

MENTAL HEALTH ACT 1996 REVIEW
ISSUES FOR CONSIDERATION BY THE STAKEHOLDERS
COMMITTEE

Outlined below are some comments for consideration by the Stakeholders Committee on the review of the Mental Health Act 1996.

Section 26 – Involuntary Committal

In this section I am particularly concerned about Section 26. 2) a-c which allows people to be committed on the basis of self-inflicted harm being defined as “serious financial harm and risk to reputation of both self and others”. My concerns about this piece of legislation are based on the opportunity for Psychiatry to misuse this legislation either deliberately or, through ignorance when a victim, or vulnerable person is being misused, abused, maltreated by someone in their life and they attempt to seek help from others by reporting their situation and in response end up being committed because of the im-balanced power dynamic around their circumstances. People who are victims of sexual abuse would classically fall into this situation and since 80% of women who are diagnosed with mental illness have a prior history of sexual abuse, the research supports that Psychiatry has to date failed to prevent such inappropriate situations from occurring. This section of the legislation also provides protection to people who are corrupt and want whistleblowers silenced because of the threat they present to their reputation.

In addition, this section of legislation regarding the need for treatment on the basis of serious financial harm is inappropriate as being treated in a Psychiatric facility only increases a persons financial harm. This is so because of the stigma around mental illness and the unlikelihood of employment once diagnosed, as well as the inability to continue with employment while in hospital being treated if one has a job. Most employers are not sympathetic to employees who are absent from work due to illness and as such, a manic episode affecting finances for a person employed is disadvantaged further through treatment of this issue by psychiatry in the current manner utilised. If Psychiatrists were genuinely interested in the financial welfare of people and not really wanting legislation to allow them to control people on the basis of economic factors, then as a group they should lobby to the government for changes to lenders, creditors, the gambling industry and retailers for conditions to be put in place that prevent people from misusing their financial resources. There is no place for this problem to be addressed by locking people up and forcing them to take medication under the premise of ‘treatment’ when in reality it is about control.

Section 26 is also unclear about the need for ALL of the criteria under Section 26. 1) a-d being met before someone is committed and patients are currently regularly committed involuntarily merely for being "non-compliant" or disagreeing with their treating doctor on an issue and then being deemed to "lack insight", rather than presenting a real "risk" of harm to themselves or the community. The issue around risk factors needs to be emphasised and clarified and made justifiable under the new legislation, as there should be no right for someone to be committed involuntarily merely because of a mood or belief or idea when there is no risk of harm involved. This should be justifiable on the basis of democratic rights to people in Australia being free to believe or think or express ideas about anything as long as no harm to others is presented. Issues around the need to assess "capacity to consent" also need to be incorporated into this and addressed and should allow provision for each person to be judged on an individual basis, not merely routinely being committed just because they have been presented to Graylands by someone and others believe they need treatment.

As a possible procedure to protect patients from inappropriate committals involuntarily to hospital, it may be necessary to allow patients legal representation at the assessment stage of being committed involuntarily to a Psychiatric facility once they have been brought to hospital to be seen by the committing Psychiatrist.

This should mean that the Psychiatrist must have legal justification for meeting all relevant sections of the MHA that apply under Sect 26.

Invasive Treatment

I strongly object to provisions for both ECT and Psychosurgery to be permissible under Mental Health Legislation for people suffering from mental illness. Based on anecdotal evidence of being a psychiatric patient myself, and dealing with other consumers, it seems evident that there is much support for environmental and psychological factors like prior history of abuse, drug and alcohol problems, trauma etc. contributing to someone's "mental illness", rather than factual evidence to support a medical biochemical model.

More research is needed in this area and in the meantime, I find it horrific that Psychiatry can justify using such invasive procedures for mental illness especially on an involuntary basis that in many cases cause irreparable harm. The current legislation does not protect the most vulnerable people in our society from such interventions. If these procedures cannot be removed, then review mechanisms should be built in to the new Act to ensure that patients who do consent to such procedures are protected from coercion, vulnerability etc. Under no circumstances should procedures like ECT be justifiable on an involuntary basis. A human rights argument should be used to defend this position. Even on the basis of being a life threatening situation, ECT is not justified involuntarily, as patients who have other illnesses eg. Cancer still retain the right to refuse treatment like radiotherapy and chemotherapy, despite all the best intended recommendations by a treating doctor. People with mental illness shouldn't be any different in this regard.

Systemic Change

On a philosophical basis, I do not believe victims of any kind should be subject to involuntary mental health and instead people who are suffering emotional distress for whatever reason should be able to access safe, voluntary, non-judgemental therapeutic counselling for support rather than being drugged labelled and hospitalised by Psychiatric services. This can be addressed by introducing legislation to cover duty of care issues for voluntary patients rights to access treatment and making services more accessible through increased counselling options by other professions. This would mean that Psychologists and General Practitioners for example, should be able to treat voluntarily people suffering mental or emotional distress but present no risk to the community or themselves. As such, the definition in the act for authorised mental health practitioner should be broadened to include these professions and give these parties similar powers to Psychiatrists. By allowing Psychologists and Mental Health GP's to bulk bill, such support services would be more accessible to more people and reduce the current burden on mainstream Mental Health Services.

The current involuntary system could be utilised more effectively if focussed on and targeted to "perpetrators" in society who present a real risk of harm to others.

This is particularly useful for sex offenders who cannot either be proven criminally negligible in court or are still a risk after a prison sentence and require potential lifetime community supervision. Psychiatric medication can be particularly useful for sex offenders because of the capacity to reduce sexual arousal through such medication.

Discharge from the Mental Health System

Some provisions need to be built in to the new Act to provide opportunity for people either wrongly committed into the system or no longer in need of psychiatric intervention to be discharged from this system. Current review procedures are either tokenistic or ineffective eg. Mental Health Review Board, or too expensive eg. Supreme Court. to be accessible to consumers in this situation who have no alternative but to retain a lifetime status as a person with a mental illness and no room for permanent recovery or cure. This may be a new power allocated to the Chief Psychiatrist as one option, but another mechanism debated by the Stakeholders Committee may be more effective. Whatever system is proposed, some degree of redress for justice for those unjustifiably still in the system and disadvantaged by economics, needs to be acknowledged.

Second Opinions and Treatment

The problems around obtaining second opinions can be overcome through the recommendations made about inclusion of other professional bodies for treatment of people with mental illness.

At present, Psychiatrists rarely disagree with their colleagues or are too expensive to access for a written report. Giving other professionals like Psychologists equal weight under the Act provides some real opportunity for a diverging point of view. If there is contention around this in respect to treatment issues as an example, perhaps a treatment review body should be established to hear and weigh up the different points of view from a multi-disciplinary perspective that acknowledges patients rights to have input into and choice over their treatment options. This may also provide an intermediary process for patients deemed to be "unwell" and requiring treatment, but who might be able to avoid assessment and committal in hospital if ordered to attend such a tribunal instead and they agree to do so. Patients should be entitled to access a variety of treatment options that both empower them and give them more choices when there is no risk to the community, or themselves by engaging such alternatives. Treatment approaches should move towards holistic models and away from the dominance of a medical model in isolation from other aspects of the whole person.

Duty Of Care

A chapter on issues of Duty Of Care should be included in the legislation to ensure that Psychiatrists accept full responsibility for all issues facing a patient once they have been detained in a Psychiatric facility against their will.

This should include obligations for treating practitioners to address problems facing the patient upon discharge outside of medical issues like employment, housing, support networks, ongoing therapy, drug and alcohol programs etc. which would involve prior planning by the doctor with the patient's input and consent. Too many patients are merely dumped out of hospital with poor or no follow up that often increases the risk of the initial problem relapsing or re-occurring. If this is not appropriate for legislation, it should be recommended as a policy and practice change to the current system.

Rights to Refuse and Capacity to Consent

The new Act should incorporate issues around a patient's rights to refuse treatment when they present no harm and assessment processes and legal rights for the patient to have the capacity to consent to decisions affecting them. The assessment process should help identify those individual patients who are unable to demonstrate such capacity, but allow opportunity for those who can, to do so based on each individual situation.

Contraception

Issues around female patient's rights to be in charge of their contraception of choice when in hospital should be considered as distinct from their medical treatment.

At present because of rotating shifts of nursing staff, patients using oral contraceptives are often administered their pill incorrectly placing their contraceptive cover at risk. Issues around protecting patients from assault or rape, unwanted pregnancy, while in a psychiatric facility need to be addressed. For those patients who are irresponsible in their sexual behaviour it may be necessary for legislators to look at legal provisions to protect such patients while under hospital care or in some circumstances in the community. Again this would need to be determined on an individual basis and the issues around risk and capacity to consent and be responsible would be critical.

Personal Responsibility

Current mental health should move away from paternalistic models towards ones of self determination. For those patients who commit crimes or cause harm to others or property, the current system should focus on making people responsible for their actions, even though they need treatment, rather than using treatment and illness as excuses for people's behaviour. By accepting personal responsibility patients become empowered to take control of their behaviour and their actions and this should help minimise risk of re-offending in the future.

There are probably some implications around this kind of model for the Criminal Law (MID) Act and on a practice level for treating Doctors. I believe the definitions of mental illness under CLMID Act are different from the MHA and this should be standardised to eliminate some of the complexities in this area. People suffering from intellectual disabilities or organic brain injuries like a head injury, need to be assessed for capacity to consent and treated distinct from people with psychiatric illness under mainstream definitions, who may still have sufficient intelligence to make decisions but are mentally unwell.

Minors

I also strongly oppose to children and youth being included in the current Mental Health Act 1996 under the same legislative framework as adults. The specific needs of children and young people are so different from adults that either a separate section for this target group needs to be established or a separate Act should be created altogether for minors. I strongly object under any circumstances to minors being exposed to ECT or Psychosurgery, irrespective of whether or not parental consent is obtained. I would find this particularly disturbing as many minors under Psychiatric treatment are from dysfunctional families who scapegoat individual children in their household and transfer the blame for the family dysfunction onto the child deemed "mentally ill". While this may not be true for all family situations and all minors receiving Psychiatric treatment, the dynamics amongst adults receiving treatment who have experienced this kind of situation is sufficient to conclude that is probably similar for our youth.

As an example, the situation involving a high proportion of children being medicated for ADD should be sufficient to raise concerns about these kinds of issues of misuse of medicine and medical treatment for behavioural problems and abusive power dynamics. The specific rights of children need to be addressed and spelt out in new legislation to protect our most vulnerable segment of society from systemic abuse like Psychiatric treatment which is legally sanctioned and endorsed by our community with no safeguards for our children and young people. Minors in particular would be unlikely to be aware of, or able to access legal representation, appeals mechanisms, advocates etc. This process is difficult enough and ineffective for adults with mental health, let alone our children who do not have the resources or capacity to protect themselves in such situations because of their vulnerability as children.

A handwritten signature in black ink, appearing to be 'MP', written in a cursive style.

Michelle Pule
Psychiatric Survivor

3 January 2003