Mental Health for the Young and their Families

MHYF Vic Newsletter No. 65 May 2019

This edition

Winston Rickards Memorial Oration 2019

Mental health services to remote places.

News from National Mental Health Comm.

Productivity Commission Enquiry

History Corner 1867

Winston Rickards Memorial Oration 2019

The 2019 Winston Rickards Memorial Oration was given on Monday 18th March in the Ella Latham Lecture Theatre of the Royal Children's Hospital. The oration:

Mental Health and Schooling - The Educational Challenge

by Professor Field Rickards, and Drs Lisa McKay-Brown and Peggy Kern is now published on the MHYFVic website.

News from the National Mental Health Commission

Economics of Mental Health in Australia

Since its establishment, the National Mental Health Commission has sought to put mental health on the economic agenda. The potential economic and social gains from mental health reform from investing in promotion, prevention and early intervention are considerable.

The Commission is seeking to build on the evidence base of why investing in promotion and prevention initiatives can result in benefits for the individual in terms of their mental health and also economic benefits in the form of improvements in productivity and efficiency.

Ten promotion and prevention interventions are currently being modelled using a return on investment framework.

The modelling is being completed by Deakin Health Economics with support from a Steering Committee who provide independent and expert advice on both the interventions and the modelling process. The project is expected to run from July 2018 to June 2019, with outcomes published progressively over this period.

Additional information - context for modelling

Each intervention has been tested for its effectiveness in preventing or promoting mental health. It has then undergone an assessment of cost-effectiveness using a return on investment ratio. This ratio calculates gain or loss in relation to the initial investment of funding. A return on investment ratio which is greater than $1 means that the cost savings are greater than the costs of the intervention. For example, a return on

investment of $1.50 means that for every $1 invested, $1.50 will be gained.

To calculate the return on investment ratio for each intervention, assumptions are made about how the intervention is implemented. For example, each model assumes a sufficient workforce is available and existing infrastructure is in place to deliver the intervention. These assumptions might be optimistic or conservative and can influence: the results of the modelling, the return on investment calculated, and how the results are interpreted. There may also be different ways of implementing the intervention in the real world that may not be captured in the modelling. This means that there are limitations on the applicability of the recommendations in different settings. For example, intervention 1 is modelled in businesses with more than 200 employees because this intervention has not been tested in smaller sized businesses.

Also, a return on investment framework is just one lens through which to consider the value in delivering mental health promotion or prevention interventions. There are other considerations beyond the economic rationale which may influence whether decision makers (such as government and employers) implement an intervention. These considerations include the acceptability of the intervention for the target population, sustainability of the intervention in the long term and the impacts/benefits on people around the person receiving the intervention e.g. family, carers, co-workers.

The lay summaries should therefore be read and interpreted in this context.

More details of the modelling, including technical summaries for each intervention are available from the Commission upon request.

HISTORY CORNER, 1867

As MHYFVic seeks to provide feedback to the Victorian Royal Commission into Mental Health, the history of legislation is worth overviewing. Initially the legislation concerned institutions, then was directed to the patients (lunatics), then was enlivened with new metaphors (mental hygiene and then mental health). Throughout there has been emphasis on the workforce and the overview of their behaviour; more recently this has been about registration, which is now national.

Along the way, other aspects related to mental health such as the children's court, child welfare, and mental deficiency were subject to ongoing review.

The actual legislation changed across the history of the legal entity which was the Port Phillip District (1836 - 1851), then the Colony of Victoria (1851 - 1901), and then the State Government of Victoria (from 1901). The legislation did not occur in a vacuum as until then, the statutes of the United Kingdom applied and shaped any subsequent legislation. Gaps in the local legislation were filled by the UK statutes.

The first relevant local legislation was the Hospitals and Charitable Institutions Act (1864) and the Lunacy Statute (1867). Charitable institutions like orphanages were required to be governed by trustees and committees or boards of directors elected by contributors. Institutions that complied with the legislation could receive grants from the Victorian government, subject to the condition that they submit statements of accounts and returns of contributions to the Treasurer. These were the subject of a Royal Commission into Charitable Institutions (1870)

By 1880, the Victorian government had appointed an Inspector of Public Charities,

probably as a response to recommendations made by the 1870 Royal Commission into Charitable Institutions. The Inspector undertook the investigation of the management, and audit of the accounts, of institutions receiving assistance from the Government. This Act was repealed by the Hospitals and Charities Act (1890).

Hospitals and Charities Act 1890
Hospitals and Charities Act 1915
Hospitals and Charities Act 1922
Hospitals and Charities Act 1928
Hospitals and Charities Act 1948
Hospitals and Charities Act 1958

Children's Court Act 1906 (1906 - 1915)
Children's Court Act 1915 (1915 - 1928)
Children's Court Act 1917 (1917 - 1928)
Children's Court Act 1928 (1929 - 1957)
Children's Court Act 1956 (1957 - 1959)
Children's Court Act 1958 (1959 - 1974)
Children's Court Act 1973 (1974 - 1992)

Children's Welfare Act 1924 (1924 - 1929)
Children's Welfare Act 1926 (1926 - 1929)
Children's Welfare Act 1928 (1929 - 1955)
Children's Welfare Act 1933 (1933 - 1955)
Children's Welfare Act 1954 (1955 - 1959)
Children's Welfare Act 1958 (1959 - 1971)
Community Welfare Services Act 1978 (1979 - 1983)
Community Services Act (1987)

Lunacy Act 1928 (1929 - 1959)
Lunacy Statute 1867 (1867 - 1890)

Mental Deficiency Act 1939 (1939 - 1959)
Mental Deficiency Act 1958 (1959 - 1962)

Mental Hygiene (Mode of Citation) Act 1943 (1943 - 1959)
Mental Hygiene Act 1933 (1934 - 1959)
Mental Hygiene Act 1958 (1959 - 1962)
Mental Health Act 1959 (1962 - 1987)
Mental Health Act 1986 (1987 - 2014)
Mental Health Act 2014

Lunacy Statute (1867)

12. Every medical practitioner signing any certificate under or for specify facts upon the purposes of the last preceding section of this Act shall specify which opinion of insanity has been therein the facts upon which he shall have formed his opinion that the formed. person to whom such certificate relates is a lunatic, distinguishing in such certificate facts observed by himself from facts communicated to him by others; and no person shall be received into any asylum hospital or licensed house under any such certificate which purports to be founded only upon facts have been communicated by others,

The word "lunatic" shall be construed to mean any person idiot lunatic or of unsound mind and incapable of managing himself or his affairs, and whether found lunatic by inquisition or not.

The words "lunatic patient" and "patient" shall be construed to mean any person detained at the commencement of this Act in any public or private establishment in Victoria for the reception of insane persons, and any person hereafter received into and detained in any asylum hospital or licensed house under the provisions of this Act.

Lunacy Act (1928)

“Lunatic" means any person idiot lunatic or of unsound mind "Lunatic and incapable of managing himself or his affairs, and whether found lunatic by inquisition or not.

"Lunatic patient" and " patient" mean any person detained " Lunatic at the commencement of this Act under any Act hereby patient - repealed or at any time received into detained or ordered to be received into or detained in any hospital for the insane hospital for the criminal in

27. Every medical practitioner signing any certificate in connexion with the reception of any insane person into any hospital for the insane receiving house receiving ward or licensed house shall specify therein the facts upon which he has formed his opinion that the person to whom such certificate relates is insane or apparently insane distinguishing in such certificate facts observed by himself from facts communicated to him by others ; and no person shall be received into any hospital for the insane receiving house receiving ward or licensed house under any such certificate which purports to be founded only upon facts communicated by others.

Mental Hygiene Act (1933)

This Act was largely cosmetic, directed at changing the words used to define actors such as Inspector-General becoming Director, and certain facilities being given new names. Yet, some words remained, such as “lunatic”. It was not until the next Act that the term “mentally ill” was introduced in place of “lunatic”. Lunacy had been re-worded by the Metal Hygiene Movement of Clifford Beers, founded in 1907 in Connecticut, USA. The international movement for mental hygiene was replaced by the Mental Health movement in 1949.

Mental Hygiene Act (1958)

"Lunatic" means any person idiot lunatic or of unsound mind and incapable of managing himself or his affairs, and whether found lunatic by inquisition or not.

"Lunatic patient" and "patient" mean any person detained at the commencement of this Act under any Act hereby repealed or at any time received into detained or ordered to be received into or detained in any mental hospital, hospital for the criminal insane, receiving house, receiving ward, or private mental home.

Mental Health Act (1959, operative 1962)

“Mentally ill" means to be suffering from a psychiatric or other illness which substantially impairs mental health.

“Patient" includes a repatriation patient and any person who is in any manner under any control or supervision as mentally ill or intellectually defective, and until discharged under this Act any person who was under detention control or supervision, or who is absent on trial leave or parole under this Act or any corresponding previous enactment, or who is boarded out or in a private mental home or private training centre but, does not include a voluntary patient.

Important in this new definition is the distinguishing of type of patient: Voluntary, Recommended and approved, Security, and Repatriation. There is also a change to the number of practitioners who can “Recommend”.

43. (1) Any person who in the opinion of two medical mental hospital practitioners is mentally ill may be admitted into and detained in a mental hospital or private mental home on the recommendations of the medical practitioners made in the form prescribed if it appears that each of the medical practitioners has separately from the other personally examined such person not more than seven clear days previously to the admission of that person and upon production of a request in the prescribed form signed either before or after the recommendations under the hand of some person accompanied by the prescribed statement of particulars.

In the enactment, the legislation repealed: Mental Deficiency Act (1958), Mental Hygiene Act (1958), and Public Trustee Act (1958).

Mental Health Act (1986)

Several major changes were made to the Act, some of which were terminological and many

of which were about raising the rights of patients and oversight by autonomous bodies. The extent of the changes in this Act are not to be underestimated, but most of the improvements required further adjustment in the 2014 Act.

A person was seen as mentally ill if he or she 'has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'. Added to this were grounds for exclusion: a person could not be thought to be mentally ill because of certain conditions, beliefs, views or behaviours. These included intellectual disability, immoral conduct and sexual promiscuity among 13 other conditions.

Involuntary assessment and treatment were divided into three parts: request and recommendation, Involuntary Treatment Order and Community Treatment Order. Interim treatment could be given by the registered medical practitioner prior to the person seeing the Authorised Psychiatrist if it was not in the person's interest to wait and if the person was unable to consent.

The person could be placed on an Involuntary Treatment Order to prevent a deterioration in their physical or mental condition or for the protection of the public. The person could be placed on an Involuntary Treatment Order if they refused or were unable to consent to treatment.

A patient had a right to a second psychiatric opinion. The obligation of the Mental Health Review Board or the authorised psychiatrist to consider the second opinion was not prescribed.

Information must be provided to the patient about their rights, yet, there was no provision for a patient to nominate a person to receive information about their treatment and care, and there was no mechanism to support patients to exercise their rights.

The authorised psychiatrist was able to provide substitute consent to ECT for involuntary patients if they did not have the capacity to consent. Informed consent (for patients with capacity) was not required if the authorised psychiatrist was of the view that the ECT was urgently needed. The 1986 Act was silent on children and ECT.

Restrictive interventions were defined as seclusion and mechanical restraint only. Mechanical restraint could be used for the purpose of medical treatment, to prevent the person causing injury to self or another and to prevent a person persistently destroying property. Seclusion could be used to protect the person or another person from immediate or imminent risk of harm or to prevent the person from absconding. A person subject to restraint and seclusion was required to be seen every 15 minutes by a registered nurse and examined every four hours by the authorised psychiatrist.

The chief psychiatrist was required to be given a report on episodes of seclusion and restraint every month.

The Mental Health Review Board had the function of reviewing Orders and treatment plans and hearing appeals on behalf of involuntary patients and security patients.

The Mental Health Review Board was instituted with the function of reviewing Orders and treatment plans and hearing appeals on behalf of involuntary patients and security patients. The MHRB had to act with equity and good conscience without regard to technicalities or legal forms and was bound by the rules of natural justice.

The authorised psychiatrist required to prepare, review and revise a treatment plan for each patient on a regular basis. The treatment plan had to contain an outline of the treatment the patient was to receive and had to take into account the wishes of the

patient, any guardian, family member or carer (if the patient agreed) and any beneficial alternative treatments available.

There new guidelines for monitoring, mostly by the chief psychiatrist, but with little definition of the functions of the chief psychiatrist. The chief psychiatrist received and investigated complaints or concerns from mental health consumers, but a complaints function was not assigned to any particular body.

Community Visitors were to visit mental health services in the region for which they were appointed and were able to inspect any part of the premises, make enquiries about and see any person receiving treatment unless that person asks not to be seen. They were able to inspect any document or medical record if the person receiving treatment had given consent in writing and any other records required to be kept under the Act.

Mental Health Act (2014)

The major changes in this Act relate to upgrading patient welfare and rights, including recognition of the rights of consumers and carers and facilitation of processes of monitoring of governance. Also of significance was the ongoing monitoring of the professions through registration processes. The Act was devised to effectively protect the rights articulated in the Victorian *Charter of Human Rights and Responsibilities 2006* (the charter) and the United Nations' *on the Rights of Persons with Disabilities* (the disabilities convention). The changes do not alter the working definition of a patient, but five further exclusions were added related to antisocial behaviour and economic or social status and gender identity.

Briefly, the changes include a more rigorous compulsory orders regime, the presumption of a capacity to consent to treatment, the enacted right to a second opinion for patients, inclusion of a signed statement by patient about treatment which the psychiatrist must take into account, even if the decision is to override the advance statement, the capacity of a patient to nominate someone to act on their behalf, employment of consumer advocates, consent for ECT by patient that, if declined, cannot be overridden, ECT for children when least restrictive method available, and tightened procedural guidelines for the Mental Health Tribunal.

There were substantial changes to restrictive interventions. restrictive interventions are defined as seclusion, mechanical restraint and physical restraint (mechanical restraint and physical restraint are together categorised as 'bodily' restraint). Restrictive interventions can only be used to prevent *imminent* and *serious* harm to the person or another person. Bodily restraint may be used if necessary to administer treatment or medical treatment. There is no provision for bodily restraint to be used to prevent the destruction of property. There is no provision for seclusion to be used to prevent absconding.

The concept of the treatment plan has been dropped in favour of a Treatment Order that has to be ratified by the Tribunal. The Treatment Order must state whether the Order is a Community Treatment Order or an Inpatient Treatment Order and the Tribunal must have regard to the person's views and preferences, the view the person expresses in their advance statement, the views of the nominated person, guardian, carer and parent if the person is under 16 years of age including any recovery outcomes they would like to achieve.

A person who is subject to a Temporary Treatment Order or Treatment Order (or their guardian, parent of a person under 16 years of age) may apply at any time while the Order is in force to the Tribunal to have the Order revoked.

The powers of the chief psychiatrist have been defined: the role is broader and includes clinical leadership, continuous improvement, promotion of rights and advice to the Secretary. a total of 11 functions are made explicit and include:

* monitoring compliance with standards and guidelines
* monitoring quality and safety
* undertaking clinical and practice audits
* the analysis and publication of data.
* to assist mental health service providers to comply with the Act

The Mental Health Complaints Commission was established, being appointed by Governor in Council on recommendation by the Minister. The Commissioner has functions including:

* to manage and investigate complaints relating to mental health service providers
* to resolve complaints in a timely manner using formal and informal dispute resolution and conciliation
* to issue compliance notices
* to provide advice, information and education to mental health service providers about their responsibilities for managing complaints
* to assist consumers and other persons to resolve complaints directly with mental health service providers
* to identify, analyse and review quality, safety and other issues arising out of complaints and make recommendations to providers, the chief psychiatrist, the Secretary and the Minister

Community Visitors are appointed by the Governor in Council on the recommendation of the Public Advocate. There is a requirement for the Public Advocate to appoint an equal number of male and female Community Visitors as well as people from diverse backgrounds. There is no reference to Community Visitors being appointed for each region. The term of office is defined as three years and some exclusions are identified (that the Community Visitor is not to be an employee of the Department of Health). Minimum monthly visits are no longer specified.

Nurses Act* (*1993)* and *Medical Practice Act* (*1994).

These mark the beginning of tighter registration of all professions. Eight new Acts of Parliament were subsequently passed and common core provisions were introduced to regulate the registered health professions. However, not all of the health practitioner registration Acts were updated to incorporate the modern provisions. Subsequently further legislation was introduced: *Health Legislation (Miscellaneous Amendments) Act* (2005) and *Health Professions Registration Act (2005).*

Health Practitioner Regulation National Law (Victoria) Act (2009)

This allowed for National registration and the formation of the Australian Health professionals Registration Authority.

Conclusion

So, not long after a massive set of legislation changes, we enter the process of a Royal Commission. It is worth reflecting upon the trajectory of all those changes.

There has been a move since the last Royal Commission (1870) from buildings to administrators to patients to consumers with rights. Along the way, there have been more processes of review which have been associated with legal actions and tribunals, although natural justice has been more to the fore in recent times. There has been less support for restrictive interventions and violence against patients. More recently, there has been recognition of the needs and rights of children, but mostly the regulated activities have been about the most disturbed people with the most disturbing conditions.

These people are in the public mental health system. However, most mental health services are consumed by moderately well people in private practice locations and living within families of variable functionality (prior to the 1986 legislation there was much use of the pejorative term “worried well”).

We at MHYF Vic want to see a thorough root and branch review of the system. But the Government of “doer Dan” will most likely want a list of implementable recommendations of programs. The history of the changes within the system since the days of the Port Phillip District has been of programs and procedures for the most ill.

From my point of view, I notice a big difference between mental health services for children (and families) and for adults. The latter seek to avoid deterioration, the former seek recovery. Adopting a “recovery framework” is not a simple or likely solution. I think a developmental framework is necessary and one that locates past trauma as a principle driver of anxiety, depressive, and dissociative states. I would welcome the opportunity to present this to the Royal Commission.

History can map patterns of failure. The pattern has been clear; I hope we can influence the Royal Commission to move away from programmatic responses to classes of at risk adults, to a more integrated and recovery oriented system.

Jo Grimwade

2018 MHYF Vic Committee

* President : Jo Grimwade
* Vice-President : Jenny Luntz
* Past President: Allan Mawdsley
* Secretary : Cecelia Winkelman
* Treasurer : Anne Booth
* Membership Secretary:Kaye Geoghegan
* Projects Coordinator, Allan Mawdsley
* WebMaster, Ron Ingram
* Newsletter Editor, Allan Mawdsley
* Youth Consumer Representative, vacant
* Members without portfolio:

Suzie Dean, Miriam Tisher, Celia Godfrey.

MEMBERSHIP SUBSCRIPTIONS

Annual membership of MHYFVic runs for the Financial Year. Only paid-up members are entitled to vote at our AGM, normally held in August each year. Friends and associates who are not paid-up will still receive our electronic newsletters and notices because it is our mission to promote improvements in mental health for the young and their families.

However, it is important to reflect upon the difference between paid-up and non paid-up members.

Membership subscriptions of $50 per annum enable the organisation to maintain its website, mailbox, telephone service and to undertake its administrative tasks. If you value the work that MHYFVic does, we need your financial as well as your ethical support.

Our mail address is PO Box 206, Parkville, Vic 3052. If you prefer to pay by Direct Funds Transfer, the BSB is 033 090 A/C Number 315188 with your name in the Reference tab. It would be appreciated if you could also send a confirmatory email to admin@mhyfvic.org