

## **Amendments to the *Mental Health Act 1986 (Vic)* regarding involuntary treatment and Community Treatment Orders**

**By Simon Cooke**

### **Background**

Treatment for the seriously mentally ill almost always involved detention in an asylum until effective drug treatments were developed after the Second World War. The new drug treatments allowed psychiatrists to treat an increasing proportion of patients in the community and began the process of deinstitutionalisation.

The law was slow to respond to these changes. It was not until 1986 that the Community Treatment Order (CTO) was introduced in Victoria as part of the new *Mental Health Act* ('the Act'). Despite the introduction of the CTO, the Act continued to focus on the 'detention' of patients.

The Victorian Parliament passed the *Mental Health (Amendment) Act 2003* ('the amending Act') in late 2003. The majority of the amendments in this Act have not commenced, although they must commence by 1 January 2005. These provisions amend the Act to shift its focus from the need to detain patients to the need to provide treatment. This summary focuses on the new provisions introduced by the amending Act.

### **Involuntary treatment order**

The new provisions introduce the concept of the involuntary treatment order. An involuntary treatment order is the basis for providing in-patient and out-patient treatment to involuntary patients under the Act. The criteria for making an involuntary treatment order are that:

- (a) the person appears to be mentally ill; and
- (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
- (c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

The new criteria follow the existing criteria closely, but replace of the separate criteria for admission and detention as an involuntary patient and for making a CTO currently used in the Act.

## Process for making an involuntary treatment order

The new process for making an involuntary treatment order will be similar to the current process for admitting an involuntary patient or making a CTO, but clarifies the way in which assessments and orders may be made in the community. The new process will be:

- Request and recommendation. A recommendation may only be made by a registered medical practitioner who considers that the criteria for involuntary treatment are met and that an involuntary treatment order should be made. The request and recommendation have effect for 72 hours following the examination by the practitioner who made the recommendation.
- Assessment or transport. A person who has been recommended must either be assessed in the community by a mental health practitioner or transported to an approved mental health service.<sup>1</sup>
- Involuntary treatment order. An involuntary treatment order *must* be made if the person has been recommended. The order must be made either by a mental health practitioner in the community or a registered medical practitioner at an approved mental health service. If either practitioner considers that the criteria for involuntary treatment are not met or that an order should not be made, he or she must notify the authorised psychiatrist to ensure that the '24 hour review' takes place as soon as practicable.
- 24 hour review. The authorised psychiatrist must examine the person subject to the involuntary treatment order within 24 hours of the order being made. The authorised psychiatrist must either discharge the person if the criteria for involuntary treatment do not apply to the person or confirm the order if the criteria do apply.
- Consideration of CTO. If the authorised psychiatrist confirms an involuntary treatment order, he or she may make a CTO for the person. The authorised psychiatrist may confirm an involuntary treatment order without making a CTO *only if* he or she is satisfied that the treatment required for the person cannot be obtained through the making of a CTO.

## Community Treatment Order

The new provisions contain a new procedure that must be followed when a CTO is made. The authorised psychiatrist must:

- inform the person that the order has been made;
- give the person a copy of the order; and

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<sup>1</sup> In some circumstances, a person may still be transported to an approved mental health service without a recommendation having been made.

- inform the person of the grounds on which the authorised psychiatrist decided to make the order.

A CTO can only be made for a period not exceeding 12 months but may be extended. The procedural requirements for making a CTO also apply to extensions of CTOs. The new provisions confirm the effect of the decision of the Supreme Court in *Wilson v Mental Health Review Board* that a person ceases to be an involuntary patient if his or her CTO simply expires. If a person is discharged from a CTO, then his or her involuntary treatment order also expires.

The new provisions specify that the supervising medical practitioner must assess the person who is subject to a CTO at regular intervals. If this practitioner considers that the criteria for involuntary treatment do not apply to the person or that the treatment required for the person cannot be obtained under the CTO, he or she must notify the monitoring psychiatrist. The monitoring psychiatrist must then examine the person as soon as practicable.

A CTO may be revoked (and the person detained) if either:

- the involuntary treatment criteria apply but the treatment required cannot be obtained under the CTO; or
- the person has not complied with the order or treatment plan, reasonable steps have been taken to obtain compliance, and there is a significant risk of deterioration because of non-compliance.

Non-compliance, on its own, is no longer sufficient to justify revocation of a CTO.

### **Treatment plans**

The new provisions require each patient to have a treatment plan prepared by the authorised psychiatrist. The authorised psychiatrist must review the plan on a regular basis and revise it as necessary. The authorised psychiatrist must take into account:

- the wishes of the patient, as far as they can be ascertained;
- unless the patient objects, the wishes of any guardian, family member or primary carer who is involved in providing ongoing care or support to the patient;
- whether the treatment to be carried out is only to promote and maintain the patient's health or well-being;
- any beneficial alternative treatments available;
- the nature and degree of any significant risks associated with the treatment or any alternative treatment; and
- any prescribed matters (none are prescribed as yet).

The content of the treatment plan is set out in the following table. The authorised psychiatrist must give the patient a copy of the treatment plan and discuss it with the patient.

<b>Content of treatment plan</b>	
<b>Patient is detained</b>	<b>Patient is subject to a CTO</b>
<ul style="list-style-type: none"> <li>• an outline of treatment;</li> <li>• anything else the authorised psychiatrist thinks appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• an outline of treatment;</li> <li>• the monitoring psychiatrist (an authorised psychiatrist or delegate);</li> <li>• the supervising medical practitioner;</li> <li>• the patient's case manager;</li> <li>• the place at which the patient is to receive treatment;</li> <li>• the times at which the patient is required to attend to receive treatment;</li> <li>• the intervals at which the supervising medical practitioner must submit a written report concerning the patient's treatment to the monitoring psychiatrist;</li> <li>• anything else the authorised psychiatrist thinks appropriate</li> </ul>

### **New powers for the Mental Health Review Board**

The amendments give the Mental Health Review Board (MHRB) a number of new powers.

During each appeal and review, the MHRB must review the patient's treatment plan to determine whether the authorised psychiatrist has taken the necessary matters into account and whether the plan is capable of being implemented by the approved mental health service. The MHRB can order the authorised psychiatrist to revise the treatment plan.

The MHRB has been given the power on review of a patient detained under an involuntary treatment order to order the authorised psychiatrist to make a CTO within a reasonable period. The Explanatory Memorandum states that this time is 'for accommodation and appropriate community support to be arranged for the patient'. During this period, the authorised psychiatrist may apply to the MHRB to reconsider its order. The Explanatory Memorandum states that the clause means that the authorised psychiatrist may bring the matter back to the MHRB if 'circumstances change'. This new power raises difficult questions about the liability of a health service for events while a patient is subject to a CTO that the MHRB ordered the authorised psychiatrist to make, and its responsibility to bring the matter back to the MHRB or to revoke the CTO.

The new provisions also require an authorised psychiatrist who is notified of a person's review to inform the patient's case manager of the review.

## **Amendments already in effect**

### **Confidentiality**

Amendments to the confidentiality provisions regarding the exchange of information between persons were reported in the November 2003 Issue of the Health Legal Report.

The confidentiality provisions are also amended to allow use of RAPID by public sector mental health services (not just approved mental health services) and DHS.

These amendments commenced on 22 October 2003.

### **Consent to non-psychiatric treatment**

The Act required that consent to non-psychiatric treatment (other than major non-psychiatric treatment) was 'informed consent' if given in writing after a clear explanation of the treatment and advice as to the reasons why it was necessary. The new provisions remove the requirement that this consent be given in writing. This amendment commenced on 22 October 2003.

### **Reportable death**

The new provisions amend the definition of 'reportable death' in the *Coroners Act 1985* (Vic) to confirm that it includes a patient within the meaning of the Act who was not a person held in care. This amendment commenced on 22 October 2003.

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As the name of the first suggests, the team focuses solely on the needs of the health sector.

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