



THE ROYAL
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS
ABN 68 000 439 047

VICTORIAN BRANCH

Submission to Hon. Lisa Neville MP, Minister for Mental Health regarding the Mental Health Act 1986 Review

27 February 2009

1. INTRODUCTION

This submission is made by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Victorian Branch to the Minister for Health review of the Mental Health Act 1986 (the Act) with respect to the Terms of Reference:

- to examine whether the Act provides an effective legislative framework for the treatment and care of people with a serious mental illness in Victoria.
- to aim to ensure that the Act appropriately protects human rights in light of the Charter of Human Rights and Responsibilities.
- to not examine the criteria and pathways by which security and forensic patients enter the mental health service system in the *Mental Health Act*, the *Sentencing Act 1991* and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for setting the training program, examining

and providing access to Fellowship of the College to medical practitioners. There are approximately 1000 Fellows of the RANZCP in Victoria.

As a key stakeholder, RANZCP Victorian Branch welcomes the review of the Mental Health Act 1986 as an opportunity to recommend areas where the Act could be amended or modernised to better meet the needs of the community.

2. BACKGROUND

This section is provided in the knowledge that this submission will become a public document. It is the desire of the RANZCP Victorian Branch that all who read the contents view the recommendations made in the wider context of mental health services and also from the viewpoint of psychiatrists who take a leadership role in mental health and treatment of mental illness.

2.1 Mental health and mental illness

Mental health (a state of emotional and social wellbeing) and mental illness (a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities)¹ are vital public issues. Their impacts on individuals, families and communities are a major challenge for governments world wide. Mental illnesses are projected to be highly significant contributors to the 2020 global burden of disease. They are expected to increase their proportion of total global burden of disease from 10.5 percent in 1990 to 15 percent by 2020.²

The oft quoted "1 in 5 Australians will suffer some form of mental disability" is an annual figure. The 2007 National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics (ABS) from August to December 2007 provides information on the prevalence of selected lifetime and 12-month mental disorders by three major disorder groups: Anxiety disorders (e.g., Social Phobia), Affective disorders (e.g., Depression) and Substance Use disorders (e.g., Alcohol Harmful Use). It also provides information on the level of impairment, the health services used for mental health problems, physical conditions, social networks and care giving, as well as demographic and socio-economic characteristics.

¹<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features22007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=>

² Murray, Christopher J. L. , and Lopez, Alan D., The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020, 1996, Harvard

Of the 16 million Australians aged 16-85 years, almost half (45% or 7.3 million) had a lifetime mental disorder, i.e., a mental disorder at some point in their life. One in five (20% or 3.2 million) Australians had a 12-month mental disorder. There were also 4.1 million people who had experienced a lifetime mental disorder but did not have symptoms in the 12 months prior to the survey interview.³ The Australian Burden of Disease Study figures for disability show that 24% of overall non fatal disease burden (i.e., disability) in Australia is due to mental illness.⁴ Regrettably, the funding proportion for mental health is inconsistent with the Australian Burden of Disease.

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2.2 Psychiatry

Psychiatrists are medical practitioners with a recognised specialist qualification in assessing, diagnosing and treating mental disorders. By virtue of their specialist training they bring a comprehensive and integrated bio-psychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of mental illness. Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual's social context. They provide clinical leadership, with many working in multidisciplinary team settings. Psychiatrists treat patients and work with the patient's general practitioner, other health care providers, families and carers of patients, and the general community.

Effective psychiatric treatment requires coordinated interventions across a range of support systems. A bio-psychosocial approach encompasses treatment with medication (the biological component), psychological therapies, and social interventions such as work programs. This multifaceted approach to treating mental illness is analogous to the approach used to treat other common conditions such as heart disease, which is treated with both medication and lifestyle changes.

In 1999 a RANZCP/ Australian Medical Workforce Advisory Committee (AMWAC) survey indicated that 57.1% of RANZCP Fellows worked predominantly in the private sector, 38.3%

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<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=>

⁴ <http://www.aihw.gov.au/publications/index.cfm/title/10317>

⁵ Murray, Christopher J. L. , and Lopez, Alan D., The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020

in the public sector and 4.5% divided their working time equally between the private sector and the public sector. Subsequent RANZCP surveys have shown that the number of RANZCP Fellows working in private psychiatry is relatively unchanged, however, public psychiatry practitioner numbers have decreased significantly.

2.3 The Victorian Mental Health Act 1986

The Victorian Mental Health Act 1986 (the Act) is the key piece of legislation governing the treatment, care and protection of mentally ill people. It establishes procedures for initiating involuntary treatment, making involuntary treatment orders and independent review by the Mental Health Review Board; emphasises rights and the requirement that treatment should be provided in the least possible restrictive environment and in the least possible intrusive manner; and stipulates that interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances.

The current Act reflects a commitment to deinstitutionalised policy. This reflects a world-wide trend to de-institutionalisation as a result of hospital overcrowding, growing civil rights movements and advances in treatment made possible through the development of antipsychotic pharmaceuticals and anti-depressant medication.⁶ The move to deinstitutionalising mental health patients has increased pressure on the community sector to meet the needs of both patients and their families. The Act also establishes procedures for initiating involuntary treatment, making involuntary treatment orders and independent review by the Mental Health Review Board.

Key features of the current Act are its emphasis on rights and the requirement that treatment should be provided in the least possible restrictive environment and in the least possible intrusive manner. The Act also stipulates that interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances.

⁶ Coffey, Guy, *Madness and Post Modern Civilization – the Burdekin Report and reforming Public Psychiatry*, Arena 36, 1994

2.4 Mental Health Act (1986) review context

While there have been a range of amendments to the Act, it is timely for a full review that can take into account the experiences of all involved in mental health service provision in a deinstitutionalised, community-based context. A National Mental Health Policy⁷ provides guidelines for the guarantee and protection of rights and civil liberties of people with mental illness. The National Policy objectives provide a framework for mental health legislative development that is consistent across Australia. It affirms the rights contained within the:

- United Nations Principles for the Protection of Rights of People with a Mental Illness and for the Improvement of Mental Health Care⁸
- Australian Health Minister's Mental Health Statement of Rights and Responsibilities⁹

3. RESPONSES TO TERMS OF REFERENCE

3.1 Preamble

This submission, from a psychiatry perspective, is formulated within the following conceptual positions:

- evidence-based practice,¹⁰
- advances in treatment, care and recovery
- the rights of mentally ill people to participate as fully as possible in community life
- continuing policy development and redevelopment
- continuing service provision and resourcing reforms

Encompassed in the current Act provisions is the notion of 'community'. In biological terms, a community is a group of interacting organisms sharing an environment. In human communities, intent, belief, resources, preferences, needs, risks, and a number of other conditions may be present and common, affecting the identity of the participants and their degree of cohesiveness. In sociology, the concept of community has caused infinite debate, and sociologists are yet to reach agreement on a definition of the term. There were ninety-

⁷ http://www.mhnocc.org/resources/national_outcomes_and_casemix_collection/nmhp.pdf

⁸ <http://www.un.org/documents/ga/res/46/a46r119.htm>

⁹ <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-rights-toc>

¹⁰ Evidence-based health information aims to be objective and to communicate the best research results. It aims to distinguish what is *known* from people's opinions, best guesses, hopes and fears.

four discrete definitions of the term by the mid-1950s. Traditionally a "community" has been defined as a group of interacting people living in a common location. The word is often used to refer to a group that is organised around common values and social cohesion within a shared geographical location, generally in social units larger than a household. The word can also refer to the national community or global community.¹¹

The Victorian Branch RANZCP endorses the community-based approach where that is the best treatment option for a patient in the context of their particular mental illness. To this end, however, either through legislation of minimum standards of care, the issue of 'cultural safety' and 'vulnerable people' needs to be taken into account. In brief, expediency of treatment and saving resources at the cost of longer term benefit to a patient may simply start a vicious and growing cycle of relapsing mentally ill patients who keep representing and become increasingly vulnerable in a community.

Cultural safety and vulnerability^{12 13}

Cultural background affects how people experience mental illness and how they understand and interpret the symptoms of mental illness. ¹⁴Cultural safety means an environment which is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening. Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual or group.

Cultural safety can be compromised by racial or cultural bias that may be subconscious and unacknowledged. Equalising power differentials is a critical factor in establishing culturally safe service provision for indigenous and new Australians/Victorians. In a practical sense, for example, that there are very few Aboriginal Liaison Officers in hospitals and even fewer in psychiatric units. While it is easy to conclude psychiatric units need more dedicated Aboriginal Liaison Officers, the same line of argument can be extended to include a range of people statistically more vulnerable to mental illness including:

¹¹ <http://en.wikipedia.org/wiki/Communities>

¹² Scanlon, A., et al, The use of the term vulnerability in acute care: Why does it differ and what does it mean?, *A Journal Advanced Nursing*, 24(3), 2007

¹³ Westerman, Tracy, Engagement of indigenous clients in mental health services: What role do cultural differences play, *AeJAMH*, 3(3), 2004

¹⁴ <http://www.ruralhealth.utas.edu.au/indigenous-health/RevisedCulturalSafetyPaper-pha.pdf>

- homeless
- social security recipient
- Aboriginal or Torres Strait Islander
- cognitive, behavioural or psychological impairment
- young (17 -25 years)
- alcohol/drugs involved
- refugees
- frail elderly

An Act that purports to restrict interference with the rights, privacy, dignity and self-respect of all people with mental illness and participation in community life as far as is possible, needs to take into consideration cultural differences, vulnerability and the consequent resourcing implications to implement the ethos of the Act. The Mental Health Act itself places mental health and mental illness in a category separate from other health legislation. That runs the risk of adding to the stigmatisation of mental illness and people suffering from it. This seems at odds to the now widely accepted view that the relationship between mental disorders and physical disorders is complex and reciprocal and that it acts through multiple pathways. Mental disorders lead to poor physical outcomes, as illustrated by the significantly reduced life expectancies of persons with schizophrenia. The reverse relationship is also true: people suffering from chronic physical conditions have a greater probability of developing mental disorders such as depression. Perhaps 'mental health' needs to be more readily aligned with 'health' as a whole.

3.2 Seclusion

The Intellectually Disabled Persons' Services Act 1986 and the Mental Health Act 1986 have technical definitions for the terms "restraint" and "seclusion". It is important to appreciate what the technical terms mean in practice. The general meaning of the terms "restraint" and "seclusion" and how they are implemented are:

Restraint is any thing that impedes or stops the free movement of a person.

Restraint may be:

- *Physical*

e.g., tying someone to a chair or fastening doors so that some people aren't able to leave a room or a building when they want to.

- *Chemical*

e.g., giving someone medication or drugs to make them sleepy or stop them moving around as easily as they normally can.

- *Psychological*

e.g., threats or coercion to prevent a person from going where they want to or making a person think they are locked in a room when they aren't.

Seclusion:

Seclusion has long been used as an emergency measure to control violent or agitated patients. It is an extremely restrictive intervention for which the Act provides minimum statutory requirements.¹⁵ The Act defines seclusion as "the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside". Seclusion may be used in cases of imminent risk to self or others and to prevent a patient from absconding.

Seclusion means confining a person in a room, or some other space, by themselves. A person is secluded if he or she is shut in a room by themselves without any way of getting out except if someone comes to release him or her. This can happen if a person is locked in a room by themselves. It can also happen if a person is put alone in an unlocked room, but can't get out for some reason; for example their wheelchair may have been confiscated or they may not be able to use a door handle.

¹⁵ Seclusion, Chief Psychiatrist's Guideline, 2006,
<http://www.health.vic.gov.au/mentalhealth/cpg/seclusion.htm>

The major reasons people give for using these practices in services include the following:

- Ensuring safety, e.g., locking the doors of a residential service so that residents cannot wander out.
- Behaviour modification or behaviour management, e.g., using "time out" rooms for people who are aggressive.
- Ensuring the smooth running of the service, e.g., removing ambulatory appliances to restrict movement

The UN principles for seclusion and restraint state:

'Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.'¹⁶

Until recently, wide variations in practice were common and largely unstudied, with a consensus on neither the rationales for, nor the effects of, seclusion. Even 'seclusion' itself has been so variously described in the literature that comparative studies are difficult.¹⁷

Sailas and Fenton¹⁸ concluded that:

- No controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness.

¹⁶ UN principles for the protection of people with a mental illness, Principle 11, paragraph 11

¹⁷ RANZCP Victorian Branch adopts the Act definition: "The sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside."

¹⁸ Sailas E, Fenton M., Cochrane Database Syst Rev. 2000;(2):CD001163

- There are reports of serious adverse effects for these techniques in qualitative reviews.
- Alternative ways of dealing with unwanted or harmful behaviours need to be developed.
- Continuing use of seclusion or restraint must therefore be questioned from within well-designed and reported randomised trials that are generalisable to routine practice.

Seclusion and restraint are frequently used in the hope of preventing injury, and reducing agitation, but qualitative studies have reported substantial deleterious physical, and, more often, psychological effects on both patients and staff.¹⁹ For example, Meehan et al describe the experience of patients who were secluded during short term inpatient treatment in a mental health facility. In general:

- patients' experiences were mostly negative,
- patients expressed the desire for:
 - more information,
 - better interaction with staff,
 - more attention to privacy, and
 - effective debriefing after seclusion

More specifically:

- Some patients thought that seclusion was used inappropriately and that the seclusion period was of more benefit to staff than to patients. Most patients felt that the use of force to seclude patients, remove their clothing and personal belongings, and give medication was unjustified. Some patients associated seclusion with punishment. Other patients viewed seclusion as a safe environment in which they could gain control over their actions. Most patients felt undeserving of seclusion and identified various alternatives to being locked in a room.

¹⁹ Fisher, W. A., Restraint and seclusion: a review of the literature. *American Journal of Psychiatry* 1994;151(11):1584-91. [MEDLINE:1995030027]

- The emotional impact of seclusion included anger, which was primarily directed at staff; powerlessness, in a system that took complete control; disempowerment, described as humiliation and an inability to change anything; and fear (of confined spaces, injections, and medication), which did not dissipate once patients were released from the seclusion room.
- Sensory deprivation was a common experience. Patients described feelings of depression, a heightened awareness of sounds, difficulty in judging time, feelings of loss of control, and dysfunctional thought patterns. Patients often made suggestions about putting items such as paintings in the seclusion room to help them to cope with the boredom and isolation.
- Patients used various strategies to help them to maintain control while in seclusion (e.g., talking to themselves to break the silence or being quiet so that the seclusion period was not prolonged).
- Staff-patient interaction during and after the seclusion period was a main source of dissatisfaction for all patients. Most patients felt that more effective communication about seclusion and specific input about behaviours that warrant its use would be preventive. Patients reported that staff communication during and after the seclusion period would have been helpful and expressed the need for a debriefing period after seclusion. Patients felt that they lost claim to any individuality or rights once they were in seclusion.²⁰

The theoretical foundations of seclusion are much debated in the literature. However, the seclusion of some disturbed patients will inevitably continue to be used for the foreseeable future. It has been suggested that when a patient cannot co-operate and is at a risk of being dangerous to himself or others seclusion may be the safest and most dignified intervention, especially if there are concerns arising from the patient's medical or psychiatric history. However, few other forms of treatment which are applied to patients with various psychiatric diagnoses are so lacking in basic information about their proper use and efficacy.²¹

²⁰ Meehan, T., et al, Inpatients had mostly negative experiences of seclusion during short term treatment in a mental health facility, *Evidence-based nursing*, 2001; 4:62

²¹ Sailas, E. E. S., Fenton, M., Seclusion and restraint for people with serious mental illnesses (review), *The Cochrane Collaboration*, Wiley and Sons, 2009

The Australian Federal Government has identified problem areas²² as:

- Lack of identified good practice/agreed clinical standards for the use of restraint. No national standards on appropriate use of restraint currently exist.
- Lack of identified good practice/ agreed clinical standards for the use of seclusion. No national standards on appropriate use of seclusion currently exist.
- Inappropriate use of interventions and variation in practice, for example using threat of restraint or seclusion to coerce particular behaviour.
- Known adverse events associated with use of restraint and seclusion.
- Lack of staff knowledge or skills to prevent use and identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations.
- Lack of staff knowledge or skills regarding appropriate triaging of mental health presentations, particularly in emergency departments.
- Despite restraint being commonly practised in emergency departments, there is a lack of training about restraint practices and a lack of documentation and clinical audit of restraint practices.
- Aggressive and violent behaviours are common triggers for the use of restraint and seclusion.
- Lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint.

The Australian Federal Government is funding a national project, in which all state and territory governments are participating, to reduce and, where possible, eliminate the use of seclusion and restraint. The project is continuing to 30 June 2009. That RANZCP General Council policy on seclusion and restraint is to endorse and support in principle the national seclusion and restraint project which aims to reduce and, where possible, eliminate the use of seclusion and restraint.²³

The author of a literature review of national and international practices with respect to seclusion (2007)²⁴ concluded that while there has been a reduction in the rates of seclusion interventions in Australia there is also demonstrated disparity between the existence and detail of seclusion regulation. While the rationale for seclusion has generally been narrowed in international consensus, practice is varied. Most importantly, it is concluded that: "It is a

²²<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-safety-toc~mental-pubs-n-safety-3~mental-pubs-n-safety-3-use>

²³ <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-seclude>

²⁴ Victorian Quality Council and Chief Psychiatrists Quality Assurance Committee, *Creating safety: Addressing Seclusion Practices*, Department of Human Services Victoria, 2007

matter of concern that much current Australian legislation in this matter does not conform to UN principles into mental health care²⁵

Given that there have been tragic deaths associated with seclusion (and restraint)²⁶ the following recommendations take into account the seriousness of, and lack of complete understanding of a seclusion episode, the possible adverse effects and complications that may manifest without warning. The additional safeguards suggested will assist in the effective regulation of seclusion and overall welfare of a patient.

Recommendations:

1. That review of a secluded patient by a medical practitioner should take place at 3 hours (rather than 4 hours)
2. That a psychiatrist must be notified at the earliest opportunity of a seclusion event.
3. That a psychiatric review must take place as soon as practicable within 48 hours.
4. That a second episode of seclusion is considered extreme and must be authorised by a psychiatrist.
5. That the criteria for seclusion is limited to:
 - o risk to self and/or others
 - o where there is imminent danger
6. That any extension of an initial seclusion period must be authorised by a psychiatrist.
7. That guidelines of minimum standards of medical care for seclusion episodes should be provided by the Chief Psychiatrist²⁷.

3.3 Involuntary patients

RANZCP Victorian Branch recognises that there are circumstances where involuntary treatment may be required. The concern is that treatment is provided without delay.

²⁵ Victorian Quality Council and Chief Psychiatrists Quality Assurance Committee, *Creating safety: Addressing Seclusion Practices*, Department of Human Services Victoria, p. 30, 2007

²⁶ Review of the Mental Health Act 1986 Consultation paper – December 2008, p. 41

²⁷ RANZCP would be pleased to assist in the development of the suggested guidelines.

Topp et al (2008)²⁸ reported on the experiences of involuntary patients with the Victorian Mental Health Review Board (MHRB). This is a comprehensive research report that provides an understanding of the hearing process from the people appearing before the MHRB. All the recommendations in the report warrant consideration in the review of the Act because it represents the first Australian analysis of the processes of the review of civil detention and involuntary treatment from the perspective of those detained.

Recommendations:

8. That a MHRB review occurs at 4 weeks (instead of the current 8 weeks).²⁹
9. That a mentally ill patient has the right to immediate treatment upon being admitted as an involuntary patient.

3.4 Community treatment orders (CTO)

Community treatment orders are provided for by the Mental Health Act 1986. As a means to require treatment for mental illness of a person who is at large in the community but does not apply to a person in prison or a patient in an approved mental health service.³⁰ A community treatment order can be made instead of continuing to treat a person as an involuntary inpatient. The intention is that treatment is provided in a less restrictive community-based setting. However, CTOs still imply considerable State power over the individuals involved.

When CTOS were first introduced, the discharge of inpatients into the community was facilitated and monitoring occurred by outpatient clinics. Amendments to the Act in 1996 closed a loop hole that had allowed CTOs to be used as a direct substitute for involuntary admission as an inpatient. A person must now meet five criteria of Section 14 (1A) of the Act to be placed on a CTO by authorised psychiatrist. A delegate or the authorised psychiatrist is required to monitor treatment and the CTO can be extended indefinitely.

²⁸ Topp, et al, *lacking Insight: Involuntary patient experience of the Victorian Mental health review board*, Mental Health Legal Centre, 2008

²⁹ 8 weeks is an excessive time period to wait for a review. It could be argued that the patient is detained against their will for an excessive time, which has human rights implications.

³⁰ Mental Health Act 1986 (s.3.def)

Limitations of CTOs

It has been argued that many patients on CTOs have limited awareness of their rights and limited access to specialist legal services, particularly in rural communities.³¹ There has also been expressed concern regarding poor administration of CTOs³², that services lack the resources required to ensure accountability, lack of appreciation of the responsibility CTOs represent, and that the CTO coercive environment limits more insightful helping skills being applied.³³ The current Act has a tendency to convey coercion and compliance for CTOs rather than community-based, inclusive, patient-centred treatment and rights. The original contention of CTOs needs to be implementable otherwise they represent an injustice to patient and carers.

Efficacy of CTOs

Brophy and Ring (2004), who both have long standing knowledge and experience of the use of CTOs in Victoria, used a mixed method approach over four months to ascertain consumer and professional views about the operation of CTOs in Victoria. Though predominantly a qualitative approach, some relevant quantitative data was also collected. Sampling included rural Victoria and Melbourne suburbs. The authors concluded:

- 1) CTOs may be used appropriately as an alternative to assertive outpatient treatment and support
- 2) CTOs impact on the issues of social justice and human rights
- 3) There is a lack of strong evidence for the effectiveness of CTOs
- 4) There is a lack of strong evidence for broad based community support
- 5) The range of views in the professional data collected suggest that many aspects of the law of practice of CTOs may be contested and in need of clarification – particularly about admission, discharge and clinical interpretation
- 6) Issues surrounding CTOs are made all the more difficult if adequate community-based resources are not made available to consumers and professionals
- 7) Much room for improvement to ensure CTOs reflect in practice their initial intention

Points 3, 6 and 7 deserve special attention. It is now widely accepted that there is a discrepancy between the available psychiatric workforce and the mental health needs of the population. The National Mental Health Report 2007 shows that inpatient beds in Victoria

³¹ Mental Health Legal Centre (2000) Annual Report 2000, Mental Health legal Centre, Victoria

³² Wilson v Mental Health Review Board and others, 2000, VSC 404,, (6 October)

³³ Ring, D., Brophy, L., Gimlinger, A., Examining community treatment orders: A preliminary enquiry into their efficacy, Health issues, 66 (March), 13-17

have dropped from 21.6/100,000 in 1992-93 to 19.9/100,000 in 2004-05 in a period of rapid population growth and improving diagnosis of mental illnesses, such as depression. With this in mind, it is the considered opinion of the RANZCP Victorian Branch that there is currently a grave shortage of acute public hospital beds. There are anecdotal reports of hospital bed occupancy rates of 101% that require investigation. There is urgency about having this information clarified and the issues resolved because when a patient presents in the acute phase of mental illness they are at great risk of their condition worsening if treatment is delayed. They may also become a more troublesome patient if required to wait for extended periods before a bed is available or treatment is commenced.

Resources and CTOs

Where resourcing is inadequate as described above, CTOs may be the only way a mentally ill patient can receive treatment. It is not necessarily the most appropriate treatment. In its submission to the Victorian Legislative Council Standing Committee on Finance and Public Administration Inquiry into Public Hospital Performance Data in December 2008 the RANZCP Victorian Branch recommended an immediate increase in acute public hospital beds by a factor of at least 25% to address the lack of resources available for treating acute mentally ill patients. The Branch has also recommended urgent work, including data collection and comprehensive needs analysis from the clinician and patient perspective, into the issue of psychiatric presentations and long stays in emergency departments. The results of the Inquiry are yet to be made public. RANZCP Victorian Branch would advocate for increased funding to develop the multi-disciplinary mental health workforce.

Benefits and effectiveness of CTOs

While it may be argued that the preceding are not legislative issues in themselves, the fact remains that CTOs may not necessarily be addressing the mental health needs of many patients in the community. This needs to be considered along side the various other factors that may drive the increased use of CTOs, such as the reduction of costs of inpatient care. Limited or inadequate service provision reduces cost at one level however patients may not be receiving adequate care at their early presentation with a mental illness, only to relapse and increase the number of long term CTOs.

The RANZCP Victorian Branch would argue that practitioners being placed in a position of treating patients inadequately due to lack of resourcing of more appropriate alternatives (with the hope that they will not relapse) is far from best practice. It is more likely to perpetuate a vicious cycle of re-presentations of the same patient with increasing levels of mental illness. As the Department of Human Services publication "Because Mental Health Matters"

consultation paper describes a 'recovery orientation' that promotes access to responsive, patient-centred, effective and coordinated support and treatment of mental illness³⁴, the effectiveness, adequacy of resourcing and human rights aspects of CTOs must be addressed.

Recommendations:

10. That definitions of 'personality disorder' and 'mental illness' are reviewed together with the implications for CTO service provision³⁵
11. That the duration of a CTO is reduced to 6 months (from 12 months)
12. That provision is made for checks and balances signed off by a psychiatrist to determine if a patient is receiving appropriate treatment and overall benefit via a CTO³⁶
13. That long term CTOs should include a higher order review at 18 months to 2 years with a consultant psychiatrist required to appear at MHRB hearing. It is strongly recommended that a patient has an advocate or the Chief Psychiatrist present at a hearing to ensure patient rights are upheld.

3.5 Chief Psychiatrist

The Department of Human Services Victoria website provides a summary of the responsibilities of the Chief Psychiatrist, reproduced here to provide a context³⁷.

Responsibility exists under the Mental Health Act 1986 for the medical care and welfare of persons receiving treatment or care for a mental illness. The Chief Psychiatrist's responsibilities include monitoring the clinical standards of psychiatric practice and treatment provided by public mental health services and responding to complaints from consumers, carers and others.

The Deputy Chief Psychiatrist assists the Chief Psychiatrist in his duties, particularly with regard to Aged Persons Mental Health.

The current key functions of the Chief Psychiatrist include:

³⁴ Department of Human Services, Victoria, 2008,

³⁵ RANZCP would be pleased to assist in this endeavour.

³⁶ A recognised resource implication here but need assurance that the patient is benefiting from the CTO.

³⁷ <http://www.health.vic.gov.au/chiefpsychiatrist/>

- investigations concerning treatment-related issues where the Chief Psychiatrist determines such an investigation is warranted
- statewide clinical review of approved mental health services to examine the standard, quality and consistency of clinical practice provided
- investigation of complaints from consumers and carers
- management of enquiries and correspondence from members of the public, service providers and other organisations
- development of clinical guidelines and circulars concerning application and interpretation of the Act and establishment and maintenance of practice standards
- provision of high level advice and consultation.

3.6.1 Appointment of the Chief Psychiatrist

The appointment of a chief psychiatrist (or equivalent) varies between the States as is summarised in the table on the next page.

State/Territory	Chief Psychiatrist (or equivalent appointment) process
Victoria	The Chief Psychiatrist is appointed by the Secretary of Health and subject to the general direction and control of the Secretary.
Tasmania	The Chief Psychiatrist is appointed to a statutory role by the Secretary of Health. Alternative options, which are being contemplated locally in relation to drafting a revised Act, include appointment of the Chief Psychiatrist by the Minister for Health or by the Governor.
New South Wales	The Chief Psychiatrist position is not directly mentioned in legislation but has delegations under the Mental Health Act 2007. The Chief Psychiatrist is a Senior Executive Service Specialist Medical position. The position is appointed by the Director-General of Health or delegates. Key decisions are allocated to the Director-General and delegated to appropriate officers such as the Director Mental Health and Drug & Alcohol Programs and the Deputy Director General Strategic Development.
Queensland	Queensland has a Director of Mental Health. The appointment is made by the Governor-in-Council under the Mental Health Act and not under the Public Administration Act. The Director is not under the control of the Minister.
South Australia	The Governor appoints the Chief Advisor in Psychiatry who is a senior psychiatrist.
Western Australia	The Chief Psychiatrist is a senior public officer reporting to the Director General of Health in the Department of Health. The Chief Psychiatrist is appointed under the Health Legislation Administration Act 1984 which provides for the appointment of specific Public Servants under the W.A. Public Sector Management Act 1994.
Australian Capital Territory	The Chief Psychiatrist is a member of staff of the ACT Health and Community Care Service. The position is a statutory appointment.
Northern Territory	The Northern Territory does not have a position designated as Chief Psychiatrist.

The Office of the Chief Psychiatrist needs to be protected under the Act, and independent from the Department of Human Services, just as the Auditor General has independence.

Recommendations:

14. That the chief psychiatrist is appointed by the Governor or statutory appointment by the State Parliament.

15. That the Chief Psychiatrist should be accountable to the Parliament

3.6.2 Powers, role and responsibilities of chief psychiatrist

The complexity of the Chief Psychiatrist role is not well reflected in the Act. The Act gives enormous power to the Chief Psychiatrist to investigate anything at anytime. In this regard, there is a possible conflict where the Chief Psychiatrist investigates occurrences at a public mental health facility and is responsible to the Secretary of Health. The public expectation of the Chief Psychiatrist has changed from senior clinician to include ombudsman and advocate because of the vested powers in the position. The Chief Psychiatrist may almost simultaneously be required to be clinician, investigator, arbitrator, ombudsman and commissioner. There is enormous responsibility placed on one individual and anecdotally the power attached to the role of Chief Psychiatrist is regarded as 'unpleasant'. For example, the Chief Psychiatrist may direct a mental health facility to treat a patient that has been refused treatment. This decision has a flow on consequence of the provision of services and resources to the patient that the health facility is not budgeted for. The Chief Psychiatrist has protected the interests of the patient but is perhaps forced to make a mental health facility operate beyond funding levels that ultimately reflect negatively on it. The powers of the Chief Psychiatrist need to be clarified much more, perhaps by indicating the appropriate steps required to direct the provision of service and how the consequences of the direction can be effectively and fairly accommodated.

As mentioned before, the Chief Psychiatrist may almost simultaneously be required to be clinician, investigator, arbitrator, ombudsman and commissioner. At one moment the requirement may be to provide expert clinically-based advice and the next moment, responding to a family who wants the Chief Psychiatrist to arrange the discharge of a patient that the MHRB has refused to discharge. There are insufficient resources in the Office of the Chief Psychiatrist to meet the changed expectations of the public and the key functions of the role.

RANZCP Victorian Branch would argue that the role of the Chief Psychiatrist is not that of 'chief clinician' because there is a range of ways of practicing psychiatry. The emphasis should be on quality assurance and clinical efficacy for patients. As noted above the Chief Psychiatrist currently is expected to receive and investigate complaints from consumers and carers, and liaison with public, service providers and other organisations. The Branch would argue that the latter functions would be better placed with a new role of 'commissioner' and thereby an achievable workload for the Chief Psychiatrist.

Recommendation:

16. That the current role of the Chief Psychiatrist be divided into two distinct roles: that of a Chief Psychiatrist and a Psychiatrist Commissioner.

The role of the Chief Psychiatrist:

- not 'chief clinician'
- clinical efficacy
- quality assurance

The role of the Psychiatrist Commissioner:

- complaints and investigations
- liaison with public, service providers and other organisations

3.7 Electroconvulsive therapy (ECT)

The use of electricity in treatment

It is now widely acknowledged that the relationship between mental disorders and physical disorders is complex and reciprocal and that it acts through multiple pathways. Mental disorders lead to poor physical outcomes, as illustrated by the significantly reduced life expectancies of persons with schizophrenia. The reverse relationship is also true: people suffering from chronic physical conditions have a greater probability of developing mental disorders such as depression. Rates of suicide are higher among people with physical disorders than among other people, especially in the elderly. Increased vulnerability is frequently attributable to the social consequences of physical disability.³⁸

Electrical stimulation is used in a range of treatments:

- An electrical current can be used to cause a single muscle or a group of muscles to contract. By placing electrodes on the skin in various locations a physical therapist can recruit the appropriate muscle fibers. Contracting the muscle via electrical stimulation helps strengthen the affected muscle.
- A TENS (transcutaneous electrical nerve stimulation) uses electrical transmission to decrease pain. Electrodes are applied to the affected area, a tingling sensation is felt in the underlying skin and muscle. This signal disrupts the pain signal that is being sent from the affected area to the surrounding nerves. By breaking this signal, the patient experiences less pain.
- Electro-acupuncture is the application of a pulsating electrical current to acupuncture needles as a means of stimulating the acu-points. The procedure for electro-acupuncture is to insert the acupuncture needle as would normally be done, attain the qi reaction by hand manipulation, and then attach an electrode to the needle to provide continued stimulation as a substitute for prolonged hand maneuvering.
- ECT involves the placement of electrodes on a patient's head and a short pulse of electricity is administered. The brain functions using electrochemical messages. It is thought that ECT-induced seizures interrupt these messages and 'reset' the brain. ECT is generally used when other forms of treatment, including medication and psychotherapy, have failed. ECT is often the first treatment of choice in life-threatening situations, such as a potential suicide, because of the rapid results. Sometimes, ECT is prescribed for older patients who can't tolerate medications.

³⁸ The Mental Health Context, World Health Organisation, p. 20, 2003

- At the forefront of developing treatment using electricity is Deep Brain Stimulation, a more invasive process than ECT. It has greatly improved the life of a number of Parkinson Disease patients. For example, two tiny electrodes are placed in the subthalamic nuclei on either side of a patient's brain and wired to pacemakers implanted in the chest wall just below the collarbones. The electrodes deliver continuous, high-frequency electrical stimulation to cells in areas of the brain that control movement effectively taming overactive neurons . The treatment results in marked improvement in stiffness, slowness, tremors, weakness and other disabling symptoms of Parkinson's disease. Here the goal is to use electricity instead of medication, because the electricity can be delivered at a steady rate that can be adjusted in small steps to produce the greatest benefits and the least side-effects. This process has allowed some patients to stop taking medications at very regular interval and thereby stop the side-effects of the pharmaceuticals. The treatment has also helped patients where pharmaceutical medication is no longer effective.³⁹

Evidence-based viewpoint on ECT

Media portrayals of ECT, such as the film scenes in "One flew Over the Cuckoo's Nest" have left long standing distortions on public perceptions and attitudes despite the ECT procedures depicted representing those practised in the 1940s and 1950s – without muscle relaxants or anaesthetics, including unmodified convulsions and placing patients in danger of fractures, memory loss, confusion and anxiety. It needs to be recognised that the scenes depicted are reflecting the practice of over 50 years ago and, as with all medical treatment, a lot has changed for the better. Just as there have been enormous advancements in technology and surgical techniques, there have been similar advancements in technology and brain-based illness treatments.

The table on the next page demonstrates some of the typical erroneous viewpoints argued whereas, in stark contrast, the evidence-base viewpoint provides a quite different perspective.

³⁹ <http://www.sciencedaily.com/releases/2004/03/040302081659.htm>

	Then: Historical Viewpoint	Now: Evidence-based Viewpoint
1.	(1938) Having a fit is therapeutic ⁴⁰	(1993) No. The stimulus needs to be adequately suprathreshold ⁴¹
2.	(1963) Ultrabrief stimuli do not work ⁴²	(1998) No. They do work with square waves, regular frequencies, dosage control and sufficient suprathreshold. ⁴³
3.	(1987) Unilateral ECT does not work like bilateral ⁴⁴	(1993) It may be similar (the same?) if an adequate dose is used. ⁴⁵
4.	(1987) ECT does not work ^{46 47}	(2003) ECT does work. ^{48 49 50}
5.	<ul style="list-style-type: none"> Inducing seizures causes brain damage. Memory impairment is inevitable with ECT 	<p>(1991, 1994) No. Modern brief pulse seizures are low in dosage, more highly controlled, and oxygenation and anaesthesia are used. Structural damage has not been shown in prospective MRI studies of the brain or CSF and blood marker studies for products of neuronal breakdown.^{51 52}</p> <p>Research findings suggest structural brain changes may play a predominant role in the genesis of depression. Indications are that depression itself causes brain neuronal loss leading to memory loss.⁵³</p>

⁴⁰ Cerletti U., Bini, L., Bolletino Accademia Medica Roma, 64:136-138, 1938

⁴¹ Sackeim et al, Effects of stimulus intensity and electrode placement on the efficacy and cognitive effects of ECT, NEJ Med 328(12): 839-846, 1993

⁴² Cronholm, B., Ottosson, J-O., Ultrabrief stimulus technique in electroconvulsive therapy, I J Nerv Ment Dis, 137: 117-123, 1963

⁴³ Pisvejc, J., et al, A comparison of brief and Ultrabrief pulse stimuli in unilateral ECT, J ECT 14(2): 68-75, 1998

⁴⁴ Sackeim, H., et al, The effects of electrode placement on the efficacy of titrated, low dose ECTAm J Psychiatry, 144: 1449-1455, 1987

⁴⁵ Sackeim et al, Effects of stimulus intensity and electrode placement on the efficacy and cognitive effects of ECT, NEJ Med 328(12): 839-846, 1993

⁴⁶ Sackeim, H., et al, The effects of electrode placement on the efficacy of titrated, low dose ECTAm J Psychiatry, 144: 1449-1455, 1987

⁴⁷ Johnstone, E. C., et al Lancet 20/27December, 1317-1320, 1980

⁴⁸ NICE Report, Electroconvulsive therapy (ECT) for depressive illness, schizophrenia, catatonia and mania, www.nice.org.au, 2003

⁴⁹ Tharyan, P., Adams, C.E., Electroconvulsive therapy for schizophrenia IN: Cochrane Review, Issue 2, Oxford, 2003

Recent ground-breaking neurobiological research is revealing that both antidepressants and ECT cause an increase in a brain nerve growth stimulator, brain derived neurotrophic factor (BDNF) and other neurobiological factors that actually enhance new growth in nervous tissue.^{54 55} Furthermore, of all the antidepressant treatments, ECT seems to be the most effective method of inducing this new nerve growth, at least in animal models⁵⁶. Again, if depression causes nerve losses in important brain areas and adequate treatment can reverse the process, even if this turns out to be partial, this underscores the importance of treating depression early and adequately.

A recent paper by Sackheim et al⁵⁷ examined cognitive variables in patients having ECT in several units across the United States. Techniques varied across these units with some units using out dated older sine wave machines, and some practitioners favouring bitemporal or high stimulus to threshold administrations. They found, unsurprisingly and in keeping with other research, that these techniques were much more likely to be associated with poorer cognitive outcomes. They also found that for the majority of patients having ECT that their cognitive scores improved over the six months following ECT, probably as a result of reversing the cognitive effects of severe depression. RANZCP guidelines stipulate that practitioners should use cognitive sparing modalities of administration when commencing ECT.⁵⁸

ECT in older persons

ECT is an important treatment in older people. There are several reasons for this:

- Older people have fewer options for the treatment of depression.

⁵⁰ Van der Wurff, F. B., et al, Electroconvulsive therapy for the depressed elderly, In: Cochrane Review, Issue 2, Oxford, 2003

⁵¹ Devanand, D., D., et al, Does ECT alter brain structure?, Am J Psychiatry, 151(7): 957-970, 1994

⁵² Coffey, C., et al, Brain anatomic effects of electroconvulsive therapy. A prospective magnetic resonance imaging study, Arch Gen Psychiatry, 48(11): 1013-1021, 1991

⁵³ O'Brien, J., Dementia associated with psychiatric disorders, International Psychogeriatrics, 17(Supplement 1): S207-S221, 2005

⁵⁴ Duman, R., Depression: A case of neuronal life and death?, Biological psychiatry, 56(3): 141-145

⁵⁵ Harrison, P.J., The neuropathology of primary mood disorder, Brain, 125(7): 1428-1449, 2002

⁵⁶ Malberg, J., Implications of adult hippocampal neurogenesis in anti-depressant action, J Psychiatry Neurosci, 29(3): 196-205, 2004

⁵⁷ Sackheim, et al, The Cognitive effects of electroconvulsive therapy in community settings, Neuropsychopharmacology, 32: 244-254, 2007

⁵⁸ Electroconvulsive therapy, Clinical memorandum #12, The RANZCP, 1982 - 2007

- Older people have medical illness and may have conventional treatment contraindicated⁵⁹.
- Older people have more co-morbid medical illness, which makes the prescribing of all classes of antidepressants problematic in terms of side effects. For example, life threatening hyponatraemia (low serum sodium) can complicate the SSRI class of antidepressants and postural hypotension and abnormal cardiac rhythms complicate the tricyclic class of antidepressants, thus rendering both classes of available antidepressants unsafe for some older people.
- ECT is very effective treatment for late life depression⁶⁰ and its most severe form, melancholia⁶¹. This latter condition is much more common in older people.
- In melancholic depression the older person will stop eating and drinking thus nutrition and hydration are compromised. Treatment options are severely limited. Antidepressants take up to 6 weeks to work, if the patient can tolerate them. ECT in this condition can be life saving as it will reverse the symptoms within a week or two of starting treatment. Most Psychiatrists of Old Age would be able to cite case reports of such life saving treatment for some of their patients.
- Preventing use of ECT for older people would remove an important treatment option. All classes of antidepressants have their problems in older people and for some patients are unsafe. The patients are too sick to benefit from psychotherapy and new neurobiological work is suggesting that delaying effective treatment for older people may have long term cognitive consequences or cause dementia. ECT is a rapid and effective treatment for reversing symptoms and may have the added advantage of being the most effective treatment at inducing new neuronal growth in important areas of the brain.

ECT in pregnancy

ECT given in pregnancy is extremely rare. ECT is much more likely to be needed in the post partum period as this is when depression is much more likely to ensue because of the huge physiological changes the woman experiences plus the stresses of childbirth and having a new baby.

Early in pregnancy, there are rapid changes in the developing foetus. It is well known that this is a time when administration of medications, including antidepressant medications, may

⁵⁹ Tomac, T., et al, Safety and efficacy of electroconvulsive therapy in patients over 85, *Am J Geriatr Psychiatry*, 5(2): 126-130, 1997

⁶⁰ Van der Wurff, F. Electroconvulsive therapy for the depressed elderly, *Cochrane Database Syst Rev*, 2:CD003593, 2003

⁶¹ Hickie, I., et al, Prediction of ECT response: validation of refined sign-based (CORE) system for defining melancholia, *Br j Psychiatry*, 169(1): 68-74, 1996

have harmful effects on the developing foetus. Severe depression may occur at such a time, and ECT may be considered by the patient as a preferred option to medication on these grounds.

The anaesthetic drugs used in pregnancy have not been associated with foetal abnormalities. However, the anaesthesia for ECT is much more complicated in the pregnant patient. The airway needs to be secured by intubation as the pregnant uterus can cause reflux in the presence of muscle relaxation used for ECT. The cardiovascular effects can cause transient foetal heart rate slowing (protected by giving glycopyrrolate). The heavily pregnant uterus in the supine patient can cause compression of the vena cava lowering venous return but this can be avoided by positioning the patient so that with their left hip is raised off the bed. There are guidelines for the conduct of anaesthesia for the process.^{62 63}

Administration of ECT in pregnancy is safe providing that special precautions are taken. The ECT stimulus does not pass through the foetus, does not cause uterine muscle to contract as part of a generalized seizure⁶⁴. As the seizure is modified by anaesthesia the effect on the foetus is less than it would be in a seizure in a pregnant mother with epilepsy.

ECT and adolescents

ECT given to prepubescent children is extremely rare. It is more likely to be used as a treatment in adolescents, but even this is fairly rare treatment. Australia (New South Wales) has reported a rate of 1.53 courses /100,000 adolescents between 1990-1999⁶⁵.

A very serious complication of severe depression in younger people is suicide. Prolonged depression or psychosis in adolescents may also have profound effects on schooling and on peer or other relationships, which may have long lasting effects.

An Australian study on the experiences and attitudes of adolescents who had ECT indicated that the vast majority considered ECT a legitimate treatment and, if medically indicated, would have ECT again and would recommend it to others⁶⁶.

⁶² Rabheru, K., The use of ECT in special populations, Canadian Journal of Psychiatry, 46(8): 710-719, 2001

⁶³ Walker, R., and Swartz, C., Electroconvulsive therapy during high-risk pregnancy, General Hospital Psychiatry, 16(5): 348-353

⁶⁴ Miller, L., et al, Use of Electroconvulsive therapy during pregnancy, Hospital and Community psychiatry, 45(5): 444-450, 1994

⁶⁵ Walter, G., and J. Rey, Has the practice and outcome of ECT in adolescents changed? Findings from a whole-population study, Journal of ECT, 19(2): 84-87, 2003

A UK systematic review of 73 scientific studies in 2003⁶⁷ showed that Electroconvulsive therapy (ECT) appeared to be an effective short term treatment for depression and furthermore concluded that it may be more effective than medication. No treatment is effective long term by itself as depression may take many months to completely resolve. In practice, medication is commonly given in tandem or subsequent to ECT to continue the beneficial effect.

Patients with a diagnosis of major affective disorder (depression and mania) were the largest single diagnostic group (41.4%) receiving ECT treatment which accords with the expected indications for use. The Act allows for six ECT treatments per treatment course to be covered by one consent process. The Chief Psychiatrist's last annual report (2006)⁶⁸ reports that the average number of ECT treatments per patient is 10.2 treatments. As current consent is only for 6 treatments, most patients have to sign at least two consent forms before the treatment has had any effect.

Recommendations:

17. That initial consent for ECT to be for up to 12 treatments in the acute phase of illness.
18. That a patient should receive no more than 20 ECT in a single course of treatments without a full review.
19. That a patient may consent for one month maintenance ECT following acute phase treatment.
20. That the assumption that a patient can give informed consent be reviewed (as illness or disability may be affecting cognitive functions) and guidelines provided.⁶⁹
21. That age should not be the over-riding determinant for informed consent rather the capacity to give informed consent.

⁶⁶ Walter, G., K. Koster, and J. Rey, Electroconvulsive therapy in adolescents: experience, knowledge and attitudes of recipients, *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(5): 594-599, 1999

⁶⁷ Bauer, M., Review: electroconvulsive therapy may be an effective short term treatment for people with depression, *Journal of ECT*, 19: 139-147, 2003

⁶⁸ Chief Psychiatrists Annual Report 2006, mental health and Drugs Division, Department of Human Services Victoria, 2008, p. 9

⁶⁹ RANZCP will be pleased to assist in the development of guidelines.

22. That, except in emergencies, where a patient is unable to give consent it is advisable that a second opinion is sought from a practitioner with experience and knowledge of ECT. (This may be achieved via a panel of licensed practitioners.)
23. That there is standardised training and credentialing of a practitioner and a facility to provide ECT treatment.

3.6 Advanced directives

At common law, a presumption of competence exists – every person is presumed to be capable of consenting to or refusing treatment unless the contrary is proven. An advance directive is typically defined as a document which is created by a person while they are competent, that defines the medical treatment that the person wishes to refuse should they become incompetent in the defined circumstances. An advance directive is sometimes labelled a ‘living will’ in which a person sets out their health care preferences before incapacity occurs.⁷⁰

A report to the Office of the Public Advocate (Victoria) in 2004 noted:

In international common law advanced directives are considered to be an important way of protecting a patient’s autonomy and their right to self determination in regard to refusal of medical treatment.

The UK and Canada have led the way in ensuring that advance directives will be acknowledged and adhered to in the majority of cases, provided certain factors, outlined below, are evident. However, the Australian position is much less clear. There is no common law that is decisive in determining the status of advance directives in Australia; therefore, recourse is made to international jurisdictions.

It is important to note that common law advance directives are practically difficult to implement. This is because the person making the advance directive might not have had access to the extensive knowledge they may have needed to make an informed decision, or they have not considered the speed with which medical treatment has advanced, and will continue to advance in relation to their illness. Additionally, they may not have considered the important issues surrounding the particular illness they are suffering. ... the Courts have considered factors like these to be important in their

⁷⁰ Office of the Public Advocate, *Advanced Directives: The Legal Issues*, 2004

decision to uphold or override an advance directive. This is more clearly seen in the international jurisdictions.

In Victoria, it would seem that the law regarding advance directives is that when a person is competent, their advance directive may well be respected, subject to the issues previously discussed. However, once the person is defined as incompetent, their advance directive holds a much weaker position. The law only requires that guardians and agents take the advance directive 'into account' when they are ascertaining what treatment to refuse or consent to on behalf of the patient This effectively renders a patient's common law advance directive of little significance, unless their guardian or person responsible decides that they will respect the patient's wishes as found in their advance directive.

A Victorian lawyer and specialist in disability law has described five tests that have been used in assessing competence, based on American writing⁷¹. These five tests are:

- Can a person express a preference for or against a particular form of treatment?
- Is the person making a reasonable, right or responsible decision?
- Does the person give rational reasons for the decision?
- Is the patient able to understand, even if the decision is not rational and the decision is unwise?
- Has the patient actually understood all the major implications of a proposed course of treatment?

Note that the second test changes the focus of the enquiry from the capacity of the decision-maker to the actual decision they made. Thereby overlooking that it is possible to be competent and yet to make a 'bad' decision. The test does not allow this distinction to be made, and consequently, it is flawed to that extent.⁷²

⁷¹ A Rassaby (1987) 'Informed Consent to Medical Care by Persons with Diminished Capacity' in Law Reform Commission of Victoria, Symposia 1986: Informed Consent, pp.77-79; citing L Roth,;A Meiser and C Lidz (1977 'Tests for Competency to Consent to Treatment' Am J Psychiatry 134:3, pp.279-84

⁷² Office of the Public Advocate, Advanced Directives: The Legal Issues, p. 16, 2004,

To reiterate, there is no common law that is decisive in determining the status of advanced directives in Australia.⁷³ It would be appropriate that this gap is addressed rather than continuing to rely on international law.

Recommendations

24. That mental illness should not be treated differently to any other reason for applying advanced directives.

25. That the law of advanced directives and the Guardianship and Administration Act 1986 (Vic) be reviewed.

4. CONSOLIDATION OF RECOMMENDATIONS

Seclusion

1. That review of a secluded patient by a medical practitioner should take place at 3 hours (rather than 4 hours)
2. That a psychiatrist must be notified at the earliest opportunity of a seclusion event.
3. That a psychiatric review must take place as soon as practicable within 48 hours.
4. That a second episode of seclusion is considered extreme and must be authorised by a psychiatrist.
5. That the criteria for seclusion is limited to:
 - risk to self and/or others
 - where there is imminent danger
6. That any extension of an initial seclusion period must be authorised by a psychiatrist.
7. That guidelines of minimum standards of medical care for seclusion episodes should be provided by the Chief Psychiatrist.

⁷³ Office of the Public Advocate, *Advanced Directives: The Legal Issues*, p. 6, 2004

Involuntary patients

8. That a MHRB review occurs at 4 weeks (instead of the current 8 weeks).
9. That a mentally ill patient has the right to immediate treatment upon being admitted as an involuntary patient.

Community Treatment Orders

10. That definitions of 'personality disorder' and 'mental illness' are reviewed together with the implications for CTO service provision.
11. That the duration of a CTO is reduced to 6 months (from 12 months) and,
12. That provision is made for checks and balances signed off by a psychiatrist to determine if a patient is receiving appropriate treatment and overall benefit via a CTO.
13. That long term CTOs should include a higher order review at 18 months to 2 years with a consultant psychiatrist required to appear at MHRB hearing. It is strongly recommended that a patient has an advocate or the Chief Psychiatrist present at a hearing to ensure patient rights are upheld.

Chief Psychiatrist

14. That the chief psychiatrist is appointed by the Governor or statutory appointment by the State Parliament.
15. That the Chief Psychiatrist should be accountable to the Parliament.
16. That the current role of the Chief Psychiatrist be divided into two distinct roles, that of a Chief Psychiatrist and a Psychiatrist Commissioner.

The role of the Chief Psychiatrist:

- 1) not 'chief clinician'
- 2) clinical efficacy
- 3) quality assurance

The role of the Psychiatrist Commissioner:

- 4) complaints and investigations
- 5) liaison with public, service providers and other organisations

Electroconvulsive Therapy

17. That initial consent for ECT to be for up to 12 treatments in the acute phase of illness.
18. That a patient should receive no more than 20 ECT in a single course of treatments without a full review.
19. That a patient may consent for one month maintenance ECT following acute phase treatment.
20. That the assumption that a patient can give informed consent be reviewed (as illness or disability may be affecting cognitive functions) and guidelines provided.
21. That age should not be the over-riding determinant for informed consent rather the capacity to give informed consent.
22. That, except in emergencies, where a patient is unable to give consent it is advisable that a second opinion is sought from a practitioner with experience and knowledge of ECT. (This may be achieved via a panel of licensed practitioners.)
23. That there is standardised training and credentialing of a practitioner and a facility to provide ECT treatment.

Advanced directives

24. That mental illness should not be treated differently to any other reason for applying advanced directives.
25. That the law of advanced directives and the Guardianship and Administration Act 1986 (Vic) be reviewed.

Signed



Date: 27 February 2009

Dr Alan Jager Chair Email: jageral@bigpond.com

For further reference please contact the author, Dr Bruce D. Watson (DEd, *Melb*), Policy Research Officer, RANZCP Victorian Branch, bruce.watson@ranzcp.org, 03 9601-4992