C.A.S.P.
Comprehensive Area Service Psychiatrists Special Interest Group

Chairman: Dr Andrew Campbell: 36 Marlborough St. Drummoyne 2047
Secretary: Dr Alan Rosen: 24 Olga St., Chatswood NSW 2067
CASP policy: Dr Roger Gurr: Ph (02) 94483266

Report from the CASP Workshop held at Rozelle on 30 November 2004 with Mr Michael Sterry and Ms Leeanne O'Shannessy re the Submission to the Review of the Mental Health Act 1990
Present: Drs A Campbell, Alan Rosen, Victor Storm, Dorothy Kral, Joseph Menendez, Charles Doutney, Michael Paton

Summary of issues raised by clinicians at the meeting:

The Mental Health Act 1990 is seen as an essential and generally effective tool in the provision of mental Health services. The act attempted to strike a balance between preserving individual civil liberties and ensuring care and treatment for mentally ill persons. It also introduced symptom & behavioural based assessment of mental illness rather than relying on diagnosis.

However new knowledge about mental illnesses, changes in the delivery of psychiatric services and experience from other States that subsequently developed contemporary Mental Health Acts shown that some aspects of the current NSW Act require urgent review after 15 years operation.

In particular the NSW Act is now seen as unnecessarily complex and the intention of the act has been variously interpreted even by experts and requires a reading of the Minister's parliamentary introduction speech to understand.

The separate provisions for ongoing involuntary treatment in the community arising from involuntary admission (CTO) and treatment initiated in the community as an early intervention measure (CCO) was intended as "least restrictive" but as drafted are unenforceable and therefore "non restrictive" and are not used by clinicians except where a CTO was inadvertently allowed to lapse and the person concerned needs treatment and is not yet schedulable under the Act. Almost invariably this strategy fails and the person eventually requires readmission.

The result of having an ineffective CCO is that most serious and unstable cases of psychosis have to be treated as involuntary patients in the acute hospital system before effective care can be instituted and maintained.

The separate jurisdictions of the magistrates hearings and MHRT review has made evaluation of the cost/effectiveness and clinical value of the MH Act impossible as files are kept separately and no outcome studies were envisaged or funded.

Clinical studies and research over the past 15 years have conclusively demonstrated that the main cause of disability in people who develop psychosis is due to the functional cognitive impairment that develops prior to the onset of acute symptoms such as hallucinations and delusions. Also the long term prognosis and capacity of the individual to recover is mainly determined by the persistence of this impairment. The only way this fundamental impairment can be

recognised under the act is through requirement of demonstrated "thought disorder" which is an extremely vague and clinically undefined term.
Recent research in the USA and Holland has demonstrated that heavy use of cannabis and stimulants results in prolonged changes in adolescent brain function and increases the odds of developing schizophrenia like psychosis. The identified steady increase in cannabis and stimulant drug use in adolescents in NSW is probably resulting in a real increase in young adults developing schizophrenia and related affective disorders. Currently males under 35 with cannabis induced chronic psychosis account for at least 75% of the involuntary community treatment orders currently issued in NSW (Campbell). The lack of effective early intervention community treatment orders is resulting in a situation where young people have to develop an acute psychosis and have several admissions before effective treatment is instituted. Repeal of the Inebriates Act without complementary provision of a clause in the Mental Health allowing for compulsory treatment of people at demonstrably risk of permanent incapacity from drug induced psychosis.

Recommendations:

1: Simplification of the Act:

CTO's and CCO's be replaced by one Treatment order that can be initiated whilst in hospital or the community that obliges the person to accept recommended treatment. Failure to comply would result in an obligatory psychiatric review, either in Hospital or the community, which could then order readmission if considered clinically appropriate. The Order would be for 6 months and not automatically lapse if the person is certified by a psychiatrist as requiring further involuntary treatment in a Gazetted Hospital.

2: Accountability:

That decision to cancel an involuntary treatment order only be under the authority of the Director of the Mental Health service or psychiatrist delegated to have such authority.

3: Recognition of recent advances in understanding mental illness:

a: That the definition of Mental Illness include clinical, neuropsychological or neuro-physiological evidence of cognitive impairment that could reasonably be expected to result in significant impairment of psychological or social function places the person or others at serious risk.

b: That involuntary ECT can be administered to a discharged patient under an involuntary community treatment order.

5: Integration:

That the current two tier system be integrated to enable more accountable implementation and review of involuntary treatment and where treatment is available orders. Preferably this would be achieved by appointing to the MHRT specialist lawyers to replace magistrate hearings or by allowing a longer period of involuntary detention so that a full tribunal panel can review all persons detained over say 3 weeks.

6: Clarification:

That the aims and objective of the NSW MH Act be more clearly defined along the lines of the Queensland or Victorian acts. In particular the intention should be to facilitate the service to be able to provide appropriate and necessary treatment which would be applied in the least restrictive manner, and not simply provide the "least restrictive care".

7: Early intervention and prevention:

That the current Inebriate Act be incorporated into the Mental Health Act to allow for involuntary periods of detoxification for people who are clearly at risk of permanent incapacitation from cannabis and stimulant addiction in appropriate treatment Units. The utilisation of Mental Health Act will so ensure access to appropriate care and treatment is facilitated whilst individual civil rights are respected.

8: Evaluation:
The revised act should incorporate provision for evaluation and require funding to achieve this purpose.

9: Review: Patients required to take potentially toxic medications over along period should have access to an independent diagnostic and treatment review if this is considered appropriate by reviewing authorities.

10: National integration: Compulsory Treatment Orders under State jurisdiction should be recognised by other Commonwealth States and Territories.

Submitted on behalf of CASP members 24/12/04

Dr Andrew Campbell, Convenor C.A.S.P