21 July 2011

Dear Sir/Madam,

According to the *Mental Health Act 2000* (the "Act") the position you hold as Director of the psychiatric unit requires you to uphold the responsibility of ensuring that the operations of your unit are in compliance with the Act.

According to Sections 489 (1) (A), (B), (C) & (Ca) of the Act the Director has the following functions:

- ensuring the protection of the rights of involuntary patients under this Act;
- ensuring involuntary admission, assessment and treatment of persons complies with this Act; and
- facilitating the proper and efficient administration of the Act and monitoring and auditing compliance of the Act.

It is evidently clear that there are some areas of the Act that are being disregarded by your hospital.

According to *Section 8 (B), (C) and (E)* of the *Mental Health Act* 2000 to the greatest extent practicable, a person is to be encouraged to take part in making decisions especially about their treatment. A person is also presumed to have capacity to make decisions about their assessment and treatment. A person is to be provided with necessary support and information to enable the person to exercise their rights under this Act and is encouraged to be self reliant. A person's religious beliefs must be taken into account. *Section 12 : (2) of the Mental Health Act* states that a person must not be considered to have a mental illness merely because of particular religious beliefs and *Section 8 (g)* states that to the greatest extent practicable a person's religious beliefs must be maintained.

In accordance with this area of legislation even when patients are well it is clear that in the public system they are still being dictated to by psychiatrists regarding their medication and treatment and are not being respected as individuals with the capacity to make their own decisions. Religious beliefs are also sometimes treated by public hospital psychiatrist as part of a patient's psychosis. It is highly evident that this area of the act must be brought into compliance as there are other over sighting bodies such as the Ombudsman and the CMC as well as media attention that can be sought by consumers for compliance with the Act.

In juxtaposition to *Section 8 (B), (C), and (E),* according to *Sections 72, 110, 111 and 124* of the *Mental Health Act 2000* a treatment plan must be prepared for the patient and discussed with the patient. The word discussion means a dialogue with the patient, not a psychiatrist's monologue. In dictionary terms the word discussion means to deliberate and converse. It is clear that patients are being dictated to by psychiatrists as to what medication and treatment they must receive, without any opportunity to question their treatment, make their own informed decisions or be given access to information about the medication that is enforced upon them. With this kind of treatment, which appears to be based on the old historical injustices of Mental Asylums, persons suffering from mental illness will never gain their independence or be able to break away from being treated without human dignity and respect. This kind of treatment is highly infectious for a low sense of self worth, a constant reminder of incapability and mental illness without the hope for recovery. Hence the revolving doors of the Mental Health System. Excessive use of ECT and Involuntary Treatment Orders along with consumer reports validates this non compliance.

Section 151 of the Mental Health Act 2000 states that seclusion must only be authorised when it is necessary to protect the patient or other persons from imminent physical harm and there is no less restrictive way of ensuring the safety of the patient or others. It is evident that seclusion is used on non-violent patients as a form of punishment because they do not comply with treatment, despite the fact that less restrictive methods are available. At other times seclusion is enforced simply because it has been used in the past despite the fact that the patient is clearly presenting as non-violent.

Sections 344 & 345 of the Mental Health Act 2000 state that all involuntary patients must be given a statement of rights upon admission into hospital. In addition to the statement of rights the patient must be given an oral explanation in the language or way the patient understands it. It is evident that patients are not given a statement of rights upon admission into hospital and are not given an oral explanation in a way that they can understand it.

Section 3 of the *Mental Health Review Tribunal rule 2009* affirms that patients must be given a copy of their clinical report within 7 days before the day notified of the hearing of a review. It is clear that patients are still not given a copy of their clinical report 7 days before their hearing.

According to the Mental Health Act Liaison officer as published on their website and the *Mental Health Act 2000* Section 342 (3), if a patient is not able to choose an 'allied person' the hospital administrator must choose a person to be the patient's allied person. It is clear that the hospital administrator has never chosen an allied person for any involuntary patient in Queensland.

Section 25 (1) of the *Mental Health Act 2000* states that an ambulance officer or health practitioner may take a person for whom assessment documents are enforced to a mental health service and the police may get involved if requested by the ambulance service. Upon talking to a police officer from Oxley station I was advised that the police actually have a policy whereby an ambulance officer must be called first. However, the officer advised that police are not following this policy and that a letter should be sent to the Queensland Commissioner of Police alerting him of this fact.

Unfortunately for persons with mental health issues police are constantly taking involuntary patients to mental health units without any ambulance service involvement (often when these persons are not a danger to themselves or anyone else). This kind of behavior not only criminalizes mental illness but enforces the powerlessness of persons concerned. As the Director your position is required to liaise with police to make sure such patients are treated as having an illness and therefore needing an ambulance officer, not the criminalization of a police escort.

Involuntary patients have to endure a ride to the hospital in the back of a police car followed by a negative and dictatorial psychiatric assessment that assumes the mental illness will never improve, contrary to research demonstrating complete recovery even in the 3rd and 4th decade. They have to endure involuntary electro-convulsive therapy, involuntary treatment orders and public hospital processes that embrace isolation and loneliness without making use of humane nursing practices. Patients who are restricted to the ward have to endure being left alone all day with other patients without being offered any communication or activity with nursing staff and the hospital. After this experience patients are tossed back into society and expected to cope.

The main point is that if the public mental health system does not embrace recovery and offer in hospital activities based on hope, healing and positivity, mental health consumers will continue to believe there is no hope and no recovery and will continue with future exacerbation of mental illness.

Psychiatric hospitals have by far the widest scope of advantage over any other service regarding offering consumers recovery based programs/courses due to the live in position of consumers in hospitals. According to the National standards for Mental Health Services recovery means gaining and retaining hope, resilience, understanding ones abilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self. With this information the formulation of an effective in-patient recovery program is highly possible. In addition there are already many non clinical community based services in mental health offering recovery programs with high success rates of consumer participation and development. If clinical are only going to concentrate on the consumers mental illness constantly, such as nursing staff, hospital practices, out-patient practices, you are concentrating on the most negative aspects of a person's character and you will ultimately bring the person down, which only creates damaging impact to a consumers recovery. You should also be providing programs to instill hope and positivity to the consumer. The National Standards for Mental health Services also state that for recovery to take place an individual must be empowered to be at the centre of their care with their attitude and rights taken seriously and from a perspective of listening to the consumer and learning from the consumer.

A copy of this letter has been sent to all allied departments, Government officials and health authorities. I trust that you will bring the mentioned areas of the *Mental Health Act 2000* into compliance and provide a written response which outlines in detail, the changes to your services that address compliance with the Act.

Yours sincerely

Natalie Cermak
Malcolm Campbell
Sally Harbison
Andrew Royle
Victoria Musgrave

Mental Health
Action Reform Group