Royal Commission into Victoria's Mental Health System

Formal Submission

- *Thinking about what Victoria's mental health system should ideally look like, tell us what areas and **reform** ideas you would like the Royal Commission to prioritise for change?*
- *What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?*
- *Is there anything else you would like to share with the Royal Commission?*

Significant legislative reform is required, including the *Mental Health Act* 2014 (Vic) itself, to **truly** protect people living with a mental illness and their rights. Further reform is also required to **truly** protect Carers and Nominated Persons and their rights. The nightmare ordeal that our family as a whole endured in recent months must be highlighted to the Royal Commission. Areas and reform ideas ought to be based on real-life examples of how the "system" currently works and therefore how it must be changed for the better.

Broad snapshot of what happened:

(1) I have been supporting my son and assisting him with the management of his medical condition and medication for the last approximate ten (10) years since his diagnosis.

(2) Please note, that my son has **never** been hospitalised since his initial admission and diagnosis **until** last year (2018).

(3) The 2018 admission was due to my son not being treated adequately by a Private Psychiatrist who canvassed change in medication options. We put faith and trust in a so-called "Professor". Unfortunately, during the medication change process, my son's mental state deteriorated rapidly.

(4) This resulted in an acute relapse that was triggered by 'rebound psychosis', caused by sudden withdrawal from his medication of previous nine years.

(5) This diagnosis was confirmed when my son **voluntarily** admitted to a public hospital. Whilst this hospital unit put my son back on his previous medication for 9 years, they unfortunately also continued with the new changed medication as well. I pleaded with that treating team that it is not a good idea to continue on that new medication since my son did not respond well to it.

(6) At that time the treating team started putting pressure on me to take my son home. I declined to take him home because he was not well. On the contrary, he was getting worse again.

(7) To 'remedy' the situation the treating team added another drug (this time an antidepressant) to the mix of three (3) antipsychotics they implemented. The public hospital then discharged my son on a cocktail of antipsychotics and antidepressants.

(8) It took several months "in the community" via the Public Hospital's "in Community" health service branch to remove the cocktail from four (4) drugs back to one (1) (i.e. the one medication of the previous nine years).

(9) During this time, research of alternative medication was also explored via **another** private psychiatrist.

(10) Noting the one medication of previous nine years (which my son overall responded well to), research lead to a **new updated version of this medication** by the **same** manufacturer. The Therapeutic Goods Administration (TGA) enlists on its records the manufactures Guidelines (with strict instructions on how to undertake medication change in this particular instance).

(11) However, the "in Community" health service branch became increasing less transparent and issues were arising, including agonising delays. For example, on the day the new updated version of medication was supposed to be implemented, the Registrar (doctor) did not show up on the day (i.e. took a day off work). The Registrar even failed to put **any** notes on their medical records that it was supposed to be the important day of the medication change. Even the Case Manager was concerned by the incident having to call and double-check etc.

(12) We did not receive any written Treatment Plan by this health service, despite our requests to ascertain dosages for implementation stage and beyond.

(13) The start of 201**9** continued with these concerns. It became more clear via their verbal advice that the conversion dosage of the new updated version of medication was questionable. I highlighted these concerns a number of times. On my own initiative, I researched further of this updated medication which included finding the **TGA** approved manufactures Guidelines issued for health practitioners.

(14) The "in Community" health service branch did **not** follow any such guidelines. Therefore, the **dosages**, **sequence** and **frequency** were **all wrong**. Despite highlighting the guidelines multiple times, they still refused to follow manufactures guidelines.

(15) The "in Community" health service branches actions **and** lack of actions resulted in –

- **a.** Initial **under-**dose;
- **b.** followed by brief period of **over-**dosage, then **acute relapse**; and
- **c.** back to **under-**dose.

There were other key issues such as shallow injections (i.e. not properly injecting into the inter-muscular). Overall, instability of this kind resulted in acute relapses. By early March 2019, it lead to the point my son rapidly became catatonic. He **voluntarily** admitted to the Emergency Department at Hospital. He stayed in ED overnight and hospital staff were concerned about the "in Community" health service branch conduct with implementation of the new medication etc. Nevertheless, the following morning they referred my son back to the "in Community" health service branch.

(16) No doctors "were available" at the "in Community" health service branch when we had an appointment. It lead to us resorting to a Private Psychiatrist for help and authorised injection according to the manufacturer's Guidelines. My son's mental state stablished and improved afterwards.

(17) During this cycle, it was exactly the point in time when the "in Community" health service branch could have done something to support my son since my son was in fact significantly under-dosed, at that point in time. However, they refused to do anything in adjusting the dosages accordingly to TGA/Manufacturer guidelines to prevent the danger of relapsing again.

(18) Déjà vu occurred with "in Community" health service branch stonewalling again, leading to resorting to a Private Psychiatrist for help again. The "in Community" health service branch bluntly refused to adjust dosage to appropriate levels to prevent relapse and ascertain my son's recovery.

(19) Due to "in Community" health service, within a fortnight, my son's condition deteriorated. We sought the Ambulance to take my son to the Emergency Department. The Ambulance crew were two female staff and they felt they should seek assistance with Police as a protocol on standby. My son

voluntarily went with the Ambulance. The Police **only** just drove behind to the Ambulance to the Hospital. Since it was **voluntary** admission, the Police left upon arrival at Hospital. The female Ambulance staff stayed until eventual allocation of an E.D. pod took place. Eventually in early AM hours, a Triage Nurse arrived to the pod to assess my son. Things were going as expected until this nurse suddenly stated that my son was going to be admitted **in**voluntary. We highlighted that in fact is was **voluntary**. The Ambulance records clearly highlight **voluntary** admission. The nurse failed to clarify and left the pod. After some time, and no appearance, we could not allow a false occurrence of **in**voluntary happening. We left to make ensure in the morning any error be rectified with the "in Community" health service branch.

(20) We attended an appointment the "in Community" health service branch early morning. **Voluntary** admission was highlighted a number of times to rectify the nurses failures. Unfortunately, the "in Community" health service branch **forced** **in**voluntary admission by issuing an "Assessment Order" (**AO**). My son and family kept requesting **voluntary** admission. They declined but let us go back home. In the meantime, an Ambulance would be arranged. We went to the shops via our way back home.

(21) Eventually once returning home in the afternoon, a staff member from the "in Community" health service branch arrived with Police as well as Ambulance. There was no need for Police assistance and my son and I stated at least 4 times in their presence that admission is **voluntary**. My son went into the Ambulance **voluntarily** and police just drove behind to hospital and police left straightaway upon arrival at hospital.

(22) On admission, my son was assessed by a Psychiatrist in charge, and the fact of **voluntary** admission was emphasised once again. Any hospital has a maximum 72 hours during an Assessment Order (AO) period. Despite seeking clarity on next steps, two days **after** the 72 hours **expired**, my son and I were only presented with a **backdated** Temporary Treatment Order (**TTO**). Issues of validity were highlighted; however please note the distressing nature of circumstances and sagas by hospital staff was challenging to keep up with. The Psychiatrist that my son was under was formerly a staff member from the "in Community" health service branch and that psychiatrist did everything possible **to deny** that the deterioration of my son was because of the failures of the "in Community" health service branch.

(23) Very little information and transparency by hospital staff and associated issues kept occurring on a daily basis.

(24) Just hours before a public holiday shutdown, **without** any notice or discussion, the Hospital forced a **sudden** change to an unknown & unconsented drug. Please note, neither my son or myself were not informed about what medication the hospital was going to force nor they told us about dosages etc or **any** details whatsoever. My son was simply taken by force to a room by bouncers in rubber gloves and the medication was forced on my son. Afterwards, it became apparent other staff had to sway the Psychiatrist to implement a sub-variety of that drug that only lasts for 3-4 days as a way to "test it", rather than a fortnight dosage. The previous updated medication **could still be applied** after the 3-4 day sub-variety.

(25) During the public holiday weekend, my family had very little options or resources to seek assistance. It took a **non-**lawyer family member to draft an **injunction** application to have on stand-by when the 3-4 days approaches with the all the indications that the hospital will force the change of medication on my son.

(26) When the time approached, we made every possible effort (along with my son) to request to **continue** with the **pre-existing treatment** (i.e. the new updated version of medication since January 2019), rather than a sudden unconsented and forced change to a **totally different** drug

that was never previously tried on my son. The Psychiatrist was so **un**reasonable, it lead to us serving the **injunction** application with no other choice. After this stressful meeting, our family went for a coffee (outside of the ward whilst my son still had to stay there). By the time we got back, the hospital **still went ahead and forced** the change of medication.

(27) On-going issues continued on a daily basis to say the least. During this time, we lodged an application to revoke the Temporary Treatment Order (**TTO**) to the relevant tribunal.

(28) The following week the Hospital issued a "Report to Compulsory Treatment". It soon was understood that this meant, the tribunal would hear and determine **both** –

a. The application for revocation of the Temporary Treatment Order (**TTO**); **and**

b. To hear and determine whether "Treatment Order" (*T.O.*) ought to be made.

(29) Numerous issues arose and became apparent, including (to put it politely) the **lack of** arms-length between the health organisation and the tribunal, including the health organisation able to push-back hearing dates that favoured them and severely disadvantaged my son etc.

(30) To put it very shortly, the health service (and as an entity) did all things possible to stack the odds against my son and myself. Also during this time, jurisdictional issues with **injunction** application also arose. In totality, the sheer distress and exhaustion of the whole ordeal is indescribable.

(31) The odds stacked against us, along with **lack of** arms-length between organisations, lead to an **unfair** hearing and **shocking** outcome to put it very simply.

(32) Please note that my son only been allowed leave for 7 hours in total in the 6 weeks since he has admitted. The on-going unjustified increases of anti-psychotic medication was used a form of punishment for attempting to seek independent medical assessment, amongst other things.

(33) There was no choice but to appeal further to another appeal body. Other jurisdictional issues arose that in effect stacks the odds even more against us to put it in short.

The *Mental Health Act* 2014 (Vic) itself and other enabling enactments need to reform including –

- Further rights that ensure Patients and Carers/Nominated Persons have;
  - **Real** rights **to decide** treatment/medication.
  - **Real** legal **instruments** that can be used, **if ever needed**, to **truly protect** rights as well as the mental health principals enshrined in with connection to Human Rights.
  - **Real** mechanism to access information immediately (not just verbal advice but receiving actual documentation that can be relied upon at the time **when really needed**).
- Health services/organisations (Hospitals and in "community" branches) to be **truly accountable** with **actual oversight**.
- **Urgently prioritise** real oversight and accountability on the primary "appeal" tribunal and laws that **ensure arms-length rules** between that tribunal and health organisations. Further, improve laws for persons with mental illness and Carers, if ever needing to **appeal higher up**.

We request an opportunity to be allowed to either appear at a scheduled hearing or provide further details to the Royal Commission. By providing key examples of what happened at key points in time, can assist in conjunction with RCVMHS's recommending changes to Victoria's mental health system and support improvements that last via implementing many reforms.

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