FORCED MEDICATION: BEYOND THE LIMITS

Photo of Kerry O'Malley (credit: Mad in America).

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Executive Summary

Forced medication is one of the most invasive, insulting, violating, and ultimately degrading, exercises of government power against its citizens. By its compulsory nature it will almost always occur in the absence of any therapeutic relationship. Usually the relationship will be one of frank opposition. The process itself does enormous, lasting and often irreversible harm to those subjected to it. That is in addition to the direct pharmacological effects of the drugs (of which much the same can often be said).

Parliament has tried to put safeguards around the exercise of that power—limits on the power to forcibly medicate. The language of the *Mental Health Act* is sometimes broad, but it has been given some definition by the few cases that have found their way to court. Although those limits could no doubt be improved, at least they are there: they are not illusory—at least in theory.

In practice those limits are not being observed. They are being diluted, avoided, flouted, ignored—case by case, and also at a systemic level. There are a range of reasons for this, including unhelpful and inequitable procedures, lack of resources, and even misstatements of the law from within the government itself.

This paper:

- carefully examines and establishes the existing legal limits on forced medication;
- shows how and why they are being broken in practice;
- outlines a path to ensuring that the practice of ordering CTOs is conducted consistent with the law and and with the basic human rights of those considered to be mentally ill; and
- proposes a foundation for dialogue with Health authorities aimed at better incorporating empathetic care and scientifically supported treatments into their protocols.

A case study: Kerry O'Malley

The devastating effects on the lives of those involved can be readily imagined. But examples also help. Consider the case of 74-year-old Kelly O'Malley.[1] Ms O'Malley was subjected to a forced medication order that caused severe mental and physical consequences, including: increased anxiety, lack of motivation, poor concentration, weight gain, hair loss, and feelings of degradation from being robbed of her autonomy.

What was the entry point to this personal hell? In about 1968 she was accused of sitting in a chemist store, displaying signs of confusion, for a duration of six hours. No doubt her presence was inconvenient; but there was no suggestion that she posed any risk of even minor harm (let alone serious harm) to herself or others. She had no previous history of self-harm or causing harm to anyone else. This highlights the unnecessary nature of the medication order imposed upon her. As is explained below, in the absence of any risk of *serious harm*, she could not be a "mentally ill person", and the Tribunal had no power to make a compulsory treatment order.

The Mental Health Review Tribunal rejected her proposed alternative plan, which took a "recovery approach" by incorporating medical and social intervention strategies to enhance control over her own life, opting to pursue a biomedical model of treatment instead.

In the Tribunal, Kerry was effectively unable to protect her own interests. Kerry was not able to get representation by an advocate of her choosing, and there was no-one to provide an independent view to the Tribunal. Despite her evident confusion (which had brought her to the Tribunal), Kerrie had to be her own advocate - and she had to do that at a great disadvantage as she was not allowed to see her files. Not surprisingly, the Tribunal made a CTO, including for forced medication. Those orders were renewed, on and off, for the next 47 years, with the effects described above.

[1] To see a brief interview with Kerry O'Malley story click here. Her case was celebrated by the world-leading website 'Mad in America' as a momentous representation of speaking out against the degrading treatment and removal of individual autonomy suffered.

Kerry's medication nightmare ended only when she obtained independent representation, through the non-government organisation Justice Action. Justice Action took up Kerry's case at the suggestion of her personal psychiatrist. It met nothing but opposition from those carrying out treatment under the CTO, the Department of Health, and the Mental Health Review Tribunal. Eventually Justice Action took Kerry's challenge to the Supreme Court of NSW. Just before the case came on for hearing the Department of Health admitted that the CTO was invalid, and consented to its being set aside, with the Department paying Kerry's costs.[2]

How many more such cases are there? Currently 5,000 people in New South Wales,[3] and thousands more Australia-wide, are forcibly medicated under Community Treatment Orders (CTOs). This is not a niche issue!

Trampling limits on the power to order forced medication

In New South Wales, the power to permit forced medication of people through CTOs is provided under sections 14 and 53 of the *Mental Health Act 2007* (NSW). Those sections also set limits on that power. The body of this paper examines those limits in careful detail. At this stage we will mention the following:

- that the order must be *necessary* to prevent *serious harm* (to themselves or others); and
- *no other care of a less restrictive kind* is appropriate and reasonably available.

But in practice, CTOs, including orders for forced medication, are made when there is no credible evidence of risk of serious harm, and where it has not been established

[2] That concession avoided the Supreme Court from passing judgment on the case, which meant that the Department escaped the risk of criticism by the Court, and (more importantly) that the potential for a precedent-setting judgment to clarify the law was also avoided. It also meant they could not be ordered to produce Kerry O'Malley's medical records. Kerry had issued a subpoena for her records, and—incredibly—the Health Department had applied to have the subpoena set aside.

[3] MHRT annual report

(because it has not been properly explored) that no other, less restrictive, care is available.

A number of factors contribute to this situation, and this paper identifies them and proposes remedies. But there is one major contributor which can easily be fixed: on the key issue of what counts as "serious harm", the Department and the Tribunal follow, and publish, guidelines which are wrong. They do not reflect the Act, and they contradict the court decisions about the meaning of "serious harm" in this context. Those guidelines lower the threshold of "seriousness" of harm almost to nothing, which of course means CTOs are made when they should not have been and probably without jurisdiction (and therefore unlawfully).[4]

Those guidelines come from a communiqué issued by the NSW Chief Psychiatrist in 2014. That communiqué must be publicly withdrawn as a matter of urgency. It is obviously desirable that it be replaced with accurate guidance; but it is so wrong, and so harmful, that its withdrawal should be immediate. It should not be held up waiting for new guidelines to be drafted.

This paper also shows that in any event there is no obligation to follow the (mis)guidance of the communiqué. It does not have, or even pretend to have, any legal force. It is not framed as a direction, or as a statement of policy. Therefore, whether or not it is withdrawn, the communiqué should not be followed.

Better approaches

This paper then proceeds to propose better models for managing people than the current reliance on forced medication. We believe that affected persons, and the community at large, can be better protected by measures that are more humane; that respect and enhance affected people's autonomy and desires, and ultimately their humanity.

[4] Given the lack of effective representation in the Tribunal, it is not surprising that the communiqué's inconsistency with authoritative court decisions seems to have gone unnoticed.

Recommendations

1) Health authorities must keep at the forefront of their minds 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 communiqué of 2014 should be withdrawn immediately.

3) Without delaying the withdrawal of the Chief Psychiatrist's communiqué, more accurate guidelines to the application of the Act should then be issued, encompassing clear definitions of 'serious' harm, 'reasonable grounds', 'necessary', and how to determine whether any other care, of a less restrictive kind, is "reasonably available". It should include a dynamic list of alternatives to forced treatment, with links to providers.

4) Community Treatment Orders should only be issued as a last resort.

5) Funded legal assistance should be available to those facing an application for an order, or wishing to appeal against an 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 actively considered and proved unsuitable or not reasonably available before any order is made permitting the medical assault by forced injection of an individual.

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

Suffering from a "mental illness"

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 defined as socially problematic can qualify as mental disorders. The effects of the stigmatization of individual idiosyncrasies[5] 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. However, there is no uniform accepted legal definition for 'mental illness'[6] under Australian law.[7]

[5] Wakefield, J., 1992. "The Concept of Mental Disorder: On the Boundary between Biological Facts and Social Values" **[citation, and ideally hyperlink, needed–Richard]**
[6] *Harry v The Mental Health Review Tribunal* (1994) 33 NSWLR 315, 333.
[7] 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].

Overarching consideration

We now begin a detailed consideration of the relevant provisions of the *Mental Health Act* 2007 (NSW) (***MHA***), and what they mean. In this exercise it is important to keep in mind these overarching consideration:

> [8] The provisions of the Act governing the making and implementation of a community treatment order must be read against the background of the common law's entrenched concern for the protection of civil liberties, especially in relation to medical treatment. The norm is that a prerequisite to the medical treatment of an individual is a need for the individual's consent to that treatment: Rogers v Whitaker (1992) 175 CLR 479 at 489.
>
> [9] Forced medical treatment is exceptional; but, subject to procedural safeguards, permissible when justified by necessities recognised by the law: *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315 at 323E, 332G-333F and 334B-335D.
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> [10] It is because of the intrusive effect of a community treatment order on the civil liberties of an affected person that Parliament has laid down conditions for the making of such an order: *Z v Mental Health Review Tribunal* [2015] NSWCA 373 at [35].[8]

The Definition in the *Mental Health Act*

Under the New South Wales *Mental Health Act* 2007 (***MHA***), orders for forced medication can be made only for "mentally ill persons" or "mentally disordered persons". be made for forced medication may be made applies to persons who have a 'mental illness' or 'mental disorder'. In order for the NSW Department of Health or Mental Health[9] Review Tribunal to intervene in an individual's life and potentially subject them to medication, they must be satisfied that a person is a 'mentally ill person' or 'a mentally disordered person' within the definition of the *Act*.[10]

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

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[8] *T v South Western Sydney Local Health District* [2022] NSWSC 1173 (Lindsay J) at [8].
[9] *Mental Health Act 2007* (NSW) s 14 ('*MHA*').
[10] *MHA* s 53(4).

the person or others from serious harm'. The continuing state of the person, including any likely deterioration[11] in their condition and effects, must be considered.[12]

For a person to be a 'mentally ill person', the Act requires the person to be 'suffering from a mental illness', which is defined as follows:[13]

> ***mental illness*** means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is echaracterised 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).

There are no definitions for the above symptoms set out in the *Act* itself, however, 9th edition of *NSW Mental Health Act (2007) no.8* Guide Book (incorporating the 2015 Mental Health Act Amendments)[14] gives advice on how to interpret these symptoms. They should be given their 'ordinary accepted meanings in the psychological sciences, without reference to overly clinical complexities or distinctions'. The Guide Book further provides the 'examples' of each symptom's interpretation:[15]

- Delusion – may be considered to be a false, fixed and irrational belief held in the face of evidence normally sufficient to negate that belief.
- Hallucination – subjective sensory experience for which there is no apparent external source or stimulus.
- Serious disorder of thought form – a loss of coherence, i.e., one idea does not follow or link logically to the next (this is said to be 'the main characteristic' of the symptom).

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[11] *MHA* s 14(1).
[12] *MHA* s 14(2).
[13] *MHA* s 4(1) s.v. "mental illness"
[14] *NSW Mental Health Act (2007) no.8* Guide Book <https://www.heti.nsw.gov.au/__data/assets/pdf_file/0009/457983/mental-health-act-2017-guidebook.pdf>
[15] Ibid.

- Severe disturbance of mood – sustained and profound change in mood that substantially impairs a person's level of functioning.
- Irrational behavior – behavior which a member of the community to which the person belongs would consider concerning and not understandable. In deciding whether the person suffering from a 'mental illness' the term 'irrational behavior' includes the additional test that it can be inferred from the behavior that the person is suffering from delusions, hallucinations, serious disorder of thought, or severe mood disturbance. In determining whether a person is suffering from a 'mental illness' the irrational behavior must be sustained or repeated.

The New South Wales *Mental Health Act* also gives power to forcibly medicate "mentally disordered persons",[16] who are defined in s15:

> **15 Mentally disordered persons** (cf 1990 Act, s 10)
>
> 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

Court 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.[17]

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

[16] There is no definition of "mental disorder" in the *MHA*. The term "mental disorder" is used only in s68.
[17] See *DAW v Medical Superintendent of Rozelle Hospital* (unreported, SC(NSW), Hodgson J, No 20629 of 1996, 14 February 1996).

of serious harm. A psychologist gave evidence with their concerns regarding the patient's physical and[18] mental health after assessing her.[19]

Nonetheless, the case law indicates that a mental *illness* is to be distinguished from a mental *impairment*, which does not fit within the scope and operation of the *MHA*. 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. Unlike a mental illness,[20] mental impairments are generally less severe and sporadic in nature.

Standardisation of Mental Health 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 a recognised mental illness is warranted. Such categorical assessment of symptoms may[21] pathologise an individual's lived experience with mental illness and create arbitrary distinctions for who is classified as a mentally ill person 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 a *mentally ill person.* The first criterion looks for the presence of behaviour that indicates a mental illness as per the Act's definition, and the second pertains to how the mental illness affects 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:

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[18] *Sullivan* [2019] NSW MHRT 3.
[19] Ibid.
[20] 'What is Mental Illness', *NSW Health* (Web Page, January 2020) <https://www.health.nsw.gov.au/mentalhealth/psychosocial/foundations/Pages/mental-illness.aspx#:~:text=%E2%80%9CA%20mental%20illness%20is%20a,Australia%20Department%20of%20Health>.
[21] See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Publishing, 5th ed, 2013).

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

(b) the protection of others from serious harm".[22]

The important question of what can amount to "serious harm" is considered in detail later in this paper.

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 person's mental health. The process of defining an individual as a mentally ill person 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.

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 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 considered a *mentally ill person* 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. Because it is not a formal diagnosis, and often takes into consideration[23] 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.' This evaluation contains inherently subjective aspects such as[24] making observations about a person's behaviour, demeanour, attitude and speech. Therefore, conflicts of interest may arise

[22] *MHA* (n 4) Schedule 1.
[23] 'Mental state examination', *The Royal Children's Hospital Melbourne*, (Web Page, November 2018) <https://www.rch.org.au/clinicalguide/guideline_index/Mental_state_examination/>.
[24] Voss RM, M Das J,. Mental Status Examination in *Treasure Island* (StatPPearls Publishing, 2020).

when the assessment is conducted by a medical professional who is working under the Department of Health or who is or might be involved in the person's treatment, rather than a neutral third party.

Objectivity and impartiality are pivotal in considering the assessment of mentally ill persons in section 14 of the *MHA*. Mental Health Review 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, and also input from

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 service and health departments in acquiring background information regarding a patient to inform the evaluation of 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 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. The Act permits an[25] examination to 'determine whether the treatment criteria apply to the person', rather than[26] 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). The application of this legal solution is integral and should be further considered as a[27] reasonable alternative in reducing the impact of, and mitigating the grounds to, forced medication. The process of the evaluation and the decision-making for CTOs can also be found in the *Mental Health Act* of Victoria. 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

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[25] *Mental Health Act 2014* (Vic), s 11(a)-(e) ("*MHA (Vic)*").
[26] Ibid s 28.
[27] *MHA* (n 4).
[28] 'Assessment and treatment orders', *Victoria Legal Aid* (Web Page, 5 August 2016). <https://www.legalaid.vic.gov.au/assessment-and-treatment-orders>.

promote a pluralistic society in which expression is encouraged and equality in treatment is ensured.

"Serious Harm"

Central to the definition of a "mentally ill person", and to the justification of a CTO, is the concept of "serious harm". And a "mentally ill person" is not simply a person with a "mental illness":[29]

> **14 Mentally ill persons (cf 1990 Act, s 9)**
>
> (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.

What does "serious harm" mean? In particular:

- *Harm:* what types of harm can meet the threshold? and
- *Serious:* how serious must it be?

Interpreting an Act is a search for the parliament's intention in passing the Act. What did they intend here?

Guidance from within the Act

Our starting point must be the *Mental Health Act* itself.

The first thing to note is that neither "serious" nor "harm" is defined in the Act.

In the immediate context of s14, the definition of a "mentally disordered person", in s15, is substantially identical to the definition in s14, except that instead of "serious harm" it refers to "serious *physical* harm" (italics added). The difference is clearly deliberate, and it shows that "serious harm", in s14, is not confined to physical harm.[30] Which doesn't sharpen the definition much.

[29] *MHA* s 3(1)(a) s.v. "mentally ill person"; s 14.
[30] *Re J (No. 2)* [2011] NSWSC 1224 (White J) at [16].

Another approach to the meaning of a provision is to identify its purpose (in the mind of the Parliament). Parliament has told us its purposes, at a general level, in s3:

> **3 Objects of Act**
>
> The objects of this Act are—
>
> (a) to provide for the care and treatment of, and to promote the recovery of, persons who are mentally ill or mentally disordered, and
>
> (b) to facilitate the care and treatment of those persons through community care facilities, and
>
> (c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and
>
> (d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care and, where necessary, to provide for treatment for their own protection or the protection of others, and
>
> (e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment.

We note, in particular:

- the preference for voluntary treatment over involuntary treatment in paragraph (c);
- the qualification that treatment be provided for "while protecting the civil rights of those persons" in paragraph (d); and
- the object of "facilitat[ing] the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment".

Those objects express a clear preference for preserving the autonomy, agency, and dignity of patients. That suggests a high threshold should be satisfied before a CTO can be made.

That is strengthened by other restraints on granting CTOs. To grant one, the Tribunal must have determined that:

> *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. [emphasis added][31]

The language is uncompromising. "**No** other care … ". "**least restrictive** alternative". Clearly, Parliament does not want these orders to be handed out like lollies.

Nor should they be, given how damaging and degrading they can be. And the potential seriousness of the effects of such an order is a further basis for inferring that parliament's intention is to require more, rather than less, "seriousness" in the potential harm, as a prerequisite to ordering a CTO.

The requirement for that the harm be "serious", and that that word has significant weight, may affect the types of harm that are likely to satisfy the requirements. For example, It may perhaps rule out emotional harm, but not psychological harm.

In summary, a consideration of the Act shows:

- "serious" and "harm" are not defined;
- the "seriousness" of the harm must be substantial;
- "harm" is not confined to *physical* harm; and
- that requirement for substantial "seriousness" may limit the types of harm that can meet the threshold.

In the result, the meaning has tightened a little, but not a lot. We next look at what light the courts have shone on the meaning of "serious harm" here.

Case law

The cases are not many. We have considered not only cases on CTOs under the *Mental Health* Act, but also cases on Forensic Community Treatment Orders (**FCTOs**) under the **[Act]**. The language is very similar, and of course there is much in common between the two orders and their effect.

Some of the cases deal with potential harm to self, some to potential harm to others. As they are treated identically in s14, there should be no difference in applying the test. We will assume that cases on harm to self also apply to harm to others, and vice versa.

[31] S 53(3) of the Act.

One general point is already fairly obvious; but it is worth stressing, because it must never be lost sight of:

> The question is not "what is the best treatment for the person's mental illness", or "what is in the person's best interests"? It is whether the order is *necessary* to prevent serious harm, and is the least restrictive available option.[32]

Physical harm?

Unsurprisingly, when the effects of a person's mental illness threaten to kill them, the threshold of "serious harm" is met. So in *Sullivan*[33], as a result of a diagnosed mental illness the person was refusing food, and continued to do so despite having entered severe malnutrition. The Mental Health Review Tribunal granted a CTO in the basis that the person required "treatment and care for her own protection" and that there "was no other less restrictive alternative".

How low does the threshold for physical harm go?

In *Kereopa*[34] Hulme J said:[35]

> 16 The "risk of causing serious harm to others" was considered by Davies J in his judgment on the preliminary hearing of the present matter. I agree with his Honour that it may concern physical or psychological harm. In terms of physical harm it does not require a concern about harm to the level of "grievous bodily harm" (defined in the criminal law as really serious bodily harm). I accept the submission on behalf of Mr Kereopa that it contemplates something more than would satisfy the minimum threshold for "actual bodily harm" under the criminal law.

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32 Cf. *Re J (No 2)* [2011] NSWSC 1224 (White J) at 112.

33 [2019] NSW MHRT 3

34 *Attorney General for NSW v Kereopa* (No 2) [2017] NSWSC 928 (Hulme J). Similarly, in *Re J (No 2)* [2011] NSWSC 1224, White J (at [78] noted that "grievous bodily harm … is explained to juries as being 'really serious injury', a concept that must be on a higher plane than 'serious harm'."

35 At [16].

Psychological harm?

In *Kereopa (No 2)*, immediately after the previous passage, Hulme J continued: [36]

> I also accept the submission that psychological harm must be something more than emotions such as fear or panic. Such things are not "serious harm".

Not surprisingly, the courts do recognise that the risk of serious psychological harm will be sufficient to make a person a "mentally ill person" and to ground a CTO for forced treatment, including forced medication. This was made clear in the passage just cited. **[What can we add here? Anything about what (apart from excluding mere "emotional harm") constitutes "serious" psychological harm? Life-changing? Long-lasting?]**

Emotional harm?

From the passage of Kereopa (No 2) just cited (and the cases citing the passage with approval), it appears that harm that constitutes only negative emotions, such as fear or even panic, is not sufficient to constitute "serious harm" for the purposes of s14.

Sexual harm?

"Sexual harm" has been referred to in cases, but we are not aware of any where the sexual harm did not constitute physical harm and psychological harm. As such, it would undoubtedly qualify if it meets the seriousness test for physical or psychological harm.

[36] Loc. cit. The passage was cited with approval in *Attorney General for New South Wales v Skerry (by his tutor Ramjan)(Final)* [2022] NSWSC 99 (N Adams J) at [79], and *Attorney General of New South Wales v Lane (Final)* [2019] NSWSC 1460 (Lonergan J) at [65]; *Attorney General for NSW v MZ* [2017] NSWSC 1773 (Fullerton J) at [14]; *Attorney General for NSW v Peckham (Final)* [2019] NSWSC 1775 (Cavanagh J) at [98].

Financial harm?

In *Re J (No. 2)*.[37] "the only issue"[38] was:

> whether continued involuntary detention can be justified on the ground that the plaintiff might suffer financial harm by spending money when he was not capable of making a proper judgment about the wisdom of the expenditure due to his mental illness

It was argued that financial harm could be enough to satisfy the definition of "mentally ill person" and to ground an order. The court was sceptical:[39]

> I think there would be much to be said for the submission of counsel for the plaintiff that serious harm under s 14 refers to what counsel calls either physical harm or psychological harm.

However, the court did not resolved that question, as it was able to decide the case on a different basis. Assuming (for the purpose of argument) the risk of financial harm could be enough, that harm could be dealt with by a less restrictive remedy, namely, the Tribunal could make a financial management order, putting the management of the person's assets into someone else's hands. The court said:[40]

> [97] Read as a whole, the scheme of Chapter 3 is that involuntary detention is to be a measure of last resort to protect against harm. In the present case, that protection could have been provided by a financial management order if the Tribunal or this Court, if an application were made to this Court, were satisfied that the plaintiff was not capable of managing his affairs.
>
> [98] Given that available remedy, I do not consider that the plaintiff's involuntary detention can be justified on the basis that it was necessary to prevent his spending his money unwisely. Of course, if it were found that the plaintiff was capable of managing his affairs, then there would be even less justification for his involuntary detention on that ground.

In practical terms, that reasoning is likely to apply in any case where a person is at risk of serious financial harm by reason of a mental illness. It may never be necessary to

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[37] *Re J (No 2)* [2011] NSWSC 1224 (White J).
[38] *Ibid.* at [76].
[39] *Ibid.* at [89] – [94].
[40] *Ibid.* at [97] – [98]. Although this relates to FCTOs, as we have shown above the considerations recited in relation to that Act also apply to CTOs under the *Mental Health Act*.

resolve the question, whether the requirement for "serious harm" can be satisfied by financial harm alone—let alone how serious the potential harm must be.[41]

Reputational harm?

We have not found any clear cases dealing with whether reputational harm can be "serious harm" for the definition of "mentally ill person". Before 1997, s 9 of the Mental Health Act 1990 dealt separately with the necessity to protect a person suffering from mental illness from serious physical harm and from serious financial harm and from serious damage to the person's reputation. Those separate provisions were replaced in 1997 by a section in terms that have been repeated in s14 of the current Act. In Re J (No 2) (which, as noted above, dealt with financial harm), it was submitted, partly on the basis of that prior legislative history, that financial harm could, by itself, constitute "serious harm" for the purpose of s14. Reputational harm was not in question in that case, but the arguments based on legislative history are equally applicable to reputational harm. The court doubted the relevance of the prior history in interpreting the current Act, and therefore doubted that financial harm was enough. The same doubts must attach to reputational harm as potentially constituting "serious harm" for s14.

In the result, the question, whether reputational harm can be enough to constitute "serious harm", has not been decided and has not been directly considered by any judge. There are no judicial dicta in support, but the dicta in Re J (No 2) raise doubts.

Summary

Types of harm

On the types of harm that could potentially constitute "serious harm" for the definition of "mentally ill person", the case law says:

Physical harm	**can** qualify
Psychological harm	**can** qualify

[41] There is the theoretical possibility that a person's mental illness may cause a risk of financial harm to someone else, in which case a financial management order may not be the answer, although there may be other answers short of involuntary psychiatric treatment including medication.

Sexual harm (which is likely to constitute physical and psychological harm)	**can** qualify
Emotional harm	is **not** sufficient
Financial harm	(a) is **unlikely** to be sufficient, and (b) in practice a less restrictive remedy than a CTO is available—a financial guardianship order—will always be available.
Reputational harm	is at best **doubtful**

How serious?

There is very little guidance about seriousness, outside the suggestion that, in the case of *physical* harm, the threshold rests somewhere above "actual bodily harm" but below the standard required for "grievous bodily harm".

Current practice in NSW: the Chief Psychiatrist's communiqué

The current practice in NSW is described as follows by the Department of Health:[42]

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

…

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).

[42] "Amendments to the NSW Mental Health Act (2007) FACT SHEET: Community Medical Practitioners" https://www.health.nsw.gov.au/mentalhealth/resources/Factsheets/community-medical-practitioners.pdf . As far as we are aware the Communiqué itself has not been published to the public.

We will show that that communiqué is harmful and inaccurate. It should be withdrawn, and in the meantime it should not be followed.

The communiqué is harmful and inaccurate

The communiqué purports to explain what "is intended" by "serious harm" in the Act. How to find out what "is intended" by parliament when making legislation is well established. We have done that exercise (see above). It appears the Chief Psychiatrist has not. The communiqué is inconsistent with the meaning of the Act reflected in the authoritative decisions of the courts.

Types of harm

As to type of harm, the communiqué gets the law wrong. Perhaps the simplest way to illustrate that is to extend the table given above, and compare the conclusions above with the communiqué.

Type of harm	**Court decisions**	**Communiqué**
Physical harm	**can** qualify	**can** qualify
Psychological harm	**can** qualify	**can** qualify
Sexual harm (which is likely to constitute physical and psychological harm)	**can** qualify	**can** qualify
Emotional harm	is **not** sufficient	**can** qualify
Financial harm	(a) is **unlikely** to be sufficient, and (b) in practice a less restrictive remedy than a CTO is available—a financial guardianship order—will always be available.	**can** qualify
Reputational harm	is at best **doubtful**	**can** qualify

The communiqué gives unqualified support to types of harm that the courts have said either they are not sufficient (emotional harm) or they are doubtful (financial harm; reputational harm) and unlikely in any event to justify a CTO (financial harm).

Degree of harm (seriousness)

As to how serious is "serious", the communiqué gives no guidance at all. That leaves the impression that seriousness is not an important consideration—not only when it

comes to determining what orders might be appropriate, but at the threshold stage of determining whether the person is even a "mentally ill person". Remember, if the person is not a "mentally ill person", then the Tribunal does not have the power to make a CTO.[43]

The communiqué should be withdrawn …

That the communiqué is wrong should be enough to show it should be withdrawn; but there is more. Application of the communiqué leads to CTOs being made where they are inappropriate and indeed where the Tribunal does not have the power to make them. The communiqué is a cause of misery and lasting psychological damage, unlawfully inflicted.

… and in any event it should not be followed

Even if it is not withdrawn, the communiqué should not be followed—again, because it is wrong.

There is no legal impediment to the Health Department, and the Mental Health Review Tribunal, not following the communiqué. There is no legislative authority for the communiqué: it is merely a guideline which the Health Department and the Mental Health Tribunal choose to follow. It is not, on its face, a direction or an expression of government policy within the discretions granted by the act. Even if it were, it could have no force. The executive government—ministers and public servants—can publish policies and, in some cases, give directions as to how discretions are to be exercised. But the communiqué is not that. It is a statement of the Chief Psychiatrist's opinion on the meaning of "serious harm" in the Mental Health Act. It relates not to how the Tribunal is to exercise its powers to make CTOs, but to something that must be established before the Tribunal even has that power (a jurisdictional fact). And, as explained, it is wrong and therefore harmful.

[43] For reasons already discussed, overlooking the "seriousness" of the harm might have contributed to the over-wide list of *types* of harm the could ground a CTO.

Definition of 'serious harm' in Victoria

Once again, it is worth considering how "serious harm" is interpreted in a similar context 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, enhanced by court decisions clarifying what actions or issues can constitute serious harm. In *WCH v Mental Health Tribunal* the court said:

> "The word 'serious' has been described as having a meaning which includes[44] 'important, demanding consideration and not slight or negligible'. The Macquarie Dictionary[45] defines 'serious', in the context of an illness as 'giving cause for apprehension; critical'. The[46] word 'harm' has been defined as including 'hurt, injury or damage'. In the matter of *JMN*, 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".[47] [48]

In comparing the Victorian law with the NSW counterpart, it is clear that the meaning of 'serious' is more clearly established in the Act and the case law. It emphasises closer attention to individual circumstances. That is reflected in Tribunal decisions, such as *ZIF*.[49] where the Tribunal said:

> "*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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[44] *WCH v Mental Health Tribunal (Human Rights) (Amended)* [2016] VCAT 199.
[45] Ibid at [65].
[46] *Macquarie Dictionary* (online at 9 October 2020) 'serious'.
[47] Ibid 'harm'.
[48] *JMN* [2015] VMHT 29 (9 February 2015).
[49] *ZIF* [2015] VMHT 132 (12 August 2015)

Those statements correspond closely with our analysis, above, of the legal position in New South Wales.

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'. In relation to suggesting repeals to the Victorian legislation,[50] 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.[51]

[50] 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.
[51] Ibid.

Part 2
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 to prevent serious harm'. This means that the Mental Health Review Tribunal must be satisfied [52] that there are reasonable grounds to believe that serious harm will arise as a result of mental illness, unless the person is forcibly treated. However the specific phrasing has resulted in ambiguity surrounding the implementation of this *Act,* as the precise meaning of the words remains unclear.[53]

Definitions of 'reasonable grounds' and 'necessary'

To gain a clear understanding of who is a "mentally ill person" within the definition in *MHA* s14, it is crucial that 'reasonable grounds' and 'necessary' are defined. That is important, because it affects not just what orders the Tribunal can make but whether it has any power to make an order in the first place: unless the Tribunal is of the opinion that the person is a "mentally ill person" it has no power to make a CTO.[54]

As these terms are not defined by the *Mental Health Act* itself, extrinsic and secondary sources are required to interpret their meaning.

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[52] *MHA* (n 4) s 14.
[53] Ibid.
[54] *MHA* s 53(4), discussed above [cross-ref].

The Cambridge Dictionary defines 'reasonable' as a decision that is 'based on or using good judgment and therefore fair and practical.' As such, the decision that care, treatment or control[55] 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.' Hence, under section 14 of the *Mental Health Act,* when using the word[56] 'necessary,' it is implied that care, treatment or control of the person is **needed** to protect an individual from harming oneself and others, otherwise serious harm would occur. "Necessary" is a strong word, and it is further limited by the prevention of serious harm. The power to order forced medication is not a general power to order treatment because the Tribunal believes it is in the patient's best interests. The power is there to prevent serious harm. It follows that the order should go no further than treatment that has that result. If treatment A is enough to prevent serious harm, but the Tribunal believes that treatments A, B and C would be the best thing for the person, it must stop at treatment A. That follows from the purpose of the power and the serious nature and consequences of forced medication; and it is reinforced by the express requirement that any treatment ordered be the "least restrictive alternative". Therefore, 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 it is appropriate and reasonably available.[57]

Clarification for 'reasonable grounds' and 'necessary' definitions

The cases of *Talovic,* and *Sullivan,* examine how the courts interpret both phrases of 'reasonable grounds' and 'necessary'.[58] While *Sullivan* found that a CTO was 'necessary' because of the life threatening state of the patient with no other less restrictive measures, *Talovic* exemplified an instance where 'reasonable grounds' were not met.

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[55] *Cambridge Dictionary* (online at 18 June 2023) 'reasonable'. <https://dictionary.cambridge.org/dictionary/english/reasonable>
[56] Ibid 'necessary'.
[57] *MHA* (n 4) s 53(3a).
[58] *Talovic* (2014) 87 NSWLR 512 ('*Talovic*'); *Sullivan* [2019] NSWMHRT 3 ('*Sullivan*').

In the case of *Sullivan* 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' and consequent physical decline which placed her at serious risk to herself. Furthermore, Ms Sullivan was not receptive to educational [59] 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.

The case of *Talovic* is also valuable in examining the court's interpretation of 'reasonable grounds.' Mr Talovic had complained to his insurer that its late payment of workers compensation was 'sending people on the streets and letting them die'. The insurer interpreted that as a threat to kill himself, and notified police. Police came and searched his apartment (without a warrant or Mr Talovic's consent) and took him into custody. He was taken (without consent) to 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

[59] Ibid.

belief, having regard to the information which was in the police officer's mind, and the circumstances.[60]

The court found that it was not sufficient that the officer believe that it is *probable* that the relevant person *may*, *might*, or *could* attempt to kill themselves. The belief must be that they *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. Similarly, decisions made by tribunals and courts about mentally[61] 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 continue to be made on inadequate information, such mistakes can continue under section 14, which would be detrimental to the people affected.

Boundaries of 'reasonable' and 'necessary' supported by case law

Case law within New South Wales on the use of forced medication confirms that forced medication is recognised as adverse in nature, so that the limits on forced medication are necessary and must be observed.

In *S v South Eastern Sydney*,[62] S was diagnosed with a 'low grade schizophrenic illness' and, after several years of hospital admissions and refusal to take medications or medical treatments, had been subjected to a CTO that required S to take a fortnightly injection, despite having objected to injections and seeking to have medications consumed through oral means. In his judgment, Brereton J found that despite the necessity to impose a CTO on the plaintiff, the CTO made by officials was not the 'least

[60] Ibid 184, 191.
[61] Ibid 160.
[62] *& Illawarra Area Health Service and anor* [2010] NSWSC 178 ('*S v South Eastern Sydney*').

restrictive alternative consistent with safe and effective care',[63] and went beyond the boundaries of what was reasonable or necessary. Oral medication was a perfectly viable solution, with which S was willing to comply; but the Tribunal had ignored that in framing the CTO.[64] S was capable of adhering to a treatment plan appropriate to meet their needs. Where S was willing to take medication orally but objected to injections, and the medication was available orally, forced injection was clearly not the "least restrictive alternative". This judgment therefore reveals the necessity for CTO's not to go beyond the treatments that are reasonable and necessary to prevent serious harm.

In more recent case law, notably *T v South Western Sydney Local Health District,*[65] the use of CTO's were significantly discussed. In similar circumstances to *S v South Eastern Sydney*, the plaintiff was in agreement to being subject to a CTO, objected to the imposition of a fortnightly injection due to possible side effects caused by the injection that would impede on her ability to engage in her newfound employment opportunity. The Court found that the requirements to fulfill a CTO were not met, and thus the order could not be made.

- Lindsay J discusses the 'relevance of administrative convenience to the making and implementation of a CTO.'[66]
- The case establishes that, citing *Rogers v Whittaker,*[67] that it is required that for medical treatment to be administered to an individual, the individual must consent to the suggested method of treatment.[68]
- Affirms aspects of the discussion in *Z v Mental Health,* in arguing that due to the intrusive effects of a CTO on the affected person's civil liberties, specific conditions must be met in the making of a CTO.[69]

[63] Ibid [41].
[64] Ibid [38].
[65] [2022] NSWSC 1173 ('*T v South Western Sydney*').
[66] Chris Chosich, 'Court revokes community treatment order because of interference with patient's capacity to work — 'T v South Western Sydney Local Health District'' February 2023 <https://search.informit.org/doi/abs/10.3316/agispt.20230228083896>.
[67] *(1992)* 175 CLR 479 at 489. <https://jade.io/article/67721>
[68] *T v South Western Sydney* [8].
[69] Ibid [35].

Part 3
Alternatives to Forced Medication

Commentary

Forcibly medicating mental health consumers against their expressed wishes under the term Community Treatment Orders (CTO)[70] 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.' The *Act* further states that the Tribunal may only[71] 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.' It is also a requirement that the affected person would benefit from the order.[72]

The Tribunal is obligated to work with the consumer rather than impose medications that potentially have severe side effects. However, the use of CTOs today has been proven to be inefficient, and their coercive nature undermines their intended therapeutic benefits. They are invasive treatments that go against the[73] wishes of an individual, and can cause additional trauma and fear. This in turn may exacerbate[74] negative symptoms amongst mental health consumers. Also, evidence to support the benefits and effectiveness of mandatory community treatment orders is at best limited. Multiple studies, confirmed by meta-analytic evidence, have shown that CTO's do not achieve

[70] *Community Treatment Orders*
https://www.mhrt.nsw.gov.au/civil-patients/community-treatment-orders.html
[71] *MHA* (n 4) s 53.
[72] Ibid.
[73] 'Community Treatment Orders' (Research Paper, Justice Action, March 2014) 1, 7-11.
[74] Ibid 7-8.

their stated goals.[75] 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.[76]

It is essential to focus on alternative ways to support mental health consumers as CTO's have been shown to be ineffective, necessitating more appropriate solutions be pursued. 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.' As CTOs are imposed against a person's will, it should be an option of last resort.[77] 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)*, the matter related to the *Mental Health (Forensic Provisions) Act*, and whether a forensic patient should be forcibly hospitalised and detained under section 14.[78] The Commission noted that any decision to involuntarily detain someone should be made in consideration of an individual's right to liberty. They determined the question was not whether the plaintiff ought to be hospitalised due to mental illness,[79] but whether it was necessary to protect them from serious harm.[80]

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[75] See our analysis in "Community Treatment Orders" (Research paper, Justice Action, March 2014) https://justiceaction.org.au/community-treatment-orders/.
[76] 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.
[77] *MHA* (n 4) 53(3)(a).
[78] *Re J (No 2)* [2011] NSWSC 1224.
[79] Ibid.
[80] Ibid [62].

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. In this particular decision, the Court decided that the CTO was the best and 'least restrictive option', given the individual's chronic condition and risks of non-compliance.[81] The decision was reached as the alternative was forced hospitalisation (i.e. individual is permanently bound to the hospital). In short, a 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 ordinary private citizens who are merely deemed 'mentally ill persons' under the *Mental Health Act.*

The requirement that the Tribunal be satisfied that

> no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonablzy available[82]

requires active consideration of other possible modes and sources of care. Nowadays that should include the potential availability of a package under the NDIS. Where there is no effective advocacy for the affected person, and the applicant is the body proposing to carry out the proposed order, the likelihood that alternative, less restrictive treatments will be explored in the Tribunal hearing is very low.

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 that achieve better health outcomes for all mental health consumers.

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[81] *Re J (No 2)* [2011] NSWSC 1224.
[82] *MHA* s 53(3)(a)

Alternative Treatment Options

Little seems to have been gained in Australian trials and studies to effectively driving down coercive practices within it'a mental health facilities, and it is urged to expand alternative treatments, including peer-led initiatives.

In 2018 a comprehensive literature review by the University of Melbourne explored alternatives to coercion in mental health settings, and analysed the efficacy of over 100 programs internationally[83]. It's analysis of five diverse Australian studies evaluated that there was a: preliminary benefit to Victoria's single MH acute unit's use of a sensory room[84]; although limited to its service type was viewed as beneficial (initial 36% reduction, showed no post trial benefit) following Victoria's 'Safewards' 2017 inpatient ward trial to maintaining seclusion rates[85] ('Safewards' was derived from UK to reduce conflict 'flashpoints' in psychiatric wards[86]); an Australian study in 2018 encouraged supported decision-making in clinical practice and policy among mental health practitioners and introducing legal supported decision-making mechanisms[87]; consistent with previous research, a 2014 Australian study of 88 participants' discontinuation of antipsychotic medication, showed insights into consumer's motivations for discontinuation, and that it was frequently a non-collaborative action with half having ceased without clinician knowledge or support (and suggested mental health nurses may have a role in future)[88]; following a 'Care without Coercion Conference' in 2010, key national policy documents applying the 3 frameworks (human rights, personal recovery,

[83] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf
[84] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 149
[85] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 155
[86] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf P 193
[87] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 167
[88] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 180

trauma informed practices) identified the use of force, noting that policies do signal excluding the use of force, and suggesting applied pathways[89].

The review highlighted user-led alternatives. One was the UK National User Survivor Network campaigning against 'abusive practices of forced medication, restraint and seclusion, and stripping' stated the urgency to the search for alternatives.[90] The review recognised that user organisations include talking therapies, individual advocacy, mutual aid programs such as intentional peer support, peer-run crisis respite houses and non-medication or low-medication approaches. Yet rarely are these practices explicitly test preventing or reducing coercive interventions, and instead evaluate in terms of individual's benefit or self-reported satisfaction[91]. Other alternative strategies include the use of 'advocacy','medication discontinuation', 'crisis resolution' and 'crisis/respite houses'.[92]

The University of Melbourne review valued the services based on a user-led initiatives, such by the Users and Survivors of Psychiatry that examined the role of organised and informal peer support in 'exercising legal capacity in Kenya'. A user-led initiative explicitly designed to reduce coercive practices, commissioned by the Australian Capital Territory (ACT) Mental Health Consumer Network is Foxlewin's empirical study, examined seclusion reduction interventions at a single Australian hospital, in which seclusion incident rates reportedly fell from 6.9% in 2008/9 to less than 1% in 2010/11.[93] A USA study's policy of 'No force First' in 2012 of over 12,000 adults experiencing a mental health crisis showed success in halving chemical restraint to 1.27% of recipients in a crisis centre versus statewide use.

Australia, New Zealand and the Pacific Island countries have been urged to address coercion in mental health context 'to reduce, prevent and end coercive practices in the mental health context, including among Indigenous communities', especially in the light

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[89] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 190
[90] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 23-24
[91] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 24
[92] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p25
[93] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 25

of evidencing positive results for Tonga in strengthening disability access to mental health services.[94]

It is recognised that outcomes depend on the application of multiple contextual factors including: Advance planning, peer support, respite services, trauma-informed approaches, family and social network responsiveness, and in addressing organisational culture. To achieve the prevention and ending of coercion, a call to rebalance the current 'over-investment in academic psychiatry into the 'narrowest of biological research' as interdisciplinary research demonstrates the value of pursuing social, clinical and community studies within a humanistic frame.[95]

Option 1: Consumer Workers

An alternative to CTOs is 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: Advance Directives

In addition, 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.

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[94] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 106

[95] https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf p 109-110.

Existing uses for advance directives mainly involve situations near the end of a person's life,[96] 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 allows physicians to 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 that 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.

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.[97]

Option 3: 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. In NSW they may take one of two forms, either incorporated in an Appointment of Enduring Guardian,[98] being someone that is appointed to make health decisions on behalf of, or in a separate more informal

[96] 'Advance Directives' (Policy Statement No 3, Lived Experience Australia, June 2010) 1
[97] SR Kisely, LA Campbell, 'Advance treatment directives for people with severe mental illness' [2008] (8) *Cochrane Database of Systematic Reviews* 1, 1-44.
[98] *Guardianship Act 1987* (NSW) s 33(3).

document. The issue, however, is 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. Under common law, they can be binding if the criteria of specificity and competence at the time of writing are fulfilled.[99]

The NSW Department of Health also supports the use of advance directives, providing a guideline on its use.[100]

The Victorian Approach to 'least restrictive'

There has been significant pressure to reform the laws of mental illness in Australia in an effort to better protect mental health consumers in accordance with their human rights. A number of conventions and acts have recently been passed in consideration of these goals.[101] This includes the passage of the Victorian Charter of Human Rights in 2006, and Australia's ratification of the Convention on the Rights of Persons with Disabilities and mental illness.[102] In response, in 2014 the Victorian government passed a new *Mental Health Act*.[103] The *Act* signifies a major departure,[104] and strengthens the position for mental health consumers and their rights, autonomy, and right 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. This is not a stated objective of the NSW *Mental Health Act* as it currently stands.[105] While there is an objective to 'facilitate the involvement' in decisions, there is no intention to place mental consumers at the forefront of decisions.[106]

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[99] Sarah Ellison et. al., 'The legal needs of older people in NSW' (Research Publication, Law and Justice Foundation, 2004) 398. <http://www.lawfoundation.net.au/report/older>
[100] 'Making an Advance Care Directive' (Information Booklet, NSW Government, July 2023). <https://www.health.nsw.gov.au/patients/acp/Pages/acd-form-info-book.>
[101] 'Mental Health Bill 2014' (Research Brief No 5, Parliament of Victoria, March 2014).
[102] *Charter of Human Rights and Responsibilities Act* 2006 (Vic).
[103] *United Nations Convention on the Rights of Persons with Disabilities.*
[104] *MHA (Vic)* (n 26).
[105] Ibid s11(a)-(e).
[106] *MHA* (n 4) s 3(e).

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. 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.[107] This places the wishes and interests of mental health consumers at the forefront of any decision that would allow forced medication.[108] This allows for more effective protection of the rights, dignity and autonomy of people living with a mental illness in Victoria and should therefore be adopted by NSW.

[107] *MHA (Vic)* (n 26) s 5.
[108] Ibid s11(a)-(e).

Appendix

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 53

53 Determination of applications for community treatment orders

(1) The Tribunal is, on an application for a community treatment order, to determine whether the affected person is a person who should be subject to the order.

(2) For that purpose, the Tribunal is to consider the following--

(a) a treatment plan for the affected person proposed by the declared mental health facility that is to implement the proposed order,

(b) if the affected person is subject to an existing community treatment order, a report by the psychiatric case manager of the person as to the efficacy of that order,

(c) a report as to the efficacy of any previous community treatment order for the affected person,

(d) any other information placed before the Tribunal.

(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.

(3A) If the affected person has within the last 12 months been a forensic patient or the subject of a community treatment order, the Tribunal is not required to make a determination under subsection (3) (c) but must be satisfied that the person is likely to continue in or to relapse into an active phase of mental illness if the order is not granted.

(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.

(5) For the purposes of this section, a person has a "previous history of refusing to accept appropriate treatment" if the following are satisfied--

(a) the affected person has previously refused to accept appropriate treatment,

(b) when appropriate treatment has been refused, there has been a relapse into an active phase of mental illness,

(c) the relapse has been followed by mental or physical deterioration justifying involuntary admission to a mental health facility (whether or not there has been such an admission),

(d) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery from, the debilitating symptoms of a mental illness or the short-term prevention of deterioration in the mental or physical condition of the affected person.

(6) The Tribunal must not specify a period longer than 12 months as the period for which a community treatment order is in force.

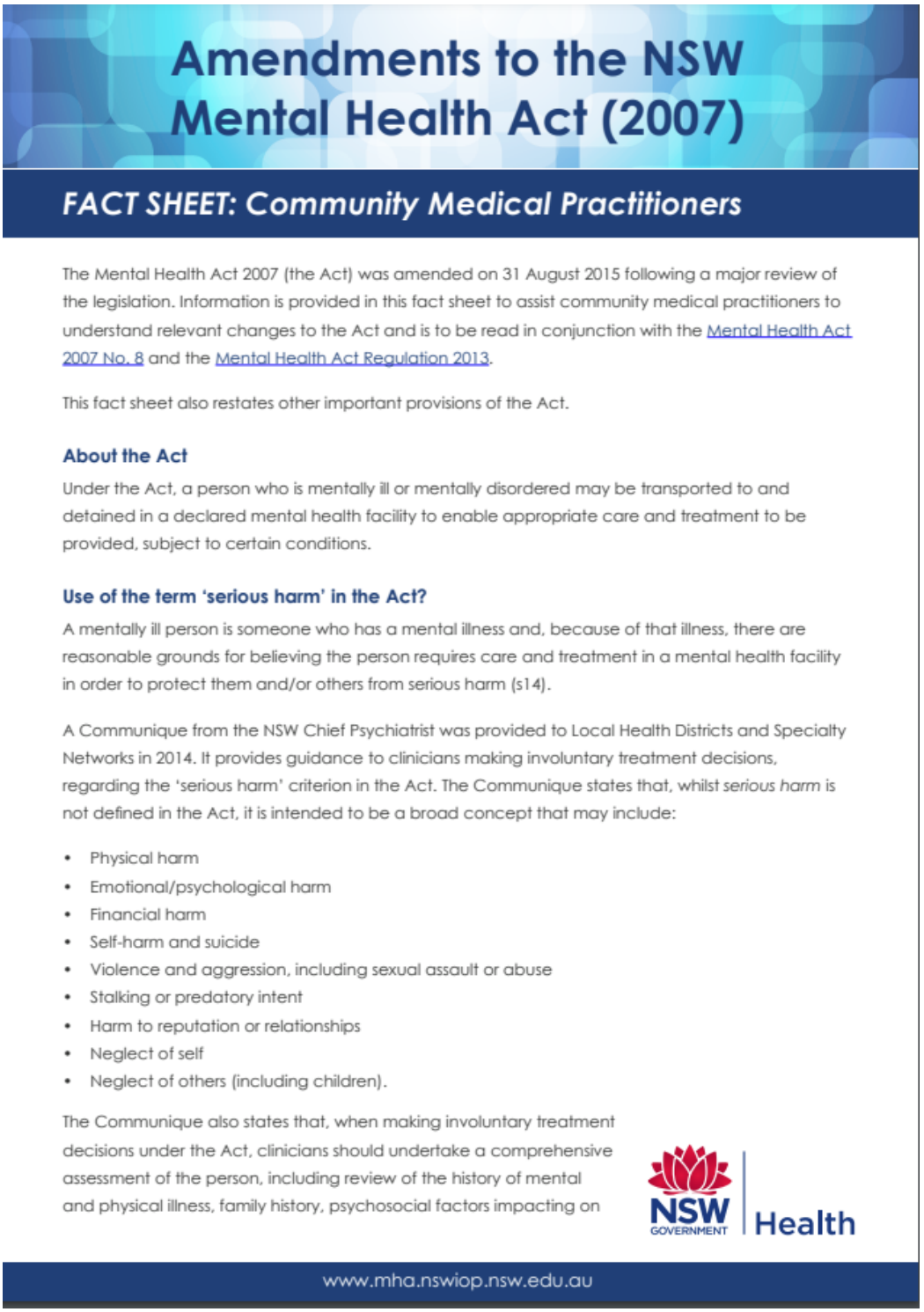
(7) In determining the duration of a community treatment order, the Tribunal must take into account the estimated time required--

(a) to stabilise the condition of the affected person, and

(b) to establish, or re-establish, a therapeutic relationship between the person and the person's psychiatric case manager.

(8) The Tribunal may 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.

Appendix 2: Department of Health Fact Sheet[109]



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

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

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'.

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

NSW GOVERNMENT Health

Appendix 3: Mental Health Tribunal Guidelines[110]

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.

[110] 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

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.

Mental Health Act 2014 (VIC) s 5

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—

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

(ii) 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.