

Sent: 27/02/2009 06:38 PM
To: <mhactreview@dhs.vic.gov.au>
Subject: RE: Mental Health Act Review

SUBMISSION ONE

IN MY ROLE AS A PSYCHOLOGIST, RELATIVE AND CARER OF SOMEONE WITH A MENTAL ILLNESS , I HAVE EXPERIENCED SOME AREAS OF CONCERN ABOUT THE MENTAL HEALTH ACT AND ITS EFFECTS ON PATIENTS, CARERS AND FAMILIES THAT I BELIEVE ARE COMMON TO CONSUMERS AND RELATIVES AND RELEVANT TO THE CURRENT REVIEW.

RELATIVES' CARERS' AND PATIENTS' CONCERNS ABOUT INADEQUACIES IN THE MENTAL HEALTH CARE SYSTEM.

People with mental health issues frequently go undiagnosed and consequently go untreated because of the difficulties encountered by these people in accessing primary care for initial diagnostic processes and referral to specialist(s) and hospital care.

Relatives and friends often recognize the person has a problem but their requests for assistance and medical intervention for ill relatives/friends are often disregarded or ignored by the medical profession.

There is a critical period for people accessing treatment. There appears to be a time lag between when a person with mental health problems agrees to seek help, and then getting an appointment with a GP for entry into the primary care level.

Access to a specialist is almost impossible to get privately because of the demand and cost, and it is impossible to get into the mental health care system on the public level unless referred by a specialist.

This frequently leads to the persons giving up or 'slipping through the net' without getting the help they need.

Areas of concern to patients and relatives of people with mental health problems, centre firstly around getting into the primary care system to obtain referrals for appointments with specialists for diagnosis and to receive treatment. Secondly relatives dealing with the patient's resistance to, and compliance with treatment.

The primary care pathway into the process and services in the mental health care system as it currently stands ,relies on the model of waiting for the ill person to have an episodic event. Next if the ill person is extremely fortunate he/she will see a health care professional, usually a GP, and may be prescribed medication and/or referred to a specialist or community treatment centre. For the concerned family member calling on and accessing help is virtually unattainable when the person has another "episode" or a crisis occurs. The 'cat' specialists are not available to the public, the ill person has to be referred, Thus the original purpose and function of the cat professionals to attend a person in crisis is made obsolete. There is a desperate need for fast access to mental health professionals when a crisis occurs. The criteria for voluntary and involuntary consent needs considerable review in this regard.

The community treatment orders are often not followed adequately by the team because of patient resistance to treatment and the criteria of consent. Relatives of the ill person feel they are not consulted or their observations and concerns are not heard or acted upon by the team.

As a result ,in this system, mental health patients are undertreated, not treated at all, or they lurch from crisis to crisis with spasmodic adherence to treatment, or resistance to intervention because they do not recognize they have an ongoing problem,

The current protocol of responding to, and treating the person's episode as short term only, is flawed and leads to much trauma and suffering for both the patient and the relatives. Some

patients already are, while others are becoming chronically ill and impaired by their illness because of this approach.

Further, expecting the ill person to comply with, self monitor, initiate and seek further ongoing treatment is unrealistic and negligent. Consequently the person is minimally and inadequately treated, becomes disabled for life and dependent on welfare and relatives.

Dealing with resistance to, and compliance with treatment. When it is apparent to relatives that there is a problem with the patients' mental health and physical wellbeing, relatives feel unheard, ignored and alienated by health care professionals at all levels. Apparently intervention when an episode occurs is dependent on the person being willing and consenting to treatment. The patient has to say 'yes'

Consent has become more important than need. The flaw in this approach is that the ill person lacks insight, and therefore intention/capacity to help themselves, so no treatment is given or they are not treated adequately and for long enough for stabilization and rehabilitation to occur.

This is most often a problem where a person has a chronic illness and needs ongoing monitoring, supervision and hospitalization to ensure they comply with treatment until stable.

Often at risk of physical harm. these ill people have the perfect escape clause, they just say 'no' to treatment. The criteria for voluntary and involuntary consent needs considerable review. As the law stands they cannot be compelled to have treatment until the situation is dangerous to self or others. This approach does not in any shape or form adequately treat the person.

SUBMISSION TWO

I am a carer who has, over a period of 20 years, despite many attempts, experienced extreme difficulty/frustration in obtaining access to diagnosis/ treatment for my mentally ill relative. Consequently, there has been a great deal of unnecessary suffering and trauma for both the ill person and her whole family.

Although treatment has recently been commenced, her mental illness has now become chronic. She has tragically lost the best 20 years of her life, and there is now less prospect of a reasonable recovery.

Since such persons exhibit symptoms of mental illness, but have no insight into their illness, they may attempt to evade treatment for as long as possible . Consequently, they are then at risk of developing a chronic mental illness due to lack of early intervention.

Further, under the current system, it can be almost impossible for family/ friends to obtain access to an initial assessment for such people.

By allowing such patients to go undiagnosed/untreated , we, as a society, are showing a lack of duty of care for those who are unable to help themselves.

There needs to be a recognition that the person with a chronic mental illness may not ever draw attention to themselves by being in crisis, (where they are at risk of harming themselves or others) .Rather, the illness may be more insidious in nature and may appear over a period of years where the patient presents with a gradual increase in strange behaviour, physical deterioration, increasing social isolation and impairment of mental function .

The current system allows such seriously ill patients to 'fall through the net'

The current "episodic model " of treatment does not cater for the needs of such patients..

There is a need for outreach facilities to deal with this problem:

- a point of contact between the public and mental health providers whose primary role is to target mental illness in the community at the sub acute stage (early intervention).
- to record the concerns of family /friends over a period of time, regarding abnormal behaviours and deteriorating general health problems of an individual, etc.

- the resulting patient history may then be taken account of and kept for possible future reference.
- to consult with concerned family/friends in order to assist with strategies for initial contact/ assessment.
- to refer the prospective patient on for involuntary treatment where appropriate.

Note: The GP would not be able to take on this role because of privacy concerns and the patient's intention to evade diagnosis means they would not attend the clinic.

Review of involuntary treatment orders

The grounds for involuntary order: points (a) to (e) should be reviewed.

When applied to a patient who has already been stabilized on medication, (who no longer appears unwell due to the effects of the medication), the ability of the medication to mask the underlying illness should be considered.

Decisions whether or not to revoke CTO' s should take into account the patient's history (eg. of chronic illness), and the individual's risk of relapse.

Input of carers is also crucial before consideration is given to patient 's dismissal from their CTO.

The risk to the patient of revoking the CTO where the illness is chronic and the patient has not developed any insight, should be considered to be too great despite the patient requests to do so.

Where anosognosia is present, the patient's ability to make decisions about their treatment is impaired. Such patients should remain under their CTO's

(The impact that the revoking of the CTO would potentially have on the carer/family as well as on the patient should be considered. Further unnecessary emotional trauma for both the patient or the carer should be avoided at all costs .)

Where a CTO is revoked it should only be done following consultation with the carer. It should occur only under strictly monitored conditions.

Where anosognosia is present, patient rehabilitation should be included in their CTO. To promote the best possible recovery.

The rehabilitation of such patients needs to be done at special live- in rehabilitation facilities in the community. There is an urgent need for many more such facilities to be built if we sincerely intend that these non compliant individuals be effectively rehabilitated.

More resources need to be allocated to provide good quality long term supported housing for the mentally ill

Carers

The huge impact that decisions made by patients , doctors , etc , have on the lives of carers and on the broader community is largely ignored .

SUBMISSION THREE

Coroners Reports into deaths of mentally ill persons:

The following Coronial Inquest into the death of xxx, identified a number of areas in the Mental Health Act which urgently needed to be improved. In her Coronial Report the Coroner made seven Recommendations which would improve Mental Health Service Delivery. It seems not a lot has changed since 2003.

Because of the Patient privacy and confidentiality clause in the mental Health Act , those who cared most for Vivienne (her mother and sister) , were prevented from being involved in her care. We strongly recommend that Coroners Reports be acted upon.

Recommendation 1

Psychiatrists and general practitioners who prescribe medication for patients on Community Treatment Orders routinely interrogate the Health Insurance Commission Prescription Shopper Information Service or the Drugs and Poisons Branch in the Department of Human Services to determine whether or to what degree their clients are using alternative sources of medication.

Recommendation 2

That the Parliament of Victoria amend the Mental Health Act 1986 to require authorised psychiatrists to take into account longer-term variations in mental health when determining whether their patients meet the criteria specified in section 8.

Recommendation 3

That the Parliament of Victoria amend the Mental Health Act 1986 and other privacy legislation to require authorised psychiatrists to consult with other service providers when determining whether their patients meet the criteria specified in section 8.

Recommendation 4.

That the Parliament of Victoria amend the Mental Health Act 1986 and other privacy legislation to allow authorised psychiatrists to consult with family members when determining whether their patients meet the criteria specified in Section 8 and developing case management plans for involuntary treatment in the community.

Recommendation 5.

That the Government of Victoria review its allocation of resources for community based psychiatric services with a view to improving the capacity of Crisis Assessment and Treatment teams to provide on-going treatment and monitoring services to patients on involuntary orders living in the community.

Recommendation 6.

The Alfred Hospital Psychiatry Department and other psychiatric services in Victoria re-consider their hierarchical structures with respect to crisis Assessment and Treatment teams to enable priority responses to the urgent

needs of current involuntary patients when requested by the consultant psychiatrist responsible for supervision of the patient's involuntary order.

Recommendation 7

Consultant psychiatrists include orders for routine analysis for their patients' prescription medication levels in the Management Plans for patients discharged on Community Treatment orders particularly when masking of symptoms is a known issue and discharge is subject to Crisis Assessment and Treatment team involvement.

A copy of the Record of investigation into death, is available on request.

Recommendations made by Coroners should be responded to and acted upon!