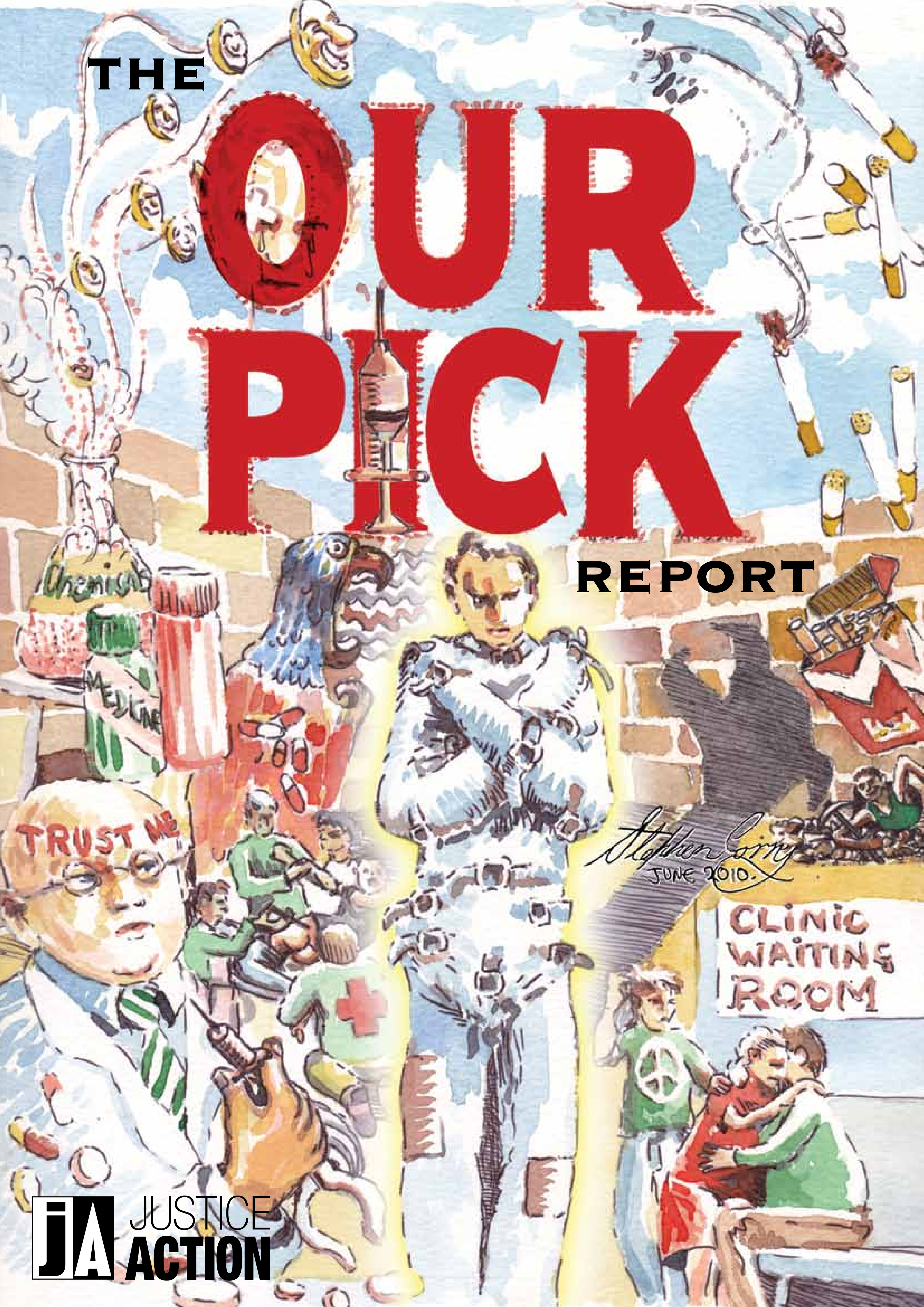
THE
OUR PICK
REPORT
Chemicals
MEDICINE
TRUST ME
Stephen Corry
JUNE 2010.
CLINIC
WAITING
ROOM
JUSTICE
ACTION

The OUR PICK Report accuses the Australian health industry of corruption and proposes the empowerment of mental health patients and prisoners to achieve effective delivery of services.

Proposal

- that a fixed percentage of 0.1% of the mental health budget be set aside as mandatory funding of independent consumer groups;
- that those consumer groups be democratically responsive to consumers' concerns, addressing issues of general importance, funding consumer-directed research and interacting with government policies;
- that in the interim, all service providers in the mental health industry fund independent consumer functions with a percentage of their budgets.

Launched at the International Conference on Penal Abolition ICOPA 13 in Belfast on June 25 2010 and in the Forensic Hospital, Long Bay, Sydney on July 1, 2010.

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The OUR PICK report

**REPORT CONFRONTING THE ABUSE OF "CARE"
IN MENTAL HEALTH AND PRISONS**

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The OUR PICK REPORT

REPORT CONFRONTING THE ABUSE OF "CARE" IN MENTAL HEALTH AND PRISONS

Introduction

Justice Action decided to focus on the mental health area after it had become apparent that a new strategy was required to defend community interests and prisoners' rights against the law and the added effects of tension, boredom, powerlessness and isolation occurring in imprisonment. Many prisoners become forensic patients or remain in prison under medication: the rates of major mental illness in prisons have been found to be three times higher than that of the general population.[1]

In mental health the focus is on making patients well, without the elements of guilt and punishment while retaining state control of citizens. Patients (consumers)[2] had been asking for our assistance, and we saw the chance of a forward defence for mental health patients' rights. If we could not defend patients' human rights what chance had we with prisoners?

Upon examination we discovered that forensic (incarcerated) mental health consumers receive even less respect for their dignity and humanity. In practice it is definitely better to be bad than mad. Lawyers who have enticed clients with a psychiatric defence are cursed from the dungeons. In both prisons and mental health wards almost everyone smokes, but it is the forensic consumers who have lost their tobacco.

Prisoners are regarded as normal people who have made mistakes, have to pay a penalty and then return to their former status. Forensic consumers however, are treated like children, unable to take responsibility for decision-making sometimes for the rest of their lives, depending on their psychiatric diagnosis. Total arbitrary control contrary to consumers' wishes is cloaked as euphemisms of expressions of care. The industry's culture creates professionals lacking empathy for patients; stumbling glassy-eyed humans are seen as effective work practice.[3] In the new Long Bay Forensic Hospital, all patients are medicated. Patient resistance is construed as sickness.

The consumer focus in mental health has been hijacked. Stated rights have become valueless in the face of this culture. External service providers dependent on government money are part of the problem. Patients are dehumanised and exploited to yield budgets of over $205,000 per forensic patient per year. Privacy and security mean hiding from examination. Visitors are discouraged and refused. Social support for patients is seen as causing disturbance rather

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1 Australian Institute of Health and Welfare (2009) *The Health of Australian Prisoners Report.*

2 The term 'consumers' was the preferred term by participants of the National Statement of Mental Health Rights and Responsibilities (1991)

3 The World Health Organisation (WHO) identified treatment of mental health consumers as one of three priority problems in its 'Health in Prisons' Project: Alex Gatherer (2005)'The World Health Organization European Health in Prisons Project After 10 Years: Persistent Barriers and Achievements' *American Journal of Public Health.*

than a community right, a necessary measure and an alternative to medication. A “clinical decision that the patient’s mental health might be affected” is enough for a refusal. There are no stated rules.

A long line of reports, including the 1992 ‘Burdekin’ Report and the 2005 Mental Health Council of Australia (MHCA) (in association with the Human Rights and Equal Opportunity Commission) ‘Not for Service’ Report, all express the failure in mental health and the need for change. However, nothing has changed on the ground despite billions of taxpayers’ dollars being spent.

The problem lies in the powerlessness of those for whom the services are provided: identified by the World Health Organisation (WHO) as one of the key barriers to consumer participation.[4] Authorities have used the stigma of mental illness and abused the trust of the public purse. They have taken control, redefined the services provided for the sick and bought the silence of those who should protest.

All participants in the public mental health area, except the consumers and carers, are paid by Health Department money and are all controlled by the same people. Obviously these services are not patient-focused: the consumers have no money. Patients’ opinions and contributions to their own wellbeing have been de-legitimized by those whom society has trusted to help them, despite involvement being essential to good health. Further, enforced medication is often used contrary to international standards to fill the gap.

Contrast this reality with the stated purpose of the health system, and the essential tenets of democracy that every human being is entitled to fair treatment and equality regardless of their mental status or disability and regardless of whether or not they are incarcerated.[5] Those principles in the Universal Declaration of Human Rights and other conventions form the basis of our laws, but there is no power of enforcement.

This paper is broken up into three parts:

1. The first describes the alarming realities for mental health consumers despite the existing legislation that is intended to protect them.
2. The second part focuses on funded and non-funded non-government organisations and their roles as mechanisms for assertion of consumers’ rights.
3. The third part of this paper is an explanation of key charters and legislation signed by the Australian government that are relevant to mental health consumers’ rights.

Proposal

We propose:

- that a fixed percentage of 0.1% of the mental health budget be set aside as mandatory funding of independent consumer groups;
- that those consumer groups be democratically responsive to consumers’ concerns, addressing issues of general importance, funding consumer-directed research and interacting with government policies;
- that in the interim, all service providers in the mental health industry fund independent consumer functions with a percentage of their budgets.

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4 WHO (1992) *British Columbia Participation Project Report.*
5 WHO (2007) *Health in Prisons Report,* xvii.

Section 1: The Realities of Mental Health Consumers

To be a mental patient is to be stigmatised, ostracised, " socialised, patronised, psychiatrised. — Rae Unzicker

The loss of control mental health consumers have over their health is disturbing on all accounts. The legislation and organisations discussed in the other sections of this paper don't effectively protect consumers' rights, but restrict them and justify their abuse. The authorities and organisations corruptly take the very resources and funding meant to service consumers' needs and use it dehumanise them.

Consumers must have power over their own lives and receive support to consider all methods of treatment (except in the case of a present serious risk to themselves or others). This should include no treatment at all, without arbitrary determination by the government, psychiatrists, and drug companies.

Justice Action has been working in mental health for decades. Our analyses are on our website. But our focus intensified after an approach by forensic patients in the Long Bay prison hospital in March 2008, discussed below.

Following this, consumers entering hospitals began to complain that smoking bans were being introduced in the mental health units and unlike other patients, they were not permitted to go outside to smoke. We then created an analysis that undermined any health justification for the ban, showing it was counterproductive and an abuse of power. In 2008 we formed the Right to Choose campaign.

We also examined the case of Saeed Dezfouli during our involvement in the mental health arena. Saaed is just a typical involuntary mental health patient. But in examining what has happened to him it became obvious that the Health Department itself is sick, that police handle mental illness very poorly and that it is difficult to support consumers' rights against the Health Department. Consumers are often at the centre of abuse and neglect. We now are Saeed's Primary Carer and stand beside him as a symbol for all involuntary consumers.

Long Bay Lockdown

Forensic patients at Long Bay prison hospital petitioned Justice Action in March 2008 following an ordered removal of 28 officers from the prison hospital area by the prison authorities. This was a part of their ironically named "Way Forward" plan. Patients were locked into solitary confinement cells at 3.30pm instead of 9pm as part of a cost-cutting measure. Neither organisations nor individuals on the ground seemed to care.

We then approached those directly involved in the issue and began a process of consultation and campaigning to force the transfer of control of the Long Bay prison hospital from the prisons to the Health Department.

The health profession, including Australia's leading forensic psychiatrists, nurses and the Mental Health Council of Australia, unanimously agreed that locking patients in solitary confinement for that period would be likely to exacerbate mental illness.

The nurses, prison officers and patients themselves agreed that it was detrimental to their recovery and would cause a huge increase in self-harm and suicide.

The nurses said that they could not give hospital care under those conditions, and that those very vulnerable patients with severe mental illnesses and medical/surgical patients would need to be transferred to general hospitals.[6]

6 To access the correspondence between Justice Action and the NSW Nurses Association and other details see http://tiny.cc/0f5e0

The patients told the manager that they would be refusing medication.

By the end of the campaign, the following action had taken place:

- Two Notices of Motion had been placed before State Parliament, decrying the practice (one each from the Liberals and the Greens)
- Supreme Court proceedings seeking orders that the practice be stopped immediately were imminent
- Legal proceedings based on breaches of Australia's human rights obligations under international treaties were also imminent
- A complaint had been made to ICAC alleging DCS employees had indulged in corrupt behaviour by misrepresenting the wishes of the patients and the dangerous health effects of the early lockdown practice
- Significant adverse media coverage had been generated in newspapers, on radio and an investigative piece had appeared on ABC TV
- A number of adverse written statements and letters to the Attorney General had been made by Australia's leading forensic psychiatrists and their representative bodies, as well as the NSW Nurses Association, HREOC, SANE Australia, NCOSS, the Aboriginal Justice Advisory Council and other significant community organisations.

Finally the government acknowledged the right of forensic consumers to treatment that respected their special needs. To cause vulnerable citizens to suffer for administrative purposes is essentially torture and diminishes us as a community. The government decided to transfer control of the Long Bay prison hospital to the Health Department.

Even then the government stalled and an Urgency Debate was placed before Parliament on 12 November 2008. Justice Action and the NSW Nurses Association provided written and oral presentations to the crossbenchers. All the parties in the Upper House joined together to ensure the motion was debated.[7]

During the course of the debate, Minister Hatzistergos gave an assurance that by 28 November 2008 all forensic patients would be transferred to the new forensic hospital. His words were unequivocal:

'Everyone knows that the current situation at Long Bay prison hospital is temporary. I say temporary because it is envisaged that on 28 November this year the new Forensic Hospital will commence to operate. When that occurs some of those persons detained in the Long Bay prison hospital who are forensic patients will move into the new forensic hospital under a regime that will be managed entirely by Justice Health. However, those inmates who remain in the prison hospital will not be forensic inmates…'[8]

But many are still there. We are watching.

Ban on Smoking in Hospitals

The Right to Choose Campaign (http://www.righttochoosealliance.com.au/) in regards to the smoking ban for patients is of special interest to Justice Action. There is no ban on smoking in regards to the larger population, and yet the government is trying to legally withhold those same rights from psychiatric inpatient consumers. In some states prisoners are also under threat. Smoking, albeit harmful to one's health, is a common recreational pastime enjoyed by an estimated 17% of the larger population of Australia that is not subjected to confinement.

The attack on the right to choose with smoking is just a symptom of the sickness in the health sector, where those for whom the service is intended receive what others decide is good for them. We challenge the policy of dictating lifestyles to consumers in closed institutions,

7 See http://tiny.cc/0f5e0 for more on this point.

8 Ibid.

including forced medication to change behaviour. We focus on the forced withdrawal of tobacco as symbolic of dishonest concern for consumers' welfare that yields counterproductive results.

Smoking is extremely important to patients and prisoners. From our own investigations we have observed that many prisoners earn less than $20 a week, and spend $18 on tobacco. In prisons and mental health units over 80% of the population smokes. It is their home. It is a personal pleasure accepted since the formation of the Penal Colony.

Justice Action strongly believes that to impose such a ban on a particularly vulnerable section of society when the same ban is not imposed on the larger community is not only undemocratic but also imposes a disproportionate level of suffering on those who are already disadvantaged. Even pubs and casinos have special areas for smokers despite patrons' ability to go outside.

The banning of tobacco – consumers' legal drug of choice – for dependent populations, whilst forcibly imposing medication to lessen the resulting trauma, is outrageous. It is in breach of ethics, laws and covenants, and does not achieve its stated intention.[9]

While the government says it is concerned about patients' health, the bans do not stop smoking in the long term. Where consumers are forced to give up smoking in mental health units, most resume smoking immediately upon discharge. One of the world's leading researchers in the area, Steve Kisely from Griffith University Medical School, is adamant that bans do not work, stating that the motivation to change theory emphasises that meaningful change will only occur when the patient has moved through the pre-contemplative, contemplative and planning stages through to the action stage.[10]

It is clear that the government position is wrong from every perspective. It is dishonest, ineffective and tries to overcome the little control that prisoners and patients have over their lives. Furthermore, it has attempted to silence dissenters. In October 2007, Justice Action was excluded from representing consumers at Justice Health's Consumer and Community Group following publicity on a possible smoking ban. As the only representative with prison experience, other participants said JA's involvement was essential, but the exclusion continues.

The lesson of the smoking case study is that only through working together with patients and prisoners can changes occur. This attempt at a ban provides an excellent chance to examine government rehabilitation policies generally including with prisoners, and why they have failed so comprehensively. The easy top-down dictatorial style of people management always fails, absorbs scarce resources and causes unnecessary tensions. Working with people requires patience and sensitivity but is more effective in the long run.

Case study of Saeed Dezfouli

The closed system of the NSW Health Department's mental hospitals is getting exposure through the window of patient Saeed Dezfouli. It shows systemic abuse of dependent people cloaked as care.

Saeed presents no threat to the community. He needs support as an Iranian refugee affected by stress and with a heart condition. In 2002 he lit a fire in his workplace to draw attention to his concerns. This was following more than five months of distressed faxes to police and politicians in which he had stated his intentions. On that day the fire escape was locked and a woman died of smoke inhalation. Saeed regretted his action immediately, hugging those outside the building. This would never have happened with proper health and police intervention.

Saeed is in a unique position. He has watched the system from inside for eight years, and points out its hypocrisy, whilst Justice Health (an arm of the Health Department) tries to crush him into submission with the rest of the patients. He is a gentle person never wanting to hurt

9 See http://tiny.cc/gjdfq for more on this point.
10 Transcript of email received by Justice Action March 2008.

anyone – they agree he is non-violent, but every two weeks eight staff hold him down and inject him with a powerful sedative while he is held in the highest security area: the Forensic Hospital. He is refused a choice of psychiatrist, education and exercise, is not permitted new visitors and the rules aren't even stated. We became his Primary Carer when there was no one else.

Saeed is suffering because he won't shut up. Justice Health has absolute power. Patients have no finite sentences and are totally dependent on the treating psychiatrist. The principles of patients' rights under s 68 of the Mental Health Act 2007 (NSW) do not apply in practice. In this 'care' system, no-one cares. Taxpayers are charged $200,000 a year for Saeed, and $130m for the new privately financed Bay hospitals.

Saeed appealed to the Supreme Court against the Mental Health Review Tribunal's refusal to order changes to his treatment. The Tribunal and the Attorney-General tried to block this first real appeal against its new powers to make orders, refusing to supply its decision, until an audio record proved Saeed's entitlement. It sees its role as supporting Justice Health and not making a separate judgment. Previously the Tribunal had called for a new review of Saeed but was overruled by Justice Health. The lack of complaint from those around Saeed shows widespread abuse and the compromise of those participating in the health system. The Tribunal tried to force Saeed to use the discredited Mental Health Advocacy Service.

We have a job and a home for Saeed, and will continue the Justice Action Mentoring relationship which is funded by Breakout DesignPrintWeb when he is released.

Involuntary Injection

Michael Heston, an involuntary mental health patient, wrote these words to Mind Freedom asking for help:

> "Life is no fun when being tortured and terrorized. Please help me. They have no right to shoot me. I want my spirit back. That's all I want is my spirit back. The drugs make me nervous and paranoid. I'm fidgety and antsy from the medicine. God made me a certain way and that's how I want to stay. I'm being shot down like a dog."[11]

These comments raise the issue of effectiveness, which is central to involuntary treatment regimes. According to Dr Penny Weller, involuntary treatments can "mask, rather than relieve the symptoms of mental illness."[12] She argues that such treatments often have sedative effects, which are used as chemical restraints. At other times, they have disabling side effects that mimic symptoms of mental illnesses, which lead to interpretations by medical officers that patients' behaviours reflect escalations of mental illness.

These findings have furthermore been complemented by studies done in this field. Alarmingly, in the Cochrane review entitled "Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders", it was revealed that there is little evidence that community treatment orders are effective for competent health care. That study concluded that statistically it takes 85 community treatment orders to prevent one re-admission, 27 to prevent one case of homelessness and 238 to prevent one arrest. This astonishing evidence is just another indication of why involuntary treatment is inappropriate for mental health patients. Furthermore, it indicates a clear waste of public expenditure in mental health treatment. Instead, such funding could be used to promote effective mental health care in accordance with fundamental human freedoms, such as treatment with free and informed consent.

According to Professor Amita Dhanda, if mental health patients refuse treatments

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11 MindFreedom. 'USA Federal Prisoner Commits Suicide After Forced Psychiatric Drugs' [online] <http://www.mindfreedom.org/kb/prison-mental-health/forced- psychiatric-drugs/?searchterm=michael%20 heston> (3 May 2010).

12 Penny Weller (2010) 'Developing Law and Ethics: The Convention on the Rights of Persons with Disabilities, 35 *Alternative Law Journal* 1, 2.

recommended to them, they are deemed to lack the capacity or insight into what are in their best interests for treatment. This may bee seen as the ‘catch-22’ of the mental health system. It is clear that this logic does not realise the capacity of “all persons, whether or not they have a disability, are more or less able to reason”. [13]

In fact, patients themselves are arguably the most capable of making decisions as to whether a treatment is in their own best interests. However, in the case of those truly lacking the capacity to make free and informed decisions, substituted decision-making is still not appropriate. Instead, supported decision-making is more desirable. This means that mental health patients should be encouraged to work in conjunction with support personnel in order to come to an adequate solution regarding health care. While it is true that the amount of support required would vary from patient to patient, if we are to respect the human rights of society’s most vulnerable friends, such an approach is necessary. The public funding currently being wasted on unjust involuntary treatment regimes can be utilised in this way to provide more respectable goals.

In NSW mental health consumers can be involuntarily sedated when they are seen as a serious risk to themselves or others in a psychiatric emergency.[14] This is governed by strict regulations under the ‘Seclusion Practices in Psychiatric Facilities’ Department of Health policy. [15] This policy directive states, “any restraint must be proportional to the actions of the patient. Any action out of proportion to the danger they are placing themselves or others in, may be considered an assault.”[16] Thus, criminal assault is relevant where disproportionate force is used in these circumstances.

However, if involuntary medication is defined as ‘treatment’ rather than sedation, such intervention intended only for psychiatric emergencies becomes a commonplace routine.

This is unacceptable - these actions should be regarded as assaults, and as discussed above, are ineffective ab initio and should have no place in the mental health system. Thus, only through accepting the limitations of involuntary injecting powers can medical practitioners perform their roles and respect the rights of mental health consumers.

Under Article 17 of the Convention on the Rights of Persons with Disabilities (CRPD) “every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.”[17] Involuntary injection is an infringement of this fundamental human right. The points just outlined aim to provide a just alternative to outdated involuntary treatment regimes that violate mental health consumers’ rights. Forcibly holding down a human being and injecting them with drugs against their will breaches all human rights.

Mental Health Consumers in the Media

The media has an enormous impact on society and how people perceive the world around them; it contributes, shapes, and forms their opinion on important issues. Mental health consumers are portrayed negatively in the media despite all declarations, conventions, and legislations that exists to protect them. The media’s negativity blatantly defies the CRPD, despite the UN’s specific purposes “to limit mechanisms that replicate and reinforce the social exclusion and marginalization of people with disabilities.”[18]

Twenty percent of news articles that cover mental health consumers use the words “psycho”,

13 Ibid, 3.
14 Mental Health Act 2007 (NSW) s 14.
15 New South Wales Health (2007) *Seclusion Practices in Psychiatric Facilities* [online] <http://www.health.nsw.gov.au/policies/pd/2007/PD2007_054.html> (22 June 2010).
16 Ibid.
17 United Nations, *Convention on the Rights of Persons with Disabilities* (2008) art 17.
18 Penelope Weller (2009) ‘Human Rights and Social Justice The Convention on the Rights of Persons with Disabilities and the Quiet Revolution in International Law’, 4 *Public Space: The Journal of Law and Social Justice,* 5.

"schizo" and "nutter".[19] Television news programs, newspapers, and radio are considered trusted news sources to society, and sometimes the only source of education to its viewers. When these news outlets highlight and exaggerate mental health consumers and crime, they are only reinforcing the stigmas that society accepts. However studies have shown that even when mental health consumers are portrayed correctly, it is only the sort of articles that dramatize the circumstances that attract the most attention.[20] American consumer and activist Rae Unzicker wrote, "To be a mental patient is to watch TV and see how violent and dangerous and dumb and incompetent and crazy you are."[21]

Seventy percent of the population believes that mental health consumers are violent which reflects public concern and government spending on security. It was found in the United States that most mental health patients in prison were uninsured, poor, homeless minority groups who had committed misdemeanor crimes.[22] They are unjustly committed as criminals into the prison system to keep them away from a society that takes no initiative to understand them.

In 1992 Brian Burdekin released the report 'National Inquiry Into The Human Rights Of People With Mental Illness'. His reason for conducting this inquiry came from evidence presented to the homeless children's inquiry, which suggested that in many areas the human rights of individuals affected by mental illness were being ignored or seriously violated.

Further research by Burdekin also indicated widespread:

- ignorance about the nature and prevalence of mental illness in the community;
- discrimination;
- misconceptions about the number of people with a mental illness who are dangerous, and;
- beliefs that few people affected by mental illness ever recover.

The MHCA/HREOC report: "Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia" showed that after 12 years of mental health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected. The adverse health, social and economic effects of Australia's mental health care system falls largely on those with recurrent or chronic disorders and their families and carers. These are some of the most vulnerable people in our community.

The Judicial System

At law, persons suffering a recognised mental illness at the time of an offence are not criminally liable for their actions.[23] Despite this, forensic consumers continue to be incarcerated for longer than if they had been found guilty of a criminal offence, particularly where they wish to alter or cease treatment.

Involuntary patients also suffer from lack of choice in treatment as a result of assumed incapacity, as discussed below.

Forensic patients

In determining whether a person can be found not guilty of an offence by reason of mental illness, the court must find that the state of the persons mind at the time of the offence was

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19 Danielle Andrewartha (2010) "World Will Never Hurt? Media stigmatisation of people with mental illnesses in the Criminal Justice Context", 35 *Alternative Law Journal* 1, 4.

20 Ibid.

21 Rae Unzicker (1984) "*To Be A Mental Patient*", National Association for Rights Protection and Advocacy, <http://www.narpa.org/to_be_a_Mental_Patient.htm/> (11 May 2010).

22 Weller, above n 18, 5.

23 Rather, they will be not guilty by reason of mental illness under Mental Health (Forensic Provisions) Act 1990 (NSW) s 38.

diseased, disordered or disturbed to such a degree that it prevented them from understanding the physical nature of the unlawful act or recognising that the offending act itself was wrong.[24]

If this is found, the court will order that the person be recognised as not guilty by reason of mental illness or not fit to be tried and detained.

The Mental Health Tribunal may make an order for release from custody “when satisfied on the balance of probabilities that the safety of the person or any member of the public will not be seriously endangered”[25] and “where other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care”.[26]

Despite these avenues for discharge, many forensic patients will remain in mental health facilities long after their criminal counterparts despite the fact they are not guilty by law of an offence. They are seen to lack the capacity to make decisions for their own medical treatment. There is no choice in this system.

Involuntary patients

A person may also be admitted to a mental health facility after the issue of a mental health certificate by an accredited person in circumstances where the person is found to be a mentally ill or disordered, and where involuntary admission and detention is deemed necessary.[27]

Under s 14 of the Mental Health Act 2007 (NSW) a person is mentally ill if the person is suffering from mental illness and owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary for the protection of the person or others from serious harm.

Researcher Amita Dhanda has identified that tests of ‘capacity’ have been entrenched into western legal systems in order to promote efficient compliance with psychiatric treatment without reference to individual’s rights and choice of treatment.[28] For example, the ‘status’ test states that where a person suffers from a severe mental illness, they will automatically lack the capacity to involve themselves in their treatment. The ‘outcome’ test in a medical context dictates that where consumers refuse treatment, this will be seen as an indication of their lack of capacity.[29]

Therefore, if a person accepts psychiatric treatment, he or she is deemed to have capacity and will be admitted to a *voluntary* treatment program, of which they may discharge themselves at any time. However, if they do not feel treatment is necessary, they will be subjected to incarceration and involuntary treatment.

These methods serve to crush mental health sufferers into submission for the purpose of achieving a quick and efficient process without substantial considerations of patients right to involvement or choice in their treatment.

24 *R v Porter* (1933) 55 CLR 182.
25 Mental Health (Forensic Provisions) Act 1990 (NSW) s 39.
26 Mental Health (Forensic Provisions) Act 1990 (NSW) s 43.
27 Mental Health Act 2007 (NSW) s 19.
28 Amita Dhanda (2005) ‘The Right to Treatment of Persons with Psychosocial Disabilities and the Role of the Courts’ 28 *International Journal of Law and Psychiatry* 155, 157.
29 Weller, above n 12, 2.

Section 2: Mechanisms for Operation in Practice

The following section focuses on the roles of non-government organisations as mechanisms for asserting the rights supposedly afforded to consumers. It also examines the effectiveness of current government funding programs.

The following is taken from the NSW Mental Health Charter[30] for care that has derived from negotiations with consumer groups. According to this charter, which is on the NSW Health website, all NSW consumers are entitled to services that abide by these guidelines.

1. Respect human rights.
2. Are compassionate and sensitive to the needs of the individuals they serve.
3. Foster positive attitudes to mental health in the larger community.
4. Promote positive mental health.
5. Encourage true consumer involvement at all levels of service delivery and policy development.
6. Provide effective treatment and care across the lifespan.
7. Are widely accessible to people with mental health needs.
8. Provide care in the least restrictive environment, consistent with treatment requirements.
9. Provide effective and comprehensive prevention programs across the lifespan.
10. Promote 'living well' with mental illness.
11. Address quality of life issues such as accommodation, education, work and income, leisure and sport, home and family and other relationships.
12. Use language that reduces stigma, discrimination, or negativity for those affected and their families.
13. Respect and are responsive to the diversity in lifestyle, sexuality and sexual preference.
14. Are culturally sensitive and appropriate to the needs of the individuals they serve.

Despite the flowery language in legislation and motives, the NSW Justice Health is part of the "system" and the system has its own agendas that are masked by words consumers are fighting to hear in a broken system that limits them. In fact, the provisions of the Mental Health Act serve to hinder the achievement of the aims stated above.

Mental Health Act 2007 (NSW)

In the Mental Health Act there exists the potential for abuse of power. It states in its objectives that the Act provides the care, treatment, and control of persons who are mentally ill or mentally disordered.[31] The fact that NSW Justice Health deliberately included the right to control mental health consumers in the objectives of the Act reinforces and provides justification to society's stereotype of metal health consumers as people to be contained and isolated from the mainstream community.

If the goals of NSW Justice Health is to provide mental health services that among other things, respect human rights, are compassionate and sensitive to the needs of the individuals they serve, and foster positive attitudes to mental health in the larger community, then slipping

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30 NSW Department of Health (2000) *Charter for Mental Health Care in NSW* [online] http://www.health.nsw.gov.au/pubs/2000/mhcharter.html (3 May 2010).

31 Contained in the Mental Health Act 2007 (NSW).

the word control into the very catalyst of trust between authorities and consumers contradicts the supposed intentions. The use of the word control is a deliberate manipulation of power and a violation of mental health consumer's inherent human rights.

Consumer and Carer Organisations

Consumer and carers' organisations are used as the mechanism for the assertion of rights of consumers in this system. Essentially, there are two types of consumer organisations discussed in this paper: non-government and grassroots consumer groups. There is one underlining difference between the two: funding.

Without the funding from the mental health department and access to the hospitals, it is difficult for organizations to be effective. Unfortunately, when organisations accept financial assistance, their actions are limited in the mental health movement and must turn a blind eye to the injustices, or lose their funding.

It is this issue which must be changed in order to truly pursue effective protection of consumer rights in this field: mandatory funding must be allocated to *independent* consumer groups in order to adequately achieve this goal.

Funded Organisations:

The Mental Health Coordinating Council is the coordinating organization for non-government organizations in mental health services in NSW. Their purpose is to seek to improve, promote and develop quality mental health services to the community. Their goal is also to extensively participate and influence policy makers to improve mental health care.

Non-funded Organisations:

Critical organisations that do not receive funding from the government are the most effective at the present time. As a result they have the ability to pursue mental health goals without any outside influences. The consumer organisation's movement is led by (most importantly) mental health consumers as well as carers, family members, doctors and others from the bottom who believe there is an alternative way to working with mental health patients instead of the Health Department taking responsibility from the top.

Justice Action has become involved due to our concern about government abuse of power. The halfway house Glebe House which was founded by the prisoner movement lost its funding due to the critical advocacy work of its Directors.

American activist Rae Unzicker and English activist R.D. Laing have made significant contributions to the movement of confronting mental health authorities. To Laing, consumer's behaviors were a response to their inability to conform to society's demands in the changing world. His ideas of treatment stemmed from the belief that consumers are responsible for their own progress, and through their progress they would be able to return to a more stable and grounded life.

Rae Unzicker, an American advocate for mental health consumers, saw mental health in a similar way. More importantly, she believed it was inexcusable to deny mental health consumers their rights, particularly the freedom to choose how and where consumers will receive treatment, if any.

Consumer organizations today continue Laing and Unzicker's work and their voices are far from silent. Groups such as The Consumer Activity Network (www.canmentalhealth.org), The Icarus Project (www.icarusproject.net), Mindfreedom (www.mindfreedom.org), and Mad Pride (www.mindfreedom.org/campaign/madpride) have all addressed their issues and concerns publicly in regards to mental health.

Mindfreedom specifically advocates the right to choose as one of their main priorities in the mental health care system. This organisation aims to establish the consumer's control over

their life and to have their opinions considered.

The Consumer Activity Network (CAN) focuses on the right of consumers to be involved in the decision-making process of treatment as part of the individual's recovery journey. This is seen as important so as to allow the consumer a quality lifestyle of choice.

The Icarus Project advocates a slightly different message. Not only do they support the right to choose the method of treatment, they also advocate the right to not be categorized as ill in the first place. The belief of this particular organization is that persons who are labeled mentally ill are really people who are able to see the world in a way that does not conform to society's view of "normal" and "sane".

Section 3: Key Charters and Legislation

The following international covenants and domestic legislation are provided below so as to highlight the differences between the obligations of the Australian government under international law and the obligations of Justice Health under domestic law in comparison to current practices experienced by consumers.

UN High Commissioner for Human Rights[32]

"Australia, being a dualist nation, needs to incorporate rights encompassed by those treaties into domestic law to make them directly justiciable. Currently, none of the aforementioned treaties has been entirely legislatively incorporated into Australian law. The Special Rapporteur regrets that there is no such formal recognition of the right to health in Australia. "

United Nations Universal Declaration of Human Rights (1948)

The following articles from this Declaration may be applied specifically to the case of patients with a mental illness. However, all the articles under the Universal Declaration of Human Rights are understood to be the rights of mental illness patients.

- All human beings are born free and equal in dignity and rights (Article 1).
- Everyone is entitled to rights and freedom without discrimination and everyone has the right to life, liberty and security (Article 2).
- No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Article 5).
- All are equal before the law and are entitled without any discrimination to equal protection of the law (Article 7).
- No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence or to attacks upon his honour and reputation. (Article 12).
- Everyone has the right to a standard of living adequate for the health and well-being of himself including food, clothing, housing and medical care and necessary social services, and the right to security …(Article 25).
- Everyone has the right to an education. (Article 26).

32 United Nations Office of the High Commissioner for Human Rights (2009) *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (Anand Grover)

United Nations Convention on the Rights of Persons with Disabilities (2007)

This Convention (CRPD) does not introduce any new rights, but holds nations responsible to protect those whose opportunities to pursue a fulfilling life has been lessened due to discrimination.[33] Once a country ratifies the convention, it is required of that nation to start implementing appropriate legislation. Australia ratified the convention on 17 July, 2008.

Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (Article 1). It is clear that mental health patients are included in persons with disabilities and should be treated as such.

- Health and Treatment (Article 9)
- States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.
- Equal recognition before the law (Article 12) States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity
- Freedom from Exploitation, Violence and Abuse (Article 16) State Parties shall take all appropriate legislative, administrative, social, educational, and other measures to protect person with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects. In order to prevent the occurrence of all forms of exploitation, violence and abuse. *States Parties shall ensure that all facilities and programs designed to serve persons with disabilities are effectively monitored by independent authorities.*
- Protecting the integrity of the person (Article 17) Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.
- Rehabilitation and Care (Article 26) Each and every individual has the right to mental health services that are compassionate and sensitive to the patients' needs and care. In relation to the Declaration of Human Rights, forensic mental health patients should not be subjected to cruel, punishment or degrading treatment.
- Education (Article 24) States Parties recognize the right of persons with disabilities to education.
- Right to Health (Article 25) States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.

Disability Discrimination Act 1992 (Cth)

While the aim of this Act is to identify the rights of mental health patients, it prohibits the consumer's own assertion of rights and leaves all powers of the matter in the hands of the Department of Health.

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33 United Nations, *Why a Convention?* (2006) [online] at <http://www.un.org/disabilities/convention/questions.shtml> (3 May 2010).

Mental Health Act 2007 (NSW)[34]

This Act lays out powers and obligations to the government to facilitate care, treatment and control of mental health patients while protecting their human rights.

Again, this Act fails to empower consumers with the right to address their own health. Instead, through this Act it is the responsibility of authoritarian figures at the top to determine what they believe is best for the consumers.

s 1: Objects of the Act:

(a) provide for the care, treatment and control of persons who are mentally ill or mentally disordered

(d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and

(e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.

s 68: Principles for care and rehabilitation

(a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,

(d) the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others

(e) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment,

Conclusion

The language authorities have used in their legislation is deceiving to constituents. The political game they play when using such flowery language only benefits their personal interests. In reality authorities give mental health patients little respect for their rights and in many cases let them waste away with little communication or stimulation. Taxpayers contribute $205,000 per patient per year. Their money is being wasted and used for abuse.

The loss of control mental health consumers have regarding their health is disturbing on all accounts. Consumers have the right to take all methods of treatment into consideration, including no treatment at all, without the overbearing influence of the government, psychiatrists, and drug companies.

No matter how their conditions are diagnosed, the western method of treatment should not be the only method taken into consideration. It is the right of the patients to have all methods considered and to be the final authority over themselves in the decision of which method to pursue. Also of equal importance, mental health patients possess the same human rights as every individual in the world. They should be treated as equals and their differences should not be exploited or used for discrimination.

34 s 76B of Mental Health Forensic Provisions Act 1990 (NSW) refers to s 68 of the Mental Health Act and states that the principles of care and rehabilitation applies to forensic patients as well as voluntary patients.

FREE SAEED

Saeed Dezfouli

- Iranian refugee
- Mental health patient costing $200,000 a year
- Not guilty due to mental illness
- Lit a fire in his workplace to draw attention – woman died
- Gentle person – Intended no harm – warned police who ignored him
- Health Department breaches its obligation of care – they don't like him
- Locked in cell for eight years
- Highest security area
- Forcibly injected every fortnight, yet non violent – breaches UN Conventions
- Refused education
- Refused psychiatrist change
- Refused access support

Action!

Sign petition
Donate to campaign
Appeal launched to Supreme Court

www.justiceaction.org.au
02 9283 0123

The Right to Choose