

Chief Psychiatrist's Treatment Plan Forum

Notes to accompany power point presentation

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Key issues/challenges

Title slide

I have entitled this "a consumer perspective", with the proviso that it is understood that the role of the consumer consultant is that of a specialist worker in the organisation who listens to and articulates the voice of the consumer body individually and as a whole. If I were to do to simply restate my own experience, then my work would eventually become redundant. The reasons for this observation are, firstly that I haven't been a consumer of public mental health services since 1994 and haven't been an involuntary patient - initially as an in-patient, and then on a 12 month CTO - since 1990 or thereabouts, so my own experience is becoming ever further in the past. For my work to stay relevant requires partly that I compare my memory of my own experience with my experience of other consumers' experience to form a perception of the change in quality of the service provided since my treatment. I hope that I integrate these to keep my contribution relevant and fresh, in spite of the passage of years since my direct experience of receiving treatment from a public mental health service.

Slides One & Two– The context of the consumer consultant's role

These are just some introductory remarks on the role of the consumer consultant. I will get through them as quickly as I can, because I realise that they only provide a context for the discussion and are not at its heart. The sources of evidence characterise the work that the role of a consumer consultant involves. The main point I want to make is that, to avoid becoming an instrument of tokenism, consumer consultants need to keep hold of their memory of their own experiences as consumers. But this needs to be integrated with a developing understanding of the diversity of other consumers experiences drawn from the same set of observations that any other professional worker would legitimately draw upon.

I want to briefly comment on the shift from the late eighties – when I began to deal with the system as a consumer, to now - when I do my best to deal with it as a worker and on behalf of other consumers. That period of time has been mapped by the evolution of the music of the day- from Tracy Chapman and Richard Marx, to Missie Higgins and James Blunt. While some things change, some stay much the same. Both pairs of musicians and their music contain for me, a mix of idealism and of the idea that love is the thing that sets people free of the structures and experiences that entrap them. I think consumers that who have made or are making this journey, then and now would agree with the musicians. I also believe that the 2004 amendments are a legitimate part of this process of freeing consumers and families from entrapment and teaching about love in the way these songs suggest.

To elaborate on the discussion of sources from the previous slide, some of the questions I am asking are: If I relapsed, was admitted and treated, in the next month or year, would the quality of care I receive in the service I work at - and at which I was also previously treated - be acceptable to me? Would it be an improvement, the same as, or worse, than my experience of a decade or more ago? In what ways and why? What could I do about it if I became a consumer again, lost the key to the unit that goes with my job, and had to find my way through the system again, with whatever extra burden went with my relapse? What about other services around the state? What would it be like if were I to move out of the region and either be successful in getting a job at, and/or alternatively relapse and receive treatment at another service? Would it be harder or easier to recover? Why would that be so? What would the system in other regions be like and how might the service respond to any belief in the need for reform? What approaches, models or philosophies of reform and system change do other consumer consultants use? Which ones work well, which ones don't and why?

Slide Three – Request One - Minimum requirement of prompt ITP provision to all

The first thing to say is that I am supportive of what I understand to be the thrust of the legislation. People lose their rights to leave a unit and to refuse consent to medication when placed on an ITP. It makes sense to me that, if we take these rights away, we need to give something in return. A plan of action for what we will do to engineer a situation in which it is feasible for consumers to regain these rights seems to me a fair and just thing. There are a lot of people placed on

involuntary orders and we need to make sure that, if and when we do so, it is in a way that respects their rights and dignity.

Services need to place mechanisms in place to ensure that, as a basic requirement, consumers do at least receive these documents. Consumers, in my service at least, did not always seem to receive these plans during the period I have had most to do with in the ITP context – that is, the relatively short period of an acute unit admission. That has begun to change and psychiatrists generally do seem to complete the forms. Also, nursing staff seem to do their part in making sure consumers receive and understand their ITP's.

In regard to promptness, I think this needs some debate to reach a decision that is fair on all parties, but particularly for the consumer and their family who are at the centre of the care. I would suggest that, with an average length of stay in an inpatient unit, this should be achieved within 24 hours of admission and initial statutory assessment and recommendation. Otherwise, the consumer is admitted, but can have little idea why or what needs to be resolved so that he/she can come and go freely and gain insight into an illness, its effects and the need for treatment.

In the community, for a CTO, a little more time might be allowed, but this still needs to be done promptly. If the ITP is given as part of the clinical treatment plan/ ISP, a longer time period will need to be spent on to research and drawing up of a good CTP/ ISP. But when an ITP is given, my belief is that this can be a summary of what a more comprehensive individual service plan, recovery plan or clinical treatment plan might hold. Time taken may vary also depending on whether this were done as a separate document in addition to the DHS document, or if the service has decided to dispense with the DHS document and replace it with a document that better reflects the individual services aspirations on behalf of its consumers and its philosophy of treatment. But there is no excuse for not giving this plan and discussing it with consumer and family at some point in the time of treatment and that it serve as the basis for that treatment. Clearly, the sooner this happens the better.

Slide Four: Request Two: ITP's as part of broader spoken conversation with consumers and family

There can be and, it can be argued, has been and continues to be, a "don't mention the war" thinking in mental health services – that is, that a consumer and his/her family no longer has the brain power or

the will to cope with news of his/her illness. I think this may stem from an outdated and largely disproven view that consumers cannot recover, or be cured, from their illnesses.

As a consumer, I was always appreciative of whatever information could be given on the specifics of my care. But I believe that when this was done in a way that made a difference to my long term sanity and peace of mind, the information was given in a way that:

- was respectful of me,
- was respectful of my own point of view but wary of the consequences of the repercussions of my decisions when I lacked insight and did not pay heed to the seriousness of the information provided,
- involved a genuine display of care and apology for the repercussions for me and, indirectly those close to me, for any poor practice in providing the information; and
- involved acknowledgment on the worker's behalf that he/she was and would remain a source or support, encouragement and advice – and in retrospect, this was fairly scant at the time of my treatment.

As a consumer consultant, that is what I try to deliver to the people with whom I work. When I get it right, consumers seem appreciative of this respect, and it seems to open the lines of communication for a trusting relationship and assistance towards recovery.

To achieve this, statutory plans need to communicate the concerns that have led to admission for the consumer. It is no good evading the issue. This seems only to create a greater sense of distress for the consumer, as he/she only becomes anxious because of the perception that he/she is not being told the whole truth and that there is something missing from the jigsaw of the treatment plan. It also does not allow the consumer to develop the resources to face the real issue that the treatment plan has omitted mentioning.

Clearly, this process requires some clinical judgment about when to communicate more sensitive, and/or complex parts of the plan. For instance, it seems to me that some attempt to communicate the reasons for admission must be communicated on that admission. More detailed work on early warning signs that were:

- not identified in an earlier plan and so not sufficiently guarded against,
- not addressed appropriately leading to the relapse;

- or ignored by the consumer and family and so not addressed, precipitating the relapse;

could probably be saved until after discharge, when the consumer is home in his or her own environment and has more time for reflection and reorientation.

Slide Five: Request Three: ITP's within a broader context of written information and plans that are well integrated with one another

The larger context includes such mechanisms - that I believe are necessary to build up a plan of treatment and care - as: -

- Outcome measures;
- The non-statutory clinical treatment/ individual treatment plans - in services where the DHS template is used;
- Rights and responsibilities information provision;
- Work with carers and support groups;
- Development of and understanding of, early warning signs and relapse signatures;
- How to observe them and what to do about them; opportunities for consumer and carer participation; opportunities for rehabilitation.

All of these issues take time to address and may not be able to be fully addressed in the time of the plan's life - that is, before providing a service to the consumer in the community as an informal patient/ consumer and discharging him/her on recovery. For these issues to be addressed, the consumer, family and service need to develop some insight into the course of the consumer's illness and signs of relapse. They also need to be part of a process of assisting the consumer to forge an identity that is robust and exists independently of, before and beyond the illness. This might be as a painter, student, chef, musician, consumer activist, partner, mother or husband, among a range of legitimate roles.

Of course, this would be understood by all of you and you would also know that it is more easily said than done, but statutory plans used well can be a crucial part of this. If plans become just another piece of paper given to consumers, without elaboration, discussion or the opportunity for ongoing input and review by consumers and families, they only add to the burden that consumers and their families carry. This is unacceptable. And what is more, I think we can do better.