The Independent Review of Compulsory Assessment and Treatment Criteria and Alignment of Decision-Making Laws: Consultation Paper

2nd June 2023

Submitted to:
The Independent Review Panel appointed by the Victorian Government to review compulsory treatment and decision-making laws in Victoria.

Online survey: https://engage.vic.gov.au/independent-review-of-compulsory-treatment-and-decision-making-laws
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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002 with a focus on the private sector. All members of our Board and staff have mental health lived experience as either a consumer, family carer or both.

Our core business is to advocate for systemic change to improve mental health care (including psychosocial disability) across the whole Australian health system, including within State and Territory jurisdictions. This includes advocating for empowerment of people with mental health lived experience (people with mental health conditions and their family, carers and kin) in the broad range of issues that impact their mental and physical health, and their lives more broadly. It includes empowering them in their own care and contact with health and social services, promoting their engagement and inclusion within system design, planning and evaluation and most importantly, advocating for systems that promote choice, inclusion, justice and fairness, and address stigma, discrimination and prejudice.

Our current feedback on the questions posed by the Independent Review Panel comes from the perspectives and experiences of consumers with lived experience of mental health treatment that has involved compulsory treatment and challenges to inclusion in decision-making, and from the perspectives of their families and carers. We welcome the opportunity to provide this feedback to the Independent Review Panel and wish the Panel well in providing its recommendations to the Victorian Minister for Mental Health at the end of 2023.

The Consultation Paper

As stated in the Consultation Paper, the consultation paper is in three parts:

A. The first part includes framing questions.

B. The second part looks at how the Victorian Mental Health and Wellbeing Act 2022 (MHWA) could be aligned with other decision-making laws.

C. The third part asks more questions about compulsory assessment and treatment.

The Panel is not considering whether rates of compulsory treatment should be reduced. The Victorian Government has already committed to this goal. Indeed, the Royal Commission recommended the government must ‘act immediately’ to make sure compulsory treatment is only used as a last resort.

The Panel will not make any recommendations about seclusion and restraint because this is beyond the Panel’s terms of reference, and due to other work already underway on this issue.

Our Feedback on the Review Questions

Part A: Introductory Questions

Question 1: There are many different perspectives on compulsory treatment. One of these is that compulsory treatment should be abolished/eliminated entirely. Do you agree with this?

Prompt: Should elimination of compulsory treatment ever be the goal (remembering that the Royal Commission recommended the elimination of seclusion and restraint within 10 years)?

Prompt: If compulsory treatment was abolished, what implications would we need to address? How could we address them?

As an organisation that represents the views of people who identify as consumers and/or carers, we acknowledge that their views on this question are mixed. The overwhelming view is that if the system was staffed by workers with greater skill in delivering compassionate care focused on building trust and 'walking alongside' the person and, where indicated, providing truly person-centred supported decision-making, then compulsory treatment could be significantly reduced or eliminated entirely.

However, views held by some LEA friends are that, for some circumstances in which they or the person they support was extremely unwell, compulsory treatment was necessary. Some have told us that they would have been in a significantly worse situation in their recovery if there had not been an initial period of compulsory treatment. Some family carers have told us that, if compulsory treatment had not been in place for their family member, the person would likely have harmed other family members and then experience extreme distress, shame, or trauma later, having recovered and realised what they had done. Some LEA friends with family members who are now in forensic mental health units feel strongly that, if there had been compulsory treatment earlier, then the person may have avoided this extreme circumstance and setting altogether. Some of our LEA friends have noted the extreme circumstances created by drug intoxication, especially when the person has used ICE, for example, and where compulsory treatment and containment may be the only option in the short term to keep everyone safe. Hence, we acknowledge the diversity of views of our LEA friends.

We stress the irreparable trauma, damage to trust in health professionals, service and family members, and impacts in the longer-term on willingness to seek help for mental health concerns when a person has experienced compulsory treatment. Research undertaken by Lawn and colleagues involving hearing the experiences of people on CTOs[1,2,3] found these impacts were among the most significant adverse consequences of compulsory treatment.

We agree that compulsory treatment should be eliminated but that this ideal will rely on many other factors within the system of care and in the community which may not be realistically achievable. Current systems have many failures in process, communication, and responsibilities to provide support for people across the mental health path.

We would also like to make the distinction between compulsory treatment and the use of seclusion and restraint; these are not always all present together as part of the person's experiences of service systems. For example, a person can be placed on a community treatment order but may never have experienced seclusion. We stress the importance of recognising the broadest definition of restraint which must include physical, chemical, social and so forth, and particularly emphasise the importance of recognising the many unacknowledged forms of restraint, especially for people in mental health aged care contexts.

Question 2: Are there any exceptional circumstances where compulsory treatment might be appropriate? If so, what are they?

Prompt: What benefits, risks or considerations might be associated with allowing compulsory treatment in these scenarios?

Prompt: How might resourcing issues be relevant to your answer to this question?

We have made the above comments, recognising that in the absence of quality mental health support by compassionate and skilled staff, earlier help, and ongoing meaningful support from services for those who need it, compulsory treatment will be default act as a perverse safety net for system failures in care. As stated above, we believe there are some circumstances, such as when the person is severely intoxicated with illicit substances, where compulsory treatment may be needed in the short-term. Lack of resources, or

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[1] Lawn, S., Delany, T., Pulvirenti, M., McMillan, J. (2016) Examining the use of metaphors to understand the experience of community treatment orders for patients and mental health workers. BMC Psychiatry, 16(1), 1-16, doi 10.1186/s12888-016-0791-z.

[2] Lawn, S., Delany, T., Pulvirenti, M., McMillan, J. (2015) A qualitative study using moral framing to understand patients' and mental health workers' experiences of community treatment orders. BMC Psychiatry, 15, 274-290.

[3] McMillan, J., Lawn, S., Delany-Crowe, T. (2019) Trust and community treatment orders. Frontiers in Psychiatry, 10 (349). https://doi.org/10.3389/fpsyt.2019.00349

for convenience of staff and services, however, should not be given as a reason for compulsory treatment. LEA friends have told us that it is not uncommon for compulsory treatment decisions to be made on a Friday, prior to weekends when staff resourcing may be less, in order to circumvent the potential for 'weekend runaways'.

Question 3: What do you think the purpose of compulsory treatment should be?

We believe the purpose of compulsory treatment should only be as an immediate response to emergencies to ensure the person and those around them are safe.

We believe there should be much more widespread support for people to develop their own Mental Health Advance Directives to ensure their preferences are known if they do become unwell and experience an emergency situation where they might experience compulsory treatment. We also stress that mental health services must respect and follow these Advance Directive, rather than dismiss them, so that the person and their wishes are shown respect and damage to trust between the person and services is minimised.

A recent national survey led by LEA for Mental Health Australia in 2023 found that very few consumers had Advance Directives, many were unaware of this option, many were open to developing one, but many needed support to do so. We found that less than 3% of consumer participants said they had a Mental Health Advance Directive. However, almost half said they were likely or very likely to create one. Almost two thirds of consumer and carer participants said that they were aware of the option to create a Mental Health Advance Directive, whereas one third were unsure or not aware. Around half of consumer participants and nearly two thirds of carer participants said support to understand how My Health Record works, and how to upload a Mental Health Advance Care Directive to My Health Record would be useful for them. One third of consumers and carers didn't trust that service providers would follow the Advance Directives anyway.

Question 4: What do you think the purpose of compulsory assessment should be?

Prompt: Are there changes that could be made to assessment orders to enable supported decision-making and reduce rates of compulsory treatment?

We believe there is an enormous amount that could be done to ensure health professionals use supported decision-making routinely across all parts of their practice, where needed. We believe strongly, that working WITH people is crucial to their overall wellbeing and is a basic human rights issue, and that working in this way would reduce rates of compulsory treatment.

We believe that all people have some capacity to know their own preferences, and that they should be supported to make their own decisions and have their choices respected. This is so whether they are, for example, a person with significant dementia who likes to wear certainly clothing or eat certain foods, or whether they are a person who is acutely unwell who expresses feeling unsafe around certain others in a closed inpatient unit, and so forth.

We also believe that the presence of lived experience peer workers across more parts of the mental health services would promote more inclusive care, build trust, and act as a bridge between the person and other mental health professionals to enhance supported decision-making. The importance of the lived experience peer workforce in helping to shift the culture of services is well recognised.

Research undertaken by Dawson, Lawn and colleagues has highlighted significant system failure to provided supported decision-making largely driven by paternalistic and coercive cultural issues within mental health services.[4,5] Many people experience compulsory assessment and then the resultant compulsory treatment within an extremely limited frame in which enforced medication is the primary or only treatment provided. People are often placed on compulsory treatment regimes devoid of any efforts to work constructively with them so that they no longer need compulsory treatment. Instead, it could be a period of focused support and learning to build recovery with the person. Instead, our research and that of many others has found that the dominant current approaches fail to engage people and many hold steadfast in rejecting any supports, even those by well-meaning health professionals.

Part B: Decision-Making

Question 5: What should supported decision-making in mental health treatment look like?

It should be a key part of everyday practice for all health professionals and disciplines, and it should be present from the outset of contact with the person. Sufficient time must be provided for supported decision-making, and peer support should be considered as an important resource available to the person at as many points of their contact with mental health services as possible.

Question 6: Why do so few compulsory patients have a nominated support person in place?

We believe there are a number of key reasons for this. Some people have lost their connections with family as a consequence of trauma, abuse, or other reasons including stigma and discrimination.

Another significant reason is that many family carers continue to be excluded by services from being involved in the support process and decisions made about support provision. Some family carers have recounted how they are co-opted by services into being medication compliance watchdogs; a situation that destroys their trusted relationship with the person. Many people do not want their family involved in their care or have information shared with their family. Whilst respecting their wishes is essential, family carers continue to tell us that service providers do little to foster a collaborative ‘triangle of care’ so that the person feels safe and supported and families can provide contributions to support that support and respect the person’s autonomy and wishes too.

We also know from LEA research on mental health and loneliness[6] that many consumers have no-one who they can confide in or turn to for support, thus limiting their options for trusted nominated support persons in their lives.

Question 7: What information should a support person receive?

A support person should receive enough information to enable them to fulfil their role in understanding and walking alongside the person in the most effective way with the person and to support the outcomes that the person finds most meaningful. If they only have limited information, then they cannot perform their role properly. The quality and accuracy of the information they receive may however be problematic, especially if the assessment undertaken by service providers reflects perspectives where the person’s views and preference have been excluded or not sought.

If the support person is a family carer who lives with the person, then they should receive sufficient information to know about the compulsory nature of the treatment plan for the person. This is especially important because they may directly experience the consequences of any changes to treatment and care

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[4] Dawson, S., Muir-Cochrane, E., Lawn, S., Simpson, A. (2021) Community Treatment Orders and care planning: how is engagement and decision-making enacted? Health Expectations, 24(5), 1859-1867. https://doi.org/10.1111/hex.13329

[5] Dawson, S., Muir-Cochrane, E., Simpson, A., Lawn, S. (2021) Risk versus recovery: care planning with individuals on community treatment orders. International Journal of Mental Health Nursing, 30(5), 1248-1262. https://onlinelibrary.wiley.com/doi/10.1111/inm.12877

[6] https://www.livedexperienceaustralia.com.au/loneliness

arrangements and must be informed and included. They are likely to act as navigators with and for the person in other settings, as holders of information and correctors or misinformation, so it is important that they have accurate, current information too.

Question 8: If people had the right to choose a substitute decision-maker for compulsory mental health treatment, what would need to be considered?

Unless there is clearly established evidence of concern, we believe that the person should have the right to choose a substitute decision-maker. This could be a family member so long as that person is able and willing to act in this role.

Question 9: If a compulsory patient has not chosen a substitute decision-maker, should it be possible to assign a substitute decision-maker other than the authorised psychiatrist?

Prompt: Should that substitute decision-maker be independent of the mental health service?

As per our comment above. They should be a person who is in a close and continuous relationship with the person, and who is trusted by the person and able to act in their best interests, and be a positive advocate for their recovery and support needs.

Question 10: What would be the best process to identify and assign a substitute decision-maker for a compulsory patient who has not identified a specific person?

Sufficient time should be spent sitting with the person to provide and explain options for identifying and assigning a substitute decision-maker. A peer work could help facilitate these types of conversations with the person, translate often complex bureaucratic language and rhetoric into clear lay language and offer ideas from a position of trust and lived experience. People in this position arguable need even stronger advocacy to ensure there experiences, preferences and needs are understood.

Question 11: What changes could strengthen advance statements? Are there alternatives that could work better than advance statements?

As per our earlier comments, more education and information about how to develop Advance Statements is needed for both consumers, and also for carers who may be in the best position to help the consumer, if they want carers' input, to talk about what content might be useful and apply it to their real-world experience and life circumstances in the community.

Question 12: What are the implications of having a values statement as an additional option for consumers?

A values statement may well be very important to the person because it can cover important relational detail and preferences that cannot be capture simply in the more instructional statements that often make up Advance Statement/Directives. Values statement help to remind others that the person is a human too, with rights and preferences.

Question 13: Do you think any changes should be made to the process of making a mental health advance statement?

Prompt: What supports should be available for the person making it? Should there be a capacity test like there is in physical health? Who should sign off on the advance statement, if anyone?

As per earlier comments, we know that people want more support to make Advance Statements and upload them to My Health Record or have some way of them being communicated effectively and in a timely way to others. However, as stated, we know that such support is often not provided. Clearly, health workforce education is needed so that Advance Statements become a part of standard practice and support to the person. However, this should not just become a paper exercise that lacks meaning for the person.

Question 14: Are there any circumstances where it might be appropriate to override an advance statement? If so, what are they?

If an Advance Statement has been made reflecting the true wishes of the person when they are in the best frame of mind to develop this statement of wants, needs and preferences, then there should be no reason to override it. So, this can come down to the quality of support to develop the statement so that there is no ambiguity that might later be confusing for staff or services to understand and follow. Hopefully, services would thoroughly check the context surrounding the person's current crisis situation that may have activated the need to consider the Advance Statement. This includes seeking collateral information from family and friends of the person who may have important information to provide. It may be, for example, that the Advance Statement on record is extremely old and potentially out-of-date and the person had intended to update it but had been unable to do so in time prior to becoming unwell. They may have spoken with family or others about this.

Part C: Compulsory Assessment and Treatment

Question 15: Are there any criteria that are particularly problematic?

The compulsory treatment criteria point No.7 'There is no less restrictive way to enable the person to receive the treatment' is open to misinterpretation and application. The service providers may argue that resourcing issues or another type of 'inconvenience' prevented them from providing other options for treatment, for example.

Also, this particular one being enacted well hinges on the being no stigma present in the process of interpreting it. We know that many mental health consumers have experienced highly stigmatising attitudes from mental health professionals. We also know that many consumers from CALD backgrounds are simply not given the opportunity to be heard so that mental health professionals can even gain a true sense of what is going on for that person, and certainly not fully taking a culturally informed view as part of their assessment processes.

Question 16: What changes could be made to the assessment and/or treatment criteria?

Prompt: How would your preferred changes help to make sure that the use of compulsory assessment and treatment is reduced, and that it stops being the defining feature of the mental health system?

The above concerns must be explicitly addressed.

Question 17: Should the compulsory assessment and treatment criteria include a decision-making capacity criterion? What are the considerations?

Prompt: Are there different considerations regarding decision-making capacity in a mental health context, as opposed to physical health?

Prompt: If a decision-making capacity criterion is introduced, are there any exceptional circumstances where the law should still allow for a person with decision-making capacity to be put on a compulsory assessment or treatment order? What are they?

We know from past research[7] that the assessment of capacity is a fraught exercise that does not adequately reflect the person's situation in a holistic way. It reflects an 'ableist'[8] and 'deficits' view of people, especially people with psychosocial disability.

Where a person's decision directly harms another person, compulsory assessment may be warranted, however, this path is also fraught because it may get caught up in considerations about dignity of risk which are themselves poorly operationalised in mental health service deliver and interactions with consumers. Families, in particular, may be caught in the middle and bear the consequences, largely because of failures by services to provide enough consistent support in the first place to the person.

Question 18: Who should be able to sign off on an:

- **assessment order**
- **temporary treatment order**
- **treatment order?**

Prompt: Could a nominated or assigned substitute decision-maker have a role? Should the person signing off on the order be independent of the service?

Prompt: What practical considerations, such as timing, need to be considered to make sure the right people can make the decision?

The making of order should take into consideration a thorough and holistic person-centred view of the person. Currently, psychiatrists dominate this process and ultimately hold the power. Research by Dawson, Lawn and colleagues, exploring the multi-D team interactions when discussing care planning for people in CTOs, for example, noted several examples where the views of nursing and allied health professionals whose views differed from the psychiatrist and aligned strongly with knowing the person and advocating for their more holistic circumstances, were dismissed.[9]

The person signing off on the order must have a thorough knowledge of the person in their life, not merely during their stage of acute unwellness. There needs to be enough time given for health professionals to be more fully informed before making such decisions about orders.

Question 19: How could the criteria for compulsory assessment, temporary treatment, and treatment orders be different to each other?

Prompt: Could different criteria make for more targeted responses? What are the implications of having different criteria?

We do not have any comments to make on this question.

Question 20: Are there exceptional circumstances in which community treatment orders are appropriate?

Prompt: Are there exceptional circumstances where continuous and/or repeated community treatment orders might be appropriate? If so, what are the considerations?

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[7] Lawn, S., McMillan, J., Comley, Z., Smith, A., Brayley, J. (2014) Mental health recovery and voting: why being treated as a citizen matters and how we can do it. Journal of Psychiatric and Mental Health Nursing 21(4), 289-295. doi: 10.1111/jpm.12109

[8] Coming from or having the belief that disabled people (= people who have an illness, injury, or condition that makes it difficult for them to do things that most other people can do) are not as good as people who are not disabled, or that they do not deserve special arrangements that help them to live their lives and be included in society.

[9] Dawson, S., Muir-Cochrane, E., Lawn, S., Simpson, A. (2021) Community Treatment Orders and care planning: how is engagement and decision-making enacted? Health Expectations, 24(5), 1859-1867. https://doi.org/10.1111/hex.13329

We do not believe there are any circumstances in which continuous or repeated CTOs might be appropriate. Such a situation, in our experience, makes service providers ‘lazy’ to implementing any recovery-oriented supports with the person. Long-term coercion then becomes the norm, and increasing stigma is likely within a situation in which the person is increasingly seen in limited terms focused only on their deficits rather than their potential and hope for recovery. Service can then fail to see ‘the person’ beyond illness. This is my direct experience of a close friend/kin who experienced more than 3 decades of continuous compulsory treatment and who died in an inpatient seclusion room largely due to mental health professionals’ failure to respond to his acute physical distress, whilst watching all this on CCTV in the nursing station and labelling his calls for help as ‘behaviour’.

Question 21: What changes to existing or planned oversight mechanisms are required to better protect the rights of compulsory patients?

Prompt: Are there alternative oversight mechanisms that would be more effective?

More compassionate care and attitudes by mental health professionals are needed. Staff must follow the guidelines in their policies and procedures for the observations and monitoring people who are compulsory patients. Direct contact, not ‘observation’ is needed. People are not animals in a cage. Be more human and humane.

Question 22: How soon after a person is placed on a compulsory assessment and/or temporary treatment order should there be some form of independent review?

Independent review should occur as soon as possible after this initial process. Where relevant, families must also be asked and included early. The current circumstances for appeal in many states are unworkable in practice and offer no tangible level playing field for the person. Appeal hearings often come days after a person has lodged a protest, by which time they may have spent many days in compulsory treatment. We are aware of a recent example of a person who was ‘detained’ in the context of a medical episode – and the much-needed treatment for that was denied to them. Even their family’s protests about the compulsory order fell on deaf ears. They or their family had been given no information about their rights by mental health staff within the inpatient unit. The family contacted LEA for advice.

Question 23: For what purpose could a substitute decision-maker make treatment decisions for a compulsory patient?

Prompt: Should the purpose change depending on whether a compulsory patient is on an assessment or treatment order?

We have no response to this question.

Contact

We thank the Independent Review Panel for the work it is doing. We wish you every success with the next steps and would be keen to be involved in any future discussions about this important topic.

Your sincerely

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