Limits of the Power to Forcibly Medicate

Photo Credit: Mad in America

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Limits of the Power to Forcibly Medicate

Executive Summary

This paper examines the law enabling the forced medication of people declared to be mentally ill, looking at the cases where the limitation of that extreme power has been declared by the courts. In practice the Health industry uses the power lightly as it is an easy way to control "different" people. This approach is grossly disrespectful for the entitlement in a democracy to be different, and can cause very serious long term side effects for the individual. But it is difficult for management to resist as a way to establish effective control. It becomes a quick injection in a secluded space, using overpowering force against a vulnerable individual.

The case of 74 year old Kerry O'Malley illustrates how pernicious is this abuse of power. Her case was celebrated by the world leading website 'Mad in America' as starkly putting a real person able to speak for herself under the microscope. Meet her here.

Ms O'Malley was subjected to an order permitting her forced medication causing severe mental and physical side effects: increased anxiety, lack of motivation, poor concentration, weight gain, loss of hair and feeling degraded by her loss of autonomy.

She was accused of sitting in a chemist shop, confused, for six hours. No evidence was given of her being a risk of serious harm to herself or others. In fact, she has never hurt herself or anyone else. The Mental Health Review Tribunal rejected her proposed alternative plan, which incorporated medical and social intervention strategies to enhance Kerry's control over her own life. This was a rejection of the "recovery" approach in favour of the biomedical model of treatment.

She is one of 5,000 in NSW and 17,000 Australia-wide currently forcibly injected under a CTO.

She was refused legal or carer representation before the Tribunal and refused access to her file. As there is no provision for independent legal assistance for people in such situations, Ms O'Malley and her treating psychiatrist sought, and received, help from the self-funded NGO Justice Action. Finally the order was struck down in the NSW Supreme Court with costs against the Health Department. Despite the victory for her personally, the Court was denied the opportunity to establish the limits of the power to forcibly medicate citizens. This paper outlines a path for applying the law in a manner consistent with the basic human rights of those of us considered to be mentally ill and provides a basis for negotiation with Health authorities to bring compassion and evidence based medicine into their procedures.

The law provides sections 14 and 53 of the *Mental Health Act 2007* (NSW) and equivalent provisions in other jurisdictions, to permit forced injections of people through Community Treatment Orders (CTOs). However the Mental Health Review Tribunal, on the application of the Health Department, must be satisfied that certain criteria are met. The actual meaning of the terms used are not clearly established in legislation. Questions as to who is "mentally ill", what is "serious harm", what are "reasonable grounds" for belief in "necessary " treatment and alternative approaches to personal problems are ill-defined in law and inconsistently addressed in practice. Previous legal challenges have interpreted the law carefully, but lack of access to legal assistance and the vulnerability of consumers have created an entrenched culture of abuse among Medical professionals and Health authorities.

This paper methodically examines the powers of Health authorities to ensure that no one is put in the position of Kerry O'Malley again. The misleading NSW Chief Psychiatrist's Communique of 2014 (Appendix 2 p.33) giving direction to clinicians to apply a broad concept of serious harms must be struck down. The Courts have restricted the use of CTO's and the powers of the Health Department to forcibly medicate. They have imposed very restrictive threshold requirements before an order for such a medical assault on a person can be lawfully made.

The interpretation of the forced medication law can be broken into four areas which are discussed in this paper. They are the questions;

1. *Is the individual a 'mentally ill' person?* The right to identify oneself as uniquely different is a protected democratic right. To pathologize and impose on someone a psychiatric illness diagnosis solely on the basis of an external perspective infringes on this right.
2. *What is 'serious harm'?* The Courts accept life threatening behaviour, physical and sexual assault as being such harm. Causing disturbance or discomfort is insufficient.
3. *Are there reasonable grounds for believing coercive treatment is both necessary and beneficial?* When using the word 'necessary,' the law says that evidence is required that treatment is needed otherwise the serious harm would occur.
4. *Are there any alternative less restrictive measures to forced medication?* The Tribunal must be satisfied that no available options are available. The freedom of the person to not be restricted, acknowledges the need for authorities to work with the person to achieve safety, rather than confronting and causing them to feel reduced or damaged. Consideration and development of all alternatives including working with carers and consumer workers must be dismissed before making an order for forced injections.

Victorian mental law is considered in each area, with the influence of the Charter of Human Rights and Responsibilities Act 2006 (Vic), indicating the existence of a national problem and direction for change.

Recommendations

1) Health authorities must respect the right of citizens to retain autonomy and responsibility for their own lives. The uniqueness of each person must be acknowledged and respected, empowering them to navigate their own recovery with support when necessary.
2) The NSW Chief Psychiatrist's Communique of 2014 should be withdrawn and replaced with a new Communique encompassing clear definitions of 'serious' harm, 'reasonable grounds' and 'necessary' as explicated in sections 2 and 3 of this report. It should include a dynamic list of alternatives to forced treatment, with links to providers.
3) Community Treatment Orders should only be issued as a last resort. Funded legal assistance should be available to those wishing to appeal against the order. All efforts must be made to work with the person to achieve safety, rather than confronting and causing them to feel reduced or damaged. Consideration and development of alternatives, including working with carers and consumer workers to develop a tailored strategy, must be dismissed before making an order permitting the medical assault by forced injection.

Part 1: Defining a 'Mentally Ill' Person Under the Act

Commentary

Defining a mentally ill person requires an examination of what it means to be 'ill', questioning the fine line between human eccentricities and mental illness, which has historically been blurred. Cultural meanings serve as a necessary element in psychological diagnosis as characteristics socially defined as problematic can qualify as mental disorders.[1] The effects of the stigmatization of individual idiosyncrasies have been historically evidenced in regards to homosexuality and autism. The right to identify oneself uniquely is a protected democratic right, and to pathologize and impose on someone a psychiatric illness solely on the basis of external perspective can infringe on this right.

The courts recognise the difficult task of the mental health system to reconcile individual rights to personal freedom alongside the need to treat individuals who are unable and/or unwilling to take care of themselves.[2] However there is no uniform accepted legal definition for 'mental illness' under Australian law.[3]

The Definition in the Mental Health Act

In New South Wales, the *Mental Health Act* (the *'Act*'), applies to persons who have a 'mental illness' or a 'mental disorder'.[4] In order for the NSW Department of Health or Mental Health Review Tribunal to intervene in an individual's life and potentially subject them to medication,

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[1] Wakefield, J., 1992. The Concept of Mental Disorder: On the Boundary between Biological Facts and Social Values. *American Psychologist*, 47(3), 384.
[2] *Harry v The Mental Health Review Tribunal* (1994) 33 NSWLR 315, 333.
[3] LexisNexis, *Halsbury's Law of Australia* (online at 9 October 2020) 285 Mental Health and Intellectual Disability, '2 Care and Treatment of Patients' [285-350].
[4] *Mental Health Act 2007* (NSW) s 14 ('*MHA*').

they must be satisfied that a person is 'mentally ill' or 'mentally disordered' within the definition of the *Act*.[5]

A person is a 'mentally ill person' if they are 'suffering from mental illness' and 'there are reasonable grounds to believe that treatment, care or control is necessary to protect the person or others from serious harm'.[6] The continuing state of the person, including any likely deterioration in their condition and effects, must be considered.[7]

For a person to be 'mentally ill', the *Act* requires the person to be 'suffering from a mental illness'.[8] It refers to a condition that seriously impairs, either temporarily or permanently, the functioning of a person and, is characterised by one or more of the following symptoms:

- Delusions
- Hallucinations
- Serious disorder of thought from, a severe disturbance of mood
- Sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms above.[9]

There are no definitions for the above symptoms set out in legislation.

The New South Wales mental health legislation also extends to persons who have a 'mental disorder'.[10] The person may or may not be also suffering from a mental illness. A person is deemed a 'mentally disordered person' 'if their behaviour at the time is so irrational that it

[5] *MHA* (n 4) s 53(4).
[6] Ibid s 14(1).
[7] Ibid s 14(2).
[8] Ibid s 9.
[9] Ibid s 4.
[10] Ibid s 15.

justifies a conclusion on reasonable grounds that temporary care, treatment or control is necessary'.[11]

Common law and tribunal decisions show there is no *'test'* to determine whether a person has a mental illness and/or disorder. The Health Authority and Mental Health Review Tribunal make an assessment based on the balance of probabilities to their mental fitness and possible illness. Reliance is placed upon evidence provided by medical experts, case history notes as well as medical and hospital records.[12]

As an example, in the matter of *Sullivan [2019]*, the Tribunal permitted an order for forced medication after they were satisfied about the existence of mental illness and risk of serious harm.[13] A psychologist gave evidence with their concerns regarding the patient's physical and mental health after assessing her.[14]

Nonetheless, the case law indicates that a mental illness or disorder is to be distinguished from a mental impairment, which does not fit within the scope and operation of the *Act*. A mental impairment or problem is characterised as a temporary response to a life situation, which is not regarded as posing a severe risk to individuals and the community.[15] Unlike a mental illness, mental impairments are generally less severe and sporadic in nature.

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[11] *MHA* (n 4) s 15.
[12] See *DAW v Medical Superintendent of Rozelle Hospital* (unreported, SC(NSW), Hodgson J, No 20629 of 1996, 14 February 1996).
[13] *Sullivan* [2019] NSW MHRT 3.
[14] Ibid.
[15] 'What is Mental Illness', *The Department of Health* (Web Page, May 2007) <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-what>.

Standardisation of Diagnostic Criteria

Mental health practitioners use standardised criteria in the realm of psychology and psychiatry to determine whether an individual is experiencing one or multiple symptoms, and whether a diagnosis of mental illness is warranted.[16] Such categorical assessment of symptoms may pathologise an individual's lived experience with mental illness and create arbitrary distinctions for who is classified as mentally ill and the subsequent restrictions they are subjected to.

As a result, the Act fails to consider individual circumstances and needs such as whether the individual believes their symptoms are causing a significant amount of distress or impairment.

However, section 14 does establish a two stage test for determining whether a person should be classified as *mentally ill.*The first criteria looks for the presence of behaviour that indicates a mental illness as per the Act's definition, and the second pertains to the person's behaviour and condition. Specifically, the Court has to consider whether there are "reasonable grounds for believing that care, treatment or control is necessary for:

(a) the person's own protection from serious harm or
(b) the protection of others from serious harm".[17]

The section further enables courts to consider the 'continuing condition' of the person, enabling the examination of past behaviour and any likely deterioration in the persons mental health.

The process of defining an individual as mentally ill is complicated and is defined by a number of administrative and psychiatric reports that the mental health consumer doesn't understand or doesn't want. These are further investigated below.

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[16] See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Publishing, 5th ed, 2013).
[17] *MHA* (n 4) Schedule 1.

Mental State Evaluation Report

As an objective assessment, a mental state evaluation report provides professionals with a useful administrative tool to examine the mental health of the patients. Often these reports are used to provide medical professionals with a framework to structure their initial impressions of a patient. Importantly, these reports all contribute to the final evaluation of the patient and the decision of whether or not the person is *mentally ill* as per the Mental Health Act.

Mental State Evaluation Reports ('MSE') are used to assess the mental state of the person at the time of examination.[18] Because it is not a formal diagnosis, and often takes into consideration factors such as appearance, behaviour, speech and whether they are experiencing hallucinations and other aspects such as their attention or memory, it cannot be used as decisive evidence to form 'reasonable grounds'.[19] This evaluation contains inherently subjective aspects such as making observations about a person's behaviour, demeanour, attitude and speech. Therefore, conflicts of interest may arise when a skilled medical professional working under the Department of Health conducts the assessment as opposed to a neutral third party.

Objectivity is pivotal in considering the definition of mentally ill persons in section 14 of the *Act*. Mental Health Tribunals are dependent on the assessment of skilled medical professionals to determine the most appropriate form of treatment a mentally ill person will receive. As such, it is vital for the Tribunal to consider the rights of the individual and knowledge of their own health.

Mental Health Outcome Assessment Tool (MH-OAT)

The Mental Health Outcome Assessment Tool is used by a state-wide record keeping programme to facilitate and document clinical interactions between consumers and carers. It is designed to support the recording, retrieval and sharing of clinical information. Such is vital in assisting

[18] 'Mental state examination', *The Royal Children's Hospital Melbourne*, (Web Page, November 2018) <https://www.rch.org.au/clinicalguide/guideline_index/Mental_state_examination/>.
[19] Voss RM, M Das J,. Mental Status Examination in *Treasure Island* (StatPPearls Publishing, 2020).

service and health departments in acquiring background information regarding a patient in order to evaluate the condition of the patient based on their record. However, MH-OAT has not yet been admitted as the assessment of 'mental illness' for the purpose of section 14. It is worthwhile to take the tools into consideration for the application of the provision and for the restriction of the power to issue a CTO.

Alternate Approaches

As discussed above the current approach to mental illness is failing society's most vulnerable and is defined by complex assessments that disenfranchise the very people that they are trying to help. Therefore, there is a need to investigate alternatives that can better assist those in need and actually address their concerns within the system. The next section of the paper focuses on the manner in which criminal law approaches mental illness and contrasts this with alternative approaches used in Victoria.

Mental Illness or Mental Disorder - Criminal Matters

The threshold requirement for the defence of 'mental illness' under the criminal realm is interpreted in common law. A person who committed a crime would not be convicted if they did not understand the nature and quality of their act due to their mental illness.[20] The defence of mental illness can be established if the court is satisfied, on the balance of probabilities, that the defendant was 'labouring under a defect of reason, owing to a disease of the mind', and the defect of reason caused the defendant to either 'not know the nature and quality' of the action, or to 'not know its wrongness'.[21] It is a stricter test compared to the one used in section 14 the *Mental Health Act.*

It is also pertinent to note that the existence of a mental illness on its own is not sufficient to constitute a defence to criminal liability on the basis of mental illness. The case of *Davey*

[20] *R v M'Naughten* (1843) 8 ER 718; *R v S* [1979] 2 NSWLR 1.
[21] Ibid.

highlighted the requirement for mental impairment to be established at the time of the offence in order to reduce moral culpability.[22]

To establish the criminal defence, medical records and expert opinion can be admitted to the court of hearing.[23] For example, in *Briggs*, written and oral psychiatric evidence was relied upon by the Court, and supported a finding that the accused was 'mentally ill' at the time of committing the offence.[24] It is an indication that expert opinions play a vital role in the cases which require an assessment of mental health for legal purposes. To this effect, the use of experts should be consistent with all decisions surrounding mental fitness and should not be different for administrative decision-makers imposing CTOs to persons like Kerry O'Malley.

Mental Illness as Defined in Victoria

The *Mental Health Act 2014 (Vic)* more extensively defines individuals who could be considered as mentally ill. Specifically, it states that it is a 'mental condition that is characterised by a significant disturbance of thought, mood, perception or memory.' A mental health assessment is used to establish an appropriate treatment to a patient's condition. Notably, in section 11, there is a clear and concise explanation on the purpose and object of the act, placing significant burdens on the protection of bodily autonomy and use of voluntary treatment.[25] The Act permits an examination to 'determine whether the treatment criteria apply to the person',[26] rather than impose forced medications in an unnecessary circumstance where a 'mentally ill person' is not actually in need of such medication.

The notion of 'mental health evaluation' is currently excluded from the *Mental Health Act 2007* (NSW).[27] The application of this legal solution is integral and should be further considered as a reasonable alternative in reducing the impact of, and mitigating the grounds to, forced

[22] *R v Davey* [2006] VSC 173.
[23] *Evidence Act 1995* (NSW) s 76.
[24] Ibid.
[25] *Mental Health Act 2014* (Vic), s 11(a)-(e) ("*MHA (Vic)*")
[26] Ibid s 28.
[27] *MHA* (n 4).

medication. The process of the evaluation and the decision-making for CTOs can also be found in the *Mental Health Act* of Victoria. The Victoria Legal Aid has provided a good summary of the relevant provisions on their website.[28]

Compared to the NSW law, Victorian legislation provides clear guidelines and definitions which appropriately cater to the rights of both voluntary and involuntary patients. The Victorian model is substantially more proactive and clearly defined in common law, which serves as a significant policy example. Such reform is necessary in NSW to create a working guideline for policy creators and decision makers that would rely on the *Mental Health Act* to issue a CTO. When pursuing tangible reform to clarify definitions and guidelines, acknowledging the nuance and subjectivity in the diagnosis of mental illness is pivotal to not only aid individuals suffering from illness, but to promote a pluralistic society in which expression is encouraged and equality in treatment is ensured.

[28] 'Assessment and treatment orders', *Victoria Legal Aid* (Web Page, 5 August 2016).

Part 2: Serious Harm

An individual is classed as a mentally ill person if said person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary;

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

(b) for the protection of *others* from **serious harm**.[29]

Commentary

A key question arises as to what constitutes serious harm under the *Mental Health Act,* which provides a vague guideline around measuring whether an individual presents a risk of 'serious harm'.[30] Where this threshold is met, intervention is allowed under statute to ensure the person's own protection, or the protection of others.

Definition of 'serious harm'

The term 'serious harm' is not defined in the Act. As such, its meaning and scope must be determined by reference to extrinsic materials.[31] The Macquarie Dictionary provides a definition for seriousness, describing it as 'grave', 'critical' and 'giving cause for apprehension'.[32] The Cambridge Dictionary also provides a definition for seriousness, describing it as 'extreme' and 'severe'.[33] This places a high threshold that must be reached for the particular harm.

[29] Ibid s 14.
[30] Ibid.
[31] Interpretation Act 1987 s 34.
[32] *Macquarie Dictionary* (8th ed, 2020) 'Serious'.
[33] *Cambridge Dictionary*, (4th ed, 2013) 'Serious'.

Examination of 'serious harm' in Case Law

The threshold of serious harm is considered to be met when an individual is at risk of death.
In the matter of *Sullivan*, the Mental Health Tribunal discussed the meaning of serious harm to oneself.[34] The individual concerned had a diagnosed mental illness, as understood under the *Act*. Evidence was given that they were refusing food despite suffering severe malnutrition. The Tribunal granted an order for forced medication on the basis that the patient required 'treatment and care and control for her own protection' and that there 'was no other less restrictive alternative'.[35] This suggests that a 'serious' harm threshold has been met when an individual presents a life-threatening risk to their own health.

In the matter of *Powers*, the Mental Health Review Tribunal discussed the meaning of serious harm to others.[36] Significant evidence was presented that there was an existing risk of violence, in the form of physical and sexual assault, towards others in the community as a 'significant link between Mr Powers' psychotic experiences and his past acts of physical and sexual violence' existed and this constituted serious harm. As such, this indicates that serious harm includes physical harm that may lead to bodily harm of others.

Conversely, in the matter of *Murray*, the Tribunal concluded that the individual did not pose any risk of serious harm to others and the restrictions placed on him could be decreased, as the risk to public safety or violence was mitigated following his treatment.[37] Therefore the Tribunal was satisfied that any risks arising from Mr Murray's behaviour could not constitute serious harm as there was 'no greater public danger than that generated by ordinary members of the community'.

[34] *Sullivan* [2019] NSW MHRT 3.
[35] Ibid.
[36] *Powers* [2018] MHRT 5.
[37] *Murray* [2018] MHRT 1.

In the case of *Re J (No 2)*, the court held that serious harm does include serious financial harm where the individual is incapable of managing their own affairs.[38] The meaning of serious harm goes beyond a mere carelessness for one's finances.

Similarly, the case of *Kereopa* discusses the meaning of 'serious harm' under the criminal law.[39] The court found that it requires an objective assessment of the harm. For physical harm, the court considered that harm need not be grievous but must go beyond mere threats of bodily harm.[40]

Finally, in the case of *Kapeen*, the Supreme Court of NSW considered 'serious' harm to others.[41] They found the risk of possible sexual violence against children constituted serious harm.

All of these case law examples indicate that there is a high threshold for serious harm, one that goes beyond an act or conduct that could cause disturbance or discomfort to individuals or the community.

Discussions of 'serious harm' in Other Areas of Law

The term 'serious harm' is treated similarly in other areas of law. For example, in *NBLC*, a migration case that turned to interpretation of 'serious harm', the Court stated that it includes:

- "A threat to the person's life or liberty"
- Significant physical harassment of the person
- Significant physical ill-treatment of the person
- Significant economic hardship that threatens the person's capacity to subsist."[42]

[38] *Re J (No 2)* [2011] NSWSC 1224 at [95].
[39] *Attorney-General (NSW) v Kereopa (No 2)* [2017] NSWSC 928.
[40] Ibid, 16.
[41] *Attorney General for New South Wales v Kapeen* [2017] NSWSC 685 at [49].
[42] *NBLC v Minister for Immigration & Multicultural & Indigenous Affairs* [2005] FCAFC 272 at [56].

Current Statement of NSW Health Policy

The 2014 Communique from the NSW Chief Psychiatrist, as outlined in Appendix 1, provides that, whilst serious harm is not defined in the Act, it is intended to be a broad concept. Whilst this provides a list of situations from which harm may arise, it does not elucidate what the threshold to meet 'serious' harm is nor does it provide a quantifiable means to measure the 'seriousness' of harm. The Communique includes physical harm, emotional/psychological harm, financial harm, self-harm, suicide, violence and aggression, including sexual assault or abuse, stalking or predatory intent, harm to reputation or relationships, neglect of self, neglect of others (including children).[43] Given the lack of definition of 'serious' harm, the term has been applied too liberally by those in charge of administering mental health care in New South Wales and is ultimately misleading. [44]

The *Mental Health Act* should always be construed to balance the freedom and importance of the individual liberty with individual and community safety.[45] This is particularly important given the inherent vulnerability of persons affected with mental illness. The legislation and cases clearly establish that the threshold of serious harm is high and this should be reflected in the Health Department's policy. Given that a risk of serious harm is often used to justify the imposition of a CTO, it is important that the legislation is only relied upon to impose CTO's when this threshold is met. Given the ambiguous nature of the definitions outlined in the *Mental Health Act* the potential for mistreatment and unjust intervention is increased, to the extent that individuals can have a CTO imposed on them despite a lack of significant illness or serious risk.

[43] NSW Chief Psychiatrist, *Amendments to the NSW Health Act (2007) Fact Sheet: Community Medical Practitioners* (Communique, 2014).
[44] Ibid.
[45] *Attorney General NSW v Doolan by his tutor Jennifer Thompson (No 2)* [2016] NSWSC 107 at [121].

Definition of 'serious harm' in Victoria

The Mental Health Act 2014 (VIC) (see Appendix 2) has an extensive outline defining those who could be considered to be mentally ill. They also have had greater common law understanding of what actions or issues comprise the issue of serious harm. In *WCH v Mental Health Tribunal*,[46] "[t]he word 'serious' has been described as having a meaning which includes 'important, demanding consideration and not slight or negligible'.[47] The Macquarie Dictionary defines 'serious', in the context of an illness as 'giving cause for apprehension; critical'.[48] The word 'harm' has been defined as including 'hurt, injury or damage".[49] In the matter of *JMN*,[50] the Victorian Mental Health Tribunal held that it is necessary to assess both the seriousness of an action and the nature of the harm in light of "an individual patient's life and circumstances".

In comparing the Victorian legislation with the NSW counterpart, it is clear that the meaning of 'serious' is more clearly established in common law. It also emphasises closer attention to individual circumstances. However, this idea is not one that has only arisen in Victoria. The Victorian matter of *ZIF*[51]establishes a definition of serious harm that closely aligns with the comments made by the NSW Chief Psychiatrist in 2014. The facts of this case concerned whether the patient posed a serious harm to herself. The Tribunal in this case stated that, "*serious harm* is most appropriately defined as encompassing physical or psychological injury, whether temporary or permanent, that endangers, or is, or is likely to be, very considerable and longstanding. It can be interpreted as extending to broader contexts of harm, such as social, financial and reputational". They go further to establish that a mere vulnerability of potentially detrimental social or financial circumstances is not enough to satisfy the requirements set out in section 5(b)(ii) of the Mental Health Act 2014 (VIC).

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[46] *WCH v Mental Health Tribunal (Human Rights) (Amended)* [2016] VCAT 199.
[47] Ibid at [65].
[48] *Macquarie Dictionary* (online at 9 October 2020) 'serious'.
[49] Ibid 'harm'.
[50] *JMN* [2015] VMHT 29 (9 February 2015).
[51] *ZIF* [2015] VMHT 132 (12 August 2015).

Furthermore, in considering the legislation from Victoria and NSW, there is a significant point to be made about the use of the phrase 'serious harm' in mental health legislation. Maylea and Hirsch state clearly that often the correlation between an individual suffering from mental health and violence is 'overblown'[52]. In relation to suggesting repeals to the Victorian legislation, Maylea and Hirsch outline that whilst there is a longstanding political paradigm that focuses on the protection of the community, there should be an evaluation of those few who are mentally ill and a potential risk to the community and these individuals should be treated in a manner that delinks their mental health and their actions[53].

[52] Chris Maylea, Asher Hirsch, 'The right to refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of Persons with Disabilities' (2017) 42(2) *Alternative Law Journal* 149, 152
[53] Ibid.

Part 3: Reasonable Grounds for Believing Treatment is Necessary

Commentary

The third consideration under section 14(1) of the *Mental Health Act* is the standard of proof for initiating treatment, regarding whether or not there are 'reasonable grounds' for believing treatment is 'necessary'.[54] This means that the Mental Health Review Tribunal must be satisfied that there are reasonable grounds to believe that serious harm will arise as a result of mental illness. However the specific phrasing has resulted in ambiguity surrounding the implementation of this *Act,*[55] as the precise meaning of the words remains unclear.

Definitions of 'reasonable grounds' and 'necessary'

To gain a clear understanding of section 14, it is crucial that 'reasonable grounds' and 'necessary' are defined. As these key terms are not defined by the *Mental Health Act* itself, extrinsic and secondary sources are required to interpret their meaning.

The Cambridge Dictionary defines 'reasonable' as a decision that is 'based on or using good judgment and therefore fair and practical.'[56] As such, the decision that care, treatment or control of a person is necessary must simultaneously be based on good judgment and be both fair and practical. Additionally, 'necessary' is defined as something 'needed in order to achieve a particular result.'[57] Hence, under section 14 of the *Mental Health Act,* when using the word 'necessary,' it is implied that care, treatment or control of the person is **needed** to protect an individual from harming oneself and others, otherwise the serious harm would occur. Therefore,

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[54] *MHA* (n 4) s 14.
[55] Ibid.
[56] *Cambridge Dictionary* (online at 2 October 2020) 'reasonable'.
[57] Ibid 'necessary'.

in the context of CTOs, if the Tribunal is considering granting a CTO, they must be satisfied that there is no other care of a less restrictive kind and that is appropriate and reasonably available.[58]

Clarification for 'reasonable grounds' and 'necessary' definitions

The cases of *Talovic,*[59] and *Sullivan,*[60] examine how the courts interpret both phrases of 'reasonable grounds' and 'necessary.' While *Sullivan* found that a CTO was 'necessary' because of the life threatening state of the patient with no other less restrictive measures,[61] *Talovic* exemplified an instance where 'reasonable grounds' were not met.[62]

In the case of *Sullivan,*[63] 'necessary' and 'reasonable grounds' to forcibly medicate individuals were elaborated on and clarified. The Mental Health Review Tribunal deemed it was 'necessary' for Ms Sullivan to be forcibly medicated as both her eating disorders seriously impaired her mental functioning which consequently put her at imminent risk of death. As such, this meant that a CTO was needed to forcibly medicate her to save her from a life-threatening state and there were no other less restrictive alternatives. This belief of necessity in regards to Ms Sullivan's forcible medication was made on the basis of 'reasonable grounds'. This was established as her severe eating disorder diagnoses amounted to a 'poor nutritional intake' which placed her at serious risk to herself.[64] Furthermore, Ms Sullivan was not receptive to educational programmes and treatments and she would remove her feeding tube which placed her at risk of death. Therefore, forcibly medicating her was based on a fair and practical judgement of Ms Sullivan's situation. Hence, *Sullivan* demonstrates the standard ascribed to the term 'necessary', whereby any decision made needs to have reasonable grounds that that is the only way to save an individual's life.

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[58] *MHA* (n 4) s 53(3a).
[59] *Talovic* (2014) 87 NSWLR 512 ('*Talovic*').
[60] *Sullivan* [2019] NSWMHRT 3 ('*Sullivan*').
[61] Ibid (n 61).
[62] *Talovic* (n 60).
[63] *Sullivan* (n 61).
[64] Ibid.

The case of *Talovic* is also valuable in examining the court's interpretation of 'reasonable grounds'. The case dealt with Mr Talovic who complained to his insurer that the late workers compensation payment was 'sending people on the streets and letting them die', which the insurer interpreted as a threat to kill himself. The police who were contacted searched his apartment, took him into custody, and was consequently taken to the hospital for a mental examination from which he was allowed to return home. Mr. Talovic argued that this constituted unlawful imprisonment and trespass to land. Although this case referred to section 22 which dealt with detention by apprehension by police, it further defined what constitutes 'reasonable grounds' in reference to whether the police were justified in their actions. The court in *Talovic* determined that reasonable grounds are judged objectively and requires the existence of facts which are sufficient to induce that state of mind in a reasonable person.

This meant that it was not for the police officer himself to express an opinion as to whether he himself had reasonable grounds for his own belief. Rather, the question was whether a reasonable man, in the position of the police officer, would have held such a belief, having regard to the information which was in the police officer's mind,[65] and the circumstances.[66]

The court found that it was not sufficient that the officer believes that it is probable that the relevant person may, might, or could attempt to kill themselves. Rather, the threshold was much higher with the court stating that the belief must be that he or she will attempt to kill themselves. This means that the officer in the case acted without 'reasonable grounds'.

Talovic illustrates how an incorrect judgment can easily be formed by police officers, who are not generally mental health experts, which in this case resulted in the 'wrongful or unlawful arrest' of Mr Talovic.[67] Similarly, decisions made by tribunals and courts on behalf of mentally ill patients under section 14 may also be susceptible to such mistakes. So long as the assessment of 'reasonable grounds' and 'necessity' remain untailored to the needs of the mentally ill, and

[65] Ibid, [184].
[66] Ibid, [191].
[67] Ibid, [160].

continue to be made on inadequate information, such mistakes can continue under section 14, which would be detrimental to the people affected.

It is important to acknowledge that *Talovic* focused on section 22 of the *Mental Health Act*, as opposed to section 14, which is the primary focus of this report. Nevertheless, there is a strong connection between sections 22 and 14, due to the fact that both sections make references to 'belief' and 'reasonable grounds,' as well as dealing with persons whom others have to judge as being capable of serious harm.

Part 4: The Alternatives to Forced Medication

Commentary

Forcibly medicating mental health consumers against their expressed wishes under the term Community Treatment Orders (CTO) amounts to a severe violation of their personal autonomy and privacy. Under section 53 of the *Mental Health Act 2007* (NSW), a CTO may only be administered against the expressed desires of the person themselves if 'the affected person has previously rejected appropriate treatment which ultimately could have resulted in amelioration or recovery from the mental illness symptoms.'[68] The *Act* further states that the Tribunal may only make a CTO for an affected person if it is determined that 'no other care of a less restrictive nature, consistent with safe and effective care, is reasonably available and appropriate to the affected person.'[69] It is also a requirement that the affected person would benefit from the order.

The Tribunal is obligated to work with the consumer rather than impose medications with possible severe side effects. However, the use of CTOs today have been proven to be inefficient and undermines their intended purposes.[70] They are an invasive treatment that go against the wishes of an individual, and can cause additional trauma and fear.[71] This in turn may exacerbate negative symptoms amongst mental health consumers. There is also limited evidence to support the benefits and effectiveness of mandatory community treatment orders. Multiple studies, confirmed by meta-analytic evidence, have shown that CTO's do not achieve their stated goals.[72] In fact, there is little evidence they improve a patient's mental health outcomes and overall social functioning. A study conducted by the University of Queensland found that it would take 85 CTOs to prevent one readmission and 238 to prevent one arrest.[73]

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[68] *MHA* (n 4) s 53.
[69] Ibid.
[70] 'Community Treatment Orders' (Research Paper, Justice Action, March 2014) 1, 7-11.
[71] Ibid 7-8.
[72] Ibid.
[73] SR Kisely, LA Campbell, NJ Preston, 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders' [2011] (2) *Cochrane Database of Systematic Reviews* 1, 1-44

It is essential to create alternative ways to support mental health consumers. CTO's have been shown to be ineffective and may further traumatise mental health consumers. As a result, it is essential that better solutions are focused on. In the following sections, we outline several measures that are preferable to CTO's, given their focus on collaboration and working with patients.

Least Restrictive Alternatives / Principle of Individual Liberty

Before imposing a CTO, the Tribunal must consider whether it is the 'least restrictive method'.[74] As CTOs are imposed against a person's will, it should be an option of last resort. A CTO should only be imposed after careful deliberation, informed by excellent professional opinion, and with an approach that actively includes the mentally ill individual in the decision.

In *Re J (No 2)*,[75] the matter related to the *Mental Health (Forensic Provisions) Act*, and whether a forensic patient should be forcibly hospitalised and detained under section 14. The Commission noted that any decision to involuntarily detain someone should be made in consideration of an individual's right to liberty.[76] They determined the question was not whether the plaintiff ought to be hospitalised due to mental illness, but whether it was necessary to protect them from serious harm.[77]

The next consideration that the Court made was whether there were **'**less restrictive measures**'** under which the patient could be treated. There are multiple considerations to take into account when determining this, including whether the patient requires medical or psychiatric care for the treatment of their mental illness and the consequences of each option.[78] In this particular decision, the Court decided that the CTO was the best and 'least restrictive option', given the

[74] *MHA* (n 4) 53(3)(a).
[75] *Re J (No 2)* [2011] NSWSC 1224.
[76] Ibid.
[77] Ibid [62].
[78] *Re J (No 2)* [2011] NSWSC 1224.

individual's chronic condition and risks of non-compliance. The decision was reached as the alternative was forced hospitalisation (i.e. individual is permanently bound to the hospital). In short, CTO was actually deemed to be the least restrictive option. Bearing in mind this matter related to a known offender who was already under the care of the criminal justice system. This can be distinguished from instances where a CTO is sought against in ordinary private citizens who are merely deemed 'mentally ill' under the *Mental Health Act.*

When imposing a CTO on a patient, it must be reasonably necessary to protect the patient from serious harm, and the least restrictive form of treatment. Accordingly, we propose some preferable and alternative treatments to CTO's which achieve better health outcomes for all mental health consumers.

Alternative Treatments

Option 1: Employ Consumer Workers

Another alternative to CTOs are the use of Consumer Workers in patient treatment programs. Consumer workers are people with 'lived experiences' and can identify with the 'person in question', that being the mentally ill person. This means that they themselves have or have had a mental illness, which allows them to empathise with the 'person in question'. This can be very beneficial to the person, since the consumer worker would be able to assist the mentally ill person by providing support with an intimate understanding of what they are facing, not just the difficulties of the illness itself but also the social stigma that comes with it.

Option 2: Use of Advance Directives

Additionally, Advance Directive is a useful tool. It allows a patient to play an active part in their own treatment, when they become incapable of making decisions for themselves. Advance Directive is a written document describing what someone wants to happen to them, when they find themselves in these vulnerable circumstances.It usually refers to medical treatment and care and stipulates where they want to be cared for, by whom and what treatments they consent to. An advance directive may also express the person's wishes about any aspect of their life or affairs.

Existing uses for advance directives mainly involve situations near the end of a person's life,[79] for use as a 'living will', but they are now increasingly used in mental health to enable patients to provide input, namely their preferences, into their own care for when they may have an acute episode.

This means that physicians have a means of respecting the patient's prior wishes, that were made when the patient was competent of making decisions.Three main forms of advance directive exist: the instructional directive, the proxy directive and the hybrid directive, which combines the advantages of the former two.

Instructional directives directly communicate instructions to the treatment providers in the event of a mental health crisis, and could contain decisions about hospitalisation, methods for handling emergencies, and people to be given responsibility for caring for children and financial matters.

Proxy directives are health care power of attorney documents, which are legal documents allowing the patient to designate someone else to make decisions on their behalf if they become incompetent.

Proxy directives are used more frequently than instructional directives, as the proxy can consider the actual circumstances of the patient's situation once they become incompetent. This effectively substitutes the patient's judgment, rather than requiring the patient to anticipate specific, future events for giving suitable instructions.

[79] 'Advance Directives' (Policy Statement No 3, Lived Experience Australia, June 2010) 1

Hybrid directives name an individual who is authorised to make treatment decisions on behalf of the patient while also providing instructions to that person. This combines the specificity of the instructional directive with the flexibility of the proxy directive.[80]

Option 3: Appointment of Enduring Guardian

In NSW, advance directives do not directly derive their legal force from legislation, and the *Guardianship Act 1987* (NSW) only implies that a person who lacks capacity may refuse treatment in advance.[81] In NSW they may take one of two forms, either incorporated in an Appointment of Enduring Guardian, being someone that is appointed to make health decisions on behalf, or in a separate more informal document. The issue is however, that if the wishes of the subject are in conflict with the guardian's authority, the guardian is then able to make the ruling decision. Although not legally binding under statute law, they are seen as strongly persuasive especially if consistent, specific and up to date.[82] Under common law, they can be binding if the criteria of specificity and competence at the time of writing are fulfilled.

The NSW Department of Health also supports the use of advance directives, providing a guideline on its use.[83]

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[80] SR Kisely, LA Campbell, 'Advance treatment directives for people with severe mental illness' [2008] (8) *Cochrane Database of Systematic Reviews* 1, 1-44.
[81] *Guardianship Act 1987* (NSW) s 33(3).
[82] Sarah Ellison et. al., 'The legal needs of older people in NSW' (Research Publication, Law and Justice Foundation, 2004) 398.
[83] 'Making an Advance Care Directive' (Information Booklet, NSW Government, August 2019)

The Victorian Approach to 'least restrictive'

There has been significant pressure to reform the laws of mental illness in Australia. Particularly to better protect Mental health consumers in accordance with their human rights.[84] A number of conventions and Acts have been recently passed in consideration of these goals. It includes the passage of the Victorian Charter of Human Rights[85] in 2006, and Australia's ratification of the Convention on the Rights of Persons with Disabilities and mental illness.[86] In response, in 2014 the Victorian government passed a new *Mental Health Act*.[87] The *Act* signifies a major departure, and strengthens the position for mental health consumers, their rights, autonomy, and rights to voluntary treatment. The stated objects of the *Act* are to place people with a mental illness at the centre of decision making about their treatment and care.[88] This is not a stated objective of the NSW *Mental Health Act* as it currently stands. While an object is to 'facilitate the involvement' in decisions, there is no intention to place mental consumers at the forefront of decisions.[89]

The requirements for a Victorian Tribunal to grant a CTO are similar, being that a person has a mental illness, requires treatment to prevent serious harm and there are 'no less restrictive means' available.[90] However, when the Tribunal is making this decision, they must consider the person's views and preferences about treatment and the reasons for those views, the views and preferences expressed in their advanced statement, and/or the views of a nominated person or carer.[91]. This places the wishes and interests of mental health consumers at the forefront of any decision that would allow forcible medication. This protects the rights, dignity and autonomy of people living with a mental illness in Victoria.

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[84] 'Mental Health Bill 2014' (Research Brief No 5, Parliament of Victoria, March 2014)
[85] *Charter of Human Rights and Responsibilities Act* 2006 (Vic)
[86] *United Nations Convention on the Rights of Persons with Disabilities*
[87] *MHA (Vic)* (n 26).
[88] Ibid s11(a)-(e).
[89] *MHA* (n 4) s 3(e).
[90] *MHA (Vic)* (n 26) s 5.
[91] Ibid s11(a)-(e).

Appendix 1: NSW Legislation

Mental Health Act 2007 (NSW) s 14

14 Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary--

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

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

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

Mental Health Act 2007 (NSW) s 52(3)

NSW Health may make a community treatment order under s 53(3). This power is limited by s 53(4).

53 Determination of applications for community treatment orders

(3) The Tribunal may make a community treatment order for an affected person if the Tribunal determines that--

(a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and

(b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it, and

(c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.

(4) The Tribunal may not make a community treatment order at a mental health inquiry unless the Tribunal is of the opinion that the person is a mentally ill person.

Appendix 2: Department of Health Fact Sheet

Fact Sheet for Community Practitioners in NSW[92]

Amendments to the NSW Mental Health Act (2007)

FACT SHEET: Community Medical Practitioners

The Mental Health Act 2007 (the Act) was amended on 31 August 2015 following a major review of the legislation. Information is provided in this fact sheet to assist community medical practitioners to understand relevant changes to the Act and is to be read in conjunction with the Mental Health Act 2007 No. 8 and the Mental Health Act Regulation 2013.

This fact sheet also restates other important provisions of the Act.

About the Act

Under the Act, a person who is mentally ill or mentally disordered may be transported to and detained in a declared mental health facility to enable appropriate care and treatment to be provided, subject to certain conditions.

Use of the term 'serious harm' in the Act?

A mentally ill person is someone who has a mental illness and, because of that illness, there are reasonable grounds for believing the person requires care and treatment in a mental health facility in order to protect them and/or others from serious harm (s14).

A Communique from the NSW Chief Psychiatrist was provided to Local Health Districts and Specialty Networks in 2014. It provides guidance to clinicians making involuntary treatment decisions, regarding the 'serious harm' criterion in the Act. The Communique states that, whilst *serious harm* is not defined in the Act, it is intended to be a broad concept that may include:

- Physical harm
- Emotional/psychological harm
- Financial harm
- Self-harm and suicide
- Violence and aggression, including sexual assault or abuse
- Stalking or predatory intent
- Harm to reputation or relationships
- Neglect of self
- Neglect of others (including children).

The Communique also states that, when making involuntary treatment decisions under the Act, clinicians should undertake a comprehensive assessment of the person, including review of the history of mental and physical illness, family history, psychosocial factors impacting on

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www.mha.nswiop.nsw.edu.au

[92] New South Wales Department of Health, *Factsheets- Community Practitioners* (Web Page), <https://www.health.nsw.gov.au/mentalhealth/resources/Factsheets/community-medical-practitioners.pdf>.

When forming an opinion as to whether a person should be taken to and detained in a declared mental health facility for further assessment, medical practitioners should consider the advice provided in this Fact Sheet in relation to the Communique on 'serious harm'.

The Act has been amended to explicitly state that a medical practitioner may examine or observe a person via audio visual link for the purposes of writing **Part 1 of Schedule 1** (s19A).

The use of an audio visual link for these assessments is subject to the following conditions:

- It may only occur where it is not reasonably practicable to personally examine or observe the person (s19A(1));
- The medical practitioner must be satisfied that they are able to examine or observe the person with sufficient skill and care so as to form the required opinion about the person (s19A(2)).

Police assistance

Section 19(3) provides for police assistance to be sought in the detention and transport of the person if there are **serious** concerns relating to the safety of the person or others without police assistance.

Medical practitioners are to complete **Part 2 of Schedule 1** when seeking police assistance in taking a person to a declared mental health facility.

Mental Health Forms

Some Mental Health Act forms have been updated and new forms have been developed (some of which relate to the Mental Health Regulation 2013).

Changes have been made to the Schedule 1 certificate and this new form must be used: Schedule 1. Medical Certificate as to Examination or Observation of Person (NH600900A) to be found at: www.health.nsw.gov.au/mhdao/Pages/legislation.aspx

All current **Mental Health Act forms** and relevant documents are available and can be downloaded for printing from the NSW Ministry of Health website: www.health.nsw.gov.au/mhdao/Pages/legislation.aspx

Relevant links

- The **Memorandum of Understanding-Mental Health Emergency Response 2007 between NSW Health, Ambulance Service of NSW and between NSW Police Force** can be found at: www.health.nsw.gov.au/mhdao/Pages/partnerships-gd.aspx
- The **Mental Health Act 2007 Guidebook**, which provides practical information to mental health practitioners, carers, and those who provide support and advice to consumers, is being updated. Once completed, the Guidebook will be available on the NSW Ministry of Health website: www.health.nsw.gov.au/mhdao/Pages/legislation.aspx

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the presentation, and evaluation of the risk of self-harm and harm to others. The assessment should include consideration of the harm that may arise should an illness *not* be treated.

Who is a mentally disordered person under the Act?

A mentally disordered person is someone whose behaviour is so irrational that there are reasonable grounds for believing the person requires care and treatment in a mental health facility to protect them and/or others from serious **physical** harm (s15).

Changes to the Act place a greater focus on consumer recovery

The term 'control' has been removed from the objects of the Act and greater emphasis has now been placed on promoting a consumer's recovery, including by encouraging clinicians to consider the consumer's views and wishes about their treatment (s3).

The principles for care and treatment in the Act have been amended so there is a greater focus on the recovery of consumers through, as far as possible:

- Supporting consumers to pursue their own recovery;
- Considering any special needs related to the disability or sexuality of a person;
- Providing developmentally appropriate services to individuals aged under 18 years;
- Recognising the cultural and spiritual beliefs and practices of Aboriginal and Torres Strait Islander people;
- Making every reasonable practicable effort to consider the views and expressed wishes of consumers when developing treatment and recovery plans; and
- Making every effort to obtain consumers' consent when developing treatment and recovery plans, to monitor their capacity to consent, and to support those who lack the capacity to understand their plans.

Changes to the initial detention of a person - Scheduling

A Schedule 1 certificate enables a person to be taken against their will to a declared mental health facility (e.g. a mental health inpatient unit, a declared emergency department, or declared Psychiatric Emergency Care Centre) for a further mental health assessment (s19).

To issue a Schedule 1 certificate, a medical practitioner must:

- Personally examine or observe the person immediately or shortly before completing the certificate;
- Form the opinion that the person is either a 'mentally ill' person or a 'mentally disordered' person;
- Be satisfied that no other appropriate means for dealing with the person is reasonably available, and that involuntary admission and detention are necessary;
- Not be a designated carer, the principal care provider or a near relative of the person.

A completed Schedule 1 is valid for up to 5 days for a 'mentally ill person' and up to 1 day for a 'mentally disordered person'.

Appendix 3: Mental Health Tribunal Guidelines

Guidelines for granting Community Treatment Orders in NSW[93]

Guidelines for Community Treatment Order Applications

Mental Health Review Tribunal

These guidelines take into account the legislative criteria in the *Mental Health Act 2007* (including Amendments to the Act commenced in August 2015), the objects of the Act in s 3 and the principles of care and treatment in s 68.

1. Criteria for community treatment orders

Section 53 of the Act permits the making of a CTO if the Tribunal is satisfied that:

- the person would benefit from the CTO as the least restrictive alternative consistent with safe and effective care; and
- the mental health facility has an appropriate treatment plan and is capable of implementing it; and
- if the person has been previously diagnosed as suffering from a mental illness, there must be a history of refusal to accept appropriate treatment,
- but, in the case of a forensic patient or a person who has been the subject of an order over the preceding 12 months there must be evidence that the person would continue in, or relapse into, an active phase of mental illness if the order is not granted.

However a CTO may only be made at a mental health inquiry if the Tribunal is satisfied that the assessable person is a mentally ill person.

The objects of the Act in s 3 reinforce the goal of access to appropriate care while protecting the civil rights of the affected person and facilitating the making of appropriate decisions about their care and treatment with the affected person and their carer. The objects also seek to facilitate voluntary care and, in limited situations, care on an involuntary basis. The principles of care and treatment in s 68 emphasise the importance of holistic care determined in collaboration with the patient and their designated carer(s) or principal carer provider.

2. The scope of treatment plans

S 54 of the Act sets out the content of treatment plans as follows:

- "a treatment plan for an affected person is to consist of the following
  a) in general terms an outline of the proposed treatment, counselling, management, rehabilitation and other services to be provided to implement the order; and
  b) in specific terms, the method by which, the frequency with which, and the place at which, the services would be provided for that purpose".

As the treatment plan is to 'consist' of specified items it may not include terms not falling within s 54 (a) or (b). Accordingly, treatment plans should only include terms which relate to services to be provided and those services should be in respect of a person's treatment, counselling, management, rehabilitation or other services.

[93] Mental Health Review Tribunal, *Guidelines forCOmmunity Treatment Order Applications* (Web Page, July 2018) <https://mhrt.nsw.gov.au/files/mhrt/pdf/CTO%20Guidelines%20for%20agencies%20update%20July%202018.pdf>.

3. Conditions purporting to limit a person's conduct other than in accordance with section 56(1)

It is acceptable for a person's conduct to be controlled by treatment plan conditions which relate to medication, therapy, counselling, management, rehabilitation and acceptance of services as per s 56 (1) (a).

However, treatment plans which include conditions as to a person's conduct, which do not do not relate to the acceptance of services, medication, therapy etc should not be included in treatment plans. This is because s 56 sets out the limits of the affected person's obligations under a CTO and requires that they be present at the reasonable times and places specified in the order to receive services related to medication, therapy, counselling, management, rehabilitation and other services provided in accordance with the treatment plan. S 57 requires the person to comply with the CTO.

Therefore the inclusion of conditions, such as requiring a person not to intimidate or harass the treating team, or to be of good behaviour, or prohibiting the use of alcohol or illicit substances may not be included in the treatment plan.

Nevertheless, it may be helpful in some circumstances for the Tribunal to make clear statements during the hearing about the negative impact on the person's mental health if they engage in behaviour such as illicit drug use or alcohol abuse, but generally a condition prohibiting such conduct should not be included in the treatment plan.

4. Treatment plan conditions

A major purpose of CTOs is to ensure that affected persons receive safe and effective care in the community rather than in the more restrictive setting of a hospital. Another important goal is the delivery of care and treatment of a kind that is recovery focussed and this may be reflected in the kind of services outlined in treatment plans.

Therefore, there may be services stipulated in a treatment plan which if refused would not result in a breach of the order.

For example, CTOs may include a requirement for attendance at counselling services but a person could NOT be breached for non compliance with the clause because a breach requires a deterioration or risk of deterioration in mental state which may be unlikely to flow from non attendance at counselling.

5. Urine drug screen clause

Where a person has an illicit drug use history which impacts on their mental health it can be appropriate to include urine screen clauses and counselling clauses in a treatment plan.

A request to supply a urine sample for illicit drug screening is capable of constituting a "service" if the subject person has a history of illicit drug use, so that the drugs might impact negatively on their mental health. Accordingly, any such clause to be consistent with the requirements of section 54(b) of the Act needs to specify the frequency of the service to be provided over a particular period. For example, a request might be made by the case manager for screening to occur not more than three times during a suitable interval (e.g. monthly) with the frequency in each case

being determined on its own facts. It is recommended that a maximum frequency of drug screening over a particular period be included.

Where the inclusion of a clause is considered to be necessary, the following wording is suggested:

*Because Mr/Ms X has a history of illicit drug use which adversely impacts on his/her mental health he/she **should refrain** from using such substances and he/she is required to accept the urine screening and/or counselling services referred to in the following conditions".*

*(insert client's name) is required to have blood tests as requested by the case manager/treating doctor/psychiatrist no more than **(insert maximum number)** times in (**insert number of months)** months **(OR as clinically indicated).***

Where it is considered that counselling is an appropriate adjunct to urine drug screening the preferred clause is as follows:

*(insert client's name) is required to attend drug and alcohol counselling **(insert maximum number)** times **(insert frequency)** as requested by the case manager/ treating doctor/ psychiatrist.*

The need for such clauses will depend on there being evidence that there is a history of illicit drug use which might affect the subject person's mental health adversely.

In cases where the patient has a clear history of relapse in the context of drug use but there is not contained in the treatment plan a clause in the above terms it may be appropriate for the Tribunal discuss the merits of doing so with the treating team and applicant of the CTO at the hearing. However, the clause should only be included if the case manager/ treating doctor agree to its inclusion.

6. Blood tests and other testing

Blood tests clauses are often inserted in treatment plans to monitor medication levels or test for side effects to medication or the emergence of syndromes as a result of taking medication are often a necessary component of an affected person's treatment. In such cases it is appropriate to have a clause as follows:

(Insert affected person's name) is required to comply with blood tests as requested by the case manager/treating doctor/psychiatrist or delegate.

If the frequency of blood tests is known by the treating team then it should be specified in the treatment plan (for example the full blood count for clozapine patients is done each month).

In cases where the tests are not required to occur at specified intervals it is appropriate to state that they are to occur as *"clinically indicated and at the direction of the case manager/and or treating doctor".*

Treatment Plans should not include a general clause allowing for tests unless the medication in the treatment plan requires such testing.

From time to time blood tests are included in treatment plans for the purpose of testing for co morbid conditions, such as HIV, thyroid, infection or general health. Consistent

with paragraph 10, such blood tests are not to be included in Treatment Plans. If there is a need for such testing it should be resolved under the Guardianship Act.

In cases where blood tests may be required because of a change of medication the treating team should seek a variation to the treatment plan (see variation to treatment plans at paragraph 12).

7. Travel restrictions

Persons subject to CTOs may wish to travel intrastate, interstate or overseas. The Act is silent on the issue of travel while subject to a CTO. However, unless arrangements are agreed with the treating team in advance, travel may result in the breach the terms of their order to be present at the times specified in the treatment plan for treatment and other services.

In appropriate cases the affected person's treating team may be able to make reciprocal arrangements at the place of destination such that they receive care and treatment in a manner which is consistent with safe and effective care. Whether the treating team can approve of a travel plan is a judgement call and this can be explained by the panel to the affected person at the hearing.

In cases where the treating team consider that a reciprocal arrangement cannot be made or that it would not be consistent with safe and effective care this should be explained to the affected person, and it may be sufficient to advise them that if they travel they are likely to breach the conditions of the order. The Tribunal panel may also wish to advise the person at the hearing that travel which results in a failure to comply with the terms of a treatment plan may lead to a breach of the order.

Nevertheless, a condition prohibiting travel should not be in a treatment plan as it is not a 'service', and does not accord with the principles of care and treatment in s 68.

8. Residence restrictions

The Act does not allow the Tribunal to compel a person subject to a CTO to live at a particular place or area, although community facilities operating under the local network system may decline to provide support unless the person lives in their area. Consequently it may not be possible to ensure a person is adequately treated in the community with an appropriate level of support, unless a community facility is persuaded to accept responsibility for them.

It has sometimes been argued that patients who frequently move residences to avoid a CTO should be required to reside at a particular place so that safe and effective care treatment can be given to them in the least restrictive environment. This is a matter which is relevant to whether a person is likely to benefit from the order and the capacity of the treating team to implement the order.

Similarly a CTO cannot compel a person to reside in a rehabilitation facility or other residential facility. However, a person subject to an order may admit themselves to a residential facility or be placed in a facility by a guardian and still be treated under a CTO.

9. CTOs for persons of no fixed abode

The Act does not require a person to have a permanent residence in order to be eligible for a CTO. In cases where the community team is able to monitor a patient's treatment despite the patient not having a fixed place of abode there is no reason why an order cannot be made, although from a practical point of view it may be more difficult to treat a patient and enforce the conditions in the treatment plan. Indeed, such people may require an order more than others.

Some inner city mental health facilities are able to effectively case manage homeless or itinerant people on a CTO. If there is evidence that an order can be implemented, and all the other criteria for making an order are met, an order may be made.

10. Medications and /or treatments for non psychiatric conditions or illnesses

Sometimes treatment plans include conditions compelling a person to accept treatment or medication for co-morbid conditions or illnesses in addition to their psychiatric medications. These have ranged from contraceptive or anti libidinal medication, to medication to treat diabetes, heart disease, and HIV.

This is a complex area as in some cases the refusal to have medication and/or treatment may be related to the person's mental illness and may cause serious harm or even be life threatening. Further, all mental health facilities are required by Departmental guidelines to have a comprehensive care plan for each patient and are expected to be pro-active in ensuring the person is treated holistically and this includes advocating for their physical health needs. This often leads case managers to argue that non–psychiatric medication should be included in the treatment plan and that the failure to do so means that the person cannot be given safe and effective care. Further, that the inclusion of non-psychiatric medication is likely to result in the person being compliant and this will contribute to their overall well being.

Although each case will turn on its own facts, as a general rule, medications of a non-psychiatric kind should not be included in a person's treatment plan. If a person is refusing to have medication for other conditions or illnesses, and they lack capacity to make informed decisions about their treatment, the appropriate course is for the case manager and treating psychiatrist to seek consent under part 5 of the Guardianship Act. That Act sets out a hierarchy of substitute consent givers depending on the nature of the illness, conditions, treatment or investigations that are required.

In cases where the medications and treatment for the co-morbid condition is not related to the person's mental illness they should not be included.

11. Variation and revocation of a CTO

Section 65 provides that the Tribunal may consider an application to vary or revoke a CTO if there has been a substantial or material change in the circumstances surrounding the making of the order, or if relevant information that was not available when the order was made has becomes available. Typically a variation is needed when the client has moved into a different area, or there has been a substantial change in the treatment plan. For example, a new medication has been introduced which requires regular blood tests and this is not covered in the original treatment plan. Before a variation or revocation hearing can take place the Tribunal must be first satisfied that the threshold has been reached.

Except for inconsequential variations, such as a change in the treating team because the affected person has changed address, variations should be dealt with at a hearing and not "on the papers".

Examples of when a hearing is required follow, but are not exhaustive.

- Changes in medication can usually be done at the discretion of the treating team but where the change is more intrusive such as changing from an oral to depot medication, or changing to a medication which involves blood or other testing, such as Clozapine, a hearing is required.

- Adding a drug urine clause or breath tests for alcohol use.

- Adding other services or conditions not on the original plan.

12. CTOs for persons presenting for the first time with symptoms of a mental illness

A person who is being treated for a mental illness for the first time can be the subject of a CTO. Some mental health clinicians are mistakenly of the view that it is necessary for a person to have a history of non compliance before a CTO application can be made. This is incorrect. Section 53 states that it is necessary to establish a failure to comply with appropriate treatment **if** there has been a previous diagnosis of mental illness. Most people presenting with a first episode qualify for an order. However, the Tribunal must be satisfied that all criteria for making an order have been met, including that it is the least restrictive option, consistent with safe and effective care.

13. Treatment Plans that nominate health professionals not employed by the mental health facility

The 2007 Act seeks to provide flexibility in the way CTOs are administered. Notably, the Act now allows for applications to be made by medical practitioners and their designated carer(s) or principal carer provider and unlike the 1990 Act there is no requirement that an affected person's case manager must be an officer or employee of the mental health facility.

As long as a mental health facility has agreed to submit a treatment plan and the Tribunal is satisfied that a CTO will be supervised and monitored by a medical practitioner or treating psychiatrist (or other mental health professional) who agrees to liaise with the director of the mental health facility as to the affected person's progress, including any failure to attend to the conditions in the treatment plan, then an order may be made.

The Tribunal is aware of one patient who is managed by a psychiatrist attached to a hospital based mental health facility because the patient has incorporated the community treating team into his delusional system. Also, some patients prefer to be managed by their own doctor as they find it less stigmatising.

14. The Tribunal's role in relation to prescribed medication

The Tribunal does not prescribe care and treatment but it is a review body and has a clear role in discussing the relative merits of depot injection or oral medication and poly pharmacy issues at a CTO hearing. The Sheedy case reinforced the need to be

concerned with whether there are less restrictive medication regimes available which are **consistent with safe and effective care**.

15. A treatment plan is not capable of implementation if the patient is resistive to it

The criterion that the CTO must be capable of implementation have on occasions been mistakenly interpreted to mean that an affected person's opposition to it means that it is not capable of implementation.

This view is incorrect as if it were true there would be little point to having CTO legislation. A large percentage of persons on orders are opposed to having them.

The criterion refers to the capacity of the mental health facility to monitor and supervise care and treatment. Page **8** of **9** MHRT – Guidelines for Community Treatment Orders March 2012.

16. The length of a CTO

The length of any order must be determined by reference to the criteria in s 53(7), namely the estimated time to stabilise the condition of the affected person and to establish, or re-establish, a therapeutic relationship between the person and the person's case manager.

The rationale for the provision is likely to be that CTOs should only be for as long as is necessary to achieve mental health stability or a therapeutic alliance such that an affected person is more likely to continue with appropriate treatment without an order. The provision attempts to strike a balance between interfering minimally with a person's civil right to be free from interference and the right to access care and treatment.

It should be borne in mind that any order for more than six months confers a right of appeal to the Supreme Court on the basis of the order's length. It is likely that the legislature intended that orders of 6 months or less would be the norm and anything longer would be require exceptional reasons and must be based on the above criteria.

17. Risk and best interests

CTOs may reduce the risk of the patient becoming unwell and consequently they may reduce other risks such as a client's risk of offending. CTOs may also be in the person's best interest. However, the test is whether the CTO is the least restrictive option for safe and effective care of the person's mental illness NOT whether the CTO will be effective in stopping the person offending or whether it is, in some clinicians view, in the best interests of the patient.

If the Tribunal considers that the person is too unwell for discharge this point can be made in the hearing. But if the panel decides not to make a CTO it will not prevent the person from being discharged. Discharge without a CTO may involve more risk.

18. Risk assessments

The Community Forensic Mental Health Service (CFMHS) is not available to do risk assessments for civil patients except in the most extreme cases. This would require the President's involvement and would usually involve cases where admission to the Forensic Hospital is being considered.

19. Breach of a CTO and Tribunal review

The status of a person admitted under the breach provisions will be that of a detained person in accordance with s 19 of the Act (s 62 (3)).

An Authorised Medical Officer (AMO) must cause a detained person to be brought before the Tribunal not later than three months after the person was detained.

The Tribunal must decide if the person is a mentally ill or a mentally disordered person for whom no care of a less restrictive kind is appropriate or reasonably available. If such a determination is made the Tribunal must determine whether the person should remain in the mental health facility until the end of the CTO or be made an involuntary patient. If the Tribunal does not determine that the person is mentally ill, or if less restrictive care is appropriate and reasonably available, it must make an order that the person be discharged from the facility and the Tribunal may make a new CTO. The Tribunal may defer the operation of the order for discharge for up to 14 days.

If at the end of the CTO the person is still a mentally ill person and there is no less restrictive form of appropriate care available the authorised medical officer may cause the person to continue to be detained in a mental health facility. Section 62(3) of the Act provides that the person is taken to be detained in the mental health facility under s 19 when the AMO takes action to detain the person.

20. Deferring discharge on the making of a CTO for an involuntary patient

Pursuant to s 53(8) the Tribunal can order that the discharge of an involuntary patient for whom a community treatment order is made be deferred for a period of up to 14 days, if the Tribunal thinks it is in the best interests of the patient to do so.

Such an order may be made when a CTO application has been made for an involuntary patient but there is a need for the patient to remain in the facility for a period of time before they can be discharged.

If the CTO is being made at a mental health inquiry, the Tribunal may, if appropriate, firstly make the patient an involuntary patient, then make a CTO and order that the discharge be deferred.

Appendix 4: Victorian Legislation

Mental Health Act 2014 (VIC) s 4 and s 5

4 What is mental illness?

(1) Subject to subsection (2), mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

(2) A person is not to be considered to have mental illness by reason only of any one or more of the following--

(a) that the person expresses or refuses or fails to express a particular political opinion or belief;

(b) that the person expresses or refuses or fails to express a particular religious opinion or belief;

(c) that the person expresses or refuses or fails to express a particular philosophy;

(d) that the person expresses or refuses or fails to express a particular sexual preference, gender identity or sexual orientation;

(e) that the person engages in or refuses or fails to engage in a particular political activity;

(f) that the person engages in or refuses or fails to engage in a particular religious activity;

(g) that the person engages in sexual promiscuity;

(h) that the person engages in immoral conduct;

(i) that the person engages in illegal conduct;

(j) that the person engages in antisocial behaviour;

(k) that the person is intellectually disabled; that the person uses drugs or consumes alcohol;

(l) that the person has a particular economic or social status or is a member of a particular cultural or racial group;

(m) that the person is or has previously been involved in family conflict;

(n) that the person has previously been treated for mental illness.

Subsection (2)(l) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has mental illness.

5 What are the treatment criteria?

The treatment criteria for a person to be made subject to a Temporary Treatment Order or Treatment Order are—

(a) the person has mental illness; and

(b) because the person has mental illness, the person needs immediate treatment to prevent—

(1) serious deterioration in the person's mental or physical health; or

(2) serious harm to the person or to another person; and

(c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and

(d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

Mental Health Act 2014 (VIC) s 11

The mental health principles

(1) The following are the mental health principles—

(a) persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment

preferred;

(b) persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life;

(c) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected;

(d) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;

(e) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted;

(f) persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to;

(g) persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to;

(h) Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to;

(i) children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible;

(j) children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected;

(k) carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible;

(l) carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

(2) A mental health service provider must have regard to the mental health principles in the provision of mental health services.

(3) A person must have regard to the mental health principles in performing any duty or function or exercising any power under or in accordance with this Act.