Chapter 8: Introduction to Involuntary Care

Joe Garside
Specialty of Psychiatry, The University of Sydney, Australia, and Australian Capital Territory, Australia.

Providing treatment to individuals without obtaining consent is not limited to psychiatry, individuals can be treated in medical emergencies when they are unable to give consent. However, involuntary treatment is a very visible aspect of the practice of psychiatry. Involuntary treatment means taking away a person's freedom and autonomy and provides the treating team with the legal right to impose treatment – something that in other circumstances could be considered to be assault.

Australia has one of the highest rates of involuntary inpatient admissions in the world averaging around 227 involuntary admissions per 100,000 people per year in 2016 (Sheridan Rains et al., 2019). An international comparison found that only Austria exceeded this with 282 involuntary admissions per 100,000 of the population. This rate was double the midpoint value of involuntary admissions across 22 other European countries and New Zealand (Sheridan Rains et al., 2019).

In New South Wales, 54% of admissions to public mental health care units were involuntary in 2022, and the primary factors related to being made involuntary were suffering from psychosis, an organic mental disorder, or a mood disorder. A comorbid substance use disorder also contributed to the risk of involuntary care (Corderoy et al., 2024). Being referred from legal services, being from a non-English speaking background and a socially disadvantaged area all increased the risk of involuntary care as did being from a First Nations people (Australian Institute of Health and Welfare, 2024; Corderoy et al., 2024).

Each state and territory in Australia have their own Mental Health Act that outline the laws and regulations pertaining to involuntary treatment. Generally, involuntary treatment can be imposed on individuals if they are suffering from a mental illness, at risk of harm to themselves or others, and the

involuntary treatment is the least restrictive alternative. This chapter will not focus on any one state's Mental Health Act but provide general ideas about involuntary treatment. A simple comparison of the Involuntary Commitment and Treatment (ICT) Criteria in Australian and New Zealand Mental Health Acts as of June 2017 can be found at **www.ranzcp.org/legislation** (Royal Australian and New Zealand College of Psychiatrists, 2017).

Involuntary Transport to Hospital

The journey to involuntary treatment often starts with being transported to a hospital by police for an assessment (Ryan et al., 2015). Depending on the jurisdiction, typically police and ambulance officers, mental health clinicians and medical practitioners are able determine that someone needs to be detained at a hospital for an assessment and are able to arrange transport for that to happen.

If the person is unwilling to go to hospital for assessment, almost the only way of transporting them is via a police vehicle. Sometimes, it is possible to use an ambulance escorted by the police, however no specialised ambulance unit is available to transport people under the Mental Health Act who do not wish to comply. This process can be very traumatic for the patient, and, in some instances, for the police or paramedics charged to bring the patient to hospital.

If the patient has evidence of a mental disorder and it is associated with risk that can only be managed in hospital, but they refuse to stay then it will be appropriate for them to be detained as an involuntary patient.

Involuntary Inpatient Admission

In Australia the evolving standard as to whether someone should remain an involuntary patient is whether they have decision making capacity. To not have decision making capacity: 'he or she must be unable to do one or more of the following: 1. Understand the information relevant to the decision; 2. 'use or weigh' that information as part of the process of making the decision; 3. communicate the decision.' (Ryan et al., 2015)

It is important to understand that lack of insight is not the same as impaired decision-making capacity. A patient with impaired decision-making capacity may argue it is pointless trying to talk them into staying in hospital because they are not unwell, and nothing works and there will be no adverse consequences if they are allowed to go home. A person with impaired insight might argue there is nothing at all wrong with them, but the tablets helped somehow last time so they're willing to give an admission a go. These are very

simplistic examples, but it is important to not conflate decision making capacity with insight.

From the outset it should be assumed that a person has decision making capacity and it is the role of an examination to test this. Also, patients need to be given all possible assistance to demonstrate they have decision making capacity by using simple language, an interpreter if necessary, and the support of family or friends if willing and available.

Other key requirements state that involuntary care should be the least restrictive option in which it is safe to treat the patient, that is the person can't be treated safely or effectively in the community, and that the treatment should be effective and available at the treating facility.

The Mental Health Review Tribunal

When someone has been detained as an involuntary inpatient in a mental health unit, they must in due course be presented to a tribunal to review if they indeed have a mental illness and require involuntary treatment. This is usually done by a Mental Health Review Tribunal (MHRT) which has the responsibility to periodically review a person detained under a Mental Health Act. Mental Health Review Tribunals generally comprise a panel of a lawyer, a psychiatrist and another member. At a tribunal hearing the patient will be offered the service of a solicitor and, if necessary, an interpreter.

The MHRT has a number of responsibilities depending upon the jurisdiction. One role of the MHRT is to make sure capacity has been tested. Other duties may include ensuring that the person detained has been provided with information about their rights, their carers have been told about the hearing, that medication hasn't interfered with the ability of a person to communicate and that cultural considerations have been taken into account when a diagnosis of a mental illness has been arrived at. The MHRT can discharge the person, make an order for continued inpatient care as an involuntary patient or discharge the person but with a continuing community treatment order. The Tribunal may also make a decision about the person's capacity to manage financial affairs.

Involuntary Community Psychiatric Care

The process of receiving involuntary care in the community is the same as receiving involuntary care as an inpatient but the least restrictive setting for care has changed. The treating team presents evidence to the MHRT about the presence of a mental illness, risk, and impaired decision-making capacity. Importantly, when

asking for an involuntary order for a patient in the community there must be a treatment that works and for which the mechanisms are in place to provide that treatment.

The rates of community treatment order (CTO) use in Australia are very high by international standards (Light, 2019). Concerns about the long-term restriction of people's freedom of choice brought about by CTOs have combined with evidence casting doubt on the efficacy of CTOs in achieving their stated aims and led to considerable controversy about their continued high usage (Brophy et al., 2021). The effectiveness of community treatment orders are debated with evidence suggesting that they are most likely to reduce the risk of readmission if sustained for at least 2 years (Kisely et al., 2021), but used less frequently (Kisely et al., 2023). The Australian Institute of Health and Welfare reported that in 2022 15% of patients managed in public community mental health teams were subject to involuntary orders (Australian Institute of Health and Welfare, 2024).

Summary

The role of involuntary care in mental health is controversial. Rates of use vary substantially from country to country which suggests that the high rates of involuntary care seen in countries like Australia may be unnecessary, particularly if the "less restrictive option" of community care is properly funded and developed (Kelly, 2019). Most patients receiving psychiatric care are in the community and are accepting it voluntarily. And most involuntary inpatients eventually become voluntary community patients. International agencies support a human rights approach that emphasises personal autonomy and community inclusions (World Health Organisation and the United Nations, 2023). The change of mental health law in Australia to be based around capacity is supportive of that human rights approach.

Further Reading

Micale, M. S., & Porter, R. (Eds.). (1994). Discovering the history of psychiatry. Oxford University Press, USA.

Cite as:

Garside, J. (2024). Introduction to involuntary care. In Boyce, P., Harris, A., and Malhi, G.S. (Eds.), *The Sydney textbook of psychiatry* (pp. 81–84). The University of Sydney.

References

Australian Institute of Health and Welfare (2024) *Involuntary Treatment in Mental Health Care*. Available at: **https://www.aihw.gov.au/mental-health/topic-areas/involuntary-treatment** (accessed 20th September 2024).

Brophy L, Edan V, Kisely S, et al. (2021) The Urgent Need to Review the use of CTOs and Compliance with the UNCRPD Across Australian Jurisdictions. *International Journal of Mental Health and Capacity Law* 28: 1-75.

Corderoy A, Large MM, Ryan C, et al. (2024) Factors associated with involuntary mental healthcare in New South Wales, Australia. *BJPsych Open* 10(2): e59.

Kelly BD (2019) Variations in involuntary hospitalisation across countries. *The Lancet Psychiatry* 6(5): 361-362.

Kisely S, McMahon L and Siskind D (2023) Benefits following community treatment orders have an inverse relationship with rates of use: meta-analysis and meta-regression. *BJPsych Open* 9(3): e68.

Kisely S, Yu D, Maehashi S, et al. (2021) A systematic review and meta-analysis of predictors and outcomes of community treatment orders in Australia and New Zealand. *Australian & New Zealand Journal of Psychiatry* 55(7): 650-665.

Light E (2019) Rates of use of community treatment orders in Australia. *Int J Law Psychiatry* 64: 83-87.

Royal Australian and New Zealand College of Psychiatrists (2017) *Involuntary commitment and treatment - mental health legislation*. Available at: **https://www.ranzcp.org/clinical-guidelines-publications/in-focus-topics/mental-health-legislation/involuntary-commitment-and-treatment** (accessed 20th September 2024).

Ryan C, Callaghan S and Peisah C (2015) The capacity to refuse psychiatric treatment: A guide to the law for clinicians and tribunal members. *Australian & New Zealand Journal of Psychiatry* 49(4): 324-333.

Sheridan Rains L, Zenina T, Dias MC, et al. (2019) Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study. *The Lancet Psychiatry* 6(5): 403-417.

World Health Organisation and the United Nations (2023) *Mental health, human rights and legislation: guidance and practice.* Geneva: World Health Organisation and the United Nations (represented by Office of the High Commissioner for Human Rights).