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REVIEW OF THE MENTAL HEALTH ACT (VICTORIA) 1986

Response to Consultation Paper 2008

(FROM JOANNE TITCHER)

RIGHTS FOR PATIENTS, NOT FOR OTHERS

It is concerning to see that the Mental Health Act, ostensibly to delineate and protect the rights of individuals with a serious mental illness, incorporates and develops rights and authorities for carers and relatives.

It must not be pre-supposed that the wishes and best interests of patients are synonymous with carers/relatives, nor without conflict.

The Act should not cede a patient's right to autonomy, self-determination, choice, privacy and confidentiality.

The Act throughout should be framed in terms of the rights of the persons the Act is intended to protect; for instance that the patient has the right but not the obligation to permit divulgence of information; the option but not the requirement to have an advance statement; the right to choose an independent support person who may not be carer or relative; choice about involving others in mapping out a treatment plan.

Emergency decision making is able to be handled by mental health professionals (upon whom, in any case, carers/relatives will depend for guidance) and Advance Statements where made by pre-existing patients.

The already comprehensive permissions in the Act for releasing information primarily apply to professionals and services, and are for the benefit of the patient, which is not necessarily so when providing information to carers/relatives.

No more information especially if allied to decision making, need be divulged than is usual with other patients, unless with consent. There is no justification for giving over to third parties information about Treatment Plans or a patient's whereabouts without prior authorisation.

Given the episodic and responsive nature of serious mental illness, with and without treatment, the law is not warranted in wresting decision making from patients in any sweeping or enduring form on the strength of a "crisis" or "lapse".

Involvement in decision making is therapeutic, re-engaging and assists a patient to re-establishing his life. It encourages confidence and self-reliance.

Substituted decision making and involving others should only be provisional and circumstantial. Major decisions by carers or family (eg. shifting residence to familial home, selling possessions) when a patient's ability is temporarily impaired may not reflect his wants or the full extent of his recovery. Patients who appear withdrawn and disordered may nevertheless be able to express lucid, considered, realistic preferences and desires. Because this requires more time and patience is no reason for the law to defer to proxies.

FROM VOLUNTARY TO INVOLUNTARY

The Mental Health Act is primarily concerned with individuals whose mental illness is severe and may necessitate crisis and long term treatment as involuntary patients.

The application to voluntary patients is scant and according to the Consultation Paper, their circumstances are dealt with more thoroughly in other legislation.

However "voluntary" and "involuntary" are not readily identifiable and discrete sets of patient, a fact the Mental Health Act needs to recognise and address.

In the clinical setting voluntary and involuntary categorisation and re-assignment are used as bargaining instruments to discipline and secure consent.

Admission to general wards in public hospitals rather than to stand-alone psychiatric institutions as in the past, results in ambiguity about the legal status of a patient, for instance after overdose, self-harm or with depression. The suggestion of involuntary status or re-classification from general to psychiatric patient, is sometimes raised when a patient wants to be discharged or is reluctant to make arrangements to be seen by psychiatric services as an outpatient.

Patients have the right to be informed at all times of their status in relation to the Act and its application should only be for genuine medical concerns not coercive.

A patient who to all intents is consenting - for example by agreeing to see a doctor, having the CAT service visit for assessment, going in their vehicle to a hospital for admission - can nevertheless swiftly find himself an involuntary patient. What is really intended by "voluntary" and "involuntary"? Are they the same in the law as in practice? Is it about detainment for observation? Until medication takes effect? Or in the clinical setting referring to the perceived seriousness of the patient's illness?

There is a prevalent notion in the community based on accounts of compulsory arraignment that deters people from seeking help with mental concerns or even relatively minor emotional problems. The perception is that the law defining voluntary and involuntary is, at least as is practised, on a sliding scale of arbitrariness and over-caution.

TREATMENT PLANS

Choices for patients are beneficial and input into Treatment Plans helps re-connect patients and improve mastery over their lives. We need to question however whether Treatment Plans (other than for assessment and administration of medication) should be mandatory for involuntary patients as opposed to being available.

A patient who strenuously rejects compulsory treatment may resent the further imposition of a detailed Treatment Plan. He is already attending under legal duress. Refusing to co-operate with a mandatory Treatment Plan types him as non-compliant, with problem behaviour, the very attributes that will commend renewing the Community Treatment Order.

The existing Act places the authorising psychiatrist when setting out a Treatment Plan, "under duty to take into account the wishes of a guardian, family member or carer, unless the patient objects". Additionally there is no provision in the Act for a patient to nominate a person, perhaps other than the "guardian, family member or carer", to receive information about his treatment and care. This quashes what should be the right of patients to nominate for themselves, if they choose, a person to receive information and be influential in developing the Treatment Plan.

As the law stands it appears that for mature patients "guardian, family member or carer" are self-appointed. "Unless the patient objects" is a very weak protection in the law. It grants rights to others that belong to the patient.

CARERS

Although responsibility and care may initially befall next-of-kin when a patient is newly diagnosed or hospitalised and perhaps unable to communicate coherently, there is too ready a

presumption that parents remain or would be chosen by the patient as long term carers with whom the patient will live, want involved in decisions about his future and to whom information should be channelled.

Especially this can be observed with adult patients thrust back into family dependence, though having previously lived independently. Note that a patient who has accommodation with, for example parents, also rates very low on priority for public housing.

More attention could be given, when patients are recovering and adjusting, to whom they prefer in their social and family network (a brother, uncle, best mate, someone from church, a girlfriend) and is available as a primary support person.

"Carer" today increasingly has remunerative implications, where the relationship between an individual with a disability and usually a family member, is defined by Social Security legislation.

The role is not solely or necessarily altruistic and from the viewpoint of social administrators largely one of economics.

The requirements for payment of carers by Centrelink eg. resident at the same address, income adjusting if the patient is earning; and the self interest of carers for continuation of maximum income can run counter to psychiatric patients retaining maximum control and flexibility in their arrangements for living.

The interests of the carer can even be subtly antagonistic to a patient's right to independent living, autonomous decision making, choices about spending, residence, occupations and relationships. Carers' perception of the intention and effectiveness of medication may be at variance with the interests of the patient in regard to docility, co-operativeness, agreeableness, risk taking.

ADVANCE STATEMENT

The Advance Statement authorising treatment in defined circumstances is preferable as a rights based legal vehicle compared with involuntary Orders (although there is the presumption that Statements are only for consent!)

Advance Statements may go some way towards ameliorating the sometimes long lasting hostility and resentment some patients feel towards persons who initiate involuntary treatment.

Patients whose mental state improves with treatment are frequently lucid and sufficiently comprehending to want to protect themselves from repeat episodes of flagrant mental illness associated with loss, embarrassment, fear, dislocation, strangeness and indignity. Many will appreciate the advantages of an Advance Statement as opposed to the compulsory nature of involuntary Orders.

Unlike the diagnostic terms currently used when issuing Treatment Orders, it may be helpful for the Advance Statement to employ behavioural descriptions that could be negotiated by and make more sense to the patient and in which advance consent is authorised.

For example, "If my conversation is not making sense", "If I am behaving in ways damaging to my health", "If I am seriously neglecting my hygiene and living arrangements", "If I am unable to maintain my everyday living such as paying bills, buying food etc.", "If my thinking becomes disordered and I am behaving in ways that seem mentally ill", "If there is serious deterioration in my mental health".

Conditions usual for this type of advance directive in other legislation would apply for altering, revoking, witnessing, lodging.

This is suitably the document for nominating a trusted person/s to be contacted, to corroborate the circumstances invoking the Statement and assist in provisional decision making; there may also be place if desired for identifying a mental health professional or service provider familiar with the patient.

A simple consent document such as this also relieves the very real burden of conscience on family or others, in requesting psychiatric assessment leading to involuntary treatment. And serves as a reminder to the patient that it is his own wishes being taken into account and helps preserve the dignity of decision making for the patient.

RESTRAINT AND SECLUSION

Restraint and seclusion may be necessary when a person is wielding or believed to be wielding a weapon; is behaving violently or destructively, in a siege situation, and perhaps to administer sedating medication in the interests of preventing harm and to enable transport to a safe setting.

But these measures should be for emergencies and of very limited duration. Incidents need to be documented.

Mechanical restraint and prolonged cell-like seclusion in an inpatient setting exacerbate fear, anger, strangeness, isolation and paranoid emotions in patients. They heighten hostility, provoke aggression, physical resistance and an urgency to "escape". They foster neither cooperation nor comfort for distressed patients, and can rarely be justified when anti-psychotics and calming drugs are as effective.

Above all patients suffer the indignity of being observed in this incarceration. It hinders the person in regaining, as quickly as possible, normal interaction with others, especially family who are likewise traumatised by the apparent barbarity of such measures.

AUTHORITY TO TRANSPORT

Experience suggests that Authority to Transport be of short - possibly 24 hour - duration before lapsing or being renewed. A mentally ill person armed, conducting a siege or publicly violent would ineluctably be dealt with by normal police procedures, not needing special Authority for arraignment and conveyance. Naturally we assume police training sensitive to the situation of a disturbed person.

Indefinite or longer periods for Authority to Transport, deters patients who have "cooled off" from returning to their residence or to some other safe, familiar place for fear of apprehension and because it is not known if police or CAT services are actively seeking to detain them (which is probably not the case).

COMMUNITY TREATMENT ORDERS

It needs taking into consideration that a non-compliant, objecting, protesting patient may represent failure in the mental health system to generate and negotiate acceptable options for that person and is not necessarily psychiatrically symptomatic. Acceptable alternatives might include "outsourcing" medication provision through a General Practitioner or Community Nurse rather in the psychiatric setting, trials on lower dose or oral rather than depot medications with a negotiated "minder" in the patient's own network.

This requires a dedication to communicating with and getting to know the patient which is understandably difficult in the pressured mental health services, but ought to be an objective. Continuing Care is an ideal vehicle for developing such options. Perhaps "contracts" are more suitable than Treatment Plans that appear imposed and from a pre-set programme and do not respect the patient as an individual and an "equal partner".

The language and terms used by mental health professionals in completing Treatment Orders (especially those renewed by the Review Board) are clinical, diagnostic and relatively meaningless to the patient.

It would be helpful to have the Order express these psychiatrically technical terms in everyday descriptive language, with observations and concerns which are understandable to the patient even if he disputes their implication of mental illness warranting the Order.

MENTAL HEALTH REVIEW BOARD

Patients going before the Mental Health Review Board to be assessed for continuation of Community Treatment Orders express these views:

The independent/community representative is an unfamiliar observer never having previously interacted with the patient and provides no meaningful advocacy or interjectory role. The representative is an irrelevant presence appearing to align with the mental health professionals on the Board and highly unlikely to be independently minded or vocal in sympathetic enquiry of the patient.

The Review Board procedure is overly formal, legalistic resembling a court hearing. Decisions are routine and pre-determined with little opportunity or possibility of a mediated or probational outcome.

Attending a Community Treatment Order review by the Board is a isolating experience. Patients do not know how to vouch for themselves, nor the criteria for having the Order lifted.

The proposals for an independent support person, along the lines developed by the A.C.T. study (Consultation Paper p 31) are highly commendable and practical. All advantages accrue to the patient and the current imbalance is largely redressed.

Having case managers provide written (preferably) or oral reports available to the Board and patients according to their legal rights would give important input. The Board however is already heavily weighted with mental health professionals and the real lack is to have information as to how the patient manages outside the clinical arrangements.

Patients do not necessarily require an advocate or advisor although this should be on offer such as the WorkAssist scheme which independently helps people preparing for and appearing at Workers Compensation Mediation Tribunals. Note that patients who are involuntary and consistently object to mental health treatment may similarly reject other "system" personnel, including advocates.

"I am not a case, I am a human being" ... Steven

A very small subset of individuals with major mental illness, a degree of insight, no history of violence, and with experience as a patient actively prefer to live the full drama of their lives.

They accept the personal cost and deeply resent the intrusion, the stigma, the affront to their dignity and freedom of being an involuntary patient, their lives arrogated for "management" by mental health services backed by the law.

It is difficult to know what is best for such individuals and for the community. Involuntary Orders and the Review Board process are clumsy ways to handle the dilemma.

Mental health personnel generally have a very limited appreciation of and greatly underestimate the ability of such individuals, including those with evident mental illness, to navigate by themselves within our well informed and accepting community. These people develop their own support systems, usually independent of families; have key supportive people; establish personal, social and sexual relationships; access a wide range of services; capably manage

their physical, financial and accommodation needs; and participate meaningfully in community life.

The mental health system does not and cannot treat all individuals with a serious mental illness. Many factors, personal and societal, regional, structural and logistical, intervene.

Therefore there is an argument that the small number of non-violent individuals who are consistently and vigorously oppositional, non-consenting, resentful and barely co-operative are best sundered from the perpetuating regime of the Community Treatment Order and treated sporadically as crisis perhaps will necessitate.

We cannot offer risk free, fully effective treatment. Can we then allow that these patients are making an informed, reasoned, evidence-based decision in refusing the treatment to which we are legally compelling them?