

Community Treatment Orders

Discussion Paper

Mental Health Branch
Department of Human Services

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Table of Contents

Introduction	2
CTOs in Victoria	2
Clarity of the CTO provisions	2
People subject to CTOs	2
Review of the CTO provisions	3
Issues	4
Expiry of a CTO	4
Detention	4
24-Hour Review by the Authorised Psychiatrist	6
Appeal and Review by the Mental Health Review Board	7
Treatment plans	8
Non-compliance with treatment	9
Revocation	11
When a CTO 'does not apply'	12
Relationship with the <i>Coroners Act 1985</i>	14
Restricted Community Treatment Orders	15
Appendix 1	17
Relevant sections of the <i>Mental Health Act 1986</i>	17

Introduction

CTOs in Victoria

Community treatment orders (CTOs) are provided for by the *Mental Health Act 1986* ('the Act'). They permit involuntary treatment of some people with mental illness while they live in the community. As such they offer a less restrictive option for involuntary treatment than inpatient treatment.

CTOs became part of Victorian law in 1986. In the second reading speech, the then Minister for Health outlined the following changes in public attitudes and the practice of psychiatry that underlay the new Act:

- increased awareness of civil rights;
- a shift from institutional to community-based services; and
- advances in psychiatric treatment.¹

The Act included a number of new policy directions that responded to these changes. In particular, the Act made provision for CTOs and the review of detention under the Act by an independent review board.

Clarity of the CTO provisions

The Mental Health Act regulates the detention of people with mental illness for the purposes of treatment and provides that treatment may be given without their consent. In doing so, the Act should provide a clear statement of the law and should be capable of being used with confidence by practitioners.

It has become apparent over a period of time that central sections of the CTO provisions are not clear and do not provide sufficient guidance for clinicians or consumers. The problems have been highlighted by:

- A criticism by the Coroner of the use of the word 'detention' in the Act in relation to CTOs, as one example of the complexity of these provisions.
- The decision in *Wilson v Mental Health Review Board* concerning the expiry of CTOs.
- A range of concerns about the CTO provisions which have been raised with the Office of the Chief Psychiatrist and by the Mental Health Legal Centre.

People subject to CTOs

CTOs are now the primary way in which people are provided with involuntary psychiatric treatment in Victoria. There are approximately 2,700 people subject to CTOs, and approximately 1,000 commencements, 470 revocations and 400 discharges per quarter.

When a CTO is revoked the person must return to inpatient treatment. Following inpatient treatment, many people who were formerly subject to a CTO that has been revoked will again be made subject to a further CTO. The approximately

¹ *Hansard* (Council), 26 March 1986, p286.

1,000 commencements of CTOs each quarter include people who have not been previously subject to an order as well as people who had been subject to a CTO before it was revoked. Approximately 400 CTOs are discharged each quarter, resulting in freedom from involuntary status.

Data from the Mental Health Review Board on the number of annual reviews (1,840 in 2000-2001) and reviews of extension of CTOs scheduled (1,876 in 2000-2001) shows that many people remain on CTOs beyond the initial order and beyond 12 months.²

Implications of the data for the review of CTO legislation

These data on the use of CTOs suggests that, in order to be workable, any proposed amendments must:

- Be administratively simple, because of the high volume of cases.
- Allow a simple procedure for revocation, inpatient treatment and return to a CTO, because of the high frequency of revocation and the importance of clinical continuity.
- Recognise that a large proportion of CTOs will be extended and will last longer than 12 months.
- Reduce social disruption and stigma for people subject to CTOs.

Review of the CTO provisions

The Mental Health Branch has undertaken a limited review of the CTO provisions in the context of the issues raised above. This discussion paper examines some of the issues and makes recommendations for legislative change to the Act. The intention of the review is to:

- Improve the operation of the CTO provisions within the current statutory framework.
- Improve clinical practice.
- Clarify and uphold the rights of involuntary patients.

Comments are invited about the various issues raised by the discussion paper and the key recommendations.

Written submissions should be addressed to:

Director, Mental Health
555 Collins Street
Melbourne 3000

And received no later than 17 March 2003.

² Mental Health Review Board, 2001, *Annual Report 2001*, Melbourne.

Issues

Expiry of a CTO

The Victorian Supreme Court examined the legislative scheme that establishes CTOs in *Wilson v Mental Health Review Board* [2000] VSC 404. The court concluded that a person's involuntary patient status ends if the CTO to which they are subject expires without having been extended.

The *Wilson* decision has been in effect since late 2000 and mental health services have incorporated this interpretation of the law into their clinical practice. Nevertheless, it is considered desirable to amend the CTO provisions to ensure ongoing clarity of this position.

It is proposed to amend the CTO provisions to provide that involuntary status is automatically discharged when a CTO expires without having been extended.

It is to be noted, however, that it is not appropriate to allow a CTO to simply expire in lieu of a formal discharge. Guidelines published by the Department of Human Services regarding the use of CTOs require that a CTO be either extended in a timely manner or that the person be discharged from involuntary status if the relevant criteria no longer apply.³

Recommendation 1: Expiry of a CTO

That the Act should be amended to provide that a person is automatically discharged from involuntary status if a CTO expires without being extended.

Detention

*Coronial Findings on the Death of Mr Nicholas McNulty*⁴

The operation of CTOs and the legislative scheme supporting it were criticised by the coroner in findings on the death of Mr Nicholas McNulty.

Coroner Heffey highlighted deficiencies in the awareness of mental health professionals concerning the legal requirements for management of CTOs. The coroner also stated that the legal requirements for management of CTOs were, themselves, unclear. In trying to interpret the Act, the coroner wrote that 'another explanation may be that 'detention' has two discrete meanings under the Act and ... that the use of the words 'detained' and 'detention' in the Act cause confusion'.⁵ The coroner recommended that the drafting of the Act be examined to address these issues.

³ *Community Treatment Orders: Guidelines*, Office of the Chief Psychiatrist, Department of Human Services, Victoria, November 2001, p27.

⁴ Record of Investigation into the Death of Nicholas McNulty Case No. 2248/1997

⁵ At paragraph 11.

Wilson Decision

In the *Wilson* decision, Justice O'Bryan rejected the Department's submission concerning underlying detention of persons subject to CTOs and agreed with a submission by counsel for Mr Wilson that 'the *essence* of a CTO is being at large in the community and *not detained*' (emphasis added).⁶ Justice O'Bryan interpreted the provision of the Act which deems a person on a CTO to be an involuntary patient detained under s12 to be the attribution of a 'fictitious' status.⁷ Hence a person subject to a CTO was not thereby also subject to underlying detention; the expiry of the CTO brought the fictitious 'detention' to an end.

Wilson raises questions about the proper relationship between involuntary inpatient and outpatient treatment and the appropriateness of using legal 'fictions' in the context of legislation restricting individual liberty.

Inconsistency between recommendation criteria and the s14 criteria

The Mental Health Act currently provides that a CTO may be made 'instead of confirming the admission of the person to an approved mental health service as an involuntary patient' (s14(1)). The decision whether or not to confirm an admission can only be made after a request and recommendation have been made (s12). A recommendation can only be made by a registered medical practitioner who considers that:

- the criteria in s8 (which require 'admission and detention') are met; and
- the person should be admitted to an approved mental health service for observation (s9(3)).

At first reading, it appears there is a contradiction. Where a CTO is to be made as an alternative to admission, the person must meet both the criteria for admission and detention (section 8) **and** the criteria for making a CTO (section 14) which don't require detention. However, the Act makes it clear that 'admission' does not require being physically taken to an approved mental health service (s12(4A)) and that a CTO may be made without requiring an inpatient admission. If the criteria in section 8 are read with this caveat in mind, then it is arguable that no contradiction arises. The criterion in section 9(3) may also be read down in this way. Notwithstanding this, the legislation could be made clearer.

It is proposed to remove the requirement for detention from the section 8 criteria to rectify the apparent inconsistency identified above. The section 8 criteria will instead focus on the admission of a person as an involuntary patient for the purpose of providing treatment. The Act already makes it clear that a person does not need to be physically admitted to an approved mental health service. Further clarification will be given by inserting a definition of 'admission'. This will be defined to mean admission to an approved mental health service as an involuntary patient, that is, to have involuntary patient status, but it does not require physical admission to hospital.

⁶ At paragraph 38.

⁷ Section 14(3)(a).

It is considered these changes will overcome criticisms of the use of 'deemed detention' as the foundation for treatment under a CTO and the interpretive difficulties that this creates.

Recommendation 2: Detention

That the section 8 criteria be amended to remove the requirement for detention and that the focus be on the necessity to provide involuntary treatment. The proposed criteria would be:

- (a) the person appears to be mentally ill; and
- (b) the person's mental illness requires immediate treatment and that treatment can be obtained from an approved mental health service; and
- (c) because of the person's mental illness, the person should receive treatment as an involuntary patient 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 that person's freedom of decision and action.

Recommendation 3: Detention

That the Act be amended to include a definition of 'admission as an involuntary patient'. The definition will clarify that a person does not need to be physically admitted as an inpatient to an approved mental health service to be made an involuntary patient. Admission as an involuntary patient will be taken to mean admission to involuntary status.

24-Hour Review by the Authorised Psychiatrist

Once a request and recommendation are made in relation to a person, the person must be admitted to an approved mental health service as an involuntary patient. The authorised psychiatrist must review the person within 24 hours of admission. Currently the authorised psychiatrist must consider the section 8 criteria and whether the 'continued detention of the person as an involuntary patient' is justified or not. If satisfied, the authorised psychiatrist must confirm the admission.

As discussed above, it is proposed to remove any reference to 'detention' in the section 8 criteria. This will change the basis for the decision by the authorised psychiatrist at the '24-hour review' since the amended section 8 criteria will only give guidance about the need for treatment. It will be necessary to include a further step in the decision by the authorised psychiatrist at the '24-hour review'. If the authorised psychiatrist determines the person requires involuntary treatment as an involuntary patient, a further decision must be made about whether the person should be detained as an inpatient to enable the treatment to be given or whether the person can be made subject to a CTO.

It is proposed to amend section 12(2) to require the authorised psychiatrist to consider whether the section 8(1) criteria apply to the person. If they do, the authorised psychiatrist must confirm the admission of the person as an involuntary patient and either detain the person in the approved mental health service as an inpatient or make the person subject to a CTO.

Recommendation 4: 24 Hour Review by the Authorised Psychiatrist

That section 12(2) be amended with the effect that the authorised psychiatrist must first consider the section 8 criteria. If the person meets the criteria, the authorised psychiatrist will confirm the admission of the person as an involuntary patient and then either detain the person in the approved mental health service or make a CTO. Possible wording for section 12(2) could be:

Where the authorized psychiatrist, upon examining the person under sub-section (1)—

(a) is not satisfied that the criteria specified in section 8(1) apply to the person, the authorized psychiatrist must discharge the person from being an involuntary patient; or

(b) is satisfied that—

(A) the criteria specified in section 8(1) apply to the person; and

(B) the treatment the person requires can be obtained by admission to and detention in the approved mental health service—

the authorized psychiatrist must confirm the admission of the person as an involuntary patient and detain the person as an inpatient in the approved mental health service; or

(c) is satisfied that—

(A) the criteria specified in section 8(1) apply to the person; and

(B) the treatment the person requires can be obtained by making the person subject to a community treatment order—

the authorized psychiatrist must confirm the admission of the person as an involuntary patient and make a community treatment order.

Appeal and Review by the Mental Health Review Board

The proposed changes to sections 8 and 12 will require consequential amendments to the powers of the Mental Health Review Board on hearing appeals or reviews.

On hearing an appeal or review in relation to a person who is subject to a CTO, the Board will be required to consider whether the section 8 criteria apply to the person, and if they do, whether the treatment the person requires can be obtained by leaving the person subject to a CTO.

The existing powers of the Board to vary or revoke a CTO or to discharge the person from being an involuntary patient will remain the same.

Recommendation 5: Appeal and Review by the Mental Health Review Board

That section 36 of the Act be amended with the effect that the Mental Health Review Board, in conducting an appeal or review in relation to an involuntary patient subject to a CTO, considers whether the section 8 criteria apply to the person and whether the treatment the person requires can be obtained by leaving the person subject to a CTO. Possible wording for section 36(4) could be:

- (4) On hearing an appeal or review in relation to a person who is subject to a community treatment order under section 14, the Board, having regard to the requirements of section 14—
 - (a) may vary the community treatment order; or
 - (b) if satisfied on reasonable grounds that the person satisfies the criteria specified in section 8(1), but the treatment the person requires can no longer be obtained subject to a community treatment order, may revoke the order; or
 - (c) if satisfied that the person does not satisfy the criteria specified in section 8(1), must discharge the person as an involuntary patient.

Treatment plans

A number of jurisdictions require that treatment plans be either attached to a CTO or be made before the order can be implemented. For example, in Queensland, a treatment plan is a plan that states:

- in general terms, an outline of proposed treatment, counselling, management, rehabilitation and other services to be provided, and
- in specified terms, the method by which, the frequency with which, and the place at which, the services would be provided, to implement a community counselling order or a CTO (Sch 1 and s3).

Treatment plans give consumers clear guidance about their obligations under a CTO and a clear statement of the treatment that they can expect. Section 6A(j) of the Victorian Mental Health Act envisages consumers will always have a treatment plan which is regularly reviewed.

It is proposed to require that a treatment plan accompany a CTO. It should, in general terms, give an outline of the proposed treatment, counselling, management, rehabilitation and other services to be provided. Details that change regularly do not need to be listed, except in the broadest sense. For example, a person might be required to attend the clinic on a fortnightly basis. However, the plan would not need to specify a regular day or time because these should be kept sufficiently flexible to accommodate the changing needs of both the person subject to the CTO and the clinicians. The treatment plan should accompany the order rather than be a condition of the order. In this way, the order does not need to be formally varied if a detail of the treatment plan needs to be changed.

An initial treatment plan should be prepared at the same time the CTO is first made. At this point the plan might be fairly simple and only include sufficient information to enable the person to engage in treatment with a community-based service. Later, the community treating team would develop a more comprehensive plan in consultation with the person. It is envisaged that the monitoring authorised psychiatrist or the supervising medical practitioner could amend the treatment plan at any time in consultation with the person.

Recommendation 6: Treatment plans

That the Act be amended to require that a treatment plan accompany a CTO.

That the treatment plan should state in general terms, an outline of the proposed treatment, rehabilitation and other services to be provided to the person subject to the CTO.

Non-compliance with treatment

The essence of involuntary treatment is the ability to legally treat a person without their consent. Section 12 of the Act currently provides that:

- Upon admission an involuntary patient is to be detained and given treatment for his or her mental illness (s.12(4)).
- If an involuntary patient refuses to consent to necessary treatment or is not capable of consenting to treatment for his or her mental illness consent in writing may be given by the authorised psychiatrist (s.12(6)).

These provisions currently apply to a person on a CTO by virtue of the deeming provision in section 14(3).

Nevertheless, there is a reluctance to use force to give treatment under a CTO. The Department of Human Services' guidelines regarding the use of CTOs state that:

'Consistent with the principle of providing treatment in the least restrictive and intrusive manner possible, it is not acceptable to use physical force to impose treatment in any community setting, whether this is a person's home, a GP's surgery, or in a community mental health service. Similarly, it is not acceptable to use the presence of others (especially police) to coerce a person to take treatment in the community.

If such a degree of force or coercion is considered necessary to ensure adherence to the CTO, then the CTO should be revoked, whereafter the person must be admitted to an inpatient unit. This allows the opportunity for the reconsideration of their clinical state, treatment needs, and treatment regime.'⁸

Currently, when a person subject to a CTO is non-compliant with treatment, the CTO is revoked and the person is returned to the approved mental health service

⁸ *Community Treatment Orders: Guidelines*, Office of the Chief Psychiatrist, Department of Human Services, Victoria, November 2001, p13.

to be treated. Often the admission is only for a brief period to enable the treatment to be administered and then a new CTO is made. It is questionable whether the use of the revocation provisions is the most appropriate way to deal with non-compliance with treatment, particularly if the person is made subject to a new CTO within a few hours. In addition, the process is administratively cumbersome and the legislation would benefit from clarification.

The legislation in New South Wales, Queensland and Western Australia contains complex procedures for requiring a person who has failed to comply with the terms of their CTO to receive treatment. A survey of clinicians in Western Australia found that these procedures were considered 'bureaucratic and not practical', especially where the clinician did not have access to the consumer.⁹ Not surprisingly, the Western Australian Mental Health Law Centre noted in its submission that the procedures to revoke an order (under the WA Mental Health Act) are used more often than the complex procedures to enforce compliance with treatment while the person remains on the order.

Suspension of a CTO

The Northern Territory's *Mental Health and Related Services Act 1998* also contains an alternative to revocation. That Act provides a power to suspend a community management order where the person subject to the order is non-compliant with treatment. The provisions allow short-term inpatient treatment without requiring the making of a new community management order. The provisions give a clear indication to the person that the inpatient treatment is intended to be short and that treatment will continue in the community following discharge. The use of suspension in these instances is an alternative to revocation and the making of a new order.

It is proposed to amend the Victorian Mental Health Act to permit a CTO to be suspended if:

- The person who is subject to a CTO has not complied with the person's treatment plan;
- Reasonable steps have been taken to obtain compliance with the treatment plan without success; and
- There is a significant risk of deterioration in the person's mental or physical condition because of the non-compliance.

The authorised psychiatrist who suspends a CTO must make all reasonable efforts to inform the person that their CTO has been suspended, the reasons for the suspension and that the person must attend the approved mental health service as an inpatient for treatment.

Once a CTO has been suspended, the person may be apprehended at any time, taken to the approved mental health service and detained for up to 24 hours to enable the treatment to be provided. During this period, the person would be deemed to be a patient detained under section 12 of the Act. If the person subject to an order remains as an inpatient longer than 24 hours, the order is automatically revoked and the person is then an involuntary inpatient detained under section 12.

⁹ Tim Rolfe, *Community Treatment Orders: A Review*, Office of the Chief Psychiatrist, Department of Health, Western Australia, December 2001, p77.

As soon as practicable after the person's treatment, the authorised psychiatrist must make arrangements for the person's return to the place from which the person was taken or to another place the person reasonably asks to be taken, for example home.

Where the authorised psychiatrist considers the treatment the person requires can no longer be obtained subject to a community treatment order, the CTO should be revoked rather than use these suspension provisions.

Recommendation 7: Non-compliance with treatment

That the Act be amended to permit a CTO to be suspended to enable treatment to be given to a person subject to the CTO who is non-compliant with their treatment plan.

Once a CTO has been suspended, the person may be apprehended at any time, taken to an approved mental health service and detained as an inpatient for a period up to 24 hours to enable the treatment to be provided.

If the person remains as an inpatient longer than 24 hours, the CTO is automatically revoked.

Revocation

Criteria for revocation of CTOs

The Act currently provides that the authorised psychiatrist may revoke a CTO if satisfied on reasonable grounds that a person who is subject to an order:

- has failed to comply with the order; or
- satisfies the criteria specified in section 8(1), but no longer satisfies the criteria specified in 14 (1A).

Following revocation, a person will be admitted as an inpatient and treated under section 12.

The power to revoke a CTO should only be exercised where the person requires inpatient treatment, that is, the treatment the person requires can no longer be obtained subject to a CTO. As discussed above, new provisions will be introduced to manage failure to comply with treatment. In this context, it is no longer necessary to retain 'failure to comply with the order' as a ground for revoking an order.

Recommendation 8: Revocation

That the Act be amended to remove 'failure to comply with a CTO' as a ground for revoking an order.

When a CTO 'does not apply'

The Mental Health Act currently defines a 'CTO' as:

'An order requiring treatment for mental illness of a person who is at large in the community but does not apply to a person who is in a prison or an approved mental health service' (s3).

The meaning of 'does not apply'

If a person subject to a CTO is admitted as an inpatient to an approved mental health service, the CTO 'does not apply' and the CTO must be revoked in order for the person to receive treatment.

However, the consequences of a CTO 'not applying' in a prison are unclear.

The Act is currently interpreted to mean that the order goes into abeyance while the person is imprisoned, reviving (if it has not expired through the passage of time) once the person is discharged. It is proposed to amend the Act to clarify that a CTO is unenforceable while a person is serving a sentence or is subject to a court order requiring the person be held in custody, for example, on remand.

Recommendation 9: The meaning of 'does not apply'

That the Act be amended to clarify that a CTO is unenforceable while a person is serving a sentence or is being held in custody on the order of a court in a prison.

The CTO will revive once the person is released from prison, unless the CTO has expired or been discharged.

Definition of 'a prison'

The extent of the exclusion intended by use of the word 'prison' in the definition of a CTO is also unclear. Elsewhere in the Act, the word 'prison' is defined to include:

- A remand centre, youth residential centre or youth training centre within the meaning of section 249 of the *Children and Young Persons Act 1989*.
- A police gaol within the meaning of the *Corrections Act 1986*.

Recommendation 10: Definition of 'a prison'

That a definition of 'prison', for the purposes of determining where a CTO may not operate, should include:

- A remand centre, youth residential centre or youth training centre within the meaning of section 249 of the *Children and Young Persons Act 1989*.
- A police gaol within the meaning of the *Corrections Act 1986*.

The effect of a transfer from prison to hospital on a CTO

No prisons are proclaimed to be approved mental health services. As a result, involuntary psychiatric treatment may not be given in prison. Should a person who is in prison require involuntary psychiatric treatment, they must be

transferred to an approved mental health service under section 16 of the Act as an involuntary or security patient.

The consequence of a transfer under section 16 for the CTO is unclear. In the community, a CTO must be revoked if the person is to receive treatment as an involuntary patient in an approved mental health service. It is unclear whether a CTO that is in abeyance must be revoked prior to the making of an order under section 16.

Recommendation 11: Transfer from prison to hospital

That the Act be amended to clarify that a CTO is automatically discharged if a person is admitted as an inpatient to an approved mental health service under section 16 of the Act.

Admission to an approved mental health service

Another consequence of the current definition of CTO is that it 'does not apply' to a person who is in an approved mental health service. This means that a person on a CTO cannot receive involuntary psychiatric inpatient treatment in an approved mental health service unless the CTO is revoked.

Problems have arisen as a result of this provision in the following scenarios:

- The provision of psychiatric treatment in accordance with the order, for example, maintenance ECT, which may be performed as a day procedure or during a short admission in an approved mental health service.
- The provision of medical treatment (other than psychiatric treatment) to a person subject to a CTO, where the hospital in which treatment is to be received is part of an approved mental health service. In practice, most major public hospitals are proclaimed as approved mental health services. In these circumstances, the main focus of the admission would be the medical condition and its treatment, although the person would continue to receive their usual psychiatric treatment.

A person should not need to have their CTO revoked in order to comply with the CTO (for example, to receive ECT as a day procedure) or to receive medical treatment in a hospital. This process is stigmatising, creates disincentives to seek treatment and is unnecessarily cumbersome.

It is proposed that a person subject to a CTO should be able to receive psychiatric inpatient treatment at an approved mental health service for a period up to 24 hours, provided that:

- the admission is with the agreement of the person, that is, no force has been used to bring the person to the approved mental health service or to keep the person in the approved mental health service; and
- the treatment is in accordance with a treatment plan.

In these circumstances, the person is not consenting to the treatment, but is complying with the treatment plan. The person must not be prevented from leaving the approved mental health service unless the CTO has been revoked. Revocation should only occur if the treatment the person requires can no longer be obtained subject to a community treatment order.

It is expected that any admission in these circumstances should only be for a period up to 24 hours. If a person requires a longer admission than 24 hours, the authorised psychiatrist must review the person and either:

- revoke the order because the person is no longer suitable for a CTO; or
- discharge the person from being an involuntary patient because they are consenting to treatment.

If a person subject to a CTO is admitted for non-psychiatric (medical) treatment to a general hospital that has been proclaimed as an approved mental health service, there should be no time limit on the admission. It is envisaged that the person would continue to receive psychiatric treatment during such an admission. If the person is non-compliant with psychiatric treatment during the medical admission, the CTO should be revoked and psychiatric treatment will be provided under the supervision of the authorised psychiatrist.

Recommendation 12: Admission to an approved mental health service

That a person subject to a CTO should be able to receive psychiatric inpatient treatment at an approved mental health service for a period up to 24 hours, without the need to revoke the CTO, provided that the person is agreeing to receive the treatment and the treatment is in accordance with a treatment plan.

That a person subject to a CTO should be able to seek and receive non-psychiatric treatment at a general hospital that has been proclaimed as an approved mental health service without the need to revoke the CTO.

That a person must not be prevented from leaving an approved mental health service unless the CTO has been revoked.

Relationship with the *Coroners Act 1985*

The *Coroners Act 1985* requires that 'reportable deaths' be reported to a coroner or officer in charge of a police station.¹⁰ The death of a person receiving treatment or care for a mental disorder from a psychiatric service which is also a reportable death must also be reported to the chief psychiatrist (Mental Health Act, s106A). A reportable death includes the death of 'a person who immediately before death was a person held in care'. A 'person held in care' includes 'a patient in an approved mental health service within the meaning of the *Mental Health Act 1986*'.¹¹

A CTO is currently made '*instead of confirming the admission of the person to an approved mental health service as an involuntary patient or continuing to detain the person in an approved mental health service*' (s14(1)). Section 3 defines a CTO to not apply to a person '*in ... an approved mental health service.*' Although s14(3)(a) deems a person on a CTO to be an involuntary patient detained under s12, it is not clear that this means that they are deemed to be 'a patient *in an*

¹⁰ *Coroners Act 1985*, s13(1).

¹¹ *Coroners Act 1985*, s3 definition of 'person held in care' sub (c).

approved mental health service'. The combined effect of s14(3)(a) with the definition in s3 is unclear.

Recommendation 13: Relationship with the Coroners Act 1985

That the Coroners Act be amended to clarify that the death of a person subject to a CTO is a reportable death for the purposes of that Act.

Restricted Community Treatment Orders

If a person is found guilty of an offence, the court has the option to make a hospital order under section 93(1)(d) of Part 5 of the *Sentencing Act 1991* instead of passing sentence. The person is then admitted and must be detained in an approved mental health service as an involuntary patient.

Hospital orders do not have a fixed period of time. When the person no longer satisfies the criteria in section 93(1) of the Sentencing Act, the Chief Psychiatrist or the Mental Health Review Board must discharge the person as an involuntary patient. The person does not need to return to court.

Restricted community treatment orders (RCTOs) may be made in respect of patients subject to hospital orders. RCTOs have some similarity to CTOs in that they enable some hospital order patients to receive involuntary treatment while living in the community. The Chief Psychiatrist makes RCTOs, but they do not come into effect until they have been approved by the Mental Health Review Board (s15A(9)). The standard conditions of a RCTO are similar to a CTO, but the Chief Psychiatrist can impose any additional conditions he or she considers appropriate (s15A(4)(g)).

As with the CTO provisions, Mental Health Branch has undertaken a limited review of the RCTO provisions.

The recommendations concerning CTOs do not automatically translate to RCTOs because the basis for the orders is different. For example, the situation of a person subject to a RCTO is different from the situation of a person subject to a CTO and is distinguishable from the principles enunciated in the *Wilson* case (see page 6). This can be clearly seen in the scheme established by the Sentencing Act and the Mental Health Act.

A hospital order always requires initial detention in an approved mental health service. Unlike CTOs, an RCTO cannot be made as an alternative to admission and detention as an inpatient in an approved mental health service.

A CTO may be made by the authorised psychiatrist and takes effect when it is made. In contrast, a RCTO is made by the Chief Psychiatrist on the recommendation of the authorised psychiatrist and does not take effect until approved by the Mental Health Review Board. The legislature showed a clear intention to ensure that a person subject to a hospital order was assessed at a number of different levels (authorised psychiatrist, Chief Psychiatrist, Mental Health Review Board) before that person was released to the less restrictive RCTO.

There is no specified time limit for a RCTO when it is first made, but a CTO may only be made for a period up to 12 months.

The Act also acknowledges the potential for other factors to be an issue in managing a person subject to a hospital order. A hospital order may arise from a variety of offences and the offending behaviour may not be directly the result of mental illness, for example, substance abuse may play a part. In these circumstances, when a person is placed in the community on a RCTO, the Act permits a wider range of conditions (eg. drug testing) to be applied to the RCTO than can be applied to a CTO.

It is also important to recognise the scheme established between Part 5 of the Sentencing Act and the Mental Health Act under which hospital orders are made. An order made under section 93(1)(e) of the Sentencing Act ('hospital security order') operates as a sentence and once discharged from that order, the person must serve the remainder of the term in prison. Where a person made subject to an 'assessment order' under sections 90 or 91 of the Sentencing Act is discharged from that order, the person is to be returned to the court.

Given all of the above, it would inappropriate to follow the *Wilson* decision and permit a person subject to a court ordered "hospital order" under section 93(1)(d) of the Sentencing Act to be automatically discharged from that order because their RCTO has expired without being extended.

On this basis, it is not proposed to amend the Act to provide that a RCTO is automatically discharged if it expires without having been extended. Instead the Act will be amended to clarify that a person continues to be a hospital order patient, even if their RCTO is not extended.

Given the wider range of conditions that can be applied to a RCTO and the greater concerns about security for hospital order patients, it is also proposed to retain 'failure to comply with the order' as a ground for revoking an order.

Other changes, such as the introduction of treatment plans and a power to suspend an order for non-compliance with the treatment plan, are proposed to be made to the RCTO provisions of the Act.

Recommendation 14: Restricted Community Treatment Orders

That recommendations 6,7, 9, 10, 12 and 13 concerning CTOs also apply to the RCTO provisions.

That the Act be amended to clarify that a person subject to a hospital order under section 93(1)(d) of the Sentencing Act is not automatically discharged from involuntary status if their RCTO expires without being extended.

Appendix 1

Relevant sections of the *Mental Health Act 1986*