

2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name

N/A

Name

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What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

"This response will focus on the role of stigma towards chronic sufferers of mental illness and stigma toward doctors with a mental illness. As a doctor working in mental health, and with a lived experience of mental illness, I believe that my insights are highly relevant. Elements are republished from this writer's personal blog, Part 1 Stigma Against Those with A Chronic Mental Illness ""We have been conditioned, with the best of intentions, through relentless advertising campaigns to be accepting of people with depression or anxiety. However, this acceptance remains conditional. We hold sufferers to a caveat. Our tolerance and sympathy last only if such people ascribe to be the good patient. We require that they get help, get treated and get better. Has the focus on Mental Health (as opposed to illness) kept us from respecting those with a relapsing, remitting condition? So often, we see people of note speaking out to raise awareness of their struggle. We applaud these people, and rightly so, for giving a face to a very private battle. Yet we must accept that these are so often the success stories of the mental health system. Rarely do we see applauded those for whom life is a daily struggle through medication, smoldering symptoms and constant vigilance for clues of their next episode. When those we are taught to feel sympathy towards, and show support to, fail to fully recover or are diagnosed with a chronic mental illness, our tolerance and sympathy wanes and fatigues. Why is it all too hard now?"" - <https://kieranallenblog.wordpress.com/2015/10/09/mental-health-week-conditional-acceptance/> Our conversations around mental health need to change if we are to address the stigma toward people with a mental illness. We have come so far in the areas of depression and anxiety awareness, but we must be careful not to portray these illnesses, and others, as ones that people always recover from and never experience a relapse. The danger in doing so, is that we portray people who do not get better as being somehow flawed or failing. Blanket exclusions on life, travel and income protection insurance cannot be justified and, simply, must end. 45% of people will experience symptoms of mental illness in their lives. How is an insurance system that potentially excludes 45% of the population from participation an effective system? The Commissioners should consider recommending that the life insurance industry transition to a population-based risk model, similar to that used in health insurance in relation to mental health claims. Part 2 The Doctor with a Mental Illness ""Many of us still guardedly believe that fellow doctors who are brave enough to seek help for their mental illness are somehow failing, particularly if they do not immediately recover. Beliefs that those with a history of mental illness are somehow less competent, less reliable and less trustworthy still perpetuate. I recall being asked some years ago whether I agreed that, a doctor who gets sick all the time can't really ever be a good doctor to their patients. This was not the dated perspectives of an aging doctor of twilight years, but rather those of a bright-eyed medical student, with their whole career ahead of them. Attitudes like these must end if doctors are to feel safe in seeking help for their mental ill-health. Fear has dictated that I, and others, hide our emotions and thoughts, lest our secret unwell identities be known to those whom we work with or treat. We are one person to our friends, another to our patients and yet

another to our colleagues. For many years my world was controlled by this fear a fear that my professional life would fall apart if people knew my secret. I feared looking pathetic and weak and that I would be seen as unable to cope with the pressure of medical study and practice. I felt an unspoken obligation to my peers and superiors to present a bravado and confidence hiding what is a daily battle to remain well." - <https://kieranallenblog.wordpress.com/2019/06/06/i-have-a-mental-illness-and-one-day-i-might-be-your-doctor/> Too often people with a lived experience of mental illness are viewed only as such. They are too seldom seen as successful in other areas of life. We have discrete examples of individuals who have felt able to stand up and be proud of their lives despite their illness, but these are usually highly successful people. The stories of the everyday person who gets out of bed, beating their illness are not given appropriate airtime. The Commissioners should encourage stigma to be addressed by recommending that the Government invest in an advertising campaign (or documentary series) chronicling the lives of people with a lived experience of mental illness as they succeed in other areas of life. I, personally, would be happy to be a part of such an endeavour."

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

N/A

What is already working well and what can be done better to prevent suicide?

N/A

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

N/A

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

N/A

What are the needs of family members and carers and what can be done better to support them?

"Legislated rights in the Act should be considered, as is the case in the NSW Act."

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

"This response will focus on why the Commission should focus on whether the Mental Health Act

2014 is achieving the objectives set out in the legislation. This writer acknowledges that significant improvements were made in the intentions of implementing the Mental Health Act 2014. The new Act was introduced to revolutionise and modernise the involvement of mental health consumers in their care, attempting to shift from a best interests model of care, to one that is least restrictive. Various mechanisms in the Act support this goal, including most notably in the Section 10 - Mental Health Principles. This section defines the role of the Act as being: (a) to provide for the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness; (b) to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity; (c) to protect the rights of persons receiving assessment and treatment; (d) to enable and support persons who have mental illness or appear to have mental illness: (i) to make, or participate in, decisions about their assessment, treatment and recovery; and (ii) to exercise their rights under this Act; (e) to provide oversight and safeguards in relation to the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness; (f) to promote the recovery of persons who have mental illness; (g) to ensure that persons who are assessed and treated under this Act are informed of their rights under this Act; (h) to recognise the role of carers in the assessment, treatment and recovery of persons who have mental illness; (i) to promote continuous improvement in the quality and safety of the mental health services provided by mental health service providers. Frankly, the Act in its current form is failing. It is not achieving its intention to support objectives (c), (d), (f), (g) and (h) and therefore failing to adequately support patients to be the drivers of their care where possible, or in ensuring that their rights are protected. These will be examined in turn, with de-identified examples taken from my clinical experience: Objective (c) and (g): Patients are too commonly denied basic rights under the Act. In particular, rights are poorly communicated to patients at the time of entry into the system. Automated notification of all patients placed on Assessment Orders to an agency such as the Office of the Public Advocate or Independent Mental Health Advocacy alongside significant increases in funding to enable greater one-on-one in-reach at the point of care would support this. Too often, patients are not even informed of their mental health act status. I draw the Commissioners to the following example: █████ a █████ year old female with a known diagnosis of bipolar affective disorder, is brought to the emergency department by her husband. She is reviewed by the emergency department mental health clinician where she is felt to be manic and at risk of legal harm and harm to her reputation and the reputation of others by posting defamatory comments on Facebook. She is placed on an Assessment Order. She is not informed of this, because the clinician is concerned that this will escalate her behaviour and may lead to an incident of aggression. Objective (d): The idea that patients actively participate in meaningful decisions about their assessment, treatment and recovery is simply inaccurate in the inpatient setting. Assessments are undertaken under threat of compulsory admission, the risks and benefits of various treatment options are not adequately explored in detail, nor is any real choice provided to patients under ITOs or CTOs. Complaints about side effects may trigger a change in medication if the patient is lucky. I draw the Commissioners to the following example: █████ a █████ year old male well known to mental health services is admitted under a TTO to the inpatient unit. He is suffering from a relapse of schizophrenia complicated by his substance misuse. He reports intermittent adherence to his prescribed antipsychotic due to complaints about weight gain and sedation. He reports being scared of needles and will be agreeable to a different medication in tablet form. Due to his previous good response to the treatment, he is commenced on a depot form of the same antipsychotic to ensure compliance. After discharge, his engagement with the community team is noticeably poorer, avoiding appointments and requiring variation back to inpatient treatment soon after his previous discharge. Objective (f): Recovery is clinically orientated in the inpatient setting,

too often focussing on the amelioration of symptoms, rather than the goals of the individual. The dignity of risk is one that the mental health professions struggle to accept. Despite attempts to shift away from a best interests model of care to a least restrictive model, we have not achieved this goal. The United Nations Convention on the Rights of Persons with a Disability and the Charter of Humans Rights and Responsibilities Act 2006 are important instruments that the Mental Health Act must be read in conjunction with. Recently, the case of PBU & NJE v Mental Health Tribunal [2018] VSC 564, highlighted the interplay of human rights in coercive treatment. This writer finds it to be a quirk of the Mental Health Act that a capacity assessment is required for treatment of mental illness with ECT, but not for other treatments which potentially carry a greater risk of harm. These treatments also constitute significant interference with a person's right to self-determination, right to privacy and right to be free of non-consensual medical treatment. In many cases, patients are willing to accept treatment alternatives rather than those suggested by the treating team (such as oral medications, instead of depot medications), yet, as there is no requirement for a capacity assessment to be undertaken in these cases, nor is there any legal imperative for advance directives to be respected, the treating team's preferences generally override the patient's preferences. It is difficult to understand the differentiation of ECT and medication along these lines from a human rights point of view. Unless changes are made to the Act requiring capacity to be considered for all forms of psychiatric treatment, or legal force provided to advance directives made at a time where capacity is preserved, patient choice will continue to be overridden. Concerns that patients will make bad decisions in advance directives are, respectfully, irrelevant. Patients have always, when possessing capacity, had the right to made so-called poor choices. I refer to the example below: █████ a █████-year-old male with a diagnosis of a fractured neck of femur, is admitted to hospital in severe pain. He requests pain relief and is provided oxycodone. The orthopaedic surgeon advises █████ that he requires surgical repair of the injury. █████ who has previously experienced a negative reaction to an anaesthetic, is fearful of undergoing surgery. He declines the operation. The surgeon, perplexed, advises █████ that he may never walk again if he doesn't receive the surgery. █████ is assessed as having capacity. Aware of this risk, states that he cannot bear the fear of undergoing another anaesthetic. He requests a prescription for a short course of oxycodone which is prescribed. He is discharged against medical advice. Compare this with the following, █████ a █████-year-old male with a diagnosis of schizophrenia, is admitted to hospital with distressing auditory hallucinations on a variation of treatment order. He is aware that he is suffering from schizophrenia and needs medication. He requests medication to calm down and is provided diazepam. The psychiatrist advises █████ that he requires a change in regular medication to olanzapine. █████ who has previously experienced a negative reaction to olanzapine, is fearful of starting olanzapine again. He declines the medication. The psychiatrist, advises █████ that he is under a treatment order and must accept treatment prescribed. █████ capacity is not assessed. He states that he cannot bear the fear of changing medication again. He requests a prescription for a short course of diazepam which is declined. He refuses olanzapine and is prescribed intramuscular olanzapine. His admission continues until he willingly accepts oral medication. Objective (h): Families and carers are too often excluded from involvement in care decisions. This is not due to a lack of desire from the treating teams but is symptomatic of the overburdened nature of the system, particularly in the inpatient setting. Further, the threat of use of compulsory treatment for voluntary patients requires close examination. I draw the Commissioners' attention to the following example: █████ a █████-year-old man, presents to the emergency department voluntarily in an agitated state with thoughts of suicide that have been worsening over the past week. His worried partner has accompanied him. █████ is assessed by the emergency department mental health clinician and a tentative diagnosis of a mixed episode of bipolar disorder is made. It is felt that an admission to the inpatient unit is required. As █████ has

presented voluntarily, he is not placed on an Assessment Order (AO), although the mental health clinician advised the head nurse of the emergency department to place Mr A on an AO if he tries to leave. ■■■■ waits in the Emergency Department overnight for a bed. During this time, his exhausted partner leaves the hospital to get some rest. ■■■■ demands to be discharged and is warned that he will be made an involuntary patient if he tries to leave. He begrudgingly accepts an admission and remains as a voluntary patient. On admission to the ward, ■■■■ again demands discharge. At this time, the medical officer places him on an assessment order. ■■■■ becomes aggressive and agitated and requires restraint, intramuscular sedation and a period of seclusion. This all too common example is one that highlights the coercion used even for voluntary patients to ensure that they accept the treating team's wishes. Patients like ■■■■ are exposed to a misuse of the Act through soft coercion. The use of this type of coercion should be looked at in the Commission's review, with consideration of whether legislative change to prohibit this type of practice is indicated. In summary, whilst improvements have been introduced into the Mental Health Act 2014, achievement of the objectives of the Act is failing at the front lines of treatment. The Commissioners should consider whether legislative change is needed to further ensure patients are aware of their rights, and that patients and family involvement in care decisions beyond tokenistic gestures is genuine. The right to equality before the law should mean that respecting patient decisions made at a time when capacity is preserved should not be excluded for patients with a mental illness."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

N/A

Is there anything else you would like to share with the Royal Commission?

N/A