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Report on South Australian Mental Health Bill
Legislative Council No. 131

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[Note: The Council did not respond to this Report and passed the Bill unamended in 2009]

This preliminary feedback offered to the SA Legislative Council (hereafter 'Council') is intended to lay the groundwork for urgently needed changes in 'mental health' legislation and comes with a request that a much broader spectrum of public input be solicited, or welcomed for current and future Bill formulations.

Given that the 2008 proposed Bill is 'primarily about the making of orders for involuntary treatment', this unsolicited report is offered on behalf of the thousands of Australians who have suffered permanent physical harm, psychological trauma, even death as a result of coercive 'psychiatric care'. The feedback offered here aims to throw light on certain disturbing trends and excesses in the 'mental health system' through which a growing number of non-violent, innocent Australians are subjected to forced psychiatric drugging. **What follows focuses on how these trends are reflected in and reinforced by the Mental Health Bill 2008.** The conclusion implied is that there is an urgent need to severely curtail and reassess currently legal psychiatric practices.

Firstly, we note that 'stakeholders', that is persons who presumably have a vested financial interest in the continuation, even expansion of coercive psychiatry, have provided advisory input for the Bill. It appears, however, that persons (professional and otherwise) with legitimate concerns about the widespread use of coercive psychiatry, ECT and psychosurgery, or persons

who have different views on how best to help people in crisis have had no say in the formulation of this Bill.

As it stands, the proposed Bill - regardless of the possibly benign intentions of its author(s) - is *based on* a combination of factual inaccuracy, circular reasoning and unstated assumptions which reflect dominant cultural beliefs about 'mental illness', but which are not borne out by statistical evidence, personal testimony, medical knowledge and independent research.

The Bill basically assumes that forced psychiatric 'treatment' (plus or minus incarceration) amounts to 'care' which facilitates the 'recovery' and 'rehabilitation' of persons labelled as 'mentally ill'. The Bill accordingly implies that forced treatment is in the best interests of the individual and society, that it causes no significant harm, that it decreases the likelihood of self-harm, and that it is not an abuse of legal or human rights.

As the following will confirm, the harsh reality is far different. Rather than aiding recovery and rehabilitation, both are hindered by coercive psychiatry. Rather than protecting the public from harm, public safety is jeopardized. Rather than protecting the 'freedom and legal rights' of people diagnosed as 'mentally ill', these rights are abolished.

The Council needs to be aware that there is a growing, worldwide movement against psychiatric coercion and against the harmful practices, hidden agendas and dogma of 'biologic' psychiatry (i.e. the psychiatric model funded by Medicare) in general. This report accordingly guides the Council toward reputable research and perspectives which *call into question or invalidate the core beliefs, aims, guidelines and recommendations which inform the Bill.*

We recommend that the Council acts *independently* to investigate the following lines of 're-search', i.e. in order to 'search again'. Given the severe impact - in terms of loss of freedom, rights, dignity, health and sometimes life - that psychiatric coercion has had on thousands of psychiatric patients, the Council undoubtedly has a moral obligation to ensure that all facts and legitimate views are considered so that 'mental health' legislation does not continue to sanction harmful, abusive and exploitative practices.

Some of the international organizations which share the concerns raised in this report are listed below. We recommend that the Council explore their websites and publications which contain a wealth of material relevant to the Bill:

International Center for the Study of Psychiatry & Psychology
www.icspp.org
As a large network of mainly professional people involved in the 'mental health' field (mainly MDs and PhDs), ICSPP is concerned with the impact of mental health theories on public policy and the effects of therapeutic practices upon individual well-being, personal freedom, and family and community values. For over 25 years ICSPP has been informing the professions, the media and the public about the potential dangers of drugs, electroshock, psychosurgery, and the biological theories of psychiatry. They inform others about the latest hazardous psychiatric invention and alert the media and the public to the dangers of treating social, interpersonal and personal problems as though they were medical diseases.

Law Project for Psychiatric Rights
psychrights.org
The Law Project for Psychiatric Rights is a public interest law firm devoted to the defence of people facing the horrors of unwarranted forced psychiatric drugging and electroshock. PsychRights is further dedicated to exposing the truth about psychiatric interventions and the courts being misled into ordering people subjected to these brain and body damaging drugs against their will. Extensive information about these dangers, and about the tragic damage caused by electroshock, is available on the PsychRights website.

Patients Rights Advocacy Waikato Inc. [NZ]
www.benzo.org.uk/prawi.htm
Membership is around 500 and includes a number of law firms, health practitioners and organizations with an interest in patients' advocacy.

Citizens Commission on Human Rights [International]
www.cchr.org
Co-founded in 1969 by Emeritus Professor of Psychiatry Thomas Szasz, CCHR was established to investigate and expose psychiatric violations of human rights and to clean up the field of mental healing. Today, it has more

than 250 chapters in over 34 countries. Its board of advisors includes doctors, lawyers, educators, artists, businesspeople and civil and human rights representatives.

The Antipsychiatry Coalition
antipsychiatry.org
The Antipsychiatry Coalition is a non-profit volunteer group consisting of people who feel we have been harmed by psychiatry - and of our supporters. We created this website to warn you of the harm routinely inflicted on those who receive psychiatric "treatment" and to promote the democratic ideal of liberty for all law-abiding people that has been abandoned in the USA, Canada and other supposedly democratic nations.

MindFreedom International [psychiatric survivors network]
www.MindFreedom.org

The rest of this report addresses four main areas, namely:

(a) **problems arising (in the Bill) from the inference that 'mental illness' is an objective medical fact rather than a subjective cultural construct,**

(b) **evidence (based on independent research) that forced psychiatric treatment does more harm than is commonly supposed,**

(c) **research-based evidence that recovery is hindered and public safety decreased by forced psychiatric treatment, and**

(d) **the inability of psychiatric respondents to obtain a fair hearing or trial at Guardianship Board and court proceedings as a result of (a), (b) and (c) being routinely ignored in favour of culturally biased beliefs and unsubstantiated 'expert' opinions.**

(a) Mental Illness as a Cultural Construct not an Objective Medical Fact

The Bill's 'Summary of Changes: Part 1 - Preliminary' states that the definition of 'mental illness' has been broadened 'so that people are not precluded from a service on the basis of their diagnosis'.

It is *equally valid* to view this widening of the net to include more people under the 'mental illness' banner as a disturbing trend to medicalize more and more normal life crises by proclaiming that they are 'illnesses' requiring 'treatment'. In this regard, psychiatry has worked to shrink the vast spectrum of 'normality' until almost any human problem can now be regarded as a 'mental disorder'.

The Bill defines 'mental illness' as 'any illness or disorder of the mind'. This definition is problematic for the following reasons:

(1) A diagnosis of 'mental illness' amounts to a subjective negative value judgment about (what is perceived as) 'disturbed' behaviours and/or beliefs, or world views that are regarded as symptoms of brain 'disease', genetic flaws, or 'chemical imbalance'. The Council needs to be absolutely clear on this point: **a person is 'mentally ill' because a psychiatrist, or other mental health 'expert' (merely) says they are.** (As well, since psychiatrists do not know the causes nor how to cure what they call 'mental illness', nor how their 'treatments' affect the brain, in what sense *are* they 'experts'?)

(2) No biochemical, anatomical or functional abnormalities have been found that reliably distinguish the brains of psychiatric patients. The Council needs to be aware that all 'mental illnesses' and 'disorders' are *voted into existence by a show of hands* at psychiatric conventions. On the 'invention of mental illness' see the attached synopses of two relevant books - there are many similar others.

(3) Since neither 'mental illness' nor 'mental disorder' can be objectively confirmed or ruled out, how would the Council distinguish the two? Or does the Council regard the two terms as interchangeable? If the latter, the Council needs to be aware that there are now 374 listed 'mental disorders' in DSMIV, the *Diagnostic and Statistical Manual of Mental Disorders* which, worldwide, is the standard psychiatric diagnostic reference text.

(4) The wording of the Bill is therefore misleading. Strictly speaking, a person does not 'have a mental illness' in the same sense that someone has, say, diabetes, Alzheimer's, or cancer, all of which can be verified with objective biologic tests. It is (therefore) meaningless for the Bill to talk about a person

'having or appearing to have' a mental illness, since there is no possibility of objectively distinguishing the two options. A diagnosis of 'mental illness' is *always* based on a subjective evaluation of appearance.

(5) It is equally absurd for the Bill to refer to a 'medical examination' of a person's mental state, since no objective medical results are obtainable for any 'mental illness' or 'disorder'.

(6) Anyone - including whoever is reading this - could be labelled with a 'mental disorder'. For example, 'General Anxiety Disorder' would, we suggest, apply to just about all of us in light of the current global financial and climatic crises.

In the same vein, would the Council seriously accept that people who drink too much coffee ('Caffeine Intoxication Disorder'), or overuse the pokies ('Gambling Disorder'), or who are giving up smoking ('Nicotine Withdrawal Disorder'), or use herbal remedies ('Herbal Remedies Disorder'), or have trouble with reading and writing ('Disorder of Written Expression'), or maths ('Mathematics Disorder'), have a 'mental disorder', or that people who, with valid reasons, resist psychiatric drug treatment ('Non-compliance with Treatment Disorder'), or deny that they're mentally ill must therefore be mentally ill? (All of these 'disorders' are listed in DSMIV).

Homosexuality was voted in as a 'mental disorder' until it was voted out in response to gay protests. ADHD - the 'diagnosis' through which 20 million children worldwide are drugged with amphetamine-like drugs - was voted into existence by a show of hands. How sillier can all this get? We may as well cut to the chase and say that 'being human' is a form of mental illness.

(7) Why, then, does the Bill exclude 'antisocial behaviour' as a form of 'mental illness' when (presumably) drinking too much coffee, gambling and the rest of the above absurdities are potentially included? Besides, there are numerous 'mental disorders' that could be classed as 'antisocial behaviour', for example, 'Disruptive Behaviour Disorder' and 'Oppositional Defiant Disorder'.

(8) The vast majority of people subjected to forced psychiatric drugging are those labelled with some form of 'schizophrenia'. Contrary to unfounded public fears (often fueled by the media), most of these folk are not violent but

rather sensitive, intelligent, often creative people whose only 'crime' is that they are undergoing acute personal, often spiritual crises which psychiatrists refuse to validate, or which are at odds with psychiatry's biologic dogma.

There is no objective diagnostic criterion for 'schizophrenia' - no defining symptom, no brain image, no blood test - no psychological test result. What is problematic here is that the diagnostic criteria for schizophrenia are for the most vague value judgments about modes of thinking and behaviour that psychiatry doesn't condone. In this sense, policing non-violent 'spiritual' experiences, behaviours, beliefs and world views can legitimately be viewed as a form of *social control masquerading as medicine.*

To quote Prof. Szasz: 'Schizophrenia is defined so vaguely that, in actuality, it is a term often applied to almost any kind of behaviour of which the speaker disapproves.' (p. 30, *Psychiatry: Harming in the Name of Healthcare*, Citizens Commission on Human Rights, USA 2002). Soviet dissidents, for example, were routinely labelled with 'schizophrenia' to punish and silence them.

Additional reference: Richard Gosden, PhD, *Punishing the Patient: How Psychiatrists Misunderstand and Mistreat Schizophrenia* (Melbourne: Scribe Publications, 2001).

Dr Gosden argues that people with schizophrenic symptoms 'should be thought of as belonging to two broad, non-medical classes: those who are undergoing a spiritual/mystical emergency, and those who do not conform to social expectations. In each case, psychiatric misunderstanding and mistreatment has led to patients' human rights being violated on a massive scale.'

If these kinds of legitimate views are evident in openly published Australian books, why is a similar critical attitude not evident in 'mental health' legislation?

(b) Evidence (based on independent research) that forced psychiatric treatment causes significant harm:

See 'The Brain-Disabling Principles of Psychiatric Treatment' by Peter Breggin, MD [forensic medical expert and US psychiatrist] and other papers on www.breggin.com

Summary: all psychiatric treatments 'work' by impairing normal brain function. All psychiatric drugs are toxic, therefore harmful. All psychiatric treatments produce the same effect on all people (and animals), i.e. they are non-specific.

The Council needs to be clear that - aside from ECT and psychosurgery (mentioned later) - most people on CTOs are forced to take, or are forcibly injected with toxic major tranquilizers called either 'neuroleptics', or 'antipsychotic' drugs (or, misleadingly, 'medication', since they are not medicines which heal). We know of no exceptions here. To designate (in the Bill) this forced drugging as 'care' is at best euphemistic; at worst it could be construed as a downright insult to the thousands of fragile and distraught people who have been *made* ill, traumatized, or killed as a result of such 'care'.

The rationale for psychiatric drugging is psychiatry's unsubstantiated belief that the drugs correct biologic brain defects, notably 'chemical imbalances'.
The following presents evidence that (1) these imbalances do not exist, and that (2) the drugs instead cause a host of debilitating side effects, including the increased likelihood that those administered them will become chronically ill. They also lower the likelihood of recovery and increase the likelihood of relapse. *The claim in the Bill that forced psychiatric drugging supports the goal of 'bringing about recovery' is, in other words, not borne out by known facts.*

The alleged biologic defects said to be 'treatable' with toxic psychiatric drugs have not been proven to exist.
Ref: Peter Breggin, MD, www.breggin.com/neuroleptics.html
See also books by Peter Breggin, MD including:
Brain-Disabling Treatments in Psychiatry: Drugs, Electroshock, and the Role of the FDA . Springer Publishing Co., 1997.

The mental and emotional suffering routinely treated with biopsychiatric interventions have no known genetic and biological cause.

'Despite more than two hundred years of intensive research, no commonly diagnosed psychiatric disorders have been proven to be either genetic or

biological in origin, including schizophrenia, major depression, manic-depressive disorder, the various anxiety disorders, and childhood disorders such as attention-deficit hyperactivity. At present, there are *no known biochemical imbalances in the brain of typical psychiatric patients – until they are given psychiatric drugs.* The failure to demonstrate the existence of any brain abnormality in psychiatric patients, despite decades of intensive effort, suggests that these defects do not exist.

'There is no significant body of research to prove that neuroleptics have any specific effect on psychotic symptoms, such as hallucinations and delusions. To the contrary, these remain rather resistant to the drugs. The neuroleptics mainly suppress aggression, rebelliousness, and spontaneous activity in general. This is why they are effective whenever and wherever social control is at a premium, such as in mental hospitals, nursing homes, prisons, institutions for persons with developmental disabilities, children's facilities and public clinics, as well as in Russian and Cuban psychiatric political prisons. Their widespread use for social control in such a wide variety of people and institutions makes the claim that they are specific for schizophrenia ridiculous. (They are even used in veterinary medicine to bend or subdue the will of animals.)

'The neuroleptics are supposedly most effective in treating the acute phase of schizophrenia, but a recent definitive review of controlled studies showed that they perform no better than sedatives or narcotics and even no better than placebo' (Keck et al., 1989, cited in Breggin).

* Patients taking moderate doses of antipsychotic drugs are at more than twice the risk for sudden cardiac death as nonusers of the drugs.

* **Psychiatric drugs increase the likelihood that a person will become chronically ill.**
See books by Peter R. Breggin, MD, including
* *Toxic Psychiatry*
* *Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Drugs*

* According to Dr Breggin, antipsychotic drugs have produced the *worst epidemic of neurological disease in history.* At the least, their use should be severely curtailed.

* Untreatable illnesses caused by psychiatric drugs include *tardive dyskinesia*, a permanent impairment of voluntary movements which appears in 5% of patients within one year. The rates increase by about 5% per year in drugged patients.

* 'The popular expressions "chemical straitjacket" and "zombie effect" well describe [antipsychotics'] unique psychomotor subduing effect' and they 'produce the most substantial iatrogenic morbidity . . .'
Civil suits have been filed against psychiatrists for damage suffered as a result of tardive dyskinesia.
Ref: *From Placebo to Panacea: Putting Psychiatric Drugs to the Test*, Ed. Seymour Fisher & Roger P. Greenberg. NY: John Wiley & Sons, Inc., p. 173.

* Neuroleptic malignant syndrome is a potentially fatal toxic reaction from which an estimated 100,000 Americans have died.

* Akathisia is an inner restlessness and anxiety that many patients describe as tormenting. It has been linked to **suicide and assaultive behaviour, including murder.** (See Theodore Van Putten, 'Behavioral Toxicity of Antipsychotic Drugs', *J. Clinical Psychiatry* 13:14 (1987).)

* Other side-effects of standard antipsychotics include permanent brain damage and an increased incidence of blindness, fatal blood clots, arrhythmia, heat stroke, obesity, rashes and seizures.

* Use of multiple antipsychotics is associated with **early death.** (See 'Mortality in Schizophrenia', *Brit. J. Psychiatry* 173: 325 (1998).)

* Newer drugs do not provide a safer alternative and there is evidence that they may be worse than older drugs.
See www.breggin.com/neuroleptics.html

* **Neurosurgery (more appropriately called 'psychosurgery' to distinguish it from reputable and ethical medical neurosurgery):** Since the brain tissue of psychiatric patients is (as the Bill acknowledges) 'apparently normal' (p. 7), there can be no rational, or medical justification for damaging, or eliminating such tissue. Genuine neurosurgeons operate only to remove, or stimulate

known brain tissue defects that are causing, or contributing to *known brain diseases*. It is a violation of the medical Hippocratic Oath to remove 'normal' tissue and cause known harm through brutal assaults on the brain.

***ECT:** 'Psychiatrists cannot explain how ECT is supposed to work, nor can they justify its extensive harm. Documented studies show that ECT creates irreversible brain damage, often causes permanent loss of memory and may result in death.' 'Two million people a year are subjected to ECT worldwide. An estimated 10,000 die as a result.'
'For $12 worth of electricity, ECT nets the psychiatric industry $5 billion in the U.S. alone. '
'Two-thirds of ECT victims are women. Fifty percent are elderly.'
[Quoted from a CCHR DVD Supplement].

In USA, 65 year olds receive 360% more electroshock than 64 year olds - because government health insurance takes effect at age 65.

(c) Research-based evidence that recovery is hindered and public safety decreased by forced psychiatric treatment

* Toxic psychiatric drugs lower the likelihood of recovery and increase the likelihood of relapse. *Research indicates that long-term recovery rates are higher for non-medicated patients than for those who are on psychiatric drugs.* It is therefore incorrect to assume that patients who do not want to take these drugs are 'non-compliant', 'lacking in insight' (alleged symptoms of 'mental illness'), or making poor decisions.

* Psychiatric drugs may exacerbate the symptoms they are intended to relieve, i.e. antidepressants may increase depression and antipsychotics can worsen psychosis.

* In the 1960s, the NIMH (US National Institute of Mental Health) conducted a 6-week study of 344 patients in 9 hospitals and found that drug-treated patients were more likely to be re-hospitalized than those receiving a placebo. [See John R. Boal et al., 'Treatment of Acute Psychosis Without Neuroleptics: Two Year Outcomes from the Soteria Project', *J. Nervous and Mental Disease* (2003) 219: 224-25].

* In the 1970s the NIMH compared drug treatment with environmental care that minimized the use of drugs. In each instance, *patients treated without drugs did better over the long term than those treated with drugs.* In other words, the drugs make some patients more likely to relapse than would be the case in the natural course of the psychosis. [See William Carpenter et al., 'The Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions', *Am. J. Psychiatry* (1977) 14: 17-19.]

* In 1994 a Boston University study reported on the longterm outcomes of 82 'chronic schizophrenics' discharged from hospital in the 1950s. 68% of this group showed no sign of schizophrenia at follow-up, since they had all stopped taking psychiatric drugs.

* In studies conducted by the World Health Organization, 63% of patients in poor countries were asymptomatic after 5 years. In USA and other developed countries only 38% were in full remission and the remaining patients did not fare well. In the poor countries, only 16% were on psychiatric drugs over the 5 years versus 61% in developed countries.

* Programs in Switzerland, Sweden and Finland developed programs which minimize the use of psychiatric drugs and have had much better results in terms of eliminating schizophrenia symptoms. One open-dialogue approach (by Jaako Seikkula) led to an 82% recovery 5 years after diagnosis and only 29% had used drugs.

* In 2007, a University of Illinois College of Medicine study reported on longterm outcomes of schizophrenia patients in Chicago since 1990. After 5 and 15 year follow-up exams, 40% of those who had not taken psychiatric drugs had recovered versus only 5% of drugged patients.

* Controlled studies by Loren Mosher, MD [Professor of Psychiatry] have shown that patients diagnosed with acute schizophrenia improve better without medication in small homelike settings run by non-professional staff who know how to listen and to care. The patients become more independent, and do so at no greater financial cost, because non-professional salaries are much lower. As an enormous added benefit, the drug-free patients do not get tardive dyskinesia or tardive dementia, as well as other drug-induced and sometimes life-threatening disorders. (See Loren M. Mosher, MD and Lorenzo

Burti, MD, *Community Mental Health,* London: W. W. Norton, 1994. See also www.moshersoteria.com).

* **The suicide rate is higher for persons 'treated' for schizophrenia by the mental health system.** [Caldwell & Gottesman, 1992; Roy, 1982 cited in Al Siebert, PhD, 'What is Wrong with Psychiatry?', *J Humanistic Psychology* Vol. 40, No. 1, 2000 pp. 34-58.]

* **Public safety is decreased through psychiatric drug treatment.** It is well-documented that psychiatric drugs can cause homicidal thoughts, suicide and aggression. There have been 383 reports (submitted to the Australian Therapeutic Goods Administration) linked to antidepressant and antipsychotic drugs for aggression, 51 reports for homicidal ideation/ behaviour and 350 for suicidal attempts and thoughts.

* TGA 'Adverse Drug Reaction' reports show that there have been 214 deaths linked to antidepressants and 399 deaths linked to antipsychotics.

* Courts have also acknowledged the clear link between violence and antipsychotic drugs. (Ref: 'Psychiatric Drugs and Violence', Citizens Commission on Human Rights report, 21/9/07).

* **Historically, psychiatrists' predictions of dangerousness (to self or others) have been recognized as totally unreliable.** The American Psychiatric Association argued to the US Supreme Court that 'such predictions are fundamentally of very low reliability' and that mental health professionals 'perform no better than chance at predicting violence, and perhaps perform even worse.' (Gottstein, cited below, p.90).

* Statistically, there is in Australia a higher rate of violence among males aged 15 - 25 than among people diagnosed as 'mentally ill', yet these young men are not drugged or incarcerated (as a form of preventative detention).

(d) Rights Violations at Guardianship Board and 'Mental Health' Court Hearings:

(1) Failure to Provide (or to Provide Information Concerning) Less Intrusive Alternatives

The Bill stipulates that forced psychiatric treatment is allowable when there are no less restrictive alternatives available. However, within the Mental Health System 'care' choices are normally a theoretical rather than a practical option. Patients (voluntary and involuntary) are routinely offered no alternatives to drugs in spite of the fact that a range of (evidence-based) viable alternatives exists. Even if patients were to be informed about alternatives, some are not yet readily accessible in Australia. As well, since Medicare does not fund alternatives to drug-based psychiatry, most patients cannot access these services because they are financially poor and/or because being on a CTO precludes them from doing so.

See Law Project for Psychiatric Rights, psychrights.org
and *Alaska Law Review* Vol. 25:51 (53-105), 'Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course', c. 2008 by James B. Gottstein, JD [Harvard Law School, 1978.]

Viable alternatives to forced psychiatric drugging include drug-free 'residential crisis care' for persons in psychosis, homeopathy, psychotherapy, Jungian psychiatry, milieu therapy, cognitive behaviour therapy, acupuncture, narrative therapy, nutritional and orthomolecular medicine.

References:
Melvyn R. Werbach, MD, *Nutritional Influences on Mental Illness,* California: Third Line Press, 2nd ed., 1999.

(2) Failure to Offer Initial Non-psychiatric Medical Screening to Exclude or Confirm Undiagnosed Physical Problems

Evidence shows that *at least* 40% of people presenting with 'psychiatric' symptoms may be suffering from undiagnosed physical conditions. In one study, 83% of people referred by clinics for psychiatric treatment had undiagnosed physical illness; 42% of those diagnosed with psychosis were found to be suffering from a physical illness.

References:
David E. Sternberg, MD, 'Testing for Physical Illness in Psychiatric Patients', *Journal of Clinical Psychiatry* 47 No. 1 (January 1986, supplement, p. 5)

Richard C. Hall, MD et al., 'Physical Illness Presenting as Psychiatric Disease', *Archives of General Psychiatry* 35 (November 1978, pp. 1315 - 20).

Such conditions include brain tumour, poor sugar metabolism, mercury poisoning, excess blood copper, food allergies, some cancers, encephalitis, autism, vitamin dependencies, hypothyroidism, and allergic reactions to environmental toxins, marijuana and other drugs (including psychiatric drugs).

We therefore recommend that *all first-admission patients (voluntary and involuntary) be legally permitted to undergo a thorough initial non-psychiatric medical examination to rule out or confirm the existence of physical illness.* This basic right should be included in the Bill as an additional safeguard against unwarranted drugging.

(3) Failure to Disclose to Patients Exhaustive Information Concerning the Known Harmful Side-effects of Psychiatric Drugs

(4) Rights Violations at Guardianship Board and Court Hearings

Current Guardianship Board and 'mental health court' proceedings offer no 'protections of the freedom and legal rights' of persons labelled as 'mentally ill.' Contrary to its stated aims, the Bill violates these rights by sanctioning the guidelines, beliefs and principles according to which these proceedings are run.

As concerned lawyers can confirm, Guardianship Board hearings are seldom impartial but are commonly of an inquisitional nature. The psychiatric patient is more often than not automatically assumed to be 'mentally ill' prior to arrival at the hearing. Furthermore, patients are commonly drugged shortly before hearings such that they are less able to defend themselves and instead (as a result of drugging) appear 'ill' to the Board.

Board members are normally psychiatrists, or other 'mental health' employees who are uncritical of existing 'mental health system' outcomes, practices and beliefs, including the belief that forced drugging is in the patient's and community's best interests.

Evidence to the contrary and evidence concerning less harmful, non-coercive alternatives is often ignored, or given far less weight than (mere) psychiatric opinion.

At mental health court trials, psychiatric respondents have less rights than a person accused of serious crime. Imagine a criminal court scenario in which the accused is not only denied a proper defence but is also found 'guilty' merely because in the prosecution's *opinion t*hey are. Not only this, but the judge has two prosecuting lawyers sitting on either side of her/him offering 'advice'. Such a 'case' would be ridiculed and legally inadmissible, yet such is, in principle, the basis of all Australian mental health court proceedings.

Gottstein (p. 51) argues that 'lawyers representing psychiatric respondents and judges hearing these cases uncritically reflect society's beliefs and do not engage in legitimate legal processes when conducting involuntary commitment and forced drugging proceedings. By abandoning their core principle of zealous advocacy, lawyers representing psychiatric respondents interpose little, if any, defence and are not discovering and presenting to judges the evidence of the harm to their clients.'

Mental health courts should not engage in what is essentially a mock judicial process but should instead be based on proper litigation principles and procedures. These should include the basic pillars of the adversary system, namely, presentation of contrary evidence, burden of proof, vigorous cross-examination and the right to have hearings and court records open to the public (Gottstein, pp. 88-89).

The impartiality of judges needs to be restored through the elimination of biased co-judges (i.e. self-appointed psychiatric 'experts' sitting on the bench instead of being subject to court procedures). Judges should then be free to decide cases on the basis of evidence instead of in accord with the 'opinions' and 'beliefs' of pro-coercion, pro-drugging 'advisors'.

Courts must insist that 'deprivations of the fundamental right to liberty occur only when the legal predicates are truly met. This includes proper evidentiary gate-keeping to ensure reliability to guard against erroneous deprivations of liberty. Three key factual issues where improper and unreliable psychiatric opinion is regularly allowed are dangerousness, capacity (competency), and best interest' (Gottstein, p. 90).

All this begs the twin questions of when, if ever, forced psychiatric drugging should be used and what guidelines should be used for voluntary patients.

Since antipsychotic drugs are toxic major tranquilizers, we suggest that their primary use should be for the *temporary sedation of persons with violent psychoses.* In social context, they should not be used, however, when violence (in a habitually non-violent person) is a legitimate 'panic' and self-protective response to threats of incarceration and/or forced psychiatric drugging. Once threats of coercion and restraint are removed and replaced with kindness and non-judgmental, non-patronizing tolerance offered in a supportive, friendly, or homelike setting, persons in psychosis often calm down. (I have been a private practitioner helping persons in psychosis for 10 years and I have never encountered violence, or threats thereof from these folk).

Voluntary patients should be offered *their choice of* psychiatric drugs only if a) they are also offered an equally affordable, equally accessible choice of drug-free options, and b) *all* the known side-effects of the drugs are disclosed to them, and c) they are not lied to by being told that the drugs are necessary, or that they have a 'lifelong illness', or a 'chemical imbalance' requiring 'medication'.

Additional Note on Psychiatry's Hidden Agenda: Power, Prestige & Income [by Peter Breggin, MD]

If the neuroleptics are so dangerous and have such limited usefulness, and if psychosocial approaches are relatively effective, why is the profession so devoted to the drugs? The answer lies in maintaining psychiatric power, prestige, and income. What mainly distinguishes psychiatrists from other mental health professionals, and of course from non-professionals, is their ability to prescribe drugs. To compete against other mental health professionals, psychiatry has wed itself to the medical model, including biological and genetic explanations, and physical treatments. It has no choice: anything else would be professional suicide.

After falling behind economically in competition with psychosocial approaches, psychiatry formed what the American Psychiatric Association

now admits is a "partnership" with the drug companies (Sabshin, 1992). Organized psychiatry has become wholly dependent for financial support on this unholy collaboration with the pharmaceutical industry (Breggin, 1991). *To deny the effectiveness of drugs or to admit their dangerousness would result in huge economic losses* on every level from the individual psychiatrist who makes his or her living by prescribing medication, to the American Psychiatric Association which thrives on drug company largesse. [emphasis mine]

Concluding Comments

One hundred years from now, people will read current psychiatric textbooks with the same incredulity we have about blood-letting and snake oil. - Douglas C. Smith, MD, Psychiatrist, Juneau, Alaska.

The many critical challenges facing societies today reflect the vital need to strengthen individuals through workable and viable alternatives to harmful psychiatric options. Rohit Adi, MD, Mary Jo Pagel, MD, Tony P. Urbanek, MD, Julian Whittaker, MD, in 'The Real Crisis in Mental Health Today', CCHR Public Service Report, 2004, p. 4.

There is a substantial groundswell of public dissatisfaction with the 'mental health system', in particular with 'psychiatry' as it is currently preached (as a form of biologic dogma) and practised (often as little more than a form of legalized drug-pushing.)

ECT, psychosurgery, incarceration and forced drugging create additional trauma for already fragile and distressed people. There are more empowering and compassionate ways to support and help people to resolve problems and crises without having to rob them of their autonomy, or assault them physically or emotionally in doing so.

How, then, are we, the community, to understand and care for people who are in acute crises, or emotional pain? Are we to view them as 'abnormal' or 'sick', or as fellow human beings struggling with social problems, spiritual emergencies and personal conflict? As Breggin suggests, 'Giving a drug disempowers the recipient. It says, "You are helpless in the face of your problems. You need less feeling and energy, and less brain function". The true aim of therapy should be to strengthen and empower the individual.'

Once the Council has had time to consider this input and the relevant research it points to, we would welcome an opportunity to collaborate with you to formulate revised legislation that aims toward greater protection for individuals diagnosed with 'mental illness' from unwanted, often unwarranted and damaging psychiatric 'treatment'.

On behalf of all South Australians, we thank you in advance for your careful and open-minded consideration of this report. We look forward to your response at your earliest convenience.