

MENTAL HEALTH

Many people experiencing homelessness will also experience mental health issues. This often results in difficulties in accessing key services such as those relating to health and housing. This chapter looks at some of the issues experienced by homeless people experiencing mental health issues such as involuntary treatment and dealing with the criminal justice system.

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1. Introduction to Mental Health and Homelessness

One in five Australians will experience a mental illness in their lifetime. The prevalence of mental illness among people who are homeless is almost certainly much higher. Recent research suggests that approximately 30% of homeless people have mental health issues.¹

Importantly, mental illness can be both the cause and the result of homelessness. A recent study conducted in Melbourne concludes that over half of the individuals who are homeless and suffer from a mental health problem developed that problem after becoming homeless.

Moreover, people who are homeless will often have difficulty in accessing mental health and other medical services, such that their mental illness goes untreated. This is compounded by the fact that, commonly, many people with a mental health problem will deny it.

If a homeless person's mental health issues go untreated, then it is very difficult for that person to find a sustainable pathway out of homelessness. Further ongoing, long-term support may be needed to keep individuals with multiple health issues in stable accommodation.

1.1 Key issues to consider

Clients who have a mental health issue may seek information and advice on various topics, including about:

- having been made the subject of an involuntary treatment order (**ITO**) under the *Mental Health Act 1986* (Vic) or about their treatment order conditions (see section 2 below);
- the impact of their mental illness on their experience of the criminal justice system (see section 3 below);
- where and how to seek treatment for their mental illness (see section 3 below);
- discrimination on the basis of mental illness (see Chapter 2 of this Manual); and
- guardianship and administration issues (see Chapter 9 of this Manual).

1.2 Impact of the Victorian Charter of Human Rights and Responsibilities

The *Charter of Human Rights and Responsibilities Act 2007* (Vic) (**the Charter**) came into operation on 1 January 2008. Part 2 of the Charter outlines various human rights that public authorities (as defined within the Charter) must consider in the exercise of their statutory obligations and powers (see further at Chapter 3 of this Manual).

It is possible that the mental health legislation enacted in Victoria may be inconsistent with many of the rights set out in the Charter. This is because essential aspects of Victorian mental health law enable public authorities to subject people with possible mental health disorders to treatment (including detention) without their consent.

¹ Chamberlain, Johnson and Theobald, *Homeless in Melbourne: Confronting the Challenge*, Centre for Applied Social Research, RMIT University, February 2007.

Therefore the Charter should be borne in mind when considering whether a client has been lawfully treated when subjected to such laws.

The Charter may also be relevant to the sentencing of an individual who has a mental illness or disorder under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (see section 3 below).

2. Involuntary Medical Treatment of the Mentally Ill

2.1 Introduction

The primary legislation affecting people with mental health issues in Victoria is the *Mental Health Act 1986* (Vic) (**the MHA**). You can access this legislation at http://www.austlii.edu.au/au/legis/vic/consol_act/mha1986128/.

The MHA authorises the provision of treatment to people considered to have a mental illness (as defined in the MHA) without their consent (that is, **involuntary treatment**) in certain circumstances (see sections 2.2 to 2.9 below).

The legislative objects of the MHA suggest that it is to be interpreted so that people with a mental disorder are given the best possible care and treatment appropriate to their needs in the least restrictive and the least intrusive manner possible, consistent with the effective giving of that care and treatment. Notably, the objects of the MHA include protecting the rights of people with a mental disorder.²

The MHA also establishes the Mental Health Review Board (**the Mental Health Board**), the primary function of which is to review the grounds on which individuals have been prescribed involuntary treatment (see section 2.15 below). The Mental Health Board has observed that the involuntary treatment regime is such that the individual is often subjected to acts that would ordinarily be unlawful. The Mental Health Board has stated that:

the process of admission of a person to a psychiatric in-patient service will, in most cases, encompass events which, absent statutory authorisation, would constitute assault, battery and false imprisonment.³

2.2 Mental illness and mental disorder under the MHA

A person is mentally ill for the purposes of the MHA if 'he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'.⁴ However, under section 8(2) of the MHA, a person is not mentally ill only because, among other things:

- the person engages in illegal conduct;
- the person is intellectually disabled;
- the person takes drugs or alcohol;
- the person has an antisocial personality; or

² MHA, s 4.

³ WTH [1989] VMHRB 1

⁴ MHA, s 8(1A).

- the person has a particular economic or social status or is a member of a particular cultural or racial group.⁵

The MHA defines a **mental disorder** as including 'mental illness'. Some mental disorders, such as personality disorders, are not 'mental illnesses' under the MHA and cannot usually be the basis for involuntary treatment.⁶

2.3 Overview of the involuntary medical treatment regime

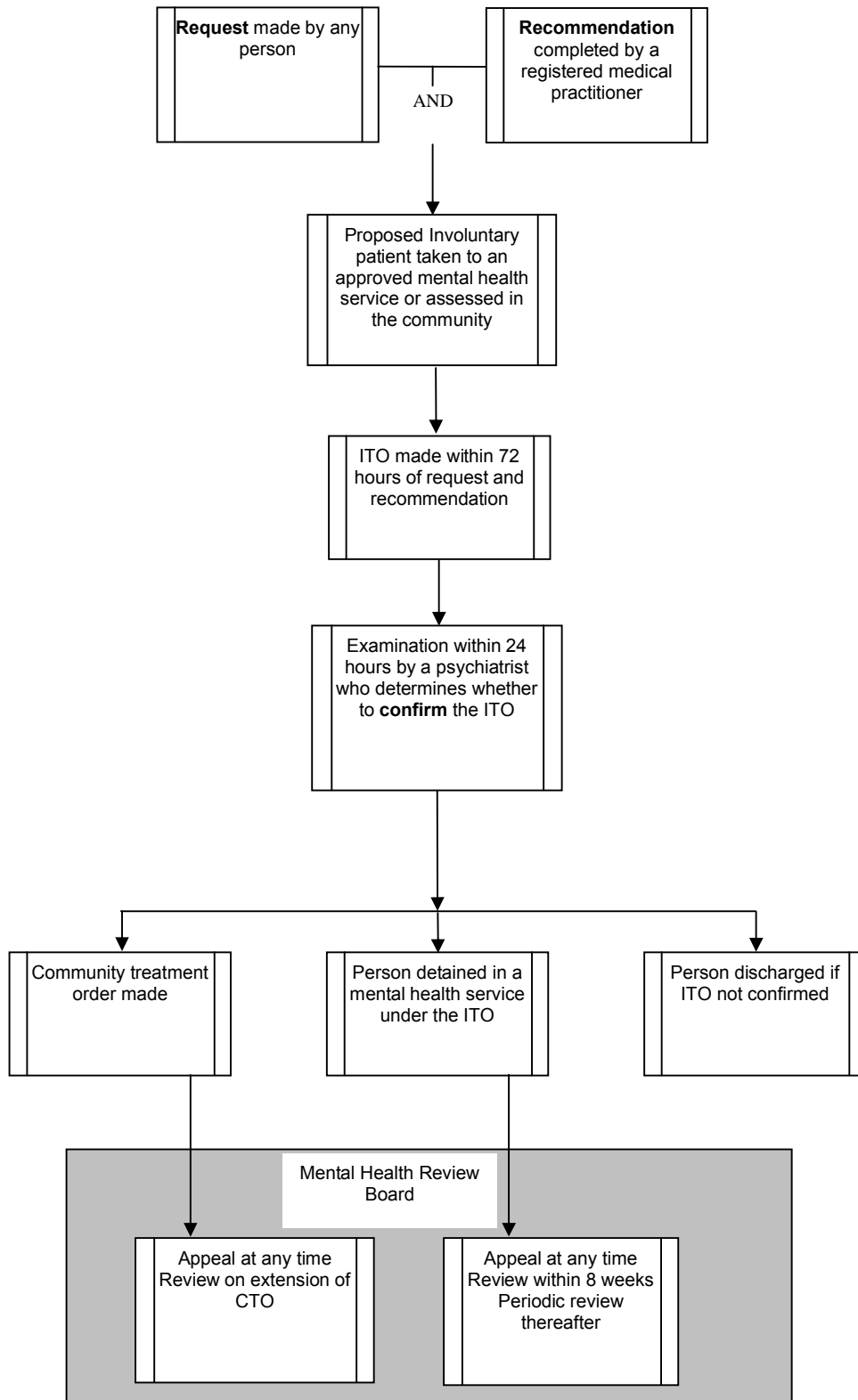
The involuntary treatment regime is contained within Division 2 of the MHA. It is a complex regime but the following diagram aims to outline its ordinary operation as prescribed by the MHA.

As the diagram on the following page suggests, an essential aspect of the regime is the making and confirming of an ITO. As described further below, the *confirmation* of an ITO gives rise to a statutory obligation to provide treatment to the individual who is the subject of the ITO regardless of whether that individual consents to that treatment.

⁵ See further factors listed in s 8(2) of the MHA.

⁶ The MHA contains one provision which authorises the detention of a person with a mental disorder who does not also have a mental illness. See ss 12A to 12D of the MHA.

Involuntary Patient



2.4 Criteria that must be satisfied in order for an ITO to be made

The criteria that determine whether an ITO may be made for an individual are listed in section 8(1) of the MHA (**the section 8(1) criteria**). These are that:

- the person appears to be mentally ill;
- the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an ITO;
- because of the person's mental illness, involuntary treatment of the person is necessary for their 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;
- the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- the person cannot receive adequate treatment for the mental illness in a manner less restrictive of their freedom of decision and action.

2.5 Process of becoming subject to an ITO

In order to trigger the involuntary treatment order regime, two prescribed forms must be completed:

- a request for a person to receive involuntary treatment (**request**); and
- a recommendation for a person to receive involuntary treatment (**recommendation**).⁷

The prescribed forms are in Schedules 1 and 2 to the *Mental Health Regulations 1998* (Vic) (**the Regulations**)

Although not addressed in the MHA, it is apparent that any individual may complete the request. However, only a registered medical practitioner (**medical practitioner**) (practising either in the community or employed in an approved mental health service)⁸ may complete the recommendation following a personal examination of the person.⁹

2.6 Recommendation that an ITO be made

A recommendation can be made only by a medical practitioner,¹⁰ who must consider that:

- the section 8(1) criteria apply to the person; and
- an ITO should be made for the person.¹¹

An individual may attend an assessment for a recommendation voluntarily, or they may be assessed without their consent in the following circumstances:¹²

⁷ MHA, s 9(1).

⁸ **Approved mental health service** is defined in s 3 of the MHA.

⁹ MHA, s 9(1).

¹⁰ MHA, s 9(1).

¹¹ MHA, s 9(3).

¹² MHA, ss 9A, 10 and 11.

- a mental health practitioner may authorise the transport of an individual to an approved mental health service if they consider that the section 8(1) criteria are satisfied and that the person should be assessed;¹³
- a member of the police force may apprehend a person whom they have reasonable grounds for believing has attempted, or is likely to attempt, suicide or to cause serious bodily harm to themselves or to some other person. The person must then be assessed as soon as practicable by a mental health practitioner or a medical practitioner;¹⁴
- any person who has reasonable grounds for believing that a person appears to be mentally ill and incapable of caring for themselves may give information upon oath to a magistrate who may then authorise and direct a medical practitioner, accompanied by police, to visit and examine the person.¹⁵

2.7 Making an ITO

Once a recommendation is made, it is effective for 72 hours.¹⁶ During this time, the request and recommendation together are authority for certain defined people¹⁷ to, without the individual's consent, either:

- arrange for the person to be assessed in the community by either a registered medical practitioner employed by an approved mental health service (a **mental health medical practitioner**) or a mental health practitioner;¹⁸ or
- take the person to an approved mental health service, where an ITO must be made by a mental health medical practitioner or a mental health practitioner.¹⁹

If the person is assessed in the community, then either:

- an ITO will be made by a mental health medical practitioner or a mental health practitioner; or²⁰
- the person will be taken to an approved mental health service, where an ITO will be made.

Therefore once a recommendation is made, presuming the necessary steps are taken within 72 hours, an ITO will be made. However, as explained further in sections 2.8 and 2.9 below, making an ITO alone does not ordinarily authorise the prescription of involuntary treatment unless and until that ITO is confirmed.

¹³ MHA, s 9A.

¹⁴ MHA, s 10.

¹⁵ MHA s 11. Note that the police may enter any premises and use such force as may be reasonably necessary.

¹⁶ MHA, s 9(4).

¹⁷ MHA, s 9(6). The defined people include: the person making the request or a person authorised by the person making the request; the police; an ambulance officer; and people listed in the Regulations, r 5.

¹⁸ MHA, s 9(5).

¹⁹ See s 9B of the MHA, which authorises:

- the use of such assistance as is required and such force as may be reasonably necessary to enter the person's premises; and
- the restraint or sedation of the person in certain circumstances.

²⁰ MHA, s 12(2).

Importantly, an ITO can be made irrespective of whether the relevant mental health medical practitioner or a mental health practitioner considers that the section 8(1) criteria apply; or that an ITO *should* be made. However, in that case, the practitioner must notify the authorised psychiatrist²¹ of the appropriate approved mental health service of this fact as soon as practicable.²²

An ITO must be in the prescribed form contained in Schedule 6 to the Regulations.²³

You can access the Schedule at

http://www.austlii.edu.au/au/legis/vic/consol_reg/mhr1998237/.

2.8 Treatment under an ITO before confirmation

The making of an ITO alone does not ordinarily authorise the prescription of involuntary treatment. Before any involuntary treatment, an authorised psychiatrist must confirm the ITO (see section 2.9 below). However, the making of an ITO *does* authorise all of the following without the person's consent:

- If the person is not already in an approved mental health service, then the practitioner who made the ITO may organise for the person to be taken to an appropriate approved mental health service.²⁴
- If the person has been transported to, or is in, an approved mental health service at the time the ITO is made, the person may be involuntarily detained in the mental health service until examination by the authorised psychiatrist.²⁵
- Before confirmation of the ITO by the authorised psychiatrist, a mental health medical practitioner may consent on behalf of the person to medical treatment if the practitioner considers that:
 - the person requires treatment immediately and is unable to consent to that treatment; and
 - the treatment would be in the best interests of the person.²⁶

2.9 Confirmation of an ITO

Once an ITO is made, the person *must* be examined by the authorised psychiatrist of the approved mental health service.²⁷ The examination must take place within 24 hours of the ITO being made.²⁸ Moreover, if the ITO was made even though the practitioner was not satisfied that the section 8(1) criteria applied or that an ITO should be made, then the authorised psychiatrist must conduct the examination sooner if it is practicable to do so.²⁹

²¹ **Authorised psychiatrist** is defined in s 3 of the MHA.

²² An ITO may be made for a person who satisfies the section 8(1) criteria and also requires medical treatment that is life-sustaining or to prevent serious physical deterioration and that can only be appropriately provided in a general hospital or emergency department of the general hospital See s 13 of the MHA.

²³ MHA, ss 12(4) and 12AA(3).

²⁴ MHA, ss 12A(6) and 12AA(7).

²⁵ MHA, ss 12A(7) and 12AA(8).

²⁶ MHA, s 12AB.

²⁷ MHA, s 12AC.

²⁸ MHA, s 12AC(1)(b).

²⁹ MHA, s 12AC(1)(b).

The medical practitioner who made the recommendation cannot conduct the examination.³⁰

Following examination of the person, there are two possible outcomes:

- the person is discharged — the person must be discharged if the authorising psychiatrist is not satisfied that the section 8(1) criteria apply;³¹ or
- the person becomes an **involuntary patient**:³² — the person becomes an involuntary patient if the authorising psychiatrist confirms the ITO.³³

Under the MHA, if the person becomes an involuntary patient (**patient**), then they must be given treatment.³⁴ **Treatment** is defined to mean:

things done in the course of the exercise of professional skills to –

- (a) remedy the mental disorder; or
- (b) lessen its ill effects or the pain and suffering which it causes.³⁵

Except for the administration of electroconvulsive therapy and psychosurgery (where the patient's informed consent is required), the patient's consent is not required for treatment.³⁶ Note that the consent of any of the following people is not relevant for the purposes of involuntary treatment:

- the patient's guardian (if any) within the meaning of the *Guardianship and Administration Act 1986* (Vic);
- a person responsible for the patient within the meaning of section 37 of the *Guardianship and Administration Act 1986* who may make decisions relating to their treatment; or
- an agent appointed for the patient under the *Medical Treatment Act 1988*.³⁷

Further, the MHA provides that the consent of the Victorian Civil and Administrative Tribunal (**VCAT**) is also irrelevant.

If a person becomes a patient, then the authorised psychiatrist must inform any guardian of the person that they have become a patient and the grounds for the authorised psychiatrist's decision.³⁸

³⁰ MHA, s 12AC(6).

³¹ MHA, s 12AC(2)(a).

³² Note that the MHA does not specify when the person becomes an 'involuntary patient'. **Involuntary patient** is defined in s 3 of the MHA to include 'a person who is subject to an involuntary treatment order ...'. However, the use of the expression 'involuntary patient' is introduced only with respect to the person once the authorising psychiatrist has confirmed the ITO. See in particular the wording of s 12AE where it states that:

If a person becomes an involuntary patient, the authorised psychiatrist must ensure that any guardian of the person is notified...[emphasis added]

³³ At the time the authorised psychiatrist confirms the ITO, they must determine whether the person the subject of the ITO will be treated under a community treatment order or while being detained in an approved mental health service. See further at sections 2.12 and 2.13 below.

³⁴ MHA, s 12AD(1). The MHA does not specify who must perform the obligation. However, the obligation is presumably that of the approved mental health service where the patient was examined.

³⁵ MHA, s 3.

³⁶ *Mental Health Act 1986* (Vic) s 12AD.

³⁷ *Mental Health Act 1986* (Vic) s 3A.

³⁸ MHA, s 12AE.

2.10 Patients' rights

Patient's rights generally

Part 3, Division 5 outlines the statutory rights of every person who becomes a patient under the MHA. These rights include³⁹:

- the right on becoming a patient to be given a statement of patients' legal rights and entitlements under the MHA and to have that statement explained to them;⁴⁰
- the right to copies of certain relevant legislation and contact information for certain relevant bodies and services;
- the right to legal representation;
- the right to a second psychiatric opinion;⁴¹ and
- the right to have any correspondence written by or to the patient to be forwarded without being opened.

Further, the patient has a right to request access under the *Freedom of Information Act* 1982 (Vic) to documents held by the mental health service about the patient's personal information.

Patient's right to a treatment plan

Division 5 provides that the authorised psychiatrist must prepare, review and revise, as required, a treatment plan for each patient, a copy of which must be provided to and discussed with the patient.⁴² The treatment plan must contain an outline of the treatment the patient is to receive.⁴³

When preparing, reviewing and revising the treatment plan, the authorised psychiatrist must take into account:

- the wishes of the patient so far as they can be ascertained and, unless the patient objects, the wishes of any guardian, family member or primary carer;
- whether the treatment 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 other matters prescribed by the MHA.⁴⁴

If a patient is subject to a community treatment order (CTO) (see section 2.12 below), then their treatment plan must also specify:

³⁹ MHA, s 18 and 20; Regulations, Schedule 7.

⁴⁰ This statement must be in the prescribed form set out in Schedule 7 to the Regulations. A link to the Regulations is at http://www.austlii.edu.au/au/legis/vic/consol_reg/mhr1998237/.

⁴¹ MHA, s 18(1)(a).

⁴² MHA, s 19A(6).

⁴³ MHA, s 19A(3).

⁴⁴ MHA, ss 19A(1) and (2).

- the authorised psychiatrist or their delegate who is to monitor the patient's treatment (**monitoring psychiatrist**);
- the registered medical practitioner supervising the treatment (**supervising medical practitioner**);
- the patient's case manager;
- the place and times at which the treatment will be received;
- the intervals of written monitoring reports of the supervising medical practitioner; and
- any further information the authorised psychiatrist thinks appropriate.⁴⁵

2.11 Treatment of the patient

A patient may receive treatment in one of two fashions. Either:

- while on a CTO (see section 2.12 below); or
- while being detained in an approved mental health service (see section 2.13 below).

The patient cannot be detained unless the authorised psychiatrist is satisfied that the patient cannot receive treatment through a CTO.⁴⁶

The authorised psychiatrist must determine whether a CTO will be made for the patient or whether the patient will be detained at the time they confirm the ITO.⁴⁷

2.12 Community treatment orders

Overview

A **CTO** is an 'order requiring the person to obtain treatment for their mental illness while not detained in an approved mental health service'.⁴⁸

If the authorised psychiatrist confirms an ITO, then they may make a CTO. Although a CTO cannot be authorised without an ITO, it does not replace the ITO. **A CTO is an additional order to the ITO.**

When a CTO is made, the authorised psychiatrist must inform the patient that the order has been made; give the patient a copy of the order and inform the patient of the grounds on which the order was made.⁴⁹ The CTO must specify the duration of the order, which cannot be for longer than 12 months.⁵⁰

Extension and variation of CTOs

Once a CTO expires, the patient's ITO is also taken to have expired and the patient must therefore be discharged.⁵¹

⁴⁵ MHA, ss 19A(4) and (5).

⁴⁶ MHA, ss 12AC(5) and 14(1).

⁴⁷ MHA, ss 12AC(3) and (4).

⁴⁸ MHA, s 14(2).

⁴⁹ MHA, s 14(4).

⁵⁰ MHA, s 14(3)(a).

⁵¹ MHA, ss 14(5) and 14B(4).

Before the expiry of a CTO, the authorised psychiatrist may extend it if they consider that the section 8(1) criteria still apply and that the patient can obtain the treatment required through the extension.⁵² Although the CTO cannot be extended for a period exceeding 12 months, there is no limit to the number of times it may be extended.⁵³

Furthermore, a CTO may be varied at any time by the authorised psychiatrist.⁵⁴

If a CTO is extended or varied, then the authorised psychiatrist must inform the patient that it has been extended or varied, give the patient a copy of the varied CTO or extension and inform the patient of the grounds for the decision.⁵⁵

Review and revocation of a CTO

While on a CTO, the patient's supervising medical practitioner (as specified on the patient's treatment plan)⁵⁶ must monitor the patient at 'regular intervals' (see section 2.10 above).⁵⁷ If, at any time, the supervising medical practitioner considers that the section 8(1) criteria no longer apply to the patient, or that the treatment required for the patient can no longer be obtained under the CTO, then the practitioner must inform the monitoring psychiatrist (as specified on the patient's treatment plan) as soon as practicable. The monitoring psychiatrist must then examine the patient as soon as practicable.⁵⁸

The CTO may be revoked if, at any time, the authorised psychiatrist is satisfied on reasonable grounds that:

- although the section 8(1) criteria still apply to the patient, the treatment required for the patient cannot be obtained under the order; or
- the patient has not complied with the CTO or their treatment plan although reasonable steps have been taken to obtain compliance, and there is significant risk of deterioration in the Patient's mental or physical condition because of the non-compliance.⁵⁹

If a CTO is revoked, then:

- the authorised psychiatrist must make reasonable efforts to inform the patient of the revocation and advise them to go to an approved mental health service; and
- the ITO remains in force and the patient is considered to be an involuntary patient who is 'absent without leave' from an approved mental health service.⁶⁰

⁵² MHA, s 14B(1).

⁵³ MHA, ss 14B(1) and (3).

⁵⁴ MHA, s 14C.

⁵⁵ MHA, ss 14B(5) and 14C.

⁵⁷ MHA, s 14A(1). The MHA does not define **regular intervals**.

⁵⁸ MHA, s 14A(3) and (4).

⁵⁹ MHA, ss 14D(1) and (2).

⁶⁰ MHA, s 14D(3).

Patient who is absent without leave

A patient who is absent without leave may be apprehended and returned to the approved mental health service at any time by certain authorised people.⁶¹ The apprehension and return of that person must be in compliance with section 9B of the MHA.

If that person remains absent from an approved mental health service for a continuous period of 12 months, they will be automatically discharged as an involuntary patient unless the Chief Psychiatrist or authorised psychiatrist applies to the Mental Health Board for an order that the patient is not to be discharged.⁶² The application to the Mental Health Board is treated as if it were an appeal. See further at section 2.15 below.

Review by the Mental Health Board

The Mental Health Board is required to review every decision to extend a CTO. If a CTO is not extended, then there is no obligation on the Mental Health Board to review the order.⁶³

Appeal to the Mental Health Board

A patient who is subject to a CTO has a right to appeal to the Mental Health Board at any time. See further at section 2.15 below.

2.13 Detention in an approved mental health service

Following confirmation of an ITO by the authorised psychiatrist, if no CTO is made, then the patient must be detained in an approved mental health service (**detained patient**).⁶⁴

Review by the Mental Health Board

The Mental Health Board must conduct an initial review of detention under the ITO within eight weeks of that order being made. After that, the Mental Health Board must conduct periodic reviews of the patient's detention under the ITO at intervals not exceeding 12 months following the initial review.⁶⁵

Appeal to the Mental Health Board

A detained patient may appeal to the Mental Health Board against their detention at any time.⁶⁶ The Mental Health Board must commence the hearing of an appeal without delay on receipt of the application.⁶⁷

Discharge of a detained patient

If the authorised psychiatrist considers that the section 8(1) criteria are no longer satisfied, then the patient must be discharged from the ITO.⁶⁸

⁶¹ MHA, s 43.

⁶² MHA, ss 42(1) and 42(3).

⁶³ This is to be contrasted with the Mental Health Board's review obligations where involuntary patients are detained.

⁶⁴ MHA, s 12AC(4).

⁶⁵ MHA, s 30.

⁶⁶ MHA, s 29(1)(a)(i).

⁶⁷ MHA, s 29(4).

In certain limited circumstances, if a detained patient is discharged from their ITO, then the individual may continue to be detained and subject to involuntary treatment if the authorised psychiatrist considers that:

- they have a mental disorder;
- they exhibit behaviour that suggests that if they are not continued to be detained and treated, they would cause serious physical harm to themselves; and
- treatment for the mental disorder can be obtained in the approved mental health service.

In that case, an application may be made to continue detention and treatment of the person for up to three months.⁶⁹ There is no limit to the number of times an application for continued detention and treatment may be made.

2.14 Restraint and seclusion of detained patients

In certain circumstances, detained patients may be subject to mechanical restraint or seclusion authorised by either:

- an authorised psychiatrist; or
- in the case of an emergency, a senior registered nurse on duty, provided certain requirements are met.⁷⁰

2.15 Mental Health Review Board

The Mental Health Board is established under the MHA.⁷¹

The primary role of the Mental Health Board is to determine whether an ITO should be continued — that is, whether a patient continues to satisfy the section 8(1) criteria.

The MHA provides for reviews to occur automatically at prescribed periods — see further below. Also, an involuntary patient, or a person acting on behalf of an involuntary patient, may lodge an appeal at any time – see also further below. In all cases, the Mental Health Board must be satisfied that the continued involuntary treatment is necessary. If satisfied, then the Mental Health Board must confirm the ITO.⁷² If not, it must discharge the person.⁷³

Before conducting a review or an appeal hearing, the Mental Health Board will be provided with a report by the treating mental health service.

Orders of the Mental Health Board

If the Mental Health Board confirms the ITO for a detained patient, but considers that the treatment the patient requires can be obtained on a CTO, then the Mental Health Board

⁶⁸ MHA, s 37(1).

⁶⁹ MHA, ss 12A(2) and 12D(1)

⁷⁰ MHA, ss 81 and 82.

⁷¹ MHA, s 21(1).

⁷² MHA, s 36(3) (person detained in a hospital); s36C(3)(a) (person on a CTO).

⁷³ MHA, s 36(2) (person detained in a hospital); s36C(2) (person on a CTO).

may order the authorised psychiatrist to place the patient on a CTO within a reasonable period.⁷⁴

Conversely, if the person is on a CTO, the Mental Health Board may vary or revoke the CTO if satisfied on reasonable grounds that treatment is no longer available in the community or that the person has not complied with either the CTO or their treatment plan, and there is a significant risk of deterioration in the patient's mental or physical condition because of their non-compliance.⁷⁵ If the Mental Health Board revokes a CTO, then the person must go, or can be taken, to a hospital.⁷⁶

The Mental Health Board may also order a psychiatrist to revise a patient's treatment plan,⁷⁷ but has no power to change or prescribe treatment itself.

Review by the Mental Health Board

The Mental Health Board must conduct a review of an ITO within eight weeks after the order is made (**initial review**), and after that at intervals not exceeding 12 months (**periodic review**).⁷⁸ If a CTO is extended, then the Mental Health Board must review the order within eight weeks of its extension.⁷⁹

Appeals to the Mental Health Board

An involuntary patient, or a person acting on their behalf, may lodge an appeal against their involuntary treatment with the Mental Health Board at any time and the Mental Health Board is required to commence a hearing without delay.⁸⁰

A community visitor or any other person who has a genuine concern for a patient (such as a friend or relative) may also lodge an appeal to the Mental Health Board on a patient's behalf.⁸¹

You can access a copy of the form that must be completed in order to bring an appeal to the Mental Health Board at http://www.mhrb.vic.gov.au/patient_information/documents/MHA5_Appeal_to_MHRB.pdf.

You can also lodge an appeal to the Mental Health Board electronically by completing the form accessible at http://www.mhrb.vic.gov.au/patient_information/appeal.htm.

⁷⁴ MHA, s 36(4).

⁷⁵ MHA, s 36D(3).

⁷⁶ MHA, ss 36(5) and s 43.

⁷⁷ MHA, s 35A(2).

⁷⁸ MHA, s 30.

⁷⁹ MHA, s 30(4).

⁸⁰ MHA, s 29.

⁸¹ MHA, s 29(1A). The Mental Health Board also has jurisdiction to review and hear appeals of orders made with respect to people who have been admitted and detained in an approved mental health service as involuntary patients, who appear to have a mental disorder but who no longer satisfy the section 8(1) criteria, and who, if not continued to be detained and treated, would cause serious physical harm to themselves (MHA, s 36E). Since these provisions came into operation on 1 July 1996, no cases have come before the Mental Health Board for determination. (Mental Health Board, *2006 Annual Report*, September 2006, 9).

Review of orders made in respect of prisoners

The Mental Health Board also reviews and hears appeals of orders made with respect to people either transferred from a prison to a mental health service or detained in a mental health service at the time of sentencing, for diagnosis, assessment or treatment of their mental illness.⁸²

Process and outcomes of review and appeal

On each review and appeal of an ITO, the Mental Health Board must review the patient's treatment plan to determine whether it complies with the requirements of the MHA and is capable of being implemented.⁸³ If a person is dissatisfied with a decision of the Mental Health Board, then they may either appeal to the Mental Health Board for a further review,⁸⁴ or to VCAT.⁸⁵

Rights of people appearing before the Mental Health Board

A person appearing before the Mental Health Board has the right:

- to legal representation. Free advice and representation may be available from the PILCH Homeless Persons' Legal Clinic, the Mental Health Legal Centre and Victoria Legal Aid (a precedent Client Interview for lawyers is also found on this website);
- to read, and obtain a copy of, any documents that the Mental Health Board will consider at the hearing. Access must be granted to the person (or their advocate) at least 24 hours before the hearing;
- to attend the hearing; and
- to request written reasons for the Mental Health Board's decision.

Resources

The following additional useful materials are available from the Mental Health Board website <http://www.mhrb.vic.gov.au>:

- recent Mental Health Board decisions;
- practice statements;
- facts sheets;
- appeal forms;
- relevant legislation; and
- other patient information.

In addition some of the Mental Health Board's more significant decisions are available through austlii at <http://www.austlii.edu.au/au/cases/vic/VMHRB/>.

⁸² MHA, s36A (hospital transfer orders); s36B (restricted ITOs); s36BA (assessment or diagnosis, assessment and treatment orders); s36D (restricted CTOs). See further at section 3.4 below.

⁸³ MHA, s 35A(1).

⁸⁴ MHA, s 29.

⁸⁵ MHA, s 120.

3. The Criminal Justice System and Mental Health

In addition to the issues surrounding involuntary medical treatment of people with a mental illness, people who are homeless and suffer from a mental illness or disorder often find themselves having to deal with the criminal justice system. This section provides an overview of some of the issues they may face.

3.1 Dealing with police

It is important to let clients with a mental illness know that when they are dealing with the police they should advise the police of their mental illness. If the police believe that a person they have arrested and are holding in custody requires psychiatric assessment or care, then they may make a referral to the Custodial Nursing Service.⁸⁶ If an assessment of whether a person is fit to be tried, fit to be charged or fit to plead is required that is to be relied on in court, then a forensic medical officer must be called by the police to make that assessment.⁸⁷

The police are also required to arrange for an independent third person to be present in a police interview if the person being interviewed has a mental illness.⁸⁸

Being in police custody can be stressful. Being interviewed by police can exacerbate this stress. Clients with a mental illness should be made aware that:

- they can ask for medication if they need it — the Custodial Medicine Unit can provide medication if required;
- they can ask to see a doctor;
- they should let the police know if their mental illness contributes to the interview being unduly distressing or uncomfortable; and
- they should tell the police if they have been held for too long without their medication.

For more information, see *Mental Illness and the Criminal Justice System in Victoria: Your Rights*, produced by the Mental Health Legal Centre, August 2006, and available at http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/yourrights_online.pdf.

3.2 Bail

If a client with a mental illness has been released on bail, then you should check whether the reporting requirements are too onerous because of the person's mental illness. If so, you can object to the bail conditions. You can also ask for your client to be bailed to a hospital for ongoing treatment. Alternatively, if bail is refused, a mentally ill person can be transferred to the Melbourne Assessment Prison's Acute Assessment Unit or the Thomas Embling Hospital.⁸⁹

⁸⁶ *Protocol between Victoria Police and the Department of Human Services Mental Health Branch* (2004) Victoria Police, Victorian Department of Human Services, Part 2.

⁸⁷ *Protocol between Victoria Police and the Department of Human Services Mental Health Branch* (2004) Victoria Police, Victorian Department of Human Services, Part 2.

⁸⁸ *Protocol between Victoria Police and the Department of Human Services Mental Health Branch* (2004) Victoria Police, Victorian Department of Human Services, Part 5; *Victoria Police Operating Procedures*, 4.6.3.

⁸⁹ See *Mental Illness and the Criminal Justice System in Victoria: Your Rights*, produced by the Mental Health Legal Centre, August 2006, p 26 at http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/yourrights_online.pdf.

3.3 Court

Magistrates' Court

If you have a client with a mental health issue who will be facing a charge in the Magistrates' Court, then you should note the following issues.

1. Support services: Mental Health Court Liaison Service

The Mental Health Court Liaison Service provides a court-based psychiatric support service in Magistrates' Courts throughout Victoria. The service is available at Melbourne, Broadmeadows, Dandenong, Frankston, Heidelberg, Ringwood, Sunshine, Ballarat, Bendigo, Geelong, Latrobe Valley and Shepparton Magistrates' Courts.

The service consists of a senior registered psychiatric nurse who is available on site as well as an on-call consultant forensic psychiatrist. The service:

- identifies and assesses people who may suffer from a mental illness;
- links people suffering from a mental illness to treatment and support centres;
- provides immediate mental health assessments;
- assesses if people are fit to plead; and
- reassesses people with a known psychiatric history.

2. Diversion Program

In the Magistrates' Court, a person charged with an offence may be able to participate in the Criminal Justice Diversion Program (**the Diversion Program**).⁹⁰

The Diversion Program gives mainly first-time offenders the chance to avoid a criminal record by fulfilling certain requirements. A person with a mental illness may make use of the Diversion Program. Either party can raise the issue of diversion throughout the court process, as long as:

- both the prosecution and the defendant consent;
- the defendant has not yet made a formal plea;
- the criminal proceeding can be tried summarily; and
- the offender admits to the facts of the case.

An application for a diversion should include a supporting letter from a mental health professional where possible (see above; you may be able to use the Mental Health Court Liaison Service to obtain an assessment from the on-call consultant forensic psychiatrist).

If the application for a diversion is approved, then a diversion hearing will be conducted before a Magistrate. A diversion plan may be created that may require the offender to:

- apologise to or compensate the victim;

⁹⁰ *Magistrates' Court Act 1989* (Vic), s 128A.

- attend counselling or treatment; or
- assist with community projects.

The Diversion Program allows offenders to receive assistance with rehabilitation and receive appropriate treatment. The offender is not required to agree to the diversion plan and may instead choose to have their offence tried before the court in the normal way (if, for example, they do not believe that they will be able to comply with the plan).

The Diversion Program requires that the offender satisfactorily complete the program and provide the court with evidence that the program has been completed in order to avoid a finding of guilt and the recording of a conviction.

3. Defence of mental impairment

In the Magistrates' Court, mental impairment may be a defence to summary offences and indictable offences tried summarily.⁹¹ The defence of mental impairment will be established if, at the time of the offence, the defendant was suffering from a mental impairment that meant that they did not know the nature and quality of the conduct or did not know that the conduct was wrong.⁹² If the Magistrates' Court finds a person not guilty because of mental impairment, then the offence must be discharged without penalty.⁹³

County Court and Supreme Court

If a client with a mental illness is required to attend the County Court or the Supreme Court, then the following principles will apply.

1. Support Services Court Network

Court Network is a general support service available at both the County and Supreme Courts. Information regarding this service can be obtained from <http://www.courtnetwork.com.au>.

2. Fitness to stand trial

A person will be found to be unfit to stand trial if, because the person's mental processes are disordered or impaired, the person is, or at some stage during the trial will be, unable to:

- understand the nature of the charge;
- enter a plea to the charge and to exercise the right to challenge jurors or the jury;
- understand the nature of the trial;
- follow the trial;
- understand the effect of any evidence; or

⁹¹ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)*, s 5(1).

⁹² *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 20(1).

⁹³ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 5(2).

- give instructions to their lawyer.⁹⁴

A person is presumed to be fit to stand trial.⁹⁵ That presumption is rebutted if it is established by an investigation⁹⁶ that the person is unfit to stand trial.⁹⁷ The question of a person's fitness to stand trial is determined on the balance of probabilities by a jury.⁹⁸ If a person is found to be unfit to stand trial, then the process to be followed is set out in sections 11 to 18 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

3. Defence of mental impairment

The question of whether the defendant is mentally impaired may be raised at any time during a trial.⁹⁹ The defence of mental impairment will be established if, at the time of the offence, the defendant was suffering from a mental impairment that meant that they did not know the nature and quality of the conduct or did not know that the conduct was wrong.¹⁰⁰ If the defence of mental impairment is established, then the person must be found not guilty because of mental impairment.¹⁰¹ The effect of a finding of not guilty because of mental impairment is that the court must declare the defendant liable to supervision¹⁰² or order the defendant to be released unconditionally.¹⁰³

4. Supervision

If a court declares that a person is liable to supervision, then the supervision order may be:

- custodial (that is, the offender is committed into strict custody in a hospital, usually the Thomas Embling Hospital, or in prison if the court cannot find an appropriate place); or
- non-custodial (that is, the offender is released on conditions decided by the court).¹⁰⁴

The court that made the supervision order must undertake a major review of the order at least three months before the end of the nominal term of the order and then at intervals not exceeding five years for the duration of the order.¹⁰⁵

A person detained under a supervision order may appeal to the Court of Appeal against the order.¹⁰⁶ An application may also be made to the court that made the

⁹⁴ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 6(1).

⁹⁵ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 7(1).

⁹⁶ The investigation is to be conducted under Part 2 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

⁹⁷ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 7(2).

⁹⁸ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 7(3)(b).

⁹⁹ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 22(1).

¹⁰⁰ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 20(1).

¹⁰¹ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 20(2).

¹⁰² The supervision would be conducted under Part 5 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

¹⁰³ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 23.

¹⁰⁴ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 26(2). Also note the possibility of leave in sections 49 to 58A of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

¹⁰⁵ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 35.

supervision order for a variation or revocation of it.¹⁰⁷ A decision on that application may also be appealed to the Court of Appeal.¹⁰⁸

5. Transfer of patients

A person in Victoria who is under a supervision order may be transferred to a participating State (or a person who is subject to an interstate supervision order may be transferred to Victoria) if, among other things, the transfer is for the benefit of the person subject to the supervision order and informed consent has been given.¹⁰⁹

6. Absconding to Victoria

A person on an interstate supervision order who has absconded to Victoria can be arrested and placed on an interim disposition order that is to be reviewed within seven days.¹¹⁰

3.4 Sentencing

Sentencing options

If your client is found guilty of an offence, then the court has various sentencing options available to it. These include:

- without a conviction, a minor charge can be dismissed;¹¹¹
- without a conviction, an order that the offender be released on the adjournment of the hearing on conditions;¹¹²
- discharge of the offender with a conviction;¹¹³
- release of the offender on adjournment of the hearing on conditions, with a conviction;¹¹⁴
- with or without a conviction, order the offender to pay a fine;¹¹⁵
- with or without a conviction, make a community-based order;¹¹⁶
- with a conviction, order a suspended sentence;¹¹⁷
- with a conviction, order imprisonment by way of intensive correction in the community (**intensive correction order**);¹¹⁸

¹⁰⁶ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 28A.

¹⁰⁷ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 31(1).

¹⁰⁸ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, s 34(1).

¹⁰⁹ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, ss 73D, 73E.

¹¹⁰ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, ss 73J, 73K, 73L.

¹¹¹ *Sentencing Act 1991* (Vic), ss 7(1)(j), 70-79.

¹¹² *Sentencing Act 1991*, ss 7(1)(i), 70-79.

¹¹³ *Sentencing Act 1991*, ss 7(1)(h), 70-79.

¹¹⁴ *Sentencing Act 1991*, ss 7(1)(g), 70-79.

¹¹⁵ *Sentencing Act 1991*, ss 7(1)(f), 49-69.

¹¹⁶ *Sentencing Act 1991*, ss 7(1)(e), 36-48.

¹¹⁷ *Sentencing Act 1991*, ss 7(1)(c), 27-31. However, note that the use of suspended sentences is currently under review and may be abolished.

¹¹⁸ *Sentencing Act 1991*, ss 7(1)(b), 19-26.

- with a conviction, make a drug treatment order;¹¹⁹
- with a conviction, order that the offender serve a term of imprisonment partly in custody and partly in the community (a **combined custody and treatment order**);¹²⁰
- with a conviction, order a term of imprisonment;¹²¹ or
- for a person aged 18 years or more but under 25 years of age, the Magistrates' Court may defer sentencing the person.¹²²

Some of the above orders have particular conditions attached to them. A client with a mental illness should be aware that some conditions may be difficult to comply with and so the conditions should be reviewed and carefully explained to the client. If appropriate, the client should be put in contact with a relevant support service to assist them in complying with the conditions.

A person sentenced by the court to a community-based order, suspended sentence, intensive correction order, drug treatment order, combined custody and treatment order or imprisonment has a right of appeal. It is necessary to look at the relevant court rules to determine the applicable process and timeframe.

Imprisonment

If a prison sentence has been imposed on an offender, then note that offenders who are mentally ill can be transferred to a hospital such as the Thomas Embling Hospital or the Melbourne Assessment Prison's Acute Assessment Unit under a hospital transfer order or a restricted hospital transfer order. A person is deemed to be **mentally ill** if they have a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.¹²³ The Secretary to the Department of Justice can make an order for a transfer if they have received a certificate from a psychiatrist and are satisfied that:

- the offender is mentally ill and requires immediate treatment;
- the detention and treatment of the person in an approved mental health service is necessary for their health and safety, or for the protection of the public;
- a psychiatrist of the service to which the offender will be transferred recommends the transfer be made and certifies that there are facilities or services available in that service for the treatment of the offender.¹²⁴

The Secretary to the Department of Justice can make a hospital transfer order, under which the offender is admitted to and detained in an approved mental health service as an involuntary patient, or a restricted hospital transfer order, under which the offender is admitted to and detained in an approved mental health service as a security patient.¹²⁵

¹¹⁹ *Sentencing Act 1991*, ss 7(1)(ac), 18X-18ZS.

¹²⁰ *Sentencing Act 1991*, ss 7(1)(ab), 18Q-18W.

¹²¹ *Sentencing Act 1991*, ss 7(1)(a), 9-18.

¹²² *Sentencing Act 1991*, ss 7(2), 83A.

¹²³ *Sentencing Act 1991*, s 3 and MHA, ss 3, 8.

¹²⁴ MHA, s 16(1),(2).

¹²⁵ MHA, s 16(3).

Hospital transfer orders and restricted hospital transfer orders are reviewed by the Mental Health Board within eight weeks of being made.¹²⁶ These orders are then reviewed every 12 months.¹²⁷ An appeal against these orders may be made to the Mental Health Board at any time.¹²⁸

Mental health orders

If a client is found guilty of an offence but is not subject to imprisonment, then the court has the option of making specific mental health orders if the court is satisfied that:

- the offender is mentally ill,¹²⁹
- the offender's mental illness may require treatment that may be obtained in an approved mental health service;
- involuntary treatment is necessary for the offender's health and safety or for the protection of the public; and
- the court has received a report from a psychiatrist of the service in which the person will be detained stating that there are facilities or services available.¹³⁰

The mental health orders available to the court are:

- **assessment order**¹³¹ — which requires the offender to be detained as an involuntary patient for up to 72 hours for an assessment to be made of their suitability for another mental health order;
- **diagnosis, assessment and treatment order**¹³² — the court may make an order for the offender to be detained in an approved mental health service as an involuntary patient for up to three months for diagnosis, assessment and treatment;
- **restricted involuntary treatment order**¹³³ — this order requires the detention of the offender in an approved mental health service as an involuntary patient for up to two years for treatment;
- **restricted community treatment order**¹³⁴ — this order may be made at any time for a person who is subject to a restricted involuntary treatment order. It is an order requiring the person to get treatment for their mental illness while not detained in an approved mental health service.
- **hospital security order**¹³⁵ — under this order, the offender is sentenced to an approved mental health service for a period of time that does not exceed the period of imprisonment to which the offender would have been sentenced had the order not been made.

¹²⁶ MHA, s 30(1).

¹²⁷ MHA, s 30(3).

¹²⁸ MHA, s 29.

¹²⁹ *Sentencing Act 1991*, s 3 and MHA, ss 3, 8.

¹³⁰ *Sentencing Act 1991*, ss 90, 91, 93, 93A, 94.

¹³¹ *Sentencing Act 1991*, ss 90, 92.

¹³² *Sentencing Act 1991*, ss 91, 92.

¹³³ *Sentencing Act 1991*, s 93.

¹³⁴ *Sentencing Act 1991*, s 93, MHA, s 15A.

¹³⁵ *Sentencing Act 1991*, ss 93A, 7(1)(aab).

All of the above orders, except the restricted community treatment order must be reviewed by the Mental Health Board within eight weeks of the order being made.¹³⁶ These orders are then reviewed every 12 months.¹³⁷

A restricted community treatment order must be reviewed by the Mental Health Board within eight weeks after the order has been in place for a 12-month period.

An appeal against any of these orders may be made to the Mental Health Board at any time.¹³⁸

A useful summary of the mental health system orders that can be made by the court can be found in the flow chart produced in *Mental Illness and the Criminal Justice System in Victoria: Your Rights* (Mental Health Legal Centre, August 2006), accessible at http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/yourrights_online.pdf.

4. Other Issues

4.1 Accessing mental health services

The MHA states that mental health services and treatment should be provided in accordance with certain principles, which apply to all people with a mental illness or disorder.

Importantly, the MHA states that people should be provided with timely and high quality treatment and care in accordance with professionally accepted standards and that, wherever possible, people should be treated in the community.

A person with a mental illness may seek access to mental health services through various avenues, including:

- seeing a general practitioner or private psychiatrist, psychologist, counsellor or other therapist;
- visiting a community mental health clinic;
- seeking admission to hospital;
- seeking assessment by a Crisis Assessment and Treatment (**CAT**) team, Youth Assessment Team (**YAT**) or a Psycho-Geriatric Assessment Team (**PGAT**); or
- seeking assessment by a Mobile Support and Treatment (**MST**) team.

¹³⁶ MHA, s 30(1).

¹³⁷ MHA, s 30(3).

¹³⁸ MHA, s 29.

4.2 Refusal of treatment or admission

If a person complains that they have been unfairly refused admission to a hospital or access to a service, they can complain directly to the service and/or can contact the Office of the Chief Psychiatrist or the Health Services Commissioner, which are charged with investigating why individuals have not received treatment. Importantly, the Chief Psychiatrist has the power to direct that the person be admitted or treated.

4.3 Discrimination

Many mentally ill people commonly face discrimination in the community — at work, in respect of housing and regarding services provision.

See Chapter 2 of this Manual for an overview of discrimination law.

4.4 Guardianship and administration

Some people who are subject to a mental health order or who have a mental illness or mental disorder may, as a result of this condition, be subject to a guardianship or administration order.

See Chapter 9 of this Manual for an overview of the law about guardianship and administration.

4.5 Intellectual disability

Section 8(2) of the MHA provides that a person who has an intellectual disability is not, for this reason alone, considered to have a 'mental illness' or 'mental disorder'.

The Department of Human Services Disability Services website contains some useful information on this issue at <http://nps718.dhs.vic.gov.au/ds/disabilitysite.nsf>.

Useful information is also available at the website of the Office of the Public Advocate at <http://www.publicadvocate.vic.gov.au/>.

5. Key Mental Health and Homelessness Resources

5.1 Salvation Army Crisis Services — Crisis Contact

The Salvation Army's Crisis Contact Centre is a State-wide service that provides information, referral, support and advocacy for people who are experiencing homelessness and mental health issues that have led them to a point of crisis. The centre is open from 9.00am to 11.00pm, seven days a week, and provides a 24-hour telephone service. The website of the Crisis Contract Centre is <http://www.salvationarmy.org.au/melbourne/homeless/default.asp>.

5.2 The Mental Health Legal Centre

The Mental Health Legal Centre provides a free and confidential legal service to anyone who has experienced mental illness in Victoria where their legal problem relates to their mental illness.

The Mental Health Legal Centre has published a *Guide to Patients' Rights* (May 2007), accessible at http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/VLA_MHLC_pr_25_05.pdf.

The Mental Health Legal Centre has also published a *Guide to Mental Illness and the Criminal Justice System in Victoria*, which is available at http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/yourrights_online.pdf.

5.3 Office of the Chief Psychiatrist

A number of useful guidelines on various topics related to mental health law and treatment of the mentally ill are available at <http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>.

For example, there are links to guides for use by clinicians and others on:

- CTOs;
- working together with families and carers;
- patient access to files for Mental Health Board hearings;
- managing people required to attend police interview or court ;
- restricted involuntary treatment orders and restricted community treatment orders; and
- the *Sentencing and Mental Health Acts (Amendment) Act 2005* (Vic) — a summary of key amendments.

5.4 Department of Human Services resources

Accessing mental health services

The following link allows you to search, by suburb, for relevant mental health service providers and their contact details:

<http://www.health.vic.gov.au/mentalhealth/services/index.htm>.

Community treatment orders

A link to the complete guidelines for CTOs developed by the Department of Human Services is set out below. These guidelines are aimed at clinicians who seek to understand the legislative requirements imposed on them under the MHA:

<http://www.health.vic.gov.au/mentalhealth/cpg/cto.htm>.

Patients' rights booklets

The following link provides access to 'patients' rights' booklets, *About your rights*:

<http://www.health.vic.gov.au/mentalhealth/patientright/downloads.htm#11>.

Each booklet addresses the rights of a person subject to involuntary treatment under the MHA. For example, there are booklets on:

- involuntary patients;

- restricted involuntary treatment orders;
- continuing treatment of involuntary patients;
- assessment orders and diagnosis, assessment and treatment orders; and
- hospital orders.

Carers' information

The following is a link to a booklet setting out information relevant to carers, friends and family members of people suffering from a mental illness or mental disorder:

http://www.health.vic.gov.au/mentalhealth/carer/family_carer.pdf.

6. Disclaimer

This Manual is intended to be used as a resource that introduces different areas of law and provides guidance on how an issue might be addressed. The Manual is not intended to be advice on any particular matter. Readers should not act on the basis of any material in the Manual without obtaining advice relevant to your own particular situations. The authors and publishers expressly disclaim any liability to any person in respect of any action taken or not taken in reliance on the contents of this Manual.

The law in this edition of the Manual is correct as at 30 June 2008