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Mental Health Treatments and Rehabilitation

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[Contents]

Ⅰ. Introduction
Ⅱ. Psychiatry in Korea and Australia
Ⅲ. Treatment of Persons with Mental Illness
Ⅳ. Assessment of suitability for community treatment
Ⅴ. Conclusion

[Abstract]

Australia and Korea have close links in psychiatry. Indeed, Dr Charles McLaren (1882-1957), an Australian psychiatrist and missionary from Melbourne, established a Department of Psychiatry at Severance Hospital in 1917 and established training for Korean psychiatrists using a Western approach. He was known to advocate for patient's rights, for instance he protested against a school's rejection of the return of a student who had recovered from depression and he promoted the idea that recovery from mental illness was possible.

Korean psychiatry is making great strides to bring a holistic approach to people with mental disabilities. In January 2012, the Korean Neuropsychiatric Association changed the Korean term for schizophrenia from *jungshinbunyeolbyung*, which literally translates to mind-split to *johyeonbyung* which means "to tune a stringed musical instrument".

The change in terminology was closely considered. It induced significantly less prejudice and stigma than the previous term *Jungshinbunyeolbyung* and is indicative of the holistic intentions of Korean psychiatry to overcome stigma and to positively influence health seeking in the population.

The change in moniker demonstrates the extent that Korean psychiatry wishes to convey that they are considering the rights and feelings of people living with mental health problems.

The medical world has moved away from paternalism to embrace

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collaborative care with patients and families. This includes respecting the wishes of patients, even if the decision is different to one that the doctor might have wished.

Many countries around the world are using the Convention of Rights of Persons with Disabilities to inform the development or review of the Mental Health Acts. Australia and Korea are both moving away from enforced treatment based on a risk of harm to ascertain whether a person has capacity to decide on treatment, which is in line with other medical specialties that afford humans the right of autonomy over their own person.

Keywords: Mental Health Treatments, Rehabilitation, Mental illness, Recovery, Mental Health Acts.

I. Introduction

Australia and Korea have close links in psychiatry. Indeed, Dr Charles McLaren (1882-1957), an Australian psychiatrist and missionary from Melbourne, established a Department of Psychiatry at Severance Hospital in 1917 and established training for Korean psychiatrists using a Western approach. He was known to advocate for patient's rights, for instance he protested against a school's rejection of the return of a student who had recovered from depression[1) and he promoted the idea that recovery from mental illness was possible

I am the refore honoured to continue our tradition of shared learning and congratulate Professor Je and the organising committee on their attempts to formulate a humane system with consideration of the needs of the patient.

Korean psychiatry is making great strides to bring a holistic approach to people with mental disabilities.

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1) Lee H. Past, Present and Future of Korean Psychiatry. Psychiatr Investig 2004;1:13-19.

translates to mind-split to *johyeonbyung* which means “to tune a stringed musical instrument”.

The change in terminology was closely considered. It induced significantly less prejudice and stigma than the previous term *Jungshinbunyeolbyung*[2] and is indicative of the holistic intentions of Korean psychiatry to overcome stigma and to positively influence health seeking in the population.

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II. Psychiatry in Korea and Australia

I am aware that Korea and Australia differ with respect to resourcing, and culture, and therefore our approaches may be different with respect to assessment of the person and the ability to provide assistance with surrogate decision making.

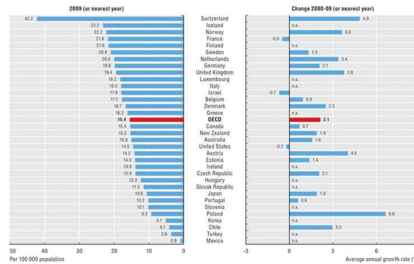
A brief overview:

〈Table 1〉

	Korea	Australia
Population	50.62 million (2015)	23.78 million (2015)[3]
Number of psychiatrists	305 (2011)	3031 (872 NSW 2013)[4]
Psychiatrists per 100,000 population	5[5]	13.1
Beds	75,000	12,048 (2014-2015)[6]
Length of stay	116 days (2011)[7]	15.7 days (2014-2015)[8]
Annual production of psychiatrists	150	106 (2016)
Duration of training	4 years	5 years
Number of trainees	621	868 basic + 204 advanced (2014)

2) SW Kim, JE Jang, JM Kim, *et al*. Comparison of stigma according to the term used for schizophrenia: split-mind disorder *vs* attunement disorder. J Korean Neuropsychiatr Assoc, 51 (2012), pp. 210-217.

As can be seen, we have a population that is half yours, and have more than three times as many psychiatrists.



[Figure 1]

We have fewer beds – Korea has 6 times as many psychiatric beds compared to Australia.

〈Table 2〉

Table 1
The number of psychiatric hospitals and clinics (Korean Neuropsychiatric Association, 2010).

	1969	1979	1985	1990	1995	2000	2005	2011
University and training hospitals	8	18	36	43	52	81	81	84
General/mental hospitals	2/6	18/6	78/6	86/24	115/27	195 (general + mental hospitals)	179/91	253/129
Private psychiatric clinics	8	85	389	251	389	540	756	861
Total	24	127	205	504	583	816	1107	1327
Population (million)	31.5	37.5	40.8	42.9	45.1	47.0	48.1	49.8

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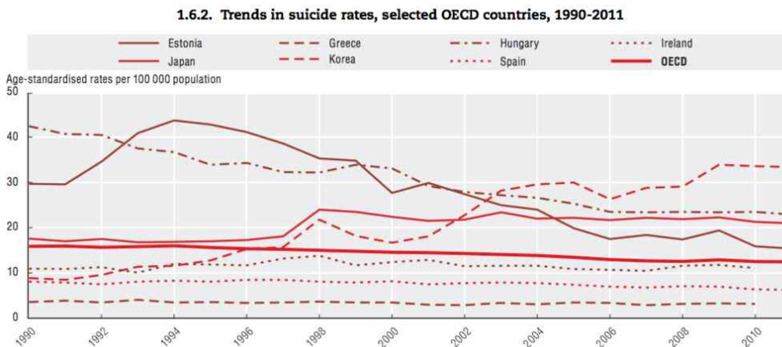
3) World Bank
4) Department of Health 2016: Australia's Future Health Workforce – Psychiatry.
5) http://www.oecd-ilibrary.org/sites/health_glance-2011-en/03/06/index.html?itemId=/content/chapter/health_glance-2011-25-en
6) Mental Health services in Australia https://mhsa.aihw.gov.au/resources/facilities/beds/,accessed 20 July 2017)
7) Kim A. Why do psychiatric patients in Korea stay longer in hospital? Int J Ment Health Syst. 2017; 11:2.
8) Admitted patient mental health-related care 2015-2016. Australian Institute of Health and Welfare: Mental Health Services in Australia.

As can be seen in this table, hospital services in Korea have grown exponentially since 1969.

It is perhaps not surprising that we have a much shorter length of stay than in your country.

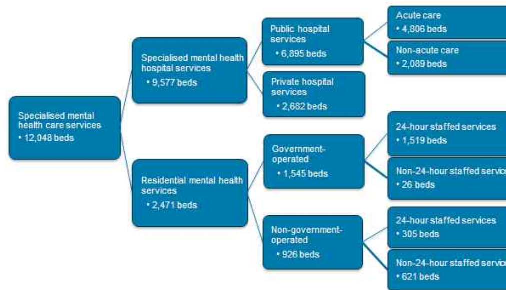
Of course, the reasons for differences in length of stay are complex and multifactorial. A contributing factor may be that in Korea, reimbursement for outpatient care for Medical Aid patients is only one tenth of the average expense of National Health Insurance psychiatric patients, whereas inpatient reimbursements are two-thirds those of National Health Insurance patients. Sixty four per cent of long term psychiatric admissions in Korea are covered by Medical Aid. This is very high, noting that only 3% of the population is supported by the Medical Aid program for very low income earners[7].

The differing prevalence of psychiatric conditions is also likely to influence the type of services required in each of our countries. As can be seen by the graph, Korea has a very high suicide rate that increased over the years from 1990 - 2011. Acutely suicidal people often need a period of inpatient treatment. In contrast, Anxiety Disorders are prevalent in Australia, and can be treated as an outpatient.



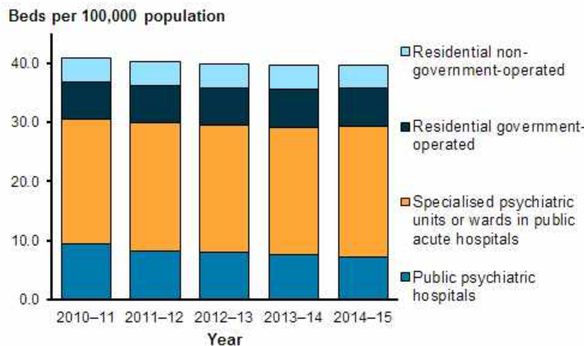
[Figure 2]

Our short length of stay leads to different problems – there are very few facilities for the chronically unwell patient who cannot reside in the community. High rates of mental illness are seen in people who are homeless and in the prison population and may be related to the lack of long stay beds.



[Figure 3]

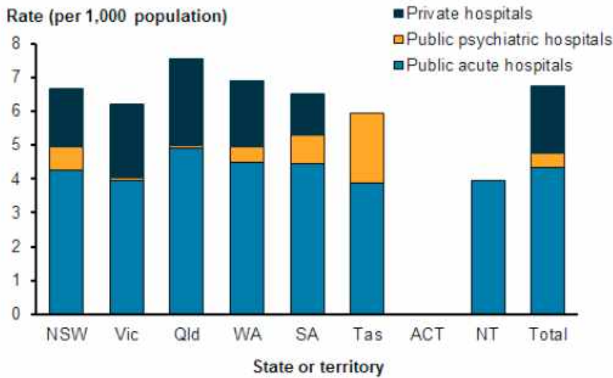
As you can see in this slide, Australia has a total of 2471 beds for residential mental health services.



[Figure 4]

This slide demonstrates that most people with psychiatric illness are treated in psychiatric units and then return to live in the community.

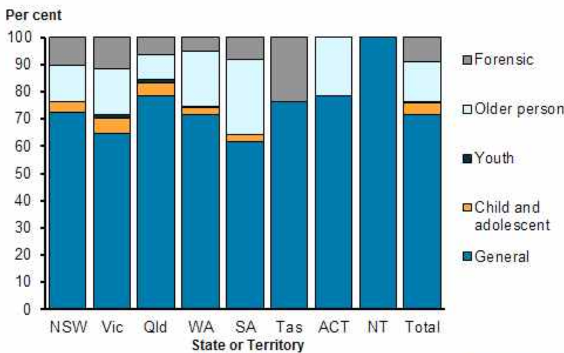
Figure AD.1: Mental health-related separations with specialised psychiatric care, state and territory, by hospital type, 2014–15



[Figure 5]

Most acute psychiatric care occurs in psychiatric wards within general public hospitals. There are few stand alone public psychiatric hospitals.

Figure FAC.5: Public sector specialised mental health hospital beds per 100,000 population, by target population, states and territories, 2014–15



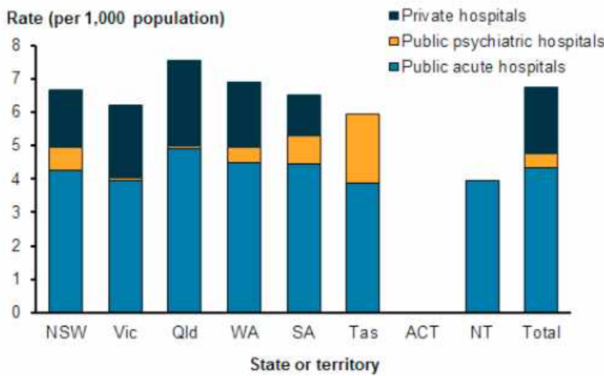
Source: National Mental Health Establishments Database. Source data: Specialised mental health care facilities Table FAC.14 (2.47 MB XLS).

[Figure 6]

Subspecialisation of treatment is reflected in psychiatric training. After basic training is completed, one can train in Old Age Psychiatry, Neuropsychiatry, Forensic, Consultation Liaison, Child and Adolescent psychiatry, General Psychiatry or Psychotherapy.

Most of the inpatient beds are for general adult psychiatry. Forensic beds are for people who have been found either not guilty of a serious crime due to mental illness or have not been fit to plead in a criminal trial. Specific wards or beds in general hospitals are reserved for youth, children and older persons.

Figure AD.1: Mental health-related separations with specialised psychiatric care, state and territory, by hospital type, 2014–15



[Figure 7]

It should be noted that Australia is made up of 6 states and 2 Territories, each with their own mental health legislation and health budget. As you can see, the rates of admission and the type of services available differ from region to region.

Ⅲ. Treatment of Persons with Mental Illness

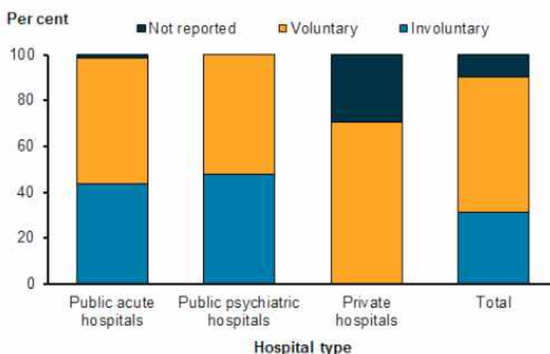
Australia ratified the Convention on the Rights of Persons with Disabilities (CRPD) in 2008, and I note that the Democratic People's Republic of Korea did so in 2016.

The CRPD specifies that persons with disabilities are entitled to recognition of having legal capacity on an equal basis with others(Article12). Most Australian States and Territories have reviewed their mental health legislations in that light. To that end, the states of Queensland, South Australia,Tasmania and Western Australia now prohibit involuntary psychiatric treatment to mentally ill people who are competent to refuse it.

People with mental health conditions can be treated in private or public psychiatric centres, as inpatients or in the community. Public hospital treatment occurs at no cost to the patient but there are long waiting lists and appointments are not readily available. Private psychiatric services are expensive.

Involuntary treatment generally can only take place in a public hospital.

Figure AD.4: Mental health-related separations with specialised psychiatric care (per cent), by mental health legal status and hospital type, 2014–15



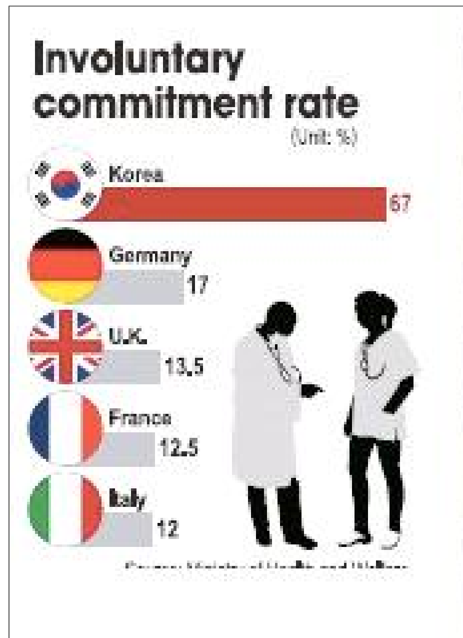
Source: National Hospital Morbidity Database.

Source data: Admitted patient mental health-related care Table AD.5 (1.19MB XLS).

[Figure 8]

Involuntary admission comprise about one third of all admissions to public and private psychiatric hospitals, and about 40% in public hospitals.

In contrast, the involuntary commitment rate is almost 70% of all admissions in Korea Involuntary detention is for a limited period only. The Mental Health Tribunal reviews the care and containment of a detained person and determines if involuntary detention and/or treatment continues.



[Figure 9]

Hospital stays are, on average, relatively brief in Australia (an average of about 2 weeks). As most psychiatrists are aware, full resolution of psychiatric illness often takes many months. Consequently, patients remain in hospital until they are deemed well enough for less restrictive means of looking after

them are available. Legal status may change over the course of the admission, such that many people who are initially detained as involuntary patients voluntarily agree to the admission at a later date.

Therefore, the emphasis of treatment in hospitals is mainly on biological therapies, such as initiation of medication or electroconvulsive therapy.

Public community health services are linked to public hospitals and can also be accessed by patients who have been discharged from private hospitals.

Services may include case management by a mental health case worker(these people have health training such as a nurse, psychologist, occupation therapist); provision of medication, psychological therapy, psychiatric review. Speciallised community services exist for the elderly and for children.

These community mental health centres are involved in managing the mental health care of people who are under involuntary treatment orders or who require follow up after an inpatient stay. People with psychiatric conditions can be assessed to determine if they require the services. In practice, people are triaged according to need. Consequently, patients with mental illnesses such as anxiety disorders are unlikely to be treated in a public community setting.

Fortunately, innovative remote services are available. These utilise manualised treatments delivered via the internet coupled with telephone consultations, usually with a psychologist.

Private psychiatric and psychological services are provided to people who are able to provide a co-payment. The Better Health Access Scheme pays a higher rebate and allows for between 6-10 sessions in a calendar year for private psychological or psychiatric treatment.

Some psychiatrists provide treatment via Skype or Facetime. “Telepsychiatry” is popular in rural and remote areas. Patients can receive a Medicare rebate that is higher than the usual rebate for face to face consultations. This is to encourage psychiatrists to provide services for rural and remote patients.

On-line treatments for anxiety and depression are becoming popular. These are funded through Medicare, a federal (as opposed to state) government funder for outpatient services. The federal government also funds treatment for a set number of sessions through the Better Mental Health subsidy.

Private fee paying arrangements are made between a private psychiatrist or psychologist and the patient, who can claim a portion from Medicare.

Ⅳ. Assessment of suitability for community treatment.

Public services are rationed due to the lack of resources. Consequently, access to community treatment by state government services is limited to patients who are thought to have the most need.

Most community mental health centres are run by the state governments and are linked to a local hospital.

Referrals are accepted from family or health providers through a telephone consultation. A nurse or mental health worker usually sees the patient for the first appointment, and people who are deemed to require treatment by a psychiatrist are booked into a clinic. Most people are seen by a trainee psychiatrist, with the trainee rotating through positions every 6 months to one year.

The level of supervision and care depends on the patients' requirements. A person with serious, chronic illness may be assigned a case manager who assists with accessing social supports, monitors the patient's mental state and assists with compliance with medication.

Patients who are not at significant risk to themselves or others are usually not able to access regular treatment as outpatients. An example would be someone with Generalised Anxiety Disorder. There are several Anxiety

Disorders Units, but waiting lists are long.

1. Emergency Treatment

A person with a suspected mental health emergency can access services through the emergency department of a public hospital (private hospitals do not, as a rule, have emergency departments) or by calling the community Mental Health Team attached to an Area Health Service (a local catchment affiliated with a state government hospital).

The mental health team is part of the community mental health service and comprises mental health workers who are able to assess patients 24 hours a day in the community, and if necessary, refer the person to a public hospital as a voluntary or an involuntary patient.

2. Involuntary detention of a person with a mental health condition

Under the NSW Mental Health Act, A person can be legally referred for an assessment conducted by a doctor at a mental health facility if they are:

i. Medical practitioner,
ii. An authorised mental health worker
iii. A police officer,
iv. Ambulance officer,
v. Magistrate or bail officer.

Referral Forms have time- limited validity. For example, a Referral form must be completed within 48 hours of a mental health assessment, and the referral lasts for 72 hours. Detention may occur if required during this period or the person can be transported for assessment.

A psychiatrist must examine the person, who can be detained for 24 hours for the examination.

If the doctor does not consider the person to be **mentally ill** or **mentally disordered**, then the person must be released.

If the doctor believes that the person IS either mentally ill or mentally disordered, but there are less restrictive alternatives to involuntary detention, the person must be released.

If the doctor believes that the person is mentally ill or mentally disordered AND requires detention, a second doctor (one of the two doctors must be a psychiatrist) reviews the person independently. If the second doctor disagrees, then a third doctor who must be a psychiatrist must examine the person.

The MHRT must be notified if a mentally ill or mentally disordered person who is detained.

3. What is meant by “Mentally Ill” or “Mentally Disordered”?

NSW Mental Health Act 2007 definition of Mental Illness

A condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

- (a) delusions,
- (b) hallucinations,
- (c) serious disorder of thought form,
- (d) a severe disturbance of mood,
- (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred

• to in paragraphs (a)-(d).

• Assessment of psychotic features such as delusions or hallucinations requires a knowledge of cultural contexts. For example, in some Australian Aboriginal communities it is normal to hear voices of a loved or be visited by their

spirit.

- In addition to mental illness, the person requires containment because they are at imminent risk of harm to themselves or others and less restrictive alternatives are not available.

Persons at risk of harm to themselves or others who do not meet criteria as a mentally ill person may meet criteria as *amentally disordered person*:

A person (whether or not the person is suffering from mental illness) is a **mentally disordered** person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

– (a) for the person's own protection from serious physical harm, or

– (b) for the protection of others from serious physical harm.

Note that the legal definitions of mental illness do not necessarily reflect the burden of the disease on a person's lifestyle or the family burden. For example, agoraphobia severely limits a person's ability to live independently and significantly impacts on the family, but severe agoraphobia is unlikely to fulfil criteria for involuntary detention.

What is the role of the family or carers?

Family, friends or carers may write to the Medical Superintendent of a Mental Health Facility or their delegate and request detention, but a medical assessment is still required.

Assessment of capacity with regard to involuntary treatment.

Capacity is task specific, and cannot be extrapolated from one task to another. It is not decided on the basis of diagnosis.

There are a hierarchy of decisions that can be made with respect to

treatment from simple decisions making (for example, to have a blood test) to complex ones (for instance to undergo difficult surgery).

- To understand the specific situation, relevant facts or basic information about choices
- To evaluate reasonable implications or consequences of making choices
- To use reasoned processes to weigh the risks and benefits of the choices
- To communicate relatively consistent or stable choices

The greater the decision to be made, the greater the cognitive capacity required.

Lets use an example:

John is 45 years old and is homeless. He has a diagnosis of chronic paranoid schizophrenia that started when he was 20 years old. He believes that people have put cameras in his house and are monitoring his every move. He hears voices telling him that the cameras are watching him. Consequently, he prefers to live on the streets where he can keep away from the people watching him. John does not want to take medication although his symptoms improve when he takes antipsychotic medication. He does not think he is ill. John is not suicidal and does not wish to harm other people. He just wants to be left alone.

Does John have capacity to refuse treatment?

Do we have grounds to treat him involuntarily?

There is no acute risk to John's safety or the safety of others. The least restrictive care would be treatment in the community.

4. Another example

Soo is 87 years old and has a diagnosis of dementia. Her doctor will not let her drive because of her cognitive impairment, and she requires assistance to

cook, to manage her medication and to shop. She can clean her house and still enjoys walking in the park. She has two children who work and no other family assistance. Her children would like Soo to move to a nursing home, but Soo does not want to because she loves talking to her neighbours, going for walks and because she has lived in the area for 30 years. She is aware that the nursing home is expensive, and does not want to pay the fees.

Basedonthisvignette,canherchildrendecidetomoveSootoanursinghome?

Soo is able to state her wishes

Nowadays, there is an emphasis on supported decision making.

1) Approach to assessing capacity to consent to mental health treatment

1. Is the person mentally ill in a clinical sense?
   That is, can a psychiatric diagnosis be made. Persons who look different or are outside of the norm in their speech or behaviour may not have a psychiatric diagnosis.
2. Does the person understand that they are unwell, that there is treatment available and the risks and benefits of the options available to them? Can they rationally explain their choices?
3. Does the psychiatric condition result in danger to the safety of the person or to others?
4. Are there alternatives to hospital?
5. Does the person meet the legal definition of a *mentally ill person or a mentally disordered person*?

2) What is risk of harm?

Does it just included physical harm to self and/or others, or can one also be a risk to reputation, finances, relationships, employment.

The concept of risk as a criterion for involuntary detention requires a

psychiatrist to predict that a future harm could befall a person. The validity of such prediction has been shown to be flawed[9], and a “best interests”test has been suggested.[10]

The psychiatrist has to balance the autonomy of the patient and the need to protect someone who does not have capacity to make adequate decisions for themselves.

Recent changes in the Mental Health Act in the state of NSW requires: that “every effort that is reasonably practicable should be made to ...”

Monitor the patient's capacity to consent

Obtain the patient's consent when developing their treatment plans and recovery plans for their care.

The states of Victoria and the Australian Capital Territory (ACT) also demand consideration of decision making capacity.

Queensland, South Australia, Tasmania and Western Australia prohibit involuntary psychiatric treatment to mentally ill people who are competent to refuse treatment.

The mental health review tribunal is the final arbiter in this case.

3) Involuntary Electroconvulsive Therapy

Australian psychiatrists have been at the forefront of developing safer ECT practices such as Ultra brief pulse stimulation ECT, which results in fewer cognitive side effects. Most patients undertake ECT as voluntary patients. That is, they are judged to be able to understand the risks and benefits of the procedure and elect to have the treatment.

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9) Large et al The validity and utility of risk assessment for inpatient suicide. Aus. Psych. 2011;19:507-512.

10) Callaghan S & Ryan C. Rising to the human rights challenge in compulsory treatment - new approaches to mental health law in Australia. ANZ J Psych 2012; 46:611-620.

Common indications for ECT are:

- Refractory Major Depressive Disorder (MDD),
- MDD associated with prominent melancholic features (early morning wakening, psychomotor slowing or agitation, diurnal mood variation).
- History of previous response.
- Patient preference.
- Parkinson's disease.

Some people with severe psychiatric illness do not have the capacity to make competent decisions regarding ECT. Such a decision is complex due to the need for a general anaesthetic and the possibility of cognitive impairment.

Indications for involuntary Electroconvulsive Therapy (ECT) include:

Catatonia,

NMS

Delirium

Risk of harm due to psychiatric illness – catatonia, extreme suicidality, anorexia.

Mania – severe

If a person is not capable of providing informed consent, the matter is decided by the MHRT.

4) Community Treatment Orders (CTO)

Community Treatment Orders are overseen by the Mental Health Review Tribunal. A person under a CTO must agree to comply with the terms of the CTO in accordance with the Mental Health Act.

Rates of CTO use range from 30.2 per 100,000 population in Tasmania to 98.8 per 100,000 in Victoria.[11] This is high by world standards.

The utility of CTOs is debatable. The OCTET trial, published in the Lancet

in 2013 showed that the rate of readmission of patients with psychosis was not reduced with community supervision.

Assessment for a CTO aims to decide if less restrictive care could be achieved in the community if the person was supervised to comply with a treatment plan.

The person is given a treatment plan, usually prepared by their case manager, and the MHRT or a magistrate determines if this is suitable.

In practise, most people who are considered for a CTO lack insight into their psychiatric condition or have other reasons why they lack the capacity to decide to continue treatment.

If the person does not comply with their treatment plan, the case manager and mental health facility try to ensure compliance. If this fails, and if the director of the mental health facility is concerned that there is a significant risk of deterioration, then the person will be informed that they will be taken to the mental health facility for treatment. The Director may effect a breach notice requiring that the person attend the hospital.

5) Rehabilitation

Recovery from a psychiatric illness can be prolonged, and is frequently complicated by the cognitive effects of mental illness. Rehabilitation in Australia integrates inpatient and outpatient services provided by state-funded health services with non-government organisations with the aim of improving specific life skills rather than having an emphasis on recovery from the symptoms of illness.

11) Light, E., Kerridge, I., Ryan, C., Robertson, M. (2012), Community treatment orders in Australia: rates and patterns of use. Australasian Psychiatry. 20(6), 478-482.

Each person has different goals that might include:

- Physical Health e.g. Weight loss.
- Activities of Daily Living (ADLs) - such as cooking, laundry.
- Employment or volunteer work.
- Social goals – participating in a certain number of activities a week, improving social skills.
- Transport – learn how to catch a bus or a train.

Rehabilitation services differ around Australia. A unit is likely to have a psychiatrist, psychologist, Occupational Therapists and Social Workers. Other health professionals may include physiotherapists or exercise physiologist. The aim is to integrate in to the community on a gradual basis, over about 3 or 4 months. Consequently, although the unit is in a hospital setting, patients are expected to very quickly manage their own cooking, shopping and to keep their rooms tidy. Skills are taught to enable independence, or people may shop/ cook in groups with supervision.

The type of patient who usually enters rehabilitation has a chronic psychiatric illness, such as schizophrenia, mood disorders or personality disorders. Substance use is often comorbid.

Referrals may also need to meet the needs of the family, for instance if there is family conflict or if the family are finding it difficult to care for the patient.

An important aspect of rehabilitation is initiating a habit of structure to the day. A timetable of group activities that patients are expected to attend provides this structure in addition to providing an opportunity to socialise.

Family are involved. They are usually very keen to bring patients in and then disengage, so set up the expectation of involvement early. Family may see SW or the psychiatrist/ psychologist.

Groups cover practical skills and psychotherapy. Other sessions in a

person's timetable cater to their individual needs. Examples of groups are:

- Mindfulness,
- Social skills,
- Psychoeducation sessions
- Exercise sessions several times a week.
- Activities - gardening, artwork.
- Life skills such as cooking, shopping Aim is to be independent in cooking within a few weeks of admission.
- Social exposure - outings to shops, on the bus. Saying hello at a coffee shop.
- Travel on public transport.

Most patients with chronic illness still require community support. In Australia, such support is provided by non-government organisations (NGOs). In order to ease the transition into the community, NGO support is engaged while the person is an inpatient.

Over the last month of admission, leave is increased and gradually includes overnight leave and leave for several days.

Any NGO's involved prior to referral must agree to remain involved during the admission. After discharge, the NGO will provide support to maintain the goals and work in conjunction with the community mental health team.

Some services have "Day Hospitals" that provide a structured rehabilitation program without inpatient admission. This is useful to effect transition into the community. Patients can start to attend day hospital programs while and inpatient, and continue to attend after they leave.

6) The future – supported decision making in psychiatry

Supported decision making is a collaborative process (Browning et al. 2014)

of decision-making between a person with impaired capacity and a supporter or supporters. The process involves knowledge building and shared learning that facilitates the choices and decisions of the person with impaired capacity (Peisah et al. *2013*). Supported decision-making is a process that enables some people to exercise their legal capacity and thus greater autonomy and self-determination.

An illustrative example is Ireland's Assisted Decision-Making (Capacity) Act 2015 which emphasizes will and preferences and outlines three levels of decision-making assistance: "decision-making assistant," "co-decision-maker" (joint decision-maker), and "decision-making representative" (substitute decision-maker).

5. Clinical Process of Supported Decision Making

Step 1. ASSESS the person's strengths and deficits, starting with an assessment of mental state and cognitive abilities, particularly assessing crucial skills such as executive function and awareness. Important executive functions relevant to decision-making include holding information in working memory, weighing alternatives and consequences, projecting, and planning. Additionally, memory, language, and communication functions are important and, if found to be lacking following assessment, can be buttressed (Zuscak et al. *2015*). Another important cognitive construct for capacity is awareness. As a more nuanced and inclusive concept than the traditional notion of insight, which tends to be categorical and exclusive, awareness is a more useful construct for supported decision-making. Importantly, awareness seems to lack the floor effects of insight and as such, is often present at severe ends of disability severity, providing it is identified. For example, Clare et al.(*2013*) demonstrated that even people with severe dementia show awareness, although this is influenced by the extent to which the environment provides opportunities for engagement and by the way in which care staff notice awareness and interact

with residents. In addition to preserved awareness, other strengths that need to be identified during assessment include carer support, including friends, family members, and professional carers. Knowing strengths and weaknesses helps to determine exactly how best to approach the next test, to simplify the task and maximize the ability to understand.

Step 2. SIMPLIFY the task. The best way to maximize participation is to limit the capacity task to the specific decision at hand and not to overstate the decision. This might mean obtaining choices and preferences about the part of decision that the person understands. For example, a person may merely understand they have a problem or a dysphoric (negative, unpleasant) experience for which they want relief. Alternatively, they may be able to articulate what makes them happy. A person who is not capable of understanding a full advance care directive may be capable of expressing a desire for care, pain relief, and comfort (i.e., participating in advance care planning), or where they want to have that care, rather than making a full advance care directive.

Step 3. KNOW the person. It is essential to ascertain the will and preferences of the person. This includes finding out what the person considers important and what their long-held values and decisions were. In particular, if there is a neurodegenerative condition such as dementia, it might be useful to cue past decisions (precedent autonomy) and check whether the person still affirms these values. Information about past trusts and allegiances might be evident in documents such as powers of attorney or wills. It is equally important to understand current preferences, understanding what is important and meaningful to the person in their life right now as it relates to the decision at hand (e.g., in an accommodation decision for residential care, the person may be more interested in food or family than accommodation). If possible respect the person's precedent autonomy, but also, where appropriate, "respect their right to change their mind when their mind has changed."

Reconciling differences between precedent and current choices may involve updating a person's self-concept. For example, a person may have previously written an advance care directive consistent with their former values and subsequently, in the face of dementia and their "new self," change their mind (Hertogh *2015*).

Step 4. MAXIMIZE the ability to understand by addressing and buttressing factors which hinder communication (Zuscak et al. *2015*). This might include giving more time, optimizing the environment, simplifying, and concretizing information and providing it in an accessible format. Visual aids should be tailored to the person's cognitive deficits including either written or visual information, with simple pictorial or linear representations of the choices to be made. People with expressive or receptive language deficits, confrontational naming, visual agnosia, dyslexia will all require different aids, and supported decision-making can be usefully assisted by a speech pathologist or neuropsychologist (Zuscak et al. *2015*). Provide interpreters where necessary or written cues in the person's language. Finally, it is respectful to elicit decisions when a person is at their best, when they are not delirious, when they are not sundowning, or when they are not in pain, drowsy, or fatigued. This might be first thing in the morning or after a treatment such as blood transfusion or dialysis.

Step 5. ENABLE participation in decision-making by using the assessment process outlined above to tailor the degree of support to the complexity and consequences of the decision. Assist and facilitate the communication and implementation of the decision.

Ⅴ. Conclusion

The medical world has moved away from paternalism to embrace

collaborative care with patients and families. This includes respecting the wishes of patients, even if the decision is different to one that the doctor might have wished.

Many countries around the world are using the Convention of Rights of Persons with Disabilities to inform the development or review of the Mental Health Acts. Australia and Korea are both moving away from enforced treatment based on a risk of harm to ascertain whether a person has capacity to decide on treatment, which is in line with other medical specialties that afford humans the right of autonomy over their own person.

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