RANZCP Auckland Training Programme

Mock Objective Structured Clinical Examination

STATION Number Bye for 3

April 2006

This is a reading "bye" station

Instructions to Candidate:

You have 20 (twenty) minutes to complete this station.

You are an adult acute inpatient team senior registrar. One of the patients for whom you are the Responsible Clinician regarding the Mental Health Act, Shannon Williams, has arranged a time to see you, as she wants to arrange weekend leave.

On the morning of the meeting you have learned that Shannon plans to include Becky Marsh a Consumer Advocate, as a support person. Becky is not previously known to you, and is apparently newly appointed within the local services. Becky has left some information for you to read the day before the appointment, and you have found some time to look at this briefly.

Your tasks are to:

1. **Read the patient's background clinical information, summarised from her records.**

2. **Read the material Becky Marsh wants you to have before the meeting.**

Please do not make marks or notes on the records or other material provided.
These items of information will be available to you again in the station.

You can make your own notes on the scrap paper provided, and can take that with you into the station, where you will continue with this scenario.

Synopsis of Shannon's history from her clinical records

Background:
Shannon Williams is a 30 year old dressmaker living alone in a rented house on the rural outskirts of the city. She does clothing alterations and make clothing, cushion covers and quilts to sell at the local market and shops, and is quite creative. She does not make much money however, and has been under some financial strain across the last year due to the need to buy another car after her old one "fell apart with rust".

Her boyfriend Mike is a musician in a folk-rock band, and flats with other band members. Shannon and he have been together for 12 months. Shannon's parents are teachers who live locally and Shannon visits them regularly. She is the eldest of 3, with a younger brother and sister still living at home.

Shannon described a happy childhood and enjoyed school. She had planned to do a university Arts degree but had a difficult relationship in her first student year, to a man who was emotionally and physically abusive, and had to drop out. Eventually she had to get a non-molestation order against this man. This stress led to Shannon developing a major depression and having several months treatment with fluoxetine, and counselling. She had gone flatting from age 18 but moved back to live with her parents across this difficult period, from which she eventually made a full recovery.

Current Episode:
Across the last 3-4 months Shannon has again become moderately depressed due to the financial stresses, and as her dog was run over. She began to smoke a lot of cannabis with Mike and his friends, having previously not used this regularly. She did not see a doctor and had no treatment for this period of depression, which would have met criteria as a Major Depressive Episode (mild). One month ago after selling an expensive quilt, she began to feel "normal again", but this rapidly progressed to an overexcited manic state across the next few days.

While manic she had a great deal of energy and creativity and sewed clothes for all the family, arriving with these at her parents in an excited, pressured, thought-disordered state and insisting that they all get dressed in the clothes and "celebrate". The clothes were highly decorated "hippy" style garments and her parents refused to wear them. Shannon believed at the time that she had started a new clothing line which would be "all the rage" in all the main department stores, and that all her financial worries were over. She ran up a debt of $1000 on her Visa buying fabrics, lace and fringing. She has also purchased an expensive sewing machine on hire purchase, as she believes that she is "made" and that she will soon be a "household name".

Shannon's parents were understandably very worried and called their GP, who arranged for a Crisis Team assessment, and as a result she was admitted to hospital via the Mental Health Act.

Shannon's grandiose delusions and flight of ideas resolved rapidly across a few days after admission, but her mood has been slower to settle and she is still somewhat hypomanic and distractible. She is still mildly elevated and can be irritable at times, complaining that the staff are "retro" and are "cramping my style".

Shannon's premorbid personality is cheerful, sociable and creative, with a leaning towards alternate lifestyle choices but with no extreme views of this sort. She agreed to take medication but has said that she would be fine without it really, and tends to say "all I need is love".

She appears to have accepted that her heavy cannabis use previously was harmful and may have contributed to the admission, and has promised to "cut down". However, she is reluctant to consider ceasing this altogether. Shannon does not drink alcohol or use any other street drugs. She has several close friends who have remained in touch and are supportive.

At present she believes that she is completely well. She wants to go away with Mike this weekend, to a Folk Festival in a nearby rural town where his band are playing. Shannon had afternoon leave with her parents 2 days ago, which went reasonably well, but has had no other leaves to date.

This is from "No Force Advocacy by Users and Survivors of Psychiatry" by Tina Minkowitz and the Mental Health Commission – I think it's relevant to Shannon's situation. Look forward to seeing you at the meeting.

- Becky Marsh, Consumer Advocate

Rights and Principles in No-Force Advocacy

An extensive range of international conventions, rights and principles support No-Force principles - however, states can and do disregard these conventions, rights and principles when it comes to madpeople.

Non-discrimination

Non-discrimination is both a right and a principle in international law. The International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) require governments to ensure equal enjoyment of the rights guaranteed in those treaties without discrimination, and ICCPR article 26 recognizes a right of individuals to equal protection of the law, without discrimination.

Discrimination is described broadly in both Covenants, including grounds of "race, colour, sex, language, political or other opinion, national or social origin, property, birth or other status". The Committee on Economic, Social and Cultural Rights, which interprets the ICESCR, has recognized that disability is a prohibited ground of discrimination included in "or other status," and it is widely accepted that this applies to the ICCPR as well.

One aspect of nondiscrimination is the "right to be different" recognized in the UNESCO Declaration on Race and Racial Prejudice. This concept has resonated strongly among people with disabilities and users and survivors of psychiatry. It is related to the call for universalizing of standards to meet individual requirements on a basis of equality, rather than treating non-disabled people as a norm and accommodations for people with disabilities as a special case.

Forced psychiatric interventions constitute torture

Protection against torture and other cruel, inhuman or degrading treatment or punishment is guaranteed to all human beings by the Universal Declaration of Human Rights (UDHR) and International Covenant on Civil and Political rights (ICCPR). The ICCPR also particularizes medical or scientific experimentation without free consent as a form of torture or other ill treatment. This protection is not subject to derogation, in keeping with the character of torture as a universal evil to be prohibited and criminalized at all times. A definition of torture is elaborated in the Convention Against Torture (CAT) and is useful in testing inherently harmful activities. Users and survivors of psychiatry have always claimed that forced drugging, electroshock, and psychosurgery, and seclusion and restraint, were torture and ill treatment, and now there is the ability to present the argument formally, to urge the acceptance of this application of human rights law.

Recognising forced interventions as a form of torture goes to the heart of the issue of free will versus coercion. Psychiatric violence breaks the will by destroying mental integrity, identity, and personality, through the involuntary use of methods that act on the mind through the brain.

The norm against torture and other ill treatment protects against harm to mental and bodily integrity, especially acts that are designed to break a person' s will or resistance. The definition of torture used most commonly in international law, from the UN Convention Against Torture (CAT) defines torture as:

- an intentional act
- inflicting severe mental or physical pain or suffering
- for purposes such as obtaining information or a confession, intimidation or coercion, punishment, or for any reason based on discrimination of any kind
- by or with the acquiescence of a public official.

Physicians who perform forced interventions are aware that severe pain and suffering is likely to result, and they proceed against the will of victims. Pain and suffering caused by these interventions may be severe, as documented both by the user/survivor movement and by organized psychiatry itself. In some instances, victims have been intended to experience pain and suffering as a desired "therapeutic" effect. Mental health laws or immunities provide state acquiescence to this.

Coercion, intimidation and punishment are often factors in the use of forced interventions like ECT, psychosurgery and forced drugging. Coercion occurs both in the use of these methods as a deterrent to undesired behaviour, and in the inherent nature of interventions that interfere with thought processes, emotion, consciousness, and self-perception. Discrimination occurs first of all, by making an exception of actions against people with psychosocial disabilities, actions which would otherwise be considered torture.

Discrimination also occurs in forced interventions where the purpose is to change a person from one state of being to another, against his or her will. This violates not only the right to informed consent and autonomy of mind and body, but also the right to be different - the right to not have our differences made the occasion for violence or coercion to change.

For users and survivors of psychiatry, application of the prohibition against torture to forced interventions would begin to redress the harm and allow for reparation to be pursued. More importantly, it would require the immediate abolition of all such forced interventions and assurances of their non-recurrence.

Self-determination

Another important principle is individual autonomy and self-determination. Self determination of peoples is enshrined in the UN Charter and in the Covenants, but individual self-determination is implicit in the human rights regime centering on rights and freedoms of the individual and can be derived from a number of core rights, such as freedom from slavery, freedom from torture, freedom from experimentation without consent, right to informed consent in health care, right to liberty of movement and to choose one' s own residence. The disability movement has embraced the concept of a right to self-determination and the UN Special Rapporteur on Disability has also supported the concept of a right to self-determination that includes the right to accept or refuse treatment.

Recognition as a person

The right to recognition as a person before the law is recognized in the Universal Declaration of Human Rights (UDHR) and the ICCPR. This right is non-derogable, that is, it may not be limited even in states of public emergency.

The right to recognition as a person before the law can be interpreted narrowly or broadly. Narrowly, it may mean that every human being is entitled to be recognized as in fact having the status of personhood, with whatever implications that may have under the law. More broadly, recognition as a person before the law entails legal capacity - the capacity to assert, exercise and enjoy rights on one' s own behalf.

Freedom from arbitrary detention

The right to be free from arbitrary detention is significant for users and survivors but it requires some careful attention. Arbitrary arrest and detention are prohibited by the UDHR and ICCPR but the right is subject to limitation in times of public emergency. Much of the advocacy on user/survivor issues related to detention has focused on the ' lawful" quality of the detention. This has limited potential because it results in establishing legal standards and procedures for detention, rather than challenging the basis of detention of users and survivors as discriminatory.

Liberty of movement

The right to liberty of movement and freedom to choose one' s residence is also guaranteed by the UDHR and ICCPR. This right is potentially subject to restrictions in the interests of national security, public order, public health or morals, or the rights and freedoms of others. However, it is a significant source for the right to remain at liberty and choose one' s residence on an equal basis with others, without discrimination.

Freedom of thought

Freedom of thought is guaranteed by the UDHR and ICCPR. The ICCPR further protects against coercion that would impair a person' s ability to have or adopt a religion or belief of his or her choice. This protection is not subject to derogation or limitation. This provision somewhat duplicates the effect of the protection against torture, but it is broader and focuses on mental freedom rather than causation of harm.

Standards of health

The right to "the highest attainable standard of physical and mental health" (recognized in the ICESCR) is not the best theoretical basis for no-force advocacy. The user/survivor movement does not necessarily accept the premise that psychiatric interventions belong in the context of health, and many prefer to see social, cultural and community-based supports rather than illness-oriented treatment. However, there are aspects of the right to health that are relevant.

The first is the right to control one' s own body and health, which includes the right to informed consent. This aspect of the right to health was recognized in General Comment No. 14 of the Committee on Economic, Social and Cultural Rights. It can be understood as a limitation on the powers of government, and also as an articulation of the role of individual autonomy in protecting bodily integrity and well-being.

Another important aspect of the right to health is that health services must be respectful of the cultures of "individuals, minorities, peoples and communities." This reflects a cultural dimension of our relationship to health and health services, which includes traditional or indigenous healing approaches as well as individual beliefs pertaining to the characterization of health needs and desirable services.

Economic, social and cultural rights

Article 22 of the Universal Declaration of Human Rights is a beautiful articulation of a concept that is central to disability movement human rights advocacy. "Everyone has the right to realization, through national effort and international cooperation... of the economic, social and cultural rights indispensable for his or her dignity and necessary for the free development of his or her personality." Users and survivors of psychiatry have struggled to find the balance between asserting the right to be left alone, and asserting a right to social support and disability-related accommodations. There is no contradiction between these rights, and article 22 helps us to articulate the interrelationship between them.