



SUBMISSION MADE BY THE COUNCIL OF OFFICIAL VISITORS

to the

**Review of the *Mental Health Act 1996* and
*Criminal Law (Mentally Impaired Defendants) Act 1996***

in accordance with the *Mental Health Act 1996*, section 215.

INVOLUNTARY STATUS AND COMMUNITY TREATMENT ORDERS

Term of Reference:

“In regards to the operation and effectiveness of the Mental Health Act 1996, consider and have regard of the:

- 1. Effectiveness and need of Part 3, Divisions 1, 2 and 3;*
- 2. The implication of Part 3 in rural and remote areas; and*
- 3. Give consideration to alterations and possible additions to Part 3.”*

UNITED NATIONS PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS AND FOR THE IMPROVEMENT OF MENTAL HEALTH CARE (“UN PRINCIPLE”)

PRINCIPLE 1

“Fundamental freedoms and basic rights

1. *All persons have the right to the best available mental health care, which shall be part of the health and social care system.*
2. *All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.*
3. *All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.*
4. *There shall be no discrimination on the grounds of mental illness. ‘Discrimination’ means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.*
5. *Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.*
6. *Any decision that, by reason of his or her mental illness, a person lacks legal capacity and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.*
7. *Where a court or other competent tribunal finds that a person with a mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person’s condition, to ensure the protection of his or her interests.”*

**Legislation: *Mental Health Act 1996*, sections 45 to 54
Criminal Code, section 337**

COMMENTARY:

Under the *Mental Health Act 1996* selected facilities have been authorised under Section 21 for the purpose of the Act to allow amongst other things the detention of people with a mental illness as involuntary patients. A number of psychogeriatric units have been authorised and are used to detain patients, many of whom are not made involuntary.

The facilities used to accommodate these psychogeriatric patients are usually comprised of a unit with one or more wings which in turn have 2 or more wards. These units are secured by mechanical, combination or electronic locking devices. Patients are confined by locking of these facilities at the unit level, and usually at the wing level and from time-to-time at the ward level.

Council is of the view that these patients are 'detained' within the ordinary meaning of that term as they are not free to move within the community.

The *Criminal Code* section 337 states:

"337. Unlawful detention or custody of persons who are mentally ill or impaired

Any person who detains, or assumes the custody of, a person suffering from mental illness (as defined in the Mental Health Act 1996) or mental impairment, contrary to that Act or any law relating to mental impairment, is guilty of a misdemeanour and is liable to imprisonment for 2 years.

Summary conviction penalty: Imprisonment for one year or a fine of \$4 000."

Sections 36, 37, 43 and 45 (leaving aside transport orders) of the *Mental Health Act 1996* permit the detention of persons as involuntary patients in authorised hospitals. Section 54 requires (in part) that once a period of detention ends the person is to be permitted to leave the hospital.

"Release when period of detention ends

54. When a period of detention of a person under this Act in an authorized hospital ends the person --

(a) is to be informed in writing of that fact as soon as is practicable after the period ends; and

(b) unless the person is further detained in the hospital under this Act, is to be permitted to leave the hospital."

With many psychogeriatric patients they are not detained under the authority of the Act but are nevertheless placed in locked wards. These patients, due to the nature of their illness, are incapable of giving any meaningful consent and also because of their condition can be regarded as vulnerable.

In response to Council's concern three arguments have been put forward to justify current practice being:

- a) Duty of Care;
- b) consent of family or a relative; and
- c) implied consent by the patient as they do not consistently try to leave.

a) Duty of Care

It has been argued that the hospital staff have a "duty of care" to ensure the physical safety and well being of the consumers (for example to stop the person wandering away from the hospital) therefore it is permissible to detain them in a locked ward.

Whilst the Council acknowledges that the hospital has a "duty of care" it would contend that "duty of care" does not arise as a reason to detain an individual in an authorised hospital for anything other than in an emergency.

In any event the *Criminal Code* in section 262 imposes a duty of care irrespective of the means by which the person became detained; and that can then be read in conjunction with section 337 of the Code, which prohibits detention except as authorised by the *Mental Health Act 1996* or other law.

b) Consent of another

It has also been suggested that for those individuals who lack the capacity to consent that the obtaining of "consent" from next of kin / family members 'authorises' the person's treatment and detention.

It is the Council's view that a relative, and indeed any person other than the person themselves, cannot consent to detention in an authorised hospital and most of the patients concerned do not have the capacity to consent.

c) Implied consent by patient

Another suggestion is that because many of these patients do not express a desire to leave or there is a 'lack of will' to leave that this somehow implies consent.

When it comes to consent the person giving consent must have the capacity to do so and must be able to understand the consequences and alternative choices.

The term "informed consent" is often used when dealing with medical treatments. The tests put forward to determine the factors which comprise "informed consent" are essentially the same as for consent to detention and more particularly so when the detention may of itself be regarded as treatment (see *E.O. – v- Metropolitan Health Services and others*) where provision of a safe environment was found to be 'treatment' for a mental illness.

Despite strenuous efforts by Council over an extended period (since August 1999) there has been no apparent change to the practice of detaining psychogeriatric patients without proper authority under the *Mental Health Act 1996*.

Council is aware of a long legal opinion obtained by the Chief Psychiatrist which principally deals with the civil law aspects but in regard to the criminal law information received by Council is the opinion is to the effect that:

“the position under the Criminal Code is one of some difficulty, for which there is no easy solution”.

Council’s experience is that generally only psychogeriatric patients are treated this way. Patients under 65 years of age are generally treated in accord with the Act and if detained are detained as involuntary patients. Council can not see any reason why the treatment of persons aged 65 years or over should be any different in regard to detention than for persons under 65 years.

Of concern is not only the lack of response to apparent and continuing breaches of the criminal law but the potential exposure of staff working in the hospitals to criminal action for illegally detaining patients.

A clear statement is required in the Act that a person is not to be detained in an authorised hospital other than in an emergency unless that detention is authorised by this Act (or another nominated Act).

RECOMMENDATION:

The *Mental Health Act 1996* be amended to include a clear statement that a person is not to be detained in an authorised hospital other than in an emergency unless that detention is authorised by this Act (or another nominated Act).

Legislation: *Mental Health Act 1996, section 26*

- “26. (1) *A person should be an involuntary patient only if-*
- (a) the person has a mental illness requiring treatment;*
 - (b) the treatment can be provided through detention in an authorised hospital or through a community treatment order and is required to be so provided in order-*
 - (i) to protect the health or safety of that person or any other person;*
 - (ii) to protect the person from self-inflicted harm of a kind described in subsection (2); or*
 - (iii) to prevent the person doing serious damage to any property;*
 - (c) the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment; and*
 - (d) the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.*
- (2) The kinds of self-inflicted harm from which a person may be protected by making the person an involuntary patient are-*
- (a) serious financial harm;*
 - (b) lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships; and*
 - (c) serious damage to the reputation of the person.”*

COMMENTARY:

1 Protection from harm

The current provisions of section 26(1)(b) provide for involuntary treatment to protect the individuals from various forms of harm. There is no limitation provided to this provision as to when the harm is likely to occur. In theory, if there were a risk of harm in 6 months time an individual would meet the current criteria for involuntary status.

In considering an order, it is necessary to consider if deterioration may or is likely to occur. It is also necessary to consider whether this is over the short-term or the long-term. If it may occur in the long-term, then it would appear inappropriate to issue an involuntary order.

In other jurisdictions (refer Northern Territory and Queensland) the criteria for involuntary status require that there is “*imminent risk of harm*”. It is the Council’s

view that the criteria for involuntary status in WA should require “imminent risk” as this is more in keeping with the principle of least restrictive alternative.

2 Consent to Treatment

Issues related to capacity to provide informed consent and degree of insight are not static nor are they a case of “*all or nothing*”.

Insight is multi-levelled and transitory with individuals having better insight at one time versus another. People can have insight into:

- (a) having a mental illness;
- (b) having a particular mental illness;
- (c) having particular symptoms;
- (d) needing treatment;
- (e) needing particular treatment;
- (f) effects of medication on the symptoms;
- (g) their relapse signature; and / or
- (h) measures necessary to arrest relapse.

If a consumer is compliant with the treatment, but lacks insight into their mental illness, then this lack of insight is irrelevant and therefore, the person should not be an involuntary patient.

Similarly, an individual’s capacity to give informed consent is multi-levelled and transitory. An individual may consent to treatment but not the specific treatment that an individual clinician prescribes. If the refusal to a particular treatment is reasonable and the individual can and does consent to a different, but valid treatment, the person should not be deemed to meet the current section 26(1) (c) criterion. This does not appear to be the current practice where refusal of a particular treatment is deemed to mean a refusal of all treatment.

The Northern Territory (NT) *Mental Health Act 2002* section 7 specifies the matters that must be considered in obtaining an individual’s informed consent. By implication to assess any lack of capacity to consent these same matters must be considered.

Section 7 requires, in part, that the patient is provided with:

- “7. (3) *A person can give informed consent only when he or she has been given –*
- (a) *a clear explanation of the assessment and possible diagnosis, the nature of the proposed treatment, including sufficient information about the type of treatment, its purpose and likely duration to permit the person to make a balanced judgement regarding undertaking it;*
 - (b) *an adequate description, without concealment, exaggeration or distortion, of the benefits, discomforts and risks associated with the treatment;*
 - (c) *an adequate description of any appropriate alternative form of treatment that is reasonably viable;”*

The criteria for involuntary admission on grounds of mental illness requires, in part:

“14. (b) as a result of mental illness –

....
(iii) the person is not capable of giving informed consent to the treatment or has *unreasonably* refused to consent to the treatment” (emphasis added).

A patient may reasonably refuse one particular type of treatment but consent to another “*appropriate alternative form of treatment that is reasonably viable*”. This right should be upheld and maintained in the legislation as it offers the least restrictive alternative.

UN Principle 9 requires that an individual treatment plan be discussed with the patient and treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

UN Principle 9

“Treatment

1. *Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.*
2. *The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.*
3. *Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental Health knowledge and skills shall never be abused.*
4. *The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.”*

To treat a person who has the capacity to consent without that consent freely given is to impinge and even destroy the person’s personal autonomy. By discussing treatment plans (and by implication options) and allowing personal autonomy for consenting to treatment the least restrictive option can be achieved.

In the application of the Rights Instrument Western Australia (WA) did rather poorly. It would appear that the reason assessed for non-compliance (Indicator 9) was there being no provision for seeking consent in the case of involuntary patients. WA’s legislation appears to assume automatically that an involuntary patient is incapable of consent.

Council is of the view that determination of a person's capacity to consent to treatment and obtaining informed consent to general mental health treatment are

essential to preserve a person's autonomy and ensuring the least restrictive alternative.

RECOMMENDATION:

It is recommended that the *Mental Health Act 1996* section 26 be amended such that:

- 1 the matters which must be considered in the provision of consent are specified (as per Northern Territory *Mental Health Act 2002* section 7);
- 2 section 26(1)(b) require protection to be from "*imminent risk of harm*"; and
- 3 section 26(1)(c) include "*unreasonably refuse*".

Legislation: *Mental Health Act 1996*, sections 37 and 40

"Choices upon examination

37. (1) A psychiatrist who examines a person received into an authorized hospital under section 36 may -

- (a) make an order under section 43;
- (b) order that the person's detention continue for further assessment of whether an order should be made under section 43; or
- (c) decide not to make an order under this Act.

(2) An order under subsection (1) (b) is to specify the day and time when it was made and the end of the period during which the person may be detained, which is to be not later than 72 hours after the person was received into the hospital.

(3) An order under subsection (1) (b) authorizes the detention of the person in respect of whom it is made-

- (a) until the end of the period specified in the order; or
- (b) until a psychiatrist who has examined the person since the order was made either makes, or decides not to make, another order in respect of the person under this Act,

whichever is first."

"Reception into hospital

40. (1) A person in respect of whom an order is made under section 39 is to be received into the authorized hospital and may be detained there for -

- (a) 72 hours after the time of reception; or
- (b) until a psychiatrist who has examined the person since the order was made either makes, or decides not to make, another order in respect of the person under this Act,

whichever is first.

(2) A person is not to be so received if more than 7 days have elapsed since the referral was made under section 29 (2) (b).

(3) Being received into an authorized hospital under this section is not admission to the hospital for the purposes of this Act.

(4) If the person has not been examined by a psychiatrist within the period specified in subsection (1) (a), the person may not be detained any longer. "

COMMENTARY:

Section 37(1) and section 40(1)(b) set out the options available to a psychiatrist who examines a person received into an authorised hospital.

A further option should be available whereby the psychiatrist may order that the person no longer be detained and be released from the hospital.

Simply deciding to not make an order under section 37(1)(c) does not effectively remove the authority to detain for the balance of the 24 or 72 hour period authorised under section 36(1)(b) or section 40(1)(a) respectively. There is no requirement to show that a decision has been made to not make an order. Whatever the decision (i.e. to make or not make an order) ought to be documented.

The Council's proposal clarifies the power to order a release rather than be reliant on section 37(3) (b) to terminate the authority to detain as there is no defining action in deciding to not make an order:

“37. (3) An order under subsection (1) (b) authorizes the detention of the person in respect of whom it is made- ...

(b) until a psychiatrist who has examined the person since the order was made either makes, or decides not to make, another order in respect of the person under this Act,”

This proposal by the Council puts the decision not to make an order for involuntary status into a positive act, that is, to make an order to release the received person from detention.

RECOMMENDATION:

It is recommended that the *Mental Health Act 1996* sections 37 and 40(1)(b) be amended to require an “*Order to release from detention*” be issued if the decision is made to not make an involuntary patient order or order an extension of detention.

UNITED NATIONS PRINCIPLE 16

Legislation: *Mental Health Act 1996*, sections 48, 49, and 50

COMMENTARY:

Figures obtained from Mental Health Review Board show that in WA for 2001/2002 64.9% of patients admitted involuntarily (1551 out of 2390) were discharged from that status within 28 days of admission (refer Mental Health Review Board Annual Report 2002, page 17). This phenomenon is experienced in other jurisdictions for example the Auditor General Victoria report, *Mental health services for people in crisis*, 17 October 2002 reported that:

“5.37 Statistics provided by the Department of Human Services show that, during 2001, 51.6 per cent of involuntary patients were discharged within the first 2 weeks of admission and were not therefore listed for initial review by the Board. Of the 6 372 initial reviews listed for hearing in 2001, 37.8 per cent of patients listed for hearing were discharged from their involuntary status prior to the hearing date. Thus, the majority of involuntary patients (69.8 per cent) do not appear before the Board to have their situation independently reviewed, unless they appeal.”

Given the high incidence of discharge from involuntary status prior to the 28-day initial period there appears grounds to ensure a regular detailed review by a psychiatrist at shorter intervals.

Under the present Act there is no requirement which ensures detailed review of any patient other than prior to expiry of orders or for a review before the Mental Health Review Board.

Extracting other figures from the Mental Health Review Board 2002 Annual Report, there were 2390 persons made involuntary in 2001/02, but only 958 reviews completed. After allowing for a number of long-term patients who in one year would have had 2 reviews, the discharge from involuntary status in the period after initial involuntary admission and before their first periodical review at a maximum of 8 weeks must be very high. The number could not be determined by the Council of Official Visitors.

This experience of high rates of discharge in the initial period is not inconsistent with the experience in Victoria (see above).

The factors which lead to these discharge rates are possibly many and vary from patient to patient.

Some other jurisdictions (e.g. Northern Territory section 39(1)(a)) have 7 days as the maximum initial period for involuntary detention until the first review. However that Act has been in operation for a very short period so its effect on the discharge rates cannot be assessed.

Council is of the view that a 14 day maximum initial period is appropriate and would be in accord with UN Principle 16.2 that involuntary admission or detention be for as short a period as possible pending a review. Under the present WA provisions there is no requirement to be seen by a psychiatrist for up to 28 days, the maximum period for initial admission, and thereafter only once each 6 months. Council considers such lengthy periods are unacceptable; good practice would demand more frequent review but there is no assurance that such reviews would occur.

Similarly Council is of the view that subsequent periods of detention / review should be 3 months not 6 months. Examination of the Mental Health Review Board Annual Report 2002 (page 14) shows nearly 30% of patients do not complete a scheduled review (1365 scheduled, 958 completed) and also reports that 64.9% of involuntary patients are discharged from their initial involuntary status in under 28 days.

When the breakdown of requested reviews is examined 229 involuntary detained patients requested reviews and nearly 52% were not completed; for periodic involuntarily detained patients 34% of reviews were not completed (Mental Health Review Board Annual Report 2002, page 14). Commentary is made by the Mental Health Review Board that some 25% of patients “... *were discharged from their involuntary order after the review had been scheduled but before it was completed. Frequently, patients are discharged from involuntary status in the 48 hours prior to the review*” (Ibid, page 16).

Reports to Council indicate discharge from involuntary status does occur on the day of the review but before the review is undertaken.

A patient is invariably seen by a psychiatrist for the purpose of a Mental Health Review Board review – the high discharge rates show that being seen by a psychiatrist can result in discharge from involuntary status. Ensuring the patient is seen by a psychiatrist earlier in their admission may result in higher rates of discharge from involuntary status resulting in the least restrictive option and co-incidentally a significant saving in mental health care costs.

RECOMMENDATION:

It is recommended that the *Mental Health Act 1996*:

- 1 section 48 provisions be amended to provide a maximum initial period of detention of 14 days; and
- 2 section 49(4) provisions be amended to provide a maximum subsequent period of detention of 3 months.

Issue: ABSENCE WITHOUT LEAVE & ABSCONDING RECEIVED PERSONS

Legislation: *Mental Health Act 1996, sections 57 and 58*

“Absence without leave

57. A person is absent without leave if, while subject to an order for detention as an involuntary patient, he or she –

- (a.) is away from an authorized hospital without having been granted leave of absence; or
- (b.) having been away from an authorized hospital on leave of absence, fails to return to –
 - (i) the authorized hospital; or
 - (ii) another authorized hospital to which the person has been transferred,

when the leave expires or is cancelled.

“Apprehension of person absent without leave

58. (1) A person who, while subject to an order for detention as an involuntary patient, is absent without leave may be apprehended by –

- (a) a person who is --
 - (i) qualified as prescribed by the regulations; and
 - (ii) employed at the authorized hospital from which the person is absent;
- (b) a person qualified as prescribed by the regulations who
 - (i) is not employed at the authorized hospital; but
 - (ii) is authorized by a person qualified as so prescribed who is employed at the authorized hospital;

or

- (c) a police officer.

(2) A person who is not a police officer who apprehends a patient under subsection (1) is to take the patient to –

- (a) the authorized hospital from which the patient is absent; or
- (b) a police officer who is to ensure that the person is taken to the authorized hospital,

as soon as is practicable.

(3) A person who has a power of apprehension under this section may --

- (a) for the purposes of this section, enter any premises where the person to be apprehended is reasonably suspected to be; and
- (b) when apprehending the person seize anything that is likely to be used by the person in a way that would prejudice the health or safety of that person or any other person or would cause damage to any property.

(4) Section 199 applies to any thing seized under this section.”

COMMENTARY:

There are no legislative provisions covering persons absconding from detention after being received and awaiting examination by a psychiatrist.

To clarify the position Council is of the view that by deleting the term '*as an involuntary patient*' in each of sections 57 and 58 where it appears then any person no matter their status while the subject of an order for detention will be covered by the sections and liable to be apprehended if absent without leave.

RECOMMENDATION:

It is recommended that the *Mental Health Act 1996*, sections 57 and 58 be amended by deleting the term '*as an involuntary patient*' so that the provisions will apply to any person subject of an order for detention, no matter their status.

Legislation: *Mental Health Act 1996*, sections 65 to 85 inclusive

COMMENTARY:

The Council considers Community Treatment Orders (CTOs) are a necessary component in a continuum of care.

Overall aims of treatment in the community should be to guarantee, as far as possible, that a person's rights are interfered with to the minimal extent necessary to ensure it is in the persons treatment and health interests. All avenues of review, appeal, and complaint available to involuntary patients in hospitals should be available to those on a CTO.

The principles relating to informed consent and involvement in the preparation of the treatment plan recommended for treatment in hospitals ought to apply to a CTO (refer to Council's comments made in relation to sections 26 and 109).

Although the present Act does not specify that a CTO can nominate where a patient resides, a residence condition has been included as part of the treatment plan in CTOs issued under the present Act. Prescription of where a patient must reside is very restrictive on a person's freedom of movement and is in contravention of *Article 12 (1) United Nations International Covenant on Civil and Political Rights* that everyone shall have the right to liberty of movement and freedom to chose his or her residence. Such prescription of residence is also considered to be inconsistent with *UN Principles for the Protection of Persons with Mental Illness* Principles 1.1, 1.5 and 9.1.

Council is of the view that a CTO should only restrict a patient's freedom of movement in the community by directing when and where the patient is to present for treatment at a specified hospital, clinic or other place (e.g. where the person lives).

Any provisions for CTOs should only include treatments / requirements directly related to the patient's mental health care needs and limited to psychiatric treatment, rehabilitation and ancillary services as provided by qualified staff.

While there is a case for a slightly modified set of criteria for a CTO over involuntary treatment in a hospital, a CTO should only be issued if the treatment is available with suitable supports in the community where the patient chooses to live.

To ensure regular review of a person's status while on a CTO a maximum period of 3 months should remain which is in line with proposals for involuntary hospitalised patients.

A CTO should be of no effect unless the subject patient is aware of the order.

RECOMMENDATION:

It is recommended that the *Mental Health Act 1996* section 26 be amended to provide a set of criteria applicable to treatment in the community.

It is recommended that the *Mental Health Act 1996* be amended to include a new provision prohibiting Community Treatment Orders from including an order to reside in a particular place.

Revocation and Breaches of CTOs

The *Mental Health Act 1996* provides:

“Revocation of a community treatment order

70. (1) *The supervising psychiatrist may revoke a community treatment order with or without making an order that the person be admitted to, and detained in, an authorized hospital as an involuntary patient.*

(2) *An order may only be revoked --*

- (a) *if the patient has failed to do anything required to be done under the order or an order to attend under section 82; or*
- (b) *if it no longer appears that the requirements of section 66 for the making of a community treatment order are satisfied.”*

Revocation of a CTO under the present legislation can be problematic. A CTO may be revoked under section 70 without there being any deterioration in the person’s mental state but merely because they have failed to comply with just one component of their treatment plan. A better approach than revocation would be to proceed by way of a breach notice (see sections 80 and 81) if a person fails to comply with their treatment plan.

Council recommends amendment to the revocation power in section 70 by limiting the power to revoke to circumstances where:

- 1 the person no longer meets the criteria for issue of a CTO; and
- 2 if the person’s mental condition has deteriorated the person may be referred to an authorised hospital for assessment by a psychiatrist.

The *Mental Health Act 1996* provides:

“Action where breach continues

82. (1) *If the supervising psychiatrist, having given the person notice under section 81(1)(b), is not satisfied that since the notice was given the person has complied with the order, the psychiatrist may make an order to attend in respect of the person.*

(2) *An order to attend is an order requiring the person to attend at a time and place specified in the order to receive treatment.*

(3) *An order to attend is to be made in writing and given to the person to whom it is directed.*

(4) *An order to attend is to be accompanied by a written warning to the person to the effect that the assistance of a police officer may be obtained to ensure that the person attends for treatment.*"

Unlike other notices and orders, an order to attend following a breach of a CTO, made under section 82, does not specify who is responsible to ensure the written notice or order is given to the person to whom it is directed (section 82(3)). Responsibility should rest with the person issuing the notice or order.

The *Mental Health Act 1996* provides:

"Police assistance

84. (1) *If the person has failed to comply with an order to attend the supervising psychiatrist may make a written order authorizing a police officer --*

- (a) *to apprehend the person; and*
- (b) *to take the person for treatment as specified in the order to attend.*

(2) *An order is not to be made under subsection (1) if there is reasonably available a suitable alternative means of ensuring that the person attends for treatment as required by the order to attend.*

(3) *A person apprehended --*

- (a) *is to be given a copy of the order made under subsection (1);*
- (b) *is to be taken to the place specified for treatment as close as is practicable to a time when the treatment can be given; and*
- (c) *may be detained under the order until the treatment is given."*

Similarly no responsible person is specified to ensure an order made under section 84(1) is given to the person apprehended or when it is to be given. Logic would require that the copy be given at the time the person is apprehended.

Section 84(3)(c) authorises the detention of an apprehended person until treatment is given. If treatment is delayed, or is a 'long term' treatment then the detention may be for an extended period of time. Furthermore detention may, at present, be in premises other than an authorised hospital and therefore not subject to scrutiny by the Council of Official Visitors. Council considers that if treatment is long-term then it would be appropriate to terminate the CTO and place the person in an authorised hospital as an involuntary patient if necessary. To ensure treatment is not unduly delayed Council recommends that a maximum time limit be placed on the detention authorised by section 84(3) (c). An appropriate limit should be 6 hours being a significant portion of an ordinary working day.

There is no time limit on the life of an order made under sections 82 or 84. Council considers that such an order should lapse with the lapse of the CTO current when the further section 82 or 84 order is made. An extension of CTO under section 76 should not be available if a section 82 or 84 order has been made and treatment has not been given when the current CTO lapses. In such circumstances the patient would not be aware of the existence of the extension of CTO.

In the case of breaches and revocations there is presently no requirement to set out the necessity to breach / revoke the CTO by showing that the patient's mental condition has deteriorated or that the failure to comply will lead to imminent harm to the patient or others.

Rather than there just being a failure to comply, if that non-compliance is to trigger breach / revocation action it must be shown to lead, or has led, to deterioration in the patient's mental condition. Further, that such deterioration will cause imminent harm to the patient or others.

Council's view is that if imminent harm cannot be demonstrated then the patient would not meet the criteria for a CTO and breach / revocation should not occur. Documentation of those links is essential for accountability.

RECOMMENDATION:

It is recommended that the *Mental Health Act 1996* sections 70 and 80 be amended to require that:

- (i) a Breach of CTO is not of itself grounds for revocation;
- (ii) the provisions governing the grounds for revocation mirror the current provision for Breaches of CTOs, that is, there is a significant risk of deterioration of the person's condition, all reasonable steps have been taken to ensure compliance, in addition to the patient's failure to comply; and
- (iii) for both breaches and revocations the specifics of the deterioration risk be identified on the documentation giving notice of the breach or in the order of revocation.

It is recommended that the *Mental Health Act 1996* sections 82(3) and 84(1) be amended to specify:

- (i) the person responsible for providing a copy of the order/s;
- (ii) the time span in which this must occur.

It is recommended that the *Mental Health Act 1996* section 84(3)(c) be amended to provide a maximum time limit on the detention authorised by that section, specifically 6 hours being a significant portion of an ordinary working day.

It is recommended that the *Mental Health Act 1996* sections 82 and 84 be amended to specify the time limit on the life of orders under these sections.

It is recommended that an extension of CTO under *Mental Health Act 1996*, section 76 should not be available if a section 82 or section 84 order has been made and treatment has not been given when the current CTO lapses.

Attention is also drawn to Recommendation Fifteen contained in the Council's separate submission in respect to the operation of Council which says:

It is recommended that amendment be made to the Mental Health Act 1996 to require that whenever a consumer is made subject to Community Treatment Order the Council of Official Visitors is notified of their details.

BIBLIOGRAPHY

REPORTS

- 2000 ***Application of Rights Analysis Instrument to Australian Mental Health Legislation, Report to Australian Health Ministers' Advisory Council National Mental Health Working Group***; Commonwealth Department of Health and Aged Care, Canberra.
- 2002 ***Mental Health Review Board Annual Report 2002***; Mental Health Review Board, Western Australia
- 2002 ***Mental health services for people in crisis***; Auditor General Victoria report 17 October 2002
- United Nations International Covenant on Civil and Political Rights***
- 1991 ***United Nations Principles For The Protection Of Persons With Mental Illness And For The Improvement Of Mental Health Care***; Adopted by General Assembly resolution 46/119 of 17 December 1991

LEGISLATION

<i>Criminal Code</i>	Western Australia
<i>Mental Health Act 1996</i>	Western Australia
<i>Mental Health Act 2002</i>	Northern Territory