

15th December 2008



Mr Julian Gardner
Chair, Community Consultation Panel
Mental Health Act 1986 Review

**CAULFIELD GENERAL
MEDICAL CENTRE**

A Member of
BAYSIDE HEALTH

Dear Mr Gardner

Thank you for your letter dated 5th December 2008 in which you invite submissions in relation to the current review of the *Mental Health Act 1986*. I am pleased to provide the following comments on behalf of Caulfield Aged Persons' Mental Health Service

*Community Services
Rehabilitation
Aged Care
Residential Care
Aged Psychiatry*

The *Key Questions* document that accompanied your letter raised some interesting questions for our service, specifically:

1. When should people who are seriously mentally ill be placed on an involuntary order under the new Act?

Often, clinicians are managing people with a well-documented history of chronic mental illness who choose at some point to become non-compliant. Their mental state may well be stable at that point, but poor insight prevents adequate compliance with the suggested treatment. It is often a dilemma in such circumstances as to whether the person should be placed under an involuntary treatment order in order to prevent the deterioration which (that person's past relapse pattern informs us) is almost certain to occur. Some guidance as to how the likely imminence and severity of such relapse might influence a decision to place (or not place) someone under an involuntary order would be welcome under the revised Act.

2. How should the new Act deal with ECT?

ECT is a safe and effective treatment for a variety of psychiatric illnesses. Its use is invaluable in public mental health services. Patients currently have the right to a second opinion prior to receiving involuntary treatment with ECT, and it is a legal requirement that patients be informed of this right under the current Act. Reasonable attempts to advise the person's next of kin or nominated caregiver must also be made.

Many public mental health services mandate a second opinion from a consultant psychiatrist as a matter of course in circumstances where involuntary ECT is being contemplated, as this approach is both medicolegally sound and good medical practice in any event.

Certain rural services may well be disadvantaged by such second opinions being mandated under the Act. This largely reflects poor staffing levels in certain rural centres. A requirement to obtain a second opinion from another psychiatrist in such circumstances may cause undue delay in initiating necessary treatment and result in patients being placed at risk.

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From figures provided in the Consultation paper, some 6197 treatments were provided to involuntary patients in 2007-08.

Were each second opinion to take one hour to complete, it would take more than three psychiatrists working eight hour days, five days per week over one year to service this demand alone.

The Mental Health Review Board is perceived to be struggling with its current workload. It is understood that the Board's current practice of reviewing involuntary orders within 8 weeks is reflective of these workload pressures (as an eight-week delay does not, *prima facie*, appear to be a timely response to safeguard against the potential for the inappropriate detention of a person within a psychiatric hospital). Were the Board required to review every decision to perform involuntary ECT, great concerns would be present about their capacity to do this in a timely way that did not unduly delay necessary treatment, or indeed result in adverse outcomes for the person.

In terms of considering those persons considered appropriate to administer ECT, the following points are made:

- ECT is not a technically complex procedure when compared with other modern medical interventions.
- All persons administering ECT currently must have completed an ECT training course approved by the Office of the Chief Psychiatrist.
- Restricting the administration of ECT to consultant psychiatrists alone would restrict the exposure of registrars to ECT (a service would have no incentive to send their registrars to a training course if they are aware that attendance at the course would not enable the registrar to perform ECT independently).
- The point is made that surgical registrars, anaesthetic registrars, physician trainees and emergency registrars routinely perform much more complex, intrusive and risky procedures on patients than ECT without the requirement for immediate consultant oversight. To make a separate set of rules governing the administration of ECT may only serve to further stigmatise the procedure.

3. How should the new Act deal with external review of involuntary orders?

As detailed above, the current practice of reviewing an order within 8 weeks seems to be inadequate. The implication of this timeline is that what might amount to an inappropriate detention may not be overturned for some two months.

A two-week maximum prior to Board review would provide much greater safeguards for patient rights in this circumstance.

It should be noted that the average length of stay in adult public metropolitan psychiatric units is around two weeks, and that the majority of involuntary patients thus do not receive the opportunity to have an appeal to the Board heard during their inpatient stay.

Whilst legal representation before the Board is a right, many patients struggle to access such representation through the Mental Health Legal Centre. We are aware of cases where representation through the Centre

has been denied because the duty lawyer felt that the chances of a successful appeal were considered low. A guarantee in relation to the availability of legal representation before the Board would go much further towards safeguarding patients' rights in this regard than any other single intervention.

4. How could the new Act improve the complaint system for mental health?

With the advent of mainstreaming psychiatric units within general hospitals, the notion of a "special" complaints system for patients receiving psychiatric care appears somewhat outdated, and may serve to only worsen the stigma with which consumers live.

General hospitals are required through their own external accreditation processes to have in place robust and transparent complaints management processes. If complaints cannot be resolved at the level of the health service, avenues of complaint to the Office of the Health Services Commissioner, state Members of Parliament and the Victorian Ombudsman exist for those in receipt of psychiatric care as much as they do for any other private individual. The Office of the Chief Psychiatrist already acts as an independent overseer of whether the provisions of the Act are being used appropriately in circumstances where persons allege otherwise.

In short, adding yet another layer of (almost certain to be perceived as equally "ineffective and inaccessible" if the complainant feels their complaint has not had a successful outcome) bureaucracy to the complaints process would seem to only further fragment and complicate the system.

5. Addressing "capacity to consent" under the Act.

This is probably an area best not addressed by legislation. Capacity requires the ability to acknowledge process and weigh relevant facts. As such, it is not an "all-or-nothing" phenomenon. Rather, it is decision-specific. The obstacles to introducing anything other than a broad legislative framework in relation to the issue of capacity seem overwhelming. The issue of insight is germane to capacity. If one does not accept the basic premise that he/she is unwell, they are by definition unable to acknowledge a relevant fact, and thus lack capacity to provide informed consent to the treatment of their illness.

6. Addressing the frequency of clinical reviews for patients subject to involuntary treatment orders and Community Treatment Orders.

Again, mandating a certain frequency of clinical review via the imposition of a "one size fits all approach" seems too inflexible. Clinical review of *any* patient should occur *as is clinically appropriate*. It may well be appropriate for a patient managed under a long-term CTO (whose only need for contact with the treating team might be for monthly administration of depot medication) to be clinically reviewed every three months. Other patients whose risk and relapse profiles differ may require clinical review fortnightly, but it would be a mistake to mandate this level of frequency for everyone.

Not only would such an approach be massively burdensome to services from a compliance perspective, but the potential for it to be unduly intrusive on the recipients of care appears very real.

Aged psychiatry services do not receive particular distinction within the current Act. A number of aged-specific issues present themselves, however, that might bear addressing under the new Act:

1. Frequently, patients with dementia are admitted to aged psychiatric units. For many years it has been common practice for these patients to be treated as voluntary (cognitive impairment and general lack of capacity to consent to treatment notwithstanding) unless they are assaultative, resistive to care or actively attempting to leave the unit. The provision of some clarity on the circumstances under which persons with dementia should be managed as involuntary patients would be most useful in the new Act
2. Disputes often arise when patients under involuntary treatment orders are taken before the Guardianship and Administration Board, the Board not infrequently taking the view that a Guardianship Order is not necessary because everything that such an order would achieve could be achieved using the provisions of the *Mental Health Act 1986*. Mental health practitioners take the view that the provisions of the Guardianship and Administration Act are less restrictive than those of the MHA, and thus should be utilised in preference. Some formal resolution of the question as to which of the two Acts is truly "least restrictive" is required.
3. Specialist psychogeriatric facilities (nursing homes and hostels) need to operate within the strictures of the MHA as well as the Commonwealth Aged Care Act. The two occasionally come into conflict (e.g. on the issue of mechanical restraint). A review of the Act such that it is consistent with the provisions of the Aged Care Act would be most welcome.
4. The requirement for an annual examination of a person under an involuntary treatment order bears review as an anachronism. It is understood that this requirement is an artefact of the days of large, stand-alone psychiatric hospitals containing hundreds of patients, when patients may well have gone for extended periods of time prior to medical review. Today it seems anachronistic, as well as burdensome to both staff and the person receiving care, the latter having the right (as does any person within the community) to access care via a general practitioner at any time of their choosing. To suggest that they do not seems patronising, disenfranchising, and unduly stigmatising.
5. Whilst it is understood and accepted that patients should be involved and in agreement with their treatment plans, many aged psychiatry patients (by virtue of cognitive impairment consequent upon dementia) lack any real capacity to appreciate the contents of their treatment plans, let alone endorse the plan. It could be proposed that in such circumstances, it might be more appropriate for persons with dementia to have their treatment plans endorsed by the next of kin/responsible person alone.
6. Aged psychiatry units are often inappropriately pressured to admit patients suffering from delirium. Such pressure may arise from general medical units' perceived inability to manage the behavioural manifestations of delirium, or from hospital administration reacting to bed pressures within the general hospital.

Whilst delirium may well fit within the Act's definition of a mental disorder, delirium also, by definition, invariably has an underlying medical cause. We are aware of cases where delirious patients admitted to stand-alone aged psychiatry inpatient units have died there due to the lack of appropriate medical resources. Some consideration should be given as to whether the primary diagnosis of delirium should be specifically excluded from the definition of mental illness under the Act.

Caulfield Aged Persons' Mental Health Service welcomes the opportunity to provide input in relation to this consultation process. We trust you will find our comments useful in your further deliberations.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Steve Macfarlane', with a long horizontal flourish extending to the right.

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