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Submissions

Two difficult aspects of the current system that need to be addressed -

- Facilitation of considerate management at a 'preliminary stage' of a person becoming recognizably ill and liable to need compulsory treatment and their connection with/introduction into the compulsory system.
- Facilitation of considerate management at the compulsory stage of the personal well being, resources and wider interests of the patient during admission and discharge.

Assume a young adult who is intelligent, pleasant, ordinarily competent, uses alcohol/drugs and has means and possessions (resources) to be safeguarded, including residential premises and savings. That person (patient) has well-motivated family members (or similar) willing and able to help (carer).

Typically, everyone but the patient recognizes the need for some form of treatment and the patient becomes increasingly unusual, unreliable, secretive and then florid and sometimes intolerable.

Typically, the system gives no real, meaningful recognition to the carer at either stage, more especially the practical role of a carer as the person who must assume continued close responsibility for the resources and wider interests of the patient as well as their personal well being.

Whether the person ultimately does not or does deteriorate to the point of admission, the system needs modification.

Four problems

Four counterproductive sources of real but unnecessarily great difficulty need to be temporarily overridden and modified to enable the patient's interests to be satisfactorily addressed in each of the preliminary and compulsory stages.

1. The intractable divide and lack of communication between a private pyschiatrist or medical practitioner and public pyschiatrists. Neither patient nor carer should be required to have to negotiate largely unassisted from one to the other and not have the benefit of their combined assistance information and experience.

2. The binary legal differentiation between mentally fit and unfit. Of course the legal difference is fundamental. But in the preliminary stage where often the patient is clearly partly 'fit' and 'unfit' it is pointless and unnecessarily unhelpful not to recognize that a patient's capacity for judgement can be gravely impaired thus warranting limited agency

by, say, a carer for certain purposes. What is insufficiently appreciated and receives no effect is that the interests of the patient at the preliminary stage need primarily to be addressed by reference to practical not legal considerations.

3. Obsessive preoccupation with and exaggerated reliance on formulaic conceptions of patient privacy and consent at both the preliminary and compulsory stages in the event a carer deals with a private practitioner, a corporate institution, police or a mental health official. You can't pay off the gas or electricity because they can only talk to the customer (patient). You can't talk to a private pyschiatrist's receptionist about prescribed medication or get other information to deal with exigencies. Compulsory practitioners prefer to avoid meaningful discussion in the absence of a too-unwell patient on these pretexts. (Yet, ironically, patients will be required to sign consent forms when hospitalised.)

4. Recognition and status are accorded the patient and (as above) not meaningfully to a carer even in the most beneficial circumstances. A committed carer is liable not to be consulted or informed until the last moment (or not at all) about many things even including, importantly, imminent discharge (ie transport, accommodation, clothes, means etc).

A temporary practical carer role

What should be introduced is a temporary status that can very quickly, cheaply, efficiently and simply be unilaterally initiated (if need be) by, and attributed to, a suitable carer to speak on behalf of a patient (potential or actual) and undertake functions for the patient the range of which in the preliminary stage would be limited and greater in the compulsory stage. The status would need to involve a simple combination of fiduciary, agent and attorney attributes and to be governed by a paramount and overriding obligation to act exclusively in the interests of the patient without financial reward. It would apply in at least two respects.

- First, to attend to everyday temporal needs: upkeep, maintenance and conservation of resources and financial needs, subject to consultation with a patient where practicable.
- Second, to give purposive standing and enable communication and dealings with corporate or government institutions or officials (eg gas utility, bank, Centrelink or police) and medical and pyschiatric bodies and personnel.

VCAT's Guardianship Division would require reformed process and alternative power to become an appropriate authorising body. Obviously some supposed carers would be unfit. More detailed analysis is superfluous without acceptance of the basic idea.

Other

For many (often very poor) carers concerned to conserve resources for the benefit - but out of reach - of a chronic patient there is great need for legislative establishment of a statutory form of disability trust to which effect can be given very cheaply – possibly on a DIY basis - which is acceptable to the ATO but more flexible and less circumscribed than the current ATO version.

In the preliminary stage process should be improved in the twilight zone preceding any compulsory stage, say -

- Readily enable a family member/putative carer to be able to consult sensibly with a CAT team or other advisory mental health official for information about the system or assistance from the system. Currently many people don't know to where to turn or when or how to do so but may be smothered in superficial, contradictory or out of date general leaflets.

- Changing the way in which a patient is inducted to compulsory treatment which is obviously confronting to a highly disturbed person wanting 'just to be left alone'. Some examples: no automatic handcuffing on the ground in front of bystanders; minimal body searching; , no automatic ambulance conveyance (with ambulance door slamming!); no automatic solitary, unaccompanied ambulance ride (with no possible companion); no hospital casualty admission and indignity, including overnight sleeping on a casualty floor.

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5 July 2019