication for mental illness. Data collection for seclusion has now started, resulting in dramatic lessening of its use, but we postulated that chemical restraint may have replaced seclusion as a result. We asked those people in authority to discuss the possibility of including in the required paperwork, a question to those receiving medication about whether they wanted it" said Mr Collins.

"Over eight months beginning December 18th we logged emails, phone calls and visits to those thirty five representatives across all jurisdictions. Most participants were contacted five times. Thirty of the thirty five acknowledged receipt of the proposal but would not engage on the issue. One person said it was out of step with reality. Only four consumer representatives indicated their support. Not one person in authority was prepared to discuss the question" said Mr Collins.

"While the psychiatrists were trying to ignore the question, patients themselves initiated the same research in one major hospital. The question raised was: Do you find the medication beneficial to you? Over 81% answered: 'no'. The medical profession is clearly in breach of their ethical obligations and they know it" said Mr Collins.
The Justice Action publication, "Mad in Australia" outlines the history of abuse of people with mental health issues breaching international expectations.

For comments: Brett Collins 0438 705003

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