They are playing a game.  
They are playing at not playing a game.  
If I show them I see they are,  
I shall break the rules and they will punish me.  
I must play their game, of not seeing I see the game

R D Laing, Knots. 1974

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December 2001
COMMUNITY TREATMENT ORDERS- A REVIEW

Preface

Community Treatment Orders (CTOs) were introduced to Western Australia as part of the Mental Health Act 1996 (the ‘Act’) which came into force on 13 November 1997. In line with the use of CTOs in other jurisdictions and Part 9, ‘Involuntary treatment in the community’, of the Model Mental Health Legislation document, the introduction of CTOs was seen as a way patients would receive treatment, if necessary without their consent, while living in the community. This form of involuntary treatment was viewed as a less restrictive option than being a detained patient in an authorised hospital and would reduce the ‘revolving door’ of admission, discharge and readmission that had become so common for many people with a mental illness.

The Act while concerned with legislative protocols and minimal requirements does not detail specific practice issues and a need has been identified for the development of CTO guidelines, which will enable clinicians to consider best practice ideas. This review of research into CTOs complements a publication ‘Community Treatment Orders: A User's Guide’, also developed by the author of this publication to address the need for best practice guidelines.

This review attempts to be as comprehensive as possible, exploring the thorny questions that arise in the debate on CTOs while referring to the extensive literature on the subject. The review is not an attempt to either justify or vilify the concept of CTOs, rather it is to examine why CTOs are used and who for; the ethical and human rights issues that arise; the consumer and carer viewpoints; the problems that have been identified in using CTOs; a consideration of how CTOs are managed in other jurisdictions and what West Australian clinicians and consumers feel about the use of CTOs in Western Australia.

The review is detailed because the issues in this area are complex and there are no jurisdictions where CTOs are managed perfectly. Consumer and clinician experience
as well as research is contributing to the debate and a number of the complaints regarding CTOs are due to attempts to be prescriptive in legislation yet flexible enough to accommodate the complexities of the relationships between consumers and clinicians. Certainly changes in legislation in Western Australia will assist with better management of CTOs, however it is also dependent on clinicians developing practices and procedures, which while paying attention to the law and using the least restriction allow the consumer to lead as fulfilled a life as possible in the community.
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Introduction

The Rand Report (Ridgley et al., 2001) notes that involuntary treatment has been the most consistently debated issue in mental health law for the last 30 years. The goals of involuntary treatment have not changed radically over time. They include insuring public safety, guaranteeing access to treatment for those who need it, and ensuring that treatment is provided in the least restrictive environment consistent with the needs of the individual. Mulvey (1987) from an historical position notes that coercive state action with individuals with a mental illness is rooted in two justifying rationales. Firstly, the power of *parens patriae*, which argues that the state is obligated and empowered to act for the betterment of citizens who have compromised capacities to act in their own best interest. Secondly, *police powers*, which argues that the state has the obligation to protect citizens and to ensure social order by restricting the freedom of identifiable dangerous individuals.

In the last twenty years however the focus on involuntary treatment has changed as jurisdictions in many countries have amended or interpreted their existing involuntary civil commitment statutes to allow for involuntary outpatient treatment. These changes in mental health law were designed to extend the mental health service’s supervisory control over people with a mental illness into the community.

Power (1999) in a review of CTOs in Australia notes that CTOs are a variation of ‘Out Patient Commitment’ (OPC) legislation used extensively in the United States. Outpatient commitment is an extension of the state’s powers of civil commitment or involuntary treatment outside the traditional confines of the hospital. It first emerged in the context of the expanding community psychiatric services as more effective psychiatric treatments and legal reform spelt the demise of institutional care. It developed partly in response to increasing concerns about the failure of deinstitutionalisation and previous over-zealous mental health reform and as a reaction to increasing community concerns regarding violence, suicide and the burden of care people with a seriously mental illness place on their families and carers. Dyer (1998) argues that although the main reason for compulsory treatment in the community is for the patient’s benefit there is the issue that community care
depends upon public acceptance. If the public perception is that community care is unsafe, there could be a backlash which would sweep people back into institutional care, including a majority who do not pose a threat to themselves or to others.

Power (1999) contends that CTOs have become increasingly popular and have demonstrated their usefulness in attempting to address some of the major difficulties faced in the management of those with a serious mental illness. They have clear advantages for some patients who might otherwise be subjected to the problems of serious mental illness and deprived of the benefit of vital treatment or care in the least restrictive setting, their home.

This view is echoed by Turner (1994) who states that a CTO is essential for those patients who lack insight, constantly relapse, are routinely readmitted under mental health legislation, yet inevitably drop out of follow-up care after discharge and this he contends is not because of failed aftercare. It is simply that some patients refuse to consider that they are ill or need help. Community treatment orders are therefore essential for a comprehensive, community-orientated service and a moral necessity to avoid the return to the use of asylums.

Others do not hold this view. Mulvey et al. (1987) states that the system of long-term institutional care has been replaced by a reactive, crisis-centred system of decentralised community care. Mulvey questions whether these changes have produced better care and treatment for some patients and because of methodalogical problems with the research it is indeed difficult to be categorical that CTOs are an improvement in care for people with a mental illness. In viewing this shift from institutional to involuntary community care a number of service providers have been less than convinced that the broadening of patients rights and the restructuring of community based services have translated into more quality care. Mulvey notes that some of those benignly neglected in institutions now appear to be blatantly neglected in urban areas. Unfortunately increased liberty and deinstitutionalisation have not been enough and have not translated into a positive service approach for the most troublesome individuals with a chronic mental illness.
For psychiatrists such as Joanna Moncreiff and Marceleno Smyth (1999) CTOs are the wrong answer to the wrong question. Their position is that the main issue is not how psychiatrists control antisocial behaviour, but how to address the gulf that exists between patients and professionals in mental health services. In their opinion psychiatrists should be concentrating on ways to improve relationships and should oppose legislation, which is likely to damage this process. Tom Burns (1999) in a commentary on Moncreiff and Smyth argued that the question is not how can psychiatry control antisocial behaviour, if it was few psychiatrists would support CTOs. Rather the question is ‘is there a group of patients who are poorly served by the present legislation who are currently repeatedly subject to compulsory admission, and whose welfare would be better served by a CTO’.

There are a number of arguments against the use of CTOs. One is that the alleged benefits of treatment to the patient can be negated by the patient's feelings of alienation and dissatisfaction. As a result the patient is less likely to comply with treatment as soon as coercion is lifted. Another argument is that other prospective patients may be deterred from seeking help voluntarily for fear that they too will be subject to involuntary status (Dennis and Monaghan, 1996).

Perhaps the most fundamental argument against CTOs is that systems of benevolent coercion rarely provide effective therapy but quickly come to serve social monitoring functions instead. Mulvey (1987) pointed out that in general efforts to do something ‘to’ someone in order to do something ‘for’ someone falls short of expectations because social monitoring inevitably takes operational precedence over treatment. In effect although CTOs are established with the intent of reaching an undeserved and difficult population they usually become little more than ways to provide standard services to marginally difficult clients. The crux of this argument is that individuals who would be left alone if the system did not exist are instead subjected to standard treatment of dubious value when the system does exist.

Previous attempts at benevolent coercion in non-institutional settings certainly do not provide a solid basis for countering this argument. Probation and parole, for example, started as rehabilitation efforts but have evolved into systems better suited
to documenting infractions and removing offenders from the community than fostering successful community reintegration. Similarly, agencies for abused and neglected children have rarely developed into the family treatment centres envisioned. Instead they are often more accurately characterised as enforcers of state’s rights against possibly recalcitrant parents. When benevolent treatment and coercion operate together it would appear that coercion becomes pervasive whereas treatment remains nominal. As a result, efforts at mixing state monitoring and community treatment often foster the concern that the inevitable outcome will be an infringement of civil liberties without any guarantee of improved functioning for the individuals involved (Mulvey 1987).

Mental health consumers and advocates are also deeply concerned that outpatient commitment extends coercive social control into the community and that the dislike of coercion deters people with mental illness from seeking treatment. (Mulvey. Geller and Roth 1987)

One of the major difficulties in the debate is the distinction between voluntary and involuntary status. It appears that voluntary status is deemed the appropriate choice (being least restrictive), with the patient realising they have a mental illness and choosing to accept treatment. Involuntary status on the other hand is linked with a lack of insight and an assumption that the patient is totally resistant to accepting treatment. The reality is more complicated. Hoge et al. (1994) found that 34% of voluntary patients did not believe they had a mental illness. The voluntary admission of 49% of these patients was initiated by someone other than the patient and 39% believed that they would have been involuntarily committed had they not volunteered to be hospitalised. The involuntary patients were also surveyed and 34% believed they did have a mental illness and 56% indicated that if offered voluntary admission they would have accepted it. Although the study suffers from a major difficulty of surveying a vulnerable group of people after the event it does show that the distinction between voluntary and involuntary may be more complex than first appears.
Rationale for Community Treatment Orders

People with a chronic mental illness

The rationale for the introduction of OPC in the United States in the early 1980’s was a realisation that the law was allowing a vulnerable group of people to slip through the cracks in mental health services and receive no assistance. Hiday and Schied-Cook (1987) note that people with a chronic mental illness who failed to obtain treatment on their own and who then decompensated and exhibited bizarre behaviour, could not be civilly committed until they did something dangerous even though they had a history of becoming dangerous in the later stages of decompensation. Family, friends, mental health professionals and courts had to sit by and wait for those persons to threaten, attempt, or complete acts which could result in harm before civil commitment could be used to restrain and force treatment on them.

As Elbogen et al. (2000) note a significant percentage of patients discharged will be readmitted to in-patient facilities shortly after discharge into the community. Up to half of people with a chronic mental illness demonstrate signs of relapse that warrant re-hospitalisation within six months.

The term given is the ‘revolving door’ and many researchers note that CTOs were primarily introduced to either stop or more realistically slow down the speed by which that door revolved. Bursten (1986) states that the problem of the ‘revolving door’ in psychiatric hospitals has vexed society for quite some time. Courts and mental health personnel alike have been increasingly discouraged by the parade of patients who improve when committed to hospitals but who fail to follow through with treatment afterward and therefore must be re-hospitalised time and time again.

Part of the concern has been the annoyance, discouragement and inconvenience to mental health clinicians who see the same faces over and over. Part of the concern has been economic in that it is expensive to reprocess the same people through the courts and admission units. However a primary concern has been a humanitarian desire to improve the lives of patients with a chronic mental illness by preventing
relapses and re-hospitalisations. Appelbaum (1986) in considering the promises and the problems of outpatient commitment notes that outpatient commitment holds a great deal of promise for the problems of an important group of people with a chronic mental illness. While Mulvey (1987) suggested that involuntary outpatient commitment presents a possible mechanism for providing mental health services to patients who never received the promised benefits of deinstitutionalisation.

From an Australian perspective McIvor (1998) notes that the rationale for the introduction of CTOs can be traced to the closure of large psychiatric hospitals and the increasing use of community based psychiatric programs. It became clear that there was a group of difficult-to-treat patients who persistently failed to comply with community treatment and required involuntary admission to hospital for stabilisation. It was for such ‘revolving door’ patients, usually suffering from severe psychotic illnesses that the CTO was developed. With compulsory community treatment, it was argued that such patients would spend less time in hospital, gain more insight into their condition and be able to make effective use of community resources, even after the order was terminated.

Dedman (1990) in reviewing the use of CTOs in Victoria, notes that it is one of the failures of contemporary psychiatry that many patients who respond well to neuroleptic medication given to them when they are in-patients relapse after discharge, as a result of not taking any further medication. Those working closely with the acute psychiatric patient in the community are often forced to stand by powerlessly as a patient deteriorates causing damage to himself and his social milieu until such a point is reached when he or she is once again ill enough to warrant compulsory admission and treatment. This process is of course devastating for a patient’s family and also disheartening for professionals involved, and Dedman suggests this is perhaps partly responsible for the high turnover of staff involved in front line services.

Overall the clinicians viewpoint is that people with a chronic mental illness need asylum and sanctuary in the community and a CTO is likely to ensure they have treatment as well.
Ridgley et al. (Rand Report, 2001) summed up the situation well in noting that in most mental health systems there are people with severe mental illness who are persistently at high risk of relapse. They have repeated hospitalisation and criminal justice contacts and disproportionately use in-patient services, which of all mental health services are the most costly. These individuals often have co-morbid alcohol and/or substance abuse problems and fail to take their psychotropic medication as prescribed, which contributes to episodic deterioration of their psychiatric condition leading to disruptive or violent behaviour. Unfortunately for various reasons even when treatment is made available some individuals do not comply with their treatment regime. Their illness when untreated can result in them being unable to care for themselves or become dangerous to themselves or others. It is imperative then that legal mandates and coercive interventions be used to leverage compliance. These mandates are believed to increase compliance with treatment and thereby prevent deterioration and harm to the patient or others.

Although it is the case that some patients are reluctant and some resistant to seeking treatment, failure to comply might be due to other factors external to the patient’s motivations. For example Hiday and Goodman (1982) in one of the first studies conducted on outpatient commitment, found that missed appointments were often due to difficulties such as transportation, childcare and sickness. In other words reasons beyond the control of the patient. These reasons combined with social and mental disorganisation resulted in non-compliance rather than any calculated recalcitrance on the part of the patient.

The suggestion is that improvement in the services offered by the mental health clinic to enable compliance, such as childcare facilities and assistance with transport would ensure patients received the treatment they required in the community. Even those who are reluctant to take medication or keep appointments are so for valid reasons. Complying would be an admission of being sick and they may not believe they are unwell or believe that they were sick but have now recovered. Discharge from hospital is often used as evidence that recovery is complete and that they no longer require treatment.
Deterioration in the community

A major problem in the past has been the inability of clinicians to influence the chronic patient in the community to continue with treatment, particularly medication. Brahms (1986) in considering the situation in the United Kingdoms states ‘as matters now stand, doctors, relatives and social workers may just have to sit by and watch a patient deteriorate until they can impose essential treatment without the patient’s consent’.

Appelbaum (1986) sums up the position as it was in the mid 1980’s. Noting that as the length of hospitalisation has decreased due to more rigorous commitment laws and to the reorientation of state hospital systems towards the provision of short-term care, a subset of patients has begun to appear regularly at the hospital’s door. All too often these patients tell the same story. Following the last hospitalisation they continued for a time taking their medication and attending outpatient therapy sessions. Soon however they came to question the value of treatment and convinced that they would not relapse stop their medications. Within a few months they have decompensated and again required in-patient care.
Aftercare

Prior to the introduction of CTOs, mental health services had developed systems, such as aftercare or long leave which enabled limited consequences should a patient in the community cease their treatment. In Western Australia under the Mental Health Act 1962 it was possible to discharge patients to aftercare. This system put more onus on community clinics to follow-up patients and allowed, when necessary, a more simplified system of re-admission. However there was little that could be done with regard to those patients who were reluctant or refusing treatment but were judged not unwell enough to require involuntary admission.

In the United Kingdoms (Mental Health Act 1983, section3) ‘long leave’ was an alternative to outright discharge and was frequently used by psychiatrists to ensure that patients although living in the community continued with their treatment. The consequences of ceasing treatment being a swift return to hospital without the requirement of additional legal paper work. However the use of ‘long leave’ renamed 'long leash' treatment, has been deemed unlawful by the Human Rights Commission of the European Union (R v Hallstrom ex parte W, 1985) (Dedman 1990).

The Mental Health Act 1984 in Scotland operated until 1996 a form of aftercare under the guise of 'leave of absence'. At the end of 1994 there were 129 people who had been on leave of absence for over 12 months. Seventeen of these had been on leave for over 3 years and a smaller group for over 4 years. According to Dyer (1998) the overwhelming experience in Scotland is that when people know there is a legal authority for their medical treatment, they accept it. However it is clear from the use of these provisions in Scotland that repeated forceful administration of medication did not occur.

In the United States for generations state hospitals had the power to 'parole' patients, that is to discharge them on the condition that they remained stable and conformed with aftercare plans. However these provisions have fallen into disuse in
most areas, in part because of difficulties in monitoring patients and in part because of uncertainties about the constitutionality of such practices (Appelbaum 1986).

The major difficulty with aftercare is the lack of enforcement mechanisms for patients who violate the conditions of outpatient care. Allowing hospitalisation only if, at the time that treatment is being refused the patient would otherwise meet the criteria for involuntary admission. Appelbaum (1986) points out that the prospect of sending out the 'mental health police' to bring patients in for their weekly injections is not a pleasant one.

However a number of clinicians see benefit in aftercare or long leave systems and one respondent to the recent survey of clinicians in Western Australia stated that he did not believe that CTOs have as much simplicity or utility as the old aftercare system. Sensky et al (1991) in a retrospective study followed up a group of patients on extended leave and found that the use of extended leave improved treatment compliance, reduced time spent in hospital and by comparing clinical characteristics before and after extended leave was able to show reduced levels of dangerousness.
Ethical Issues

CTOs raise a number of ethical and human rights issues and have led to a deep divide between proponents of the system and those who believe that CTOs represent a severe encroachment of civil liberties.

The purpose of community care was to maintain in the community the mental health of people, who had suffered from a mental illness, except at times of acute crisis requiring hospitalisation. For many CTOs represent a new discriminatory departure from this position. Compulsory community treatment means that people who are living and surviving in the community, who have committed no crime, and who are deemed competent enough to marry, vote and enter into business contracts will be deprived of certain basic human rights enjoyed by the rest of the population. For Moncreiff and Smyth 1999) tolerance means recognising that sometimes people will not do what others feel is best for them. They believe psychiatrists should respect their patient's decisions and be prepared to help manage the consequences such as providing care during relapses.

McIvor (1997) from an Australian perspective notes that despite advocating treatment in the least restrictive environment, CTOs do not appear to concur with the principles in the United Nations Charter (Principles for the protection of persons with a mental illness and for the improvement of mental health care, 1991) and interfere extensively with patients civil liberties. He contends that psychiatrists need to accept that some insightful patients will choose not to take medication and this should be respected.

Mulvey (1987) argues that it is counterproductive to try and reintegrate someone into a social structure through the use of negative sanctions. He notes that the people with a chronic mental illness who are the most likely candidates for OPC are generally alienated individuals who perceive the world as hostile and uncaring. To place them in a situation where acceptance of treatment becomes another instance in which the larger society is willing to penalise them for being unattached to regular social structures will merely perpetuate the cycle of alienation. The basic element of
a therapeutic relationship is trust and structuring the outpatient commitment contract so that trust is assumed to be unattainable is to involve mental health professionals in a monitoring rather than therapeutic relationship.

Geller’s (1990) perspective is that ‘some people are deprived of their liberties in the attempt to give them psychiatric care. Occasionally, others are deprived of psychiatric care in the attempt to guard their liberties’. The issue of liberty versus care and treatment leads to a variety of opinions. Proponents of CTOs state that to define liberty for people with a mental illness as the right to be free from non-interference is to guarantee that they will remain disenfranchised from potentially beneficial treatment and community life (Mulvey, 1987). Their argument is that liberty has to be considered more broadly in order to formulate reasonable policy for people with a mental illness. The rationale against involuntary treatment is based on a ‘negative’ conception of liberty, one in which a person is said to be free to the degree that no other person or ruling body interferes with his or her choice of activity. This negative conception of liberty does not fit the situation of disenfranchised individuals with a mental illness. It is argued that a ‘positive’ construction of liberty should be considered, one in which a person is free to the extent that he or she is a master of his or her own actions. This conception of liberty emphasises the freedom to quality of life, such as the need to be free from symptoms such as hallucinations and delusions, rather than the empty gesture of freedom from interference. The argument is that liberty means little if anything when one’s actions are constricted by forces such as mental illness symptoms which are equally as powerful as any legal intervention. The argument goes even further in proposing that mental health law by using coercive powers is furthering the ultimate freedom of these individuals despite an initial infringement of rights in order to do so.

For Geller (1986) the question of patient’s rights hinges on the balance to be struck between the required paternalism of the psychiatrist and the drive towards autonomy for the patient. He contends that these are moral dilemmas that have traditionally pitted the medical model against the civil libertarian perspective. The libertarian position is rooted in deontological concerns of fairness and justice and argues for non-intervention. In response to this position Judge Bazelon’s query is apt: "How real
is the promise of individual autonomy for a confused person set adrift in a hostile world?” Psychiatrists who have argued against the libertarian ideology have not simply adopted the consequentialist mode of the medical model but have indicated that intervention is warranted because the autonomy of the debilitated psychiatric patient is illusory. Geller (1986) concludes that unless there is some coercive community treatment the likelihood is more in-patient commitment.

Schmidt and Geller (1989) note that the in-patient who benefits from antipsychotic medication with no significant side effects but resolutely refuses its administration is the quintessential example of ‘rotting with your rights on’. Such a state can exist for prolonged time periods and has adverse effects on the patient and on the in-patient milieu. When the patient is involuntarily treated to the point of symptom remission the inability to continue involuntary administration of medication in the community may be extending to the patient ‘one right too many’.

Elbogen (2000) argues that involuntary outpatient commitment even increases patients autonomy and liberty as it is a mechanism aimed at encouraging staff to release an individual into the community once his or her condition has improved to the point that in-patient care is no longer necessary. In other words psychiatrists are more likely to release a patient on a CTO rather than wait until the person is fully recovered if a voluntary outpatient service was only available. This position postulates that CTOs actually facilitate discharge and has the chance to grant individuals more autonomy than absolute discharge because they reduce the length of stay in hospital. For example in 1995 Victoria had the lowest per capita number of psychiatric beds and according to McDonnell and Bartholomew (1997) this was due not to any policies from the then State government but rather to the use of CTOs. Their view is that policy regarding treatment in the community, compulsory if necessary, is consistent with the general shift towards distrust of institutions as a panacea, the common acceptance of libertarian philosophies of minimal intervention and the prevailing belief that community based care is more humane, therapeutic and less stigmatising. It does not grant people with a mental illness freedom from restrictions but it incorporates a positive conception of liberty.
Ridgley et al. (2001) concluded that theoretically OPC can allow a person with mental illness increased autonomy while at the same time extend the state’s supervisory control beyond the hospital and into the community. The obvious danger of this positive notion of liberty and the ‘liberating’ intention of CTOs lies in the definition of what a person ‘really needs’ in order to be considered free. The focus is on ‘needs’ rather than ‘rights’.
Therapeutic Jurisprudence

One perspective in examining the issues of ethics and patient’s rights, which has developed over the last ten years, is the application of the tenets of Therapeutic Jurisprudence (TJ) to ideas and values in mental health law. Wexler (1992) describes TJ as the study of the law as a therapeutic agent. It looks at the law as a social force that may produce therapeutic or anti-therapeutic consequences. Elbogen (2000) in looking specifically at the move from psychiatric hospital to the community notes that TJ is concerned with examining how the law is utilised in ways that either promote or frustrate mental health goals. He believes that using a TJ lens would be relevant for investigations into the therapeutic impact of involuntary community treatment, particularly with chronic patients.

Wexler (1996) identifies four overlapping areas of inquiry. Firstly, can the law be therapeutic in that interventions required by legislation actually be beneficial for the individual. Certainly much of mental health law is premised on that concept and mental health clinicians firmly believe they are applying the law to assist their client, perhaps preventing their client from harming him or herself or others. Community treatment orders are certainly situated within this framework and applying the Act is viewed as part of the overall community treatment plan.

The second issue is whether the role of the law produces psychological dysfunction. In other word are there consequences of applying the law which contribute to an anti-therapeutic effect. The literature and replies to the survey certainly raise the question of damage to clinician-consumer relationships, which may occur when the law is used. Patients may feel they are obliged to have a relationship with a clinician rather than it being an intervention freely chosen. This is bound to reflect on the quality of the relationship and some clinicians believe the patient’s mental health is better managed on a voluntary basis through a strong therapeutic relationship rather than through the law where patients may be obliged to take their treatment but only do so reluctantly. The consequence of this approach is that medication can be delivered but it is unlikely that the patient will seek the advice and assistance of the clinician with other psychological or social problems. In discussing the negative
The impact of the use of the law McIvor (1997) states that patients may come to see mental health clinicians as instruments of control who have the power to use reasonable force in insureing treatment. Compulsory treatment in the community may therefore counter-intuitively work against proper clinical care and as a result be anti-therapeutic. McIvor (1997) qualifies this by suggesting that such difficulties can be minimised with careful staff training, which is sensitive to the ethical and therapeutic issues involved.

The third issue is whether in relation to CTOs the specific requirements demanded by the Act result in a better therapeutic outcome for the patient. The Act certainly requires details in regard to a treatment plan with the intention that the patient is fully informed and aware of their obligations under a CTO. The West Australian survey indicated that this is one aspect of CTOs that clinicians find onerous and demanding. Their viewpoint is that treatment plans are continuously changing and having to specify on legal forms every change is cumbersome and does not deliver a better service for the patient.

The fourth issue is whether the law in conferring on clinicians specific duties results in a more therapeutic service for the patient. For example Dedman (1990) notes that CTOs may have a beneficial effect on patient care by committing the agencies involved with the patient to a firm plan of management on discharge. In other words CTOs cut both ways; they place obligations on the treating agencies to provide care as well as obligations on the patient. However Mulvey (1987) identified a problem of quality control. Monitoring of care offered in the community is less able to be scrutinised than in-patient care. Outpatient care could be more of a ‘hidden’ interaction between an individual professional and a patient, placing the patient in a relatively powerless position as the sole witness of any abuse.

Traditional mental health law often reflects policy and practices that choose between individual well-being, self-determination or public safety while TJ asks us to reframe how we understand the questions and challenges us to create policies that enhance individual well-being, self determination and public safety, simultaneously. The
development of practice guidelines when using legislation can be one way where enforcement of the law may result in a therapeutic outcome.
Consumer Perspective

Moncrieff and Smyth (1999) note that consumer groups in the U.K. are implacably opposed to CTOs and statements from consumer groups themselves reinforce this (MIND, 1998). Thornicroft (1993) draws attention to the fact that of 21 national organisations representing the entire range of agencies that gave evidence to the UK House of Commons Select Committee on the issue of CTOs, only 3 were in favour. They were the Royal College of Psychiatrists, the British Medical Association and the mental health charity SANE.

A review of the literature shows a dearth of surveys asking consumers their opinions about CTOs and even Ridgley et al (Rand Report 2001) who surveyed clinicians and health directors did not include consumers or carers. However one study by Lucksted and Coursey (1995) looked at the patient’s attitude towards coercion with hospitalisation. They reported that anger and resentment dominate at the time coercion is applied, however these negative feelings tend to subside afterward and be replaced with appreciation of the earlier need for coercion. According to these researchers, looking back, the majority of respondents felt that it was in their best interests to have been pressured into treatment. Hiday (1992) studied patient attitudes towards official coercion in the community and found that the majority of patients who were subject to outpatient commitment had positive attitudes towards treatment in the community. The patients found it helpful to talk about their problems, giving them a place to go and providing services they otherwise would not have received. The most important reason given by the patients however was that it enabled them to stay in their homes outside the hospital. The problem with this study done in North Carolina is that being a court procedure the choice for patients was often between involuntary in-patient or involuntary outpatient care.

Nevertheless it is clear that consumer groups have very strong feelings about CTOs, primarily expressed through newsletters and the Internet. The Coalition against Outpatient Commitment (a collection of consumer groups based in New York) detail the following reasons why consumers are against involuntary treatment in the community.
Firstly, coercion is bad for people’s mental health. They contend that research indicates that people subjected to forced treatment are at increased risk for drug dependence, disabling side-effects of medication, and suicide. It can result in damage to self-esteem and motivation for recovery and the re-triggering of problems associated with past violence and abuse. Unfortunately the Coalition does not give details of this research.

Secondly, outpatient commitment is not effective. They quote the results of a three-year pilot study of outpatient commitment at Bellevue Hospital (Steadman et al., 1998) which shows no difference in outcomes between a group of people who were subjected to outpatient commitment and a control group who received voluntary services. Their perspective is that outpatient commitment simply does not work.

Thirdly, outpatient commitment interferes with people’s right to choice. People recover when they have choice among alternative treatments and services, when they are empowered to make their own decisions and take responsibility for their lives, and when they are offered hope. These conditions are impossible under outpatient commitment.

The Coalition’s point is that for consumers, compulsory community treatment means that people who have committed no crime and who do not meet the standards for in-patient commitment can be told where, when and with whom they may live, how they must spend their days and what drugs they must take.

Specifically their arguments with regard to civil rights include the following:

a) To make an entire class of people subject to involuntary/forced treatment based on a presumed disability status will result in blanket violations of individuals' civil rights.

b) Outpatient Commitment is difficult to define and make standard. This fact can and will lead to arbitrary determinations about what constitutes outpatient commitment in different places and under different sets of circumstances. Such inconsistency will result in civil rights violations for countless individuals.
c) Current involuntary commitment laws apply to persons who are judged to be a danger to themselves and others. These laws govern in-patient commitment. Expanding involuntary commitment laws to govern outpatient commitment will open the door to impose forced treatment on persons who present no danger to themselves or others, but who, in someone else's judgement, would benefit from treatment.

With regard to treatment issues and mental health services the Coalition makes the following points-

a) When mental health services involve a therapeutic relationship, forced treatment undermines the trust needed for such a relationship to be truly helpful and therapeutic.

b) The very threat of forced treatment cause people to avoid services altogether. Coercion results in feelings of fear, anger and repugnance towards mental health services and people tend to avoid them.

c) Involuntary community treatment or outpatient commitment amounts to a form of preventive detention. Resources would be better used to provide adequate voluntary services.

d) Inadequate community services make it difficult to enforce involuntary community treatment leaving the system open to further inconsistency and arbitrariness. Scarce community resources will be diverted to support legally ordered services, further weakening the already inadequate community system.

The Coalition’s position is that rather than putting scarce resources into a coercive program that has not been proven effective, they favour increasing voluntary access to a range of services that promote recovery and rehabilitation. People with psychiatric diagnoses must be free to choose among respectfully provided services that genuinely meet their needs.

In November 1998 consumers were invited to a forum on involuntary outpatient commitment conducted in Florida by the Florida Department of Children and
Families Mental Health Program. Although the main speakers were either psychiatrists or lawyers there was an opportunity for consumers to air their views. One consumer for example pointed out the law does not permit forced treatment of other disabling conditions such as obesity or smoking, and so it is unfair to single out people with mental illness for coerced treatment. Another viewpoint was that if incentives were created for people with mental illness to use treatment options then the use of coercion might be diminished (Petrila, 1999).

It may be that the views of the vocal consumer through consumer groups are accurate representations of individual consumers, however the lack of inquiry into consumer's viewpoints leaves this area open to conjecture.

The consumer perspective is supported by some non-government organisations such as the International Association of Psychosocial Rehabilitation Services (IAPRS). They (IAPRS) claim that involuntary outpatient commitment violates the rights of people with a mental illness, that research indicates it is not an effective policy in that it causes trauma to the relationship between consumer and clinician. They quote a study (Campbell and Schraiber, 1989) which indicated that 47% of patients avoided any traditional mental health service for fear of involuntary commitment. Although that study looked at detained patients the results could indicate similar consumer perceptions for involuntary community treatment. They (IAPRS) further contend that involuntary community treatment is being promoted by a small segment of the mental health treatment community who believe that the extensive problems caused by the lack of a comprehensive, fully-funded community-based mental health system can be solved by involuntary outpatient commitment laws. However they believe that involuntary outpatient commitment will prove ineffective because of lack of funding, and where there is effective services outpatient commitment will not be necessary (IAPRS, 1999).

The perspective of carers can be somewhat different. Carne (1993) found that relatives felt relieved by the conditions of the CTO because it shifted responsibility for administration of medication from the person with a mental illness or their family to a professional clinician. McDonnell and Bartholomew (1996) suggest that this is one way in which CTOs may reduce the demands on families of caring for a person with a mental illness at home.
The Challenge of Research

Research into CTOs to determine the effectiveness of a coercive, community-based intervention poses a number of ethical and scientific challenges. Some of the most common problems with all the studies on CTOs include:

**Selection bias**: People selected to be made subject to a CTO are selected primarily because they already had certain characteristics, such as multiple admissions and a history of non-compliance with treatment. This makes it difficult to determine whether any negative or positive results are due to the CTO or other patient factors.

**Unclear target population**: Many of the studies fail to identify and apply any systematic inclusion or exclusion criteria in order to determine who is eligible for the study. This makes it difficult to know whether CTOs work and specifically for whom the intervention may be most effective.

**Variety of types of CTOs**: The definition of involuntary community treatment and the processes involved not only differ from jurisdiction to jurisdiction but what is expected under the order is not clear to patients or clinicians. Studying the outcome of a process can be meaningless without understanding the specifics of the process itself. Community treatment orders may be managed in such diverse ways that interpreting the results creates additional problems.

**Variability in treatment**: Community treatment orders require a treatment plan with which the patient must comply. However the appropriateness, nature and quality of the plan may also effect the outcome. If the treatment plan is not considered in the statistical analysis then it would be difficult to determine whether treatment is effective because any differences between the subject and control group or effectiveness of the treatment received.

Power (1999) notes that despite the increasing trend to use CTOs (OPC) there has been little research into the clinical efficacy and impact of them. For the research that has taken place there are methodological problems. Comparison between jurisdictions has been difficult due to the different types of legislation and models of community care. For example no study has attempted to measure the ‘coerciveness’ of a particular CTO procedure by rating the patients, carers or clinicians attitudes.
Whether CTOs are more effective than other forms of persuasion such as 'compliance therapy' (Kemp et al., 1998) or 'managed care' (Kihlstrom, 1998) remains unclear.

Despite the methodological difficulties encountered by researchers there has been and continues to be a number of studies examining many different facets of CTOs. Ridgley et al. (Rand Report, 2001) states that there are two generations of research on the effectiveness of involuntary OPC. The first found limited positive results, however these studies were plagued by significant methodological limitations. These limitations reduce the confidence that can placed in these findings. Data from the second generation of research is also limited. There have been only two randomised clinical trials of involuntary OPC in the USA, one in New York City and the other conducted by Duke University investigators in North Carolina. These studies come to conflicting conclusions. Preston et al (2001, unpublished) have also completed a randomised trial in Western Australia.
Using Community Treatment Orders

The utility of CTOs raise a number of questions, which research, has attempted to answer. These questions include-

a) Is involuntary treatment in the community more efficacious than hospital or other community alternatives?
b) Are CTOs effective in keeping people out of hospital?
c) Are CTOs effective in maintaining treatment compliance?
d) Are CTOs effective in reducing violence?
e) Does the criteria for CTOs hinder the process?
f) Do CTOs increase the work for community clinicians?
g) Do CTOs adversely effect therapeutic relationships?
h) Are CTOs effective in reaching their clinical goals?
i) Are there staff health and safety issues with the use of CTOs?
j) Accommodation as a treatment option with CTOs?

a) Is involuntary treatment in the community more efficacious than hospital or other community alternatives?

It is now recognised that the societal setting of community psychiatry allows for a more flexible range of treatment alternatives, including more psychosocially orientated or redintegrative approaches (Dawson, 1991).

Elbogen (2000) notes that research has shown consistently that the use of outpatient services after discharge is associated with improved functioning and fewer admissions and that individuals who received an outpatient commitment showed fewer re-hospitalisations compared to patients who were discharged without involuntary outpatient commitment. (Munetz et al., 1995)

McDonnell and Bartholomew (1997) in their review of CTOs in Victoria note that previous research indicated that people with mental illness prefer living and receiving treatment in the community rather than being in hospital. (Hoult et al., 1983; MacGilip, 1991; Okin & Pearsall, 1993; Carne, 1993) Their own research reported that consumers who responded indicated that receiving treatment in the community
allowed more freedom, more opportunities and a chance to adjust to a ‘normal’ life outside the hospital. It appears that the majority of people with a mental illness prefer the community as the locus of treatment. However some consumers in the study recognised the importance of access to in-patient care.

Vaughan (2000) and his colleagues in New South Wales looked at the readmission rates of patients on CTOs over a four year period and noted that before CTOs patients reduced the frequency of, or withdrew from, seeing their case managers and doctors, so reducing the efficacy of assertive case management. When patients refused to see mental health workers the workers were obliged to withdraw until the level of the patients disturbance resulted in a risk of harm to themselves or others such that they required admission under the NSW Mental Health Act. Their conclusions were that CTOs may reduce re-hospitalisation by use of depot medication but earlier readmission in the CTO group indicated a shorter disturbance associated with the illness re-occurring. A major difficulty with this research was accessing a control group who were not placed on CTOs.

Thompson (unpublished, 1993) canvassed the views of community mental health centres, psychiatric disability support agencies and consumers in Victoria. His findings were that service providers identified continuity of care (including the client’s relationship to the treating team) and revocation procedures as the most important factors contributing to the effectiveness of the CTO. Client’s rejection of the CTO and insufficient community supports were factors, which were reported to limit the effectiveness of CTOs.

Mulvey et al. (1987) in reviewing the promises and perils of involuntary outpatient commitment in the United States noted that there is a potential for improved treatment effectiveness with involuntary OPC. They state that treatment is greatly enhanced when it can be directed at several spheres of the patient’s life rather than myopically focused on interpersonal dynamics or biologic underpinnings. They feel that treating people in the community could allow for a psychosocial approach that is impossible in the present ‘revolving door’ system of care. Outpatient commitment could monitor a patient’s living situation and respond pro-actively to changes that
could precipitate decompensation. Their belief is that through OPC a patient could be kept in the community in a stable state long enough for the positive aspects of community life to be experienced. This is an important outcome because for a significant subset of chronic patients, psychosis free states may be historically associated solely with institutional life. With a chronic patient receiving compulsory treatment in the community it might be possible for the first time for that patient to experience a life in the community free from the burden of psychosis.

b) Are CTOs effective in keeping people out of hospital?

Statements that CTOs reduces hospital admissions or hospital stays are primarily based on data from the following published studies. Unfortunately many of these studies have methodological problems.

Fernandez and Nygard (1990) looked at the impact of involuntary OPC on the revolving-door syndrome in North Carolina. They looked at state hospital admissions and days of hospitalisation over a 3-year period for all patients committed to outpatient treatment. They claimed that this study shows a decrease in hospital admissions of from 3.7 to 0.7 per 1,000 days for those subjected to outpatient commitment. However this study had no comparison group, which means that changes in hospital admissions may not be attributable to outpatient commitment. Other factors, such as improved access to services, changes in the state service system to make more services available, etc. could have caused this effect. The study examined only two measures, in-patient admissions and the number of in-patient days. No other data was evaluated, such as patient satisfaction or improvement in symptoms or functioning.

Zanni (1986) investigated in-patient stays before and after outpatient commitment in Washington, D.C. where outpatient commitment has been an option since the early 1970s. This researcher looked at 42 patients in a one-year period who had received outpatient commitment but who had been in-patients in previous years. The results indicated a trend to shorter stays in hospital and the author claims that the findings clearly support the effectiveness of outpatient commitment. However the absence of a non-outpatient commitment comparison group means that any changes cannot be
attributed solely to outpatient commitment. Furthermore the study included only 42 patients, too few to make global inferences.

Munetz et al., (1996) studied the effectiveness of outpatient civil commitment in 20 patients in Ohio who had a history of frequent re-hospitalisations, non-compliance with treatment and good response to treatment. With outpatient commitment these patients over a 12-month period experienced significant reductions in visits to the psychiatric emergency service, hospital admissions and lengths of stay compared with the previous 12 months. The authors claimed that when used judiciously outpatient civil commitment is a helpful tool in maintaining hospital recidivists in the community. However again the absence of a non-outpatient commitment comparison group means that any changes cannot be attributed only to outpatient commitment and once again the study included only 20 patients. Furthermore the authors could not separate the effects of the outpatient commitment order itself and the expanded services, including intensive case management, that the individuals had available to them.

Swartz et al. (1999) found that the longer the duration of involuntary treatment in the community the more efficacious it is likely to be, however it would only work to reduce hospital readmissions and total hospital days when the commitment is combined with intensive treatment.

Bursten (1986) found that although there was a reduction in admissions it appeared that this was due to other factors such as policies rather than the mandatory community treatment. However, his qualifications were that outpatient commitment may be having beneficial effects such as improving the quality of life of patients while they are out of hospital, reducing the severity of illness at the time of readmission or shortening the time spent in hospital. It may also be that the failure of the law is due to OPCs not being supported by the clinics who do not enforce the law and are disinclined to accept, treat and adequately monitor indigent chronically ill and potentially dangerous patients.
In an Australian study Carne (1991) looked at the use of CTOs on patients, families and carers in New South Wales. He found that frequency and duration of hospitalisation during the six months on a CTO were significantly lower than during the six month period before the introduction of the order, although the dosage of medication was higher. However a higher number of contacts may have also led to improvements.

Only three randomised clinical trials have been completed: the Bellevue Hospital Centre Study in New York City, the Duke Study in North Carolina and the as yet unpublished study by Preston and his colleagues in Western Australia.

Ridgley et al. (Rand Report, 2001) found that the first two studies, reached ‘conflicting conclusions’. The New York study found that outpatient commitment had no statistically significant effect on re-hospitalisation rates or days spent in hospital. The study also found that involuntary outpatient commitment did not improve compliance with medication and continuation of treatment, or reduce the number of arrests or violent acts committed. However, Ridgley et al. considered the findings weakened by several limitations. Firstly involuntary outpatient commitment orders were inconsistently enforced throughout the study; secondly the involuntary outpatient group included more individuals with co-occurring disorders than the control group; and thirdly the sample size was small.

The overall findings of the North Carolina study, which Ridgley et al (2001) considers ‘the better of the two’, generally support the New York finding that outpatient commitment has no effect on hospital use. The North Carolina study also found mixed results for subgroups, depending on the length of outpatient commitment, that require further investigation. Hospital use actually increased for those with a short duration of outpatient commitment (six months or less). The only group for whom hospital use decreased was the group who received more intensive services and outpatient commitment of six months or longer. Ridgley et al. (2001) concluded that the North Carolina study ‘did not achieve outcomes that were superior to outcomes achieved in studies of assertive community treatment alone’.
Preston et al (unpublished, 2001) set out to examine whether CTOs reduce subsequent health service use compared to controls that were not placed on CTOs, controlling for socio-demographic variables, clinical features and previous psychiatric history. Their results suggest that the introduction of compulsory treatment in the community does not lead to reduced health service use.

If re-hospitalisation was one of the measures to judge whether CTOs work with less re-hospitalisation indicating a positive outcome then research so far does not assist with an answer. In fact one of the arguments is that CTOs may well increase hospitalisations because as the patient is monitored more closely a case manager will realise that the patient’s mental health is deteriorating and suggest in-patient treatment sooner than if not followed-up intensively.

c) Are CTOs effective in maintaining treatment compliance?

One of the primary reasons given by advocates of CTOs for their use is their efficacy in maintaining compliance with treatment and therefore keeping people well longer and certainly reducing re-hospitalisations. Power (1992) in a retrospective analysis of the medical records of 128 patients found that the most likely factors influencing making of a CTO was a history of poor compliance with medication. Consistent with this was the Baker et al’s (1991) survey of psychiatric nurses which found that psychiatric diagnosis, compliance history, and the number of previous admissions were the most influential factors in the decision to provide treatment by way of a CTO.

Moncrieff and Smyth (1999) state that CTOs are primarily used to enhance adherence to medications, however the effectiveness of drug treatment is limited. They refer to research that indicates that 20% of people suffering from schizophrenia fail to respond to antipsychotic drugs in the first place and that 50% of patients with schizophrenia treated with drugs relapsed over a 2 year period. Furthermore that CTOs provide no guarantee of reducing psychiatric morbidity and are likely to increase the number of people on long-term medication who derive no benefit from it. Doig (2000) noted that occasionally a patient who stops his or her antipsychotic
medication against advice, remains well for some years at least and he knows of no way this can be predicted. His conclusion is that some people may be forced indefinitely to take medication they do not need. Burns (1999) contradicts this argument noting that CTOs are to be used with patients with a demonstrated good response to medication under previous conditions of compulsion.

In a comprehensive evaluation of outpatient commitment conducted by Hiday and Scheid-Cook (1987) which included a study of 1226 adult respondents to outpatient commitment over a 6 month period, the findings were that ‘when respondents show up and begin treatment, OPC works in terms of keeping people in treatment and on medication, increasing compliance, permitting residence outside an institution and social interaction outside the home, and maintaining patients in the community with few dangerous episodes’. However they did qualify this positive statement with the caveat that some people made subject to OPC failed because primarily they were the wrong sort of patient to place on the order. In addition, the absence of a voluntary outpatient control group receiving the same services as the involuntary commitment group means that any changes in medication compliance cannot be attributed exclusively to outpatient commitment.

Munetz et al. (1996) in their much smaller study also indicated that patients on outpatient commitment significantly increased the number of appointments they kept with their psychiatrist, though it was unusual for a psychiatrist to see a patient more often than monthly. As previously mentioned this study has been heavily criticised for its small numbers (20 subjects) the absence of a comparison group and the use of Clozapine, which requires more intensive follow-up.

McDonnell and Bartholomew (1997) state that concerns have been widely expressed that medication is often the sole form of treatment given to people on CTOs and that inexpensive maintenance therapy is extensively utilised. They note that consumer groups and the Burdekin Report (1993) are critical that treatment is reduced to medication alone and that this sort of minimal intervention is allowed to develop outside hospitals where it is more difficult to monitor. In their study they note that 98% of patients on CTOs were receiving compulsory medication. The main issues
raised in the study by consumers was dissatisfaction with medication levels, side-effects and opportunities to negotiate over dosage of medications. Unlike hospital where the effects of treatment can be monitored daily and adjusted accordingly, most CTO recipients were in contact with their case manager much less frequently.

Protheroe and Carroll (2000) state that in their experience in Melbourne indicated that lower doses of medication are used in the community and certainly less than what would be used for a compulsory in-patient. Their hope is that a prolonged symptom free period may demonstrate the benefits of psychiatric care to a person with recurrent psychotic illness.

Hambridge and Watt (1995) note that the New South Wales Act allows medication, counselling and rehabilitation as components of a treatment plan however medication is the only enforceable treatment. This does not mean that the client is excluded from other rehabilitation interventions but such interventions do not form part of their treatment plan approved under the Act. Carne (1993) in his study in the same jurisdiction found that people subject to CTOs demonstrated increased medication compliance, more contact with community health facilities and significantly fewer hospital admissions than a control group treated without the use of CTOs, though these improvements might be due more to the assertive community outreach which the CTO engenders than the CTO itself.

This argument is one of the more contentious in the whole debate. Because of their legal enforcement, CTOs seem to raise the frequency of contact between client and clinician, which inevitably seems to have a better outcome for the patient. However if the number of contacts were increased by the use of additional resources or a different model of intervention without resorting to legislation and the same outcome could be achieved, then the necessity for a CTO would be negated.

Mulvey (1987) notes that in the absence of a clear statement about what should constitute treatment, confusion about the purposes of repeated contacts between the patient and the clinician could easily occur. Encounters originally designed to be therapeutic could eventually become sessions in which the patient merely 'checks
in’. McDonnell and Bartholomew (1997) note that less than half of the sample in their study received counselling or psychotherapy as part of treatment under a CTO.

d) Are CTOs effective in reducing violence?

One of the primary reasons given for the increase in the use of CTOs is the concern regarding untreated patients in the community who may become violent to others. Moncrieff and Smyth (1999) note that concern has been mounting due to cases like Clunis (a man with a mental illness living in the community who murdered a stranger) and Silcock (a man with a mental illness who jumped into the lions enclosure at London Zoo) in the U.K. with the belief that community care has failed. This despite the lack of any evidence to suggest that mental illness is less effectively treated in hospitals or the community or that violence attributable to mental illness is rising.

Burns (1999) states that a CTO is a humane and necessary part of modern mental health care. However from his perspective it is clear that CTOs would contribute little to the problems of violence or people with a mental illness who are homeless. For CTOs to work they must be part of a broader treatment package. Although there is no pretence that community treatment is entirely voluntary, it has to be negotiated. The patient must understand the implications of an order and agree with it and therefore the number of patients who benefit will be small.

Elbogen (2000) writing from a forensic viewpoint notes that with involuntary outpatient commitment risk assessments can be on-going rather than just once at discharge. Overall, in his opinion, the use of involuntary outpatient commitment better ensures public safety because absolute discharge lacks continued monitoring of the risk of violence.

The issue of violence associated with mental illness is a contentious one. There has been a view in recent times that people with schizophrenia have no higher risk of violent offending or homicide than the general population and this view was certainly used to argue against the exaggerations of the media when community care is discussed. However, research completed in the 1990s (Hodgins, 1992, Lindquist & Allebeck, 1990, Wesseley et al, 1994, Humphries et al., 1992,) indicate that there is
good evidence that serious mental illness such as schizophrenia is associated with a significant increase in the risk of violent offending, although it does not make much contribution to the overall violent crime figures. (Dyer 1998)

Swanson et al. (2000) noted that violent behaviour among people with severe mental illness causes public concern and is associated with illness relapse, hospital recidivism and poor outcomes in community based treatments. The aim of his study was to test whether involuntary outpatient commitment assisted in the reduction of violent incidents among persons with severe mental illness. A one-year randomised trial of 262 subjects were assigned to release or court-order treatment after discharge. The results were that there was a significantly lower incidence of violent behaviour occurring in subjects with more than 6 months outpatient commitment. Lower risk of violence was associated with extended outpatient commitment combined with regular outpatient services, adherence to prescribed medications and no substance misuse. The conclusions were that outpatient commitment may significantly reduce the risk of violent behaviour in persons with severe mental illness in part by improving adherence to medication while diminishing substance abuse.

However Moncreiff and Smyth (1999) take a broader view when noting that propensity to violence arises from a composite of factors and dangerous behaviour is much more strongly predicated by demographics and substance use than mental illness. (Wallace et al, 1998) Expectation that CTOs will reduce violence can not be guaranteed. Burns (1999) in his commentary on Moncreiff and Smyth believes this is a red herring as CTOs are not there to prevent violence but prevent relapse.

e) Does the criteria for CTOs hinder the process?

Hiday and Schied-Cook (1989) suggest that there are a number of problems, which have contributed to the tendency to ignore outpatient commitment as an alternative to in-patient treatment and one of these is that the criteria for outpatient and in-patient commitment are in most cases identical. In North Carolina outpatient commitment was generally ordered as a compromise when a judge felt that a
respondent was potentially dangerous but there was not enough evidence of dangerous behaviour for involuntary hospitalisation.

Appelbaum (1986) discusses the problem of differentiating between in and outpatient care and notes that the statutes frequently use identical criteria to identify patients who are appropriate for in-patient commitment and those made subject to receive outpatient care. If only patients who fulfil the criteria of dangerousness to self or others or are unable to meet their basic needs are made subject to OPC then legislation will be rarely used. He notes that the degree of psychopathology required to meet these standards often demand in-patient care; even for that fraction that could be treated as outpatients, and liability concerns may preclude outpatient commitment. He suggests that it would be unacceptable to ask psychiatrists to assume the burden of caring for people in the community who they have just characterised as imminently dangerous to themselves or others.

Geller (2000) in discussing the different types of outpatient commitment in the USA notes that with outpatient commitment there is an expansion from the 'presence' of dangerousness to the 'probability' of dangerousness based on a patient's mental illness and history. In Massachusetts for example the criteria for outpatient commitment is an assessment of competency, which is a clinical criteria rather than any assessment of dangerousness.

Sensky (1991) asked a group of British psychiatrists to identify patient characteristics, which they thought important for consideration of a CTO. Not surprisingly they concluded that decisions would be based on patient’s recent past however less important would be 'lifetime' histories of psychiatric admissions, drug abuse, forensic history and dangerousness. While Appelbaum (1986) noted that legislation in Tennessee requires that people who are subjected to enforced outpatient care be likely to deteriorate in the near future without care, as demonstrated by previous behaviour.

Hiday and Schied-Cook (1987) state that the criteria for outpatient commitment in North Carolina are that the patient firstly has a mental illness; secondly that he or
she is capable of surviving safely in the community with available supervision from family, friends or others; thirdly that the decision to use an order is based on a treatment history, and there is a demonstrable need for treatment in order to prevent further disability or deterioration which would predicable result in dangerousness and fourthly that the patient’s current mental status or nature of the illness limits or negates ability to make an informed decision to seek or comply voluntarily with recommended treatment. The authors point out that although these criteria are lower than for involuntary hospitalisation they do not widen the net of social control to include people with a mental illness who would otherwise would not be within the purview of civil commitment laws. Rather they attempt to prevent involuntary hospitalisation in the near future for those who have stopped treatment, are deteriorating, and are likely to threaten or do substantial harm as they have repeatedly done in the past.

Hambridge and Watt (1995) in reviewing CTOs in New South Wales note that to be placed on an order the client must express an interest in living in the community. He or she must have previously been unsuccessful in living in the community. The client must have the degree of competency to understand the stipulations of his/her involuntary community treatment order and the health care agency must be willing to deliver and if necessary enforce compliance with that treatment. Additionally frequency and duration of admissions, nature of behaviours exhibited when unwell and type of medication prescribed are all important issues which must be considered before a CTO is ordered.

Treatment in this context is ordered to prevent further illness rather than treat acute symptoms and Dedman (1990) pointed out that in order to succeed any CTO legislation would need to embrace the notion of preventive commitment for those with a track record of severe illness requiring compulsory hospitalisation, non-compliance and repeat admissions. However he noted the ethical problems raised by this would be considerable and likely to provide a field day for those who view the existing mental health legislation as an infringement on civil liberties.
Mulvey et al. (1987) argues that a major shortcoming of current commitment laws is a 'dichotomous system' that offers but two alternatives either total freedom from involuntary treatment or total institutionalisation in the restrictive environment of a hospital. He suggests that the criteria for imposing involuntary outpatient commitment should probably be lower and less explicit than those for involuntary inpatient commitment. Involuntary commitment standards have firmly established that mental illness and danger to self or others must both be present to justify infringement of a person’s liberty through involuntary hospitalisation. Standards for outpatient therapy would have to distinguish those for whom community integration is likely and reasonably safe. He states that three aspects of any strategy for involuntary outpatient commitment must be considered critical in striking the desired balance. First, eligibility guidelines must be clear enough to limit the possibility of state intervention to those persons with a demonstrated inability to recover spontaneously or independently and a high probability of recovery if treated. Second, consideration must be given to the range of therapeutic interventions permitted. Third, the procedural requirements for OPC must be structured to ensure continuity of care and appropriate application.

f) Do CTOs increase the work for community clinicians?

One of the reasons identified for resistance to CTOs was the proposition that CTOs increase the work for community clinicians, partly because of the legislative requirements and partly because of the extra paperwork. Where before difficult or uncooperative clients could be left to fend for themselves until they became unwell again the CTO puts responsibility on the community clinician to maintain contact, enforce treatment and do whatever is in their power to prevent re-admission. McIvor (1998) states that the provision of CTOs increases work due to the complexities of operations and increased levels of supervision.

Hambridge and Watt (1995) in reviewing CTOs in New South Wales detail the extra tasks, which may need to be performed, with no extra resources. These tasks include, discussing the implication of the order with the client then formally applying for an order. A treatment plan must then be prepared and a hearing before the
mental health Review Tribunal arranged. There must be reporting on the
effectiveness of the order and if the CTO is not successful the need for issuing
breach notices. Administratively tracking the dates of orders is essential and then
there is the completing of statistical returns.

Date (unpublished, 1998) surveyed 28 psychiatrists who had been involved in the
administering of a community order in Western Australia. A number of his
respondents elected to make comments regarding their experiences with community
treatment orders. Words such as “cumbersome”, “burdensome” and “virtually
unenforceable” were used, with the majority of respondents seeing the community
treatment order as complicated, time-consuming and only usefully applied to a
particular small group of patients. Only one respondent gave unequivocal praise for
the community treatment order.

**g) Do CTOs adversely effect therapeutic relationships?**

Perhaps the major criticism of CTOs is that the compulsory aspect defeats the
possibility of developing a therapeutic relationship between the patient and the
clinician. Moncreiff and Smyth (1999) are categorical in their opinion that CTOs
alienate patients. They indicate that consumer dissatisfaction comes from their
experience of compulsion and CTOs will further exacerbate conflict and damage
therapeutic relationships.

Brian Rogers (2001) professional officer with the Community Psychiatric Nurses’
Association in the U.K. states that most mental health nurses do not want to be
mental health ‘police’, whose relationship is based on coercion and threat. He notes
that the profession has worked hard in recent years to construct an advocating, user
friendly service that tries to develop partnerships between clients and nurses. He
states “If you don’t take your medication you’ll be back in hospital” is a less than
creative way of helping people to be well in the long term”.

Hambridge and Watt (1995) point out that case managers in New South Wales
expressed concern that their relationships with clients will deteriorate particularly
when the case manager has been working to empower the client and then by
applying for an order which appears to disempower the client. Despite that they felt that patients may be more positive if they realise that an order allows them to leave hospital earlier. One way Hambridge and Watt suggest to overcome resentment is to make the treatment plan explicitly state both the clients and the team's obligations.

Dedman (1990) found in Victoria a greater enthusiasm for CTOs among hospital staff than among staff of the community health clinics. This is perhaps understandable in terms of hospital staff feeling reluctant to see their work undone by non-compliance but not being responsible for the patient in the community. On the other hand community clinicians are used to seeing patients who elect to come and see them and may feel uneasy about entering into a relationship with a patient where there is an element of compulsion involved. Accepting a patient on a CTO means that a clinic is legally bound to provide treatment and to regularly review a patient. Dedman notes this may involve forfeiting the previously enjoyed right of clinic staff to refuse to see a particular patient.

Protheroe and Carroll (2000) suggest that the CTO is only one part of a comprehensive biopsychosocial care plan. An order may alter the dynamics of care but the clinician-patient relationship is usually remarkably well preserved. This view is echoed by Stephen Firn (2001), Director of Strategic Development and specialist mental health services in the Oxleas National Mental Health Trust (UK) when considering the introduction of CTOs to the U.K. He points out that maintaining a therapeutic relationship is not simply about being empathic to a client’s distress, it is also about helping the client maintain control and order in their lives when they are unable to do this themselves.

Turner (1994). in debating the pros and cons of introducing CTOs into the U.K. notes that some patients are extremely difficult to manage on a personal level. Although antagonistic and unlikely to generate therapeutic sympathy it can be painful to see them deteriorate, despite hoping to (if possible) move them to someone else’s patch (sic). Such challenging patients in the community lend a powerful negative image to the otherwise genuine benefits of community care. His argument is that given the political reality of hospital closures, the efficacy of medication, then the logic of CTOs
is irrefutable. He contends that it is the frontline workers opinion which is relevant not
the legal or advocates perspective as it is that frontline community worker who has to
deal on a day to day basis with the problems of managing chronically ill people in the
community. Burns (1999) supports Turner’s position by noting that community
psychiatrists have a lot of experience in managing people’s care in the community.
For example they may sometimes use leave as a compulsory mechanism for some
patients, however even negotiated compulsion requires a good working relationship
and compromise.

It is clear that therapeutic relationships are complicated, multilayered and include
paradoxes and ambiguities. Clinicians manage their therapeutic relationships in
different ways depending on their experience, their personality, their status and their
own personal ethical positions. If a clinician firmly believes that it is not possible to
have a therapeutic relationship on a compulsory basis then they may have to choose
either a voluntary therapeutic relationship or a minimal contact relationship. On the
other hand many clinicians believe that they have the skills to have effective
therapeutic relationships with patients on CTOs understanding that the compulsion
element of the order is only a very small part of the working relationship. Some
clinicians are able to separate their therapeutic functions from their ‘custodial’
functions and may even have different types of relationship with different patients.
For example they may have an intensive case management and family follow-up
program with a young first episode psychosis patient and a distant, medication
orientated relationship with a chronic patient. Advocates for CTOs point out that
Probation Officers are expected to have therapeutic relationships with people on
Probation Orders. The problem with that argument is that although Probation Orders
have obligations which if not fulfilled may lead to breach, (much as CTOs) the person
chooses to accept a Probation Order in lieu of some other more severe sentence,
while patients on CTOs do not choose to accept CTOs in lieu of being in hospital.

The difficulty for the community clinician who has reservations about accepting
patients on CTOs is that there is an expectation that as part of the role of community
clinician working with patients subject to CTOs is required. Other team members
would certainly feel aggrieved if one team member refused to accept patients on
CTO based on personal conviction. To overcome this difficulty in North Carolina extra resources were given to clinics for each patient they accepted on outpatient commitment and special teams of clinicians who would only care for patients subject to OPC was introduced (Hiday & Schied-Cook, 1987).

h) Are CTOs effective in reaching their clinical goals?

McIvor (1998) notes that while most research appears to indicate limited but improved outcomes in terms of re-hospitalisation, length of stay and compliance with treatment, many can be criticised on methodological grounds. This prompts him to assert that there is limited evidence to show that compulsory community treatment has achieved its clinical goals, which are to reduce hospitalisation and increase compliance with medication and service utilisation.

However other researchers have reached different conclusions. For example Hiday and Schied-Cook (1989) followed up a group of chronic patients in North Carolina over a six month period. They found that despite small numbers, that outpatient commitment in North Carolina was a success with the ‘revolving door’ group of patients. Those were people with a chronic mental illness who have a history of medication refusal and recurrent dangerousness who were ordered by the courts to outpatient commitment. Those who began the treatment tended to remain in treatment for six months even without continued court orders. They also tended to have more social interaction, tended not to be re-hospitalised and tended not to exhibit dangerous behaviours. For this group outpatient commitment was thus a viable less-restrictive alternative to involuntary hospitalisation. However, they do indicate that there are other variables such as the chronicity of the patient, the enthusiasm the community service has for outpatient commitment and whether a full community care service is offered or just medication which were important in judging whether outpatient commitment met there therapeutic goals.

Swartz et al. (1999) in finding that outpatient commitment can work to reduce hospital readmissions and total hospital days also emphasises that they are best seen as complimenting case management, making the patient more accessible to
counselling, psychoeducation and rehabilitation. Increased responsibility is also borne by the community service to provide adequate treatment. In other words to be effective CTOs rely on the adequacy of community service and their capacity to deliver increased community care as well as legislative powers.

Power (1999) in a controlled study of 125 patients attempted to identify the subgroup who experienced the best clinical outcomes while subject to a CTOs. Patients in this subgroup were significantly older (over 28 yrs of age) were in the mid-phase of their overall illness history and had significantly worse compliance with community treatment prior to the CTO. A very small number (4%) were clearly repulsed by the CTO procedure and resorted to extreme means to avoid conditions such as moving interstate, while 81% of patients recorded an overall improvement in outpatient treatment adherence with significant improvements noted on other outcome measures (hospitalisation rates, violence and overall symptomatic change). More interestingly while CTO patients were rated as experiencing significantly greater levels of pre-existing morbidity than a matched randomised control group of involuntary patients not placed on CTOs, the CTO patients improved relatively better than their matched controls on the above ratings of clinical outcome during the follow up period.

However Steadman et al, (2001) found no significant differences between experimental and control groups on subsequent measures of re-hospitalisation, arrest, quality of life, symptomatology or compliance with treatment.

Clearly the evidence is equivocal and the best that can be deduced is that CTOs are effective for only certain groups of people. Dedman (1990) commented that the CTO appeared to be useful only in cases of persuading the persuadable. Dawson and Romans (2001) in their survey of psychiatrists in New Zealand found that most agreed with the general notion that when a CTO is used appropriately the benefits outweigh the coercive effects.

i) Are there staff health and safety issues with the use of CTOs?
Mclvor (1998) points out that community mental health nurses may be placed at increased risk for their personal safety as they come to be seen as instruments of control who have the power to use reasonable force in ensuring treatment. Ridley (1993) states that in his experience in Victoria although there is nothing in the law to prevent treatment being given by force in a patient's own home the practical reality is that most nurses are reluctant to do this given the potential personal risk and chances of significant damage to the therapeutic relationship.

Schimidt and Geller (1989) in looking at the practicalities of outpatient commitment in Massachusetts note that usually mental health centres do not have the staff who are trained in non-violent restraining techniques that at times might be necessary. Furthermore many of these centres are private, non-profit agencies that prefer to avoid the insurance and liability problems such a function might pose. Nor do they want their many voluntary patients exposed to the spectre of an occasional, forcible administration of medication. They conclude that they would like the state hospital as the only place where physical force is used.

This addresses one of the conundrums of CTOs. Although there is legislative permission to enforce treatment in the community, for the sake of the health and safety for self and others and the therapeutic relationship, good practice would indicate that medication should only be enforced in a hospital, which has the resources to administer compulsory medication safely. The question arises why have the power if it will never be used. This may be a rather one-dimensional view as sometimes having the power can be used as leverage to obtain even reluctant consent. Many clinicians are not in favour of this sort of ‘game playing’ believing they have honest relationships with their patients, however as in most relationships the context and what is not admitted to is as powerful as content and what is agreed. It is how the power is used in the negotiations which must occur when consent is sought rather than the blatant use of the power itself which dictates how useful the clinician will find the CTO in their community care.

j) Accommodation as a treatment option with CTOs?
A safe and secure place to live is an important issue for every person. For people with a mental illness with little income, home can be something far from this ideal because the only option is to live in housing which may be temporary and linked to their illness and treatment plans. For residents of hostels and group homes, home is where they live with others not of their own choosing and under rules that do not exist in ordinary housing. Residency may be a condition of compliance with treatment or with rules of conduct such as when they vacate their bedroom, when and what they eat and where they might smoke. Behaviour is scrutinised from a clinical perspective in which disagreements over treatment, living conditions and even the smallest details of daily life can be interpreted as symptoms of illness or relapse. (Korman et al., 1996)

Section 14(2A) of the Victorian Mental Health Act provides for the authorised psychiatrist to direct where a person on a CTO may reside if this is necessary for the treatment of their mental illness. This condition may only be considered when, to enable a person to live in the community, a person requires treatment that is both essential to maintaining them in the community and only available at a particular place of residence. An example is where a person requires special personal care to ensure that they safely remain in the community, and this support is only available in a supported residential service. It is recommended that the imposition of a residency condition must not be taken lightly and there are a number of responsibilities placed on the psychiatrist and the Victorian Mental Health Review Board.

In the Australian Capital Territory under their Mental Health (Treatment and Care) Act 1994 their Mental Health Review Tribunal may make a restriction order, if satisfied that, in the interests of the patient’s health or safety or public safety a restricted CTO should be made. This order: may require a person with a mental illness to reside at a specified place (s. 27(2)(a)).

No other jurisdiction in Australia gives the clinician specific powers under a CTO to order a patient in live in a particular place, though there are some jurisdictions which expect clinicians to take an holistic view of treatment. A number of researchers pointed out the difficulty of insisting on any other treatment other than medication as
ensuring compliance would be extremely difficult. The difficulty is that accommodation issues can not be divorced from other problems that effect a patient's ability to comply with treatment. Insecure accommodation or living in a place some distance from the clinic can lead directly to non-compliance with the order. In order for patients to attend for treatment regularly there needs to be some stability and consistency in their lives.

McDonnell and Bartholomew (1997) in considering community variables in their Victorian study found that most people on CTOs had stable accommodation, living either in privately owned or rented accommodation. Whether this is due to the stabilising effects of the CTO, inadequacies in other options, or pre-existing patient characteristics and circumstances, which may have determined the patient's appropriateness for a CTO in the first place, is not known.

Clearly in deciding whether a person should be made subject to a CTO a consideration must be given to the persons ability to comply. If there is a history of an itinerant lifestyle with movement from accommodation to accommodation then the feasibility of a CTO is reduced.

The Act in Western Australia states that when a psychiatrist is placing a person on a CTO he or she must specify a treatment plan outlining the treatment that the patient is to receive under the order. Treatment per se is not defined however psychiatric treatment is defined as 'treatment for mental illness'. No further parameters are provided as to what constitutes treatment though a patient has the right to seek a second opinion and if not satisfied refer the matter to the Chief Psychiatrist.

In the case of MM v the Mental Health Review Board (WA) (1999) the Board found prior to the High Court appeal that the patient was being treated for her mental illness, not only by anti-psychotic medication, but also and more importantly by the provision of supervision and a safe environment in which to live. The safe environment being in this case a hospital. Justice Scott considered the proper construction of the word 'treatment' and whether it includes the provision of 'supervision and a safe environment in which to live'. He stated that in his opinion,
the word ‘treatment’ should be interpreted widely. Applying that definition to the case of MM, the conclusion was open to the Board that part of the ‘treatment’ of the appellant's condition was her management, including a safe environment, during the term of her illness.

Although this judgement indicates that where the person is accommodated can be construed as part of treatment, the context is one of a hospital rather than the community. The West Australian survey of the use of CTOs indicated that many clinicians believe that accommodation may be part of ‘social treatment’ and therefore could be used as a component of the treatment plan. However some clinicians doubt that a direction to live in specific accommodation can be construed as part of treatment.

The view of the Guardianship and Administration Board of Scott J's decision in MM v the MHRB is that 'treatment' in the Act could encompass the management of a person during the term of their illness which could include the provision of supervision and a safe environment in which to live. Additionally in a recent Guardianship case the Guardianship and Administration Board found that there is a "legal vacuum between the Mental Health Act 1996 and the Guardianship and Administration Act 1990". Indeed, in two recent cases before the Guardianship and Administration Board, the Board has accepted the view of Scott J but found that if the mental health system will not include accommodation conditions in a CTO or not make use of the CTO provisions, then a Guardianship Order should be made.
Guidelines for Treatment

Geller (1990) developed sequential treatment guidelines which sum up very succinctly the major issues to be considered when placing a person on a CTO. The guidelines assume that the patient has a chronic mental illness and a history of dangerousness to self or others. It appears a specific diagnosis is not important. The Guidelines include the following:

1. The patient must express an interest in living in the community. Geller believes that if a patient is unwilling to live in the community the community order will fail.

2. The patient must have previously failed in the community. If the patient can be treated on a voluntary basis and this has proved successful in the past then a compulsory order is not necessary. Only if the patient is unable to achieve sustained community tenure uninterrupted by hospital admission should he or she be placed on a compulsory order.

3. The patient must have that degree of competency necessary to understand the stipulations of his or her involuntary treatment. Persons who do not have the cognitive ability to comprehend the requirements of an order cannot be expected to comply and alternatives such as guardianship may be more appropriate.

4. The patient must have the capacity to comply with the involuntary treatment plan. A degree of cooperation is necessary. If a person is so antagonistic towards the order that there is a constant struggle with the community staff, then an order may be inappropriate. When the patient becomes so unwell that detained treatment is necessary the required steps can be taken. Geller believes that compulsory community treatment has its limitations.

5. The treatment being ordered needs to have demonstrated efficacy when used properly by the patient. If the treatment is not effective it may be thought that the patient is not being compliant when in fact the problem lies with the treatment. This proposal assumes that patients may improve in hospital for reasons other than the medication.

6. The ordered treatment must be such that it can be delivered by the community care system and that the treatment is sufficient for the patients
needs and necessary to maintain community tenure. If the community care system is inadequate then the patient will fail. If the coercion is excessive then the patient is more likely to object and the rules might be confusing. (Success depends as much on the efficiency of the service as the cooperation of the patient)

7. The ordered treatment must be such that it can be monitored by the community team. Orders that cannot be monitored strain the credibility of the clinicians and undermine the foundations of the relationship between the patient and the clinician. Examples of such ordered treatments as ‘no alcohol consumption on week-ends’ or ‘no use of over the counter medications’ are impossible to monitor or enforce.

8. The community team must be willing to deliver the ordered treatment to the patient and be willing to participate in enforcing compliance with the treatment. Unwillingness by community clinicians may be due to ideological resistance, lack of knowledge about procedures, concerns about liability, concerns about risk and ethical dilemmas.

9. The in-patient system must support the community system. An in-patient plan must include treatment in the community. Negotiation about discharge and readmission/revocation are important.

One of the purposes of guidelines is to reduce the need for coercion and Diamond (1996) articulates a number of ways that a treatment system can minimise the need for coercion. These include-

1. **Develop a continuous range of service options.** There is a tendency to label patients as ‘treatment resistant’, if they refuse to cooperate with clinicians. The result is often hospitalisation on a locked ward when perhaps a more graded response would be more appropriate. The offer of hospitalisation on an open ward or non-authorised unit may be more acceptable. Likewise refusing medication may indicate more about the relationship between clinician and patient and a change of clinician or a different tactic may produce better results. Having a variety of options along a continuous range of services should be one of the first developments of a community service.
2 **Be clear about the goals of coercion.** Clinicians may react to a problem or crisis by revocation of an order without consideration of how re-admission might help. The decision to re-admit a patient to hospital may merely be a decision about where the person lives and a change in who cares for him or her rather than an explicit need for hospitalisation. As part of a care plan failure of the CTO needs to be considered as a possibility and ideas generated as to how that should be handled rather then having an expectation that the CTO will be problem free, and when it proves not so to only have re-admission as an option.

3 **Ensure that persons with a psychiatric disability have a chance for a decent quality of life.** It is important that people with a serious mental illness have a realistic hope that their lives will get better. The patient having control in their life even with the help of medication or clinical care, should be the primary goal of the clinician. Community treatment orders are a very small component of community care and the clinician's focus should be on offering an holistic care plan which the patient and clinician can strive towards.

4 **Develop treatment systems that support respectful relationships developed over time.** The aim should be to have systems to avoid crisis rather than spending all the resources on dealing with crisis. Predicting care pathways (preventive strategies), may be more successful than just having strategies for crisis. It is often the mundane and the repetitious which prevents a crisis developing. Regular home visits or contact with the family may prevent deterioration and the inevitable crisis. This work is dependent on the development of good relationships and time spent with the patient and may prove more efficacious than attending courses on crisis management. In the end CTOs are only as successful as the relationship between the patient and clinician allows. The more trust and respect that exists the more likely that cooperation will occur.

One aspect of managing CTOs is the use of leverage, which falls somewhere between a total voluntary situation and coercion. Almost all clinical work involves some degree of leverage, using strong persuasion, incentives or limit setting. Managing CTOs particularly with hard to reach clients must rely on innovative and
adaptive clinical strategies. Persuasive techniques can span a wide range from offering incentives to making clear the consequences on non-compliance. Using any leverage must be within the context of a good relationship, must be reasonable and both clinician and consumer must see the advantages of the strategy. Negotiation obviously is an important component of the communication which needs to occur. It should also be emphasised that over time, tangible incentives give way to less tangible benefits. For example a clinician who cares about their client and will listen to him or her can have greater effect than more overt incentives. One very obvious incentive is a threat to a change in or loss of the relationship between the clinician and his or her client. Depending on the strength of the relationship this can be a powerful component in working with a client. For example one consumer respondent to the WA survey was very clear that although she did not approve of the CTO she was willing to comply because of the strength of her relationship with her case manager. She viewed the relationship important enough to tolerate the involuntary status.

Susser and Roche (1996) identify explicit uses of leverage such as money, housing and the power of revocation. Although it would be unethical to not provide a service the provision of a service may be predicated on compliance by the consumer. Case management plans need to be negotiated and as in any relationship consideration must be used on both sides. An important strategy in making sure a CTO works is therefore the use of leverage in management planning.

Draft CTO guidelines (May 2001) have been developed in Victoria by Dr Debra Wood for the Office of the Chief Psychiatrist, Mental Health Branch, Victorian Government Department of Human Services. The intention is that these guidelines when published will replace the department’s publications *Community Treatment Orders and Restricted Community Treatment Orders: Guidelines and Information*, published in May 1994.

Methods to improve Community Treatment Orders

Although most of the research is equivocal as to the efficacy of CTOs it does not prevent researchers giving us their opinions as to how CTOs could be improved. For example Bursten (1986) proposed 3 ways to improve the efficacy of mandatory community treatment. Firstly, get tough with patients. Arrange for regular and frequent monitoring including urine testing with non-compliance being picked up quickly. Secondly, get tough with mental health centres to take and treat people with a severely mental illness. Thirdly, select those patients who show the greatest probability of success and not waste time, effort and money on the rest. However, this may result in treating only the more compliant patient rather than the difficult patient.

Hiday and Schied-Cook (1991) report that success can sometimes be a drawn out process. They state that, as one would expect of patients with histories of medication non-compliance, many patients did not appear for their appointments and did not reschedule or give acceptable excuses. Despite the fact that outpatient commitment is involuntary with stringent methods to enforce it, clinicians seldom used these methods preferring softer means to obtain compliance. In their survey of a mental health service in North Carolina at the first 'no show' clinicians most often phoned or sent a letter. More than 60% of patients responded to these methods. Again phones and letters were used and the no show group fell to 22%. After that more stringent methods were used. In general almost half the patients either always attended or had a good excuse. Clearly sometimes it takes time for CTOs to be effective and the expectation that patients will either be totally accepting or totally rejecting of a CTO is basically naive. It often takes time for both the patient and the clinician to adapt to the requirements of a CTO and resorting to a breach of the order too quickly can be counter-productive.

Hambridge and Watt (1995) suggest that one way to overcome resentment from patients on CTOs is to make the treatment plan explicit by stating both the clients and the team's obligations. This promotes the idea of facing the issues together so
that there is at least the impression of joint management and equal responsibility. Heilbruin (1997) writing from a therapeutic jurisprudence perspective suggests enlisting a patient’s participation at the time of discharge could help patients set self-imposed risk reduction goals they understand and feel are within their control. The involuntary outpatient commitment may complement such efforts and help clinicians monitor the patient’s progress.

Geller (1986) conducted his own outpatient commitment experiment with some patient with a bi-polar diagnosis. He made a contract with his patients about treatment in the community, which included a punitive element of readmission if lithium levels fell. According to Geller this idea of consequences for breaking an agreement was successful despite treading on patients rights and Geller attributes this to the gaining of insight by the patient.

One of the contentious issues raised by a number of researchers is the tendency to keep patients on CTOs longer than necessary. McDonnell and Bartholomew (1999) in their Victorian study note that most CTOs were made for or close to the maximum time allowed. These researchers found this surprising given the range of individuals and diagnosis. In the same vein Hambridge and Watt (1995) note that the Mental Health Review Tribunal of New South Wales suggest that there would need to be compelling arguments to subject a person to involuntary treatment for more than 18 months. The least restrictive philosophy also makes it incumbent to consider alternatives to compulsory treatment.

McDonnell and Bartholomew (1999) relate that consumers indicated dissatisfaction at never being off an order so that hospital and community become one big institution. There is stigma being on an order and adherence to an order did not necessarily mean that you were taken off the order.

Turner (1994) suggests that using existing powers more imaginatively, with greater use of leave of absence provisions or guardianship or linking compliance with social welfare benefits will all produce better outcomes for patients on CTOs.
Alternatives to Community Treatment Orders

McDonnell and Bartholomew (1999) note that one consequence of the widespread reliance on outpatient commitment is that programs which treat people compulsorily in the community will be widely accepted as an alternative to other services simply because they are consistent with economic imperatives to reduce per capita spending. (Bromley, 1993) The conclusion is that any community-based services will have costs and better to use those resources for alternatives to CTOs rather than attempting to enforce a system that consumers and clinicians do not favour.

McIvor (1998) notes the risk that CTOs may be overused or employed as an easy option for controlling difficult patients, particularly those from ethnic minorities when other community alternatives should be employed.

Ridgley et al. (2001) note that in contrast to the paucity of studies on involuntary outpatient commitment their review of the literature found clear evidence that alternative community-based mental health treatments can produce good outcomes for people with severe mental illness. The best evidence from randomised clinical trials supports the use of assertive community treatment programs. Assertive community treatment (ACT) is a team-based approach aimed at keeping people with a mental illness in contact with services, reducing hospital admissions and improving outcomes, especially social functioning and quality of life. ACT involves the delivery of community-based care by multidisciplinary teams of highly trained mental health professionals with high staff to client ratios. Because these interventions are staff-intensive they are more expensive to implement than traditional community-based programs. They suggest that it may be more cost-effective to target assertive community treatment programs to those people with severe mental illness who are at the highest risk for negative outcomes.

Another option is the idea trialed in Wisconsin of a ‘settlement agreement’ which permits the person who is subject to a commitment order to waive a hearing if he or she agrees to 90 days of treatment. This enabled a person with mental illness to obtain treatment while foregoing the stigma attached to the commitment. Similarly in
New York, behavioural officials in some counties have chosen to use ‘voluntary compliance agreements’ rather than pursue court orders for involuntary OPC (Ridgley et al. 2001).

Holloway (1996) suggests a more positive alternative vision wherein services seek to enhance collaboration with care rather than coerce compliance with treatment. He suggests a number of components including adequate resourcing of services, adequate housing, an integrated care management structure, psychoeducation and specific interventions to enhance compliance such as ‘compliance therapy’ which is a cognitive-behavioural approach involving elements of motivational interviewing, a technique previously applied in the field of addictions. Apart from medication to control psychotic symptoms he suggests psychological techniques which have proven useful in the treatment of depression, delusional states, hallucinations and the negative symptoms of psychosis. Furthermore there are the techniques of psychiatric rehabilitation and skills training as well as involvement with the family and carers. Holloway concludes that these therapeutic strategies provide a potentially more effective alternative to compulsion and coercion in community care.

From the consumer’s perspective the Coalition to Stop Outpatient Commitment suggest that no cheap, quick political fixes will work in servicing people for whom the existing system does not work. The Coalition urges the use of alternatives to force, which do work, such as offering an adequate range of respectful and humane service choices; services which people want, which meet their needs, which respect their dignity as individual persons and fund these services adequately in order to give people real access to them. Additionally services should also provide adequate crisis prevention and crisis management services, including peer-run programs for hospital diversion and respite, drop-in centres and self-help groups.
Guardianship and Community Treatment Orders

Guardianship as an alternative to CTOs or in conjunction with mental health legislation is used in some jurisdictions and is the basis of an on-going debate in Western Australia.

United Kingdoms

Guardianship was embodied in the Mental Health Act 1959 (U.K.) and amended under their 1983 Act to apply to people with a mental illness. These powers which were subject to the consent of the nearest relative included the power to require that the patient reside at a specified place and attend for treatment, although it does not allow for compulsory medication. (Shaw, Hatfield & Evans, 2000) The intention was that Guardianship would provide for certain persons with a mental illness long-term guidance, supervision, influence and support. However due to a perceived lack of real power, practical problems and inadequate guidelines, Guardianship is not widely used.

Scotland

The Adults with Incapacity (Scotland) Act 2000 introduced a new form of Guardianship. This Act is intended to make it easier to intervene in an adult's life following the onset of incapacity including mental illness. Under Section 37 of the Mental Health (Scotland) Act 1984 a local authority or the nearest relative of a patient may apply to the sheriff's court to receive a person into Guardianship if that person is suffering from a mental illness or a mental handicap. The Guardianship can last for a period of six months and can be renewed for a further six months and thereafter annually. Guardians have three specific powers. They can require the patient to live in a specific place, to receive medical treatment, education or training; and obtain access to the patient in their own home.

Guardianship in Scotland is currently being used for a small but increasing number of patients with a mental illness and for a growing number of patients with alcohol-related brain damage. It appears that Guardianship is used in preference to Community Care orders (Atkinson & Patterson, 2001). Nearest relatives appear to play little part in the Guardianship court process and few are acting as guardians.
There was concern about conflicts of interest between families and patients, which may lead to over-protection or abuse. However, some carers may wish to play a part in the Guardianship process but are intimidated by court and do not understand their role.

New South Wales

In New South Wales a public guardian can be appointed as a guardian of a person who has a mental illness and has, as a result, an incapacity to make lifestyle decisions. (Fact Sheet 5, Office of the Public Guardian, NSW) If such a person is required to be an involuntary patient under the New South Wales Mental Health Act 1990, the Guardianship order is maintained and the guardian may continue to make decisions on behalf of the person according to the authority given in the guardianship order. However if the person is subject to a CTO or a counselling order, then the Public Guardian’s authority is suspended in those areas dealt with by the order such as consent to medication, but not in areas outside the order such as accommodation directives. The Office of the Public Guardian in NSW differentiates the role of mental health legislation with the Guardianship Act. The former provides for involuntary detention where there is risk of serious physical harm to self or others while Guardianship is solely concerned with the welfare, interests and rights of the person requiring guardianship. It appears that in NSW there is an agreed accommodation between the two Acts which allow people with a mental illness to have a Guardian and still be an involuntary patient. It does not appear that Guardianship is used as an alternative to mental health care or mental health care as an alternative to guardianship.

South Australia

The Guardianship Board in South Australia has jurisdiction under their Mental Health Act 1993 to make orders for the compulsory detention and treatment of persons with a mental illness. A continuing detention order allows the detention of a person in an approved psychiatric treatment centre against their wishes for a period of up to twelve months so that they can obtain psychiatric treatment, which can be given under a Treatment Order. There is also the power to make a CTO, which requires a
person to receive psychiatric treatment against their wishes in the community for a period of up to 12 months. Under their Act a separate appeals division of the Guardianship Board is responsible for hearing appeals against the initial detention and if the Guardianship Board is not satisfied that there is sufficient reason for the detention then it must revoke the order.

**Western Australia**

The Guardianship and Administration system in Western Australia was established by the *Guardianship and Administration Act 1990* whose objectives are to protect the best interests of adults who are unable to make reasoned decisions for themselves. The decision-making disability may occur because of dementia, mental illness, intellectual disability or acquired brain injury. The Guardianship Act allows for the appointment of a substitute decision-maker to make decisions about personal, medical or lifestyle decisions (called a Guardian) or financial decisions (called an Administrator) on behalf of the person. The Public Advocate provides advocacy at hearings at the Guardianship and Administration Board and information about ways of safeguarding the best interests of people with decision-making disabilities.

The Guardianship Board has a number of principles that must be taken into account before making any order to appoint a substitute decision-maker. These include a presumption of competence, the best interests of the person, the least restrictive alternative, and a preference for limited orders.

The authority of a Guardian may include decisions about where the person is to live, and with whom. The Guardian may also give consent to treatment on the person’s behalf. For example if the person is subject to a CTO, the CTO can include the provision of supervision and stipulate a safe environment in which to live. However a Guardian is not a case manager, service coordinator or a direct care service provider and is not able to monitor services for the person. Direct care, support and case management remains the responsibility of the service agencies and clinicians already involved.

The view of the Public Advocate’s Office is that it is generally cumbersome and sometimes unworkable to involve both Guardianship and the Mental Health
legislation. It is their preference to involve only one system if that can serve the person’s best interests. However where a person comes under both jurisdictions it is extremely important that the treating team and the Guardian are prepared to work in a collaborative way. This view is echoed by mental health services, however many clinicians in Western Australia believe that Guardianship may be an effective alternative to CTOs, particularly with chronic patients who have lifestyle problems as well as psychiatric symptoms. If a Guardianship Order can compel a patient to accept medication and it is likely that the medication will be required for a number of years, then some clinicians put forward the view that although community clinics will continue to care for the patient, legislatively Guardianship is more appropriate than a CTO. Clearly further discussion is required around these ideas and the review of the Act, which must take place shortly needs to address these issues.
Use of Community Treatment Orders in other Jurisdictions

There are a number of different types of CTOs but they basically fall into two broad categories, those that have powers to enforce treatment, usually medication, in a community setting and those that do not. Examples of the former are legislation in New Zealand, Israel and in some states of America, as well as every jurisdiction in Australia. Leave of absence in the UK and other forms of extended leave could also be viewed as de facto CTOs. Examples of the latter include Community Care Orders in Scotland, aftercare provisions in England and Wales, community counselling orders in New South Wales and some outpatient commitment legislation in the United States. However all the legislation places an obligation on patients to accept treatment in the community and on mental health clinicians to provide appropriate services.

The UK Experience

The debate regarding CTOs in the United Kingdoms has been spurred by a number of high profile cases of apparent failures of community care, which received extensive media attention. This lead the Royal College of Psychiatrists to recommended the introduction of Community Supervision Orders which would have ensured that treatment for patients was maintained outside hospital and also permit early compulsory return to re-establish treatment if necessary. The Government rejected this option as it was deemed to be inconsistent with Article 5 of European Convention of Human Rights and there was also division within the mental health community with the idea of compulsory community treatment.

The Mental Health (Patients in the Community) Act 1995 introduced the concept of supervised discharged, which is described as similar to aftercare though with fewer powers. This Act allows the power to convey a patient to a designated location for medical treatment, occupation, education or training. However no obligation on patient to accept treatment, including medication. Holloway (1996) describes the legislation as a paper tiger, providing the illusion of supervision but failing to provide the compulsory adherence to treatment. There was also criticism from Eastman (1995) stating that the Act is anti-therapeutic, evades issue of poor resourcing and
suggested that it is unlikely that an Australian type of CTO would ever become law in the UK.

In the island of Jersey there is under mental health legislation from 1969 the power in relation to a CTO to appoint a Guardian who has the power of a father over a child. There is no power to enforce treatment in the community and nurses use CTOs to persuade patients to accept medication. If that is not successful then the community care team must wait for a crisis and order readmission. They report their failure rate is low but the numbers are small (Moate et al 1993).

**The American Experience**

There are a number of similarities between American and Australian legislation with regard to compulsory treatment in the community and outpatient civil commitment is permissible in some form in most states. Outpatient commitment legislation was first introduced in the United States during the mid 1970s and by 1994 thirty-five states and the District of Colombia had laws permitting formal outpatient commitment. Three further states were considering legislation and of the 12 remaining states only one (New York) has laws prohibiting outpatient commitment. However even New York passed legislation in 1994 permitting a pilot trial of outpatient commitment in Manhattan (Power, 1999). In 1999 New York State enacted legislation that provides for assisted outpatient treatment for certain people with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. This new law is commonly referred to as "Kendra’s Law" and is named after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a person with a mental illness, Andrew Goldstein, who had previously failed to take the medication prescribed for his mental illness. In March 2000, Goldstein was found guilty of second degree murder of Kendra Webdale. Assisted outpatient treatment places expectations on the service providers and if a patient refuses to comply then the person can be returned to hospital where a psychiatrist can prescribe medication. In effect the person becomes an involuntary detained patient. Although within Australian terms this appears minimal interference with patient’s rights, the outcry in New York against Kendra’s Law was extensive. Torrey in a newspaper
article some months after the introduction of this law showed that there was no rush
to incarcerate people and that it was being used appropriately and minimally (New
York Post, February 2000).

As each state in the USA has developed separate legislation there are a variety of
mechanisms in place to enforce compliance in the community. Firstly, patients may
be conditionally released from hospital at the discretion of the hospital
superintendent, while remaining a patient of the hospital. Secondly, a patient’s
Guardian may give authority for the person with a mental illness to receive outpatient
treatment and this is form of ‘substituted consent’. Thirdly the receipt of welfare
benefits can be linked with compliance with medication with the mental health clinician handing out the benefits to the patient. Fourthly, is the mechanism of
outpatient commitment, which obliges a patient to accept treatment in the community
and failure to do so could result in re-admission (Torrey & Kaplan, 1995).

However few states apply explicit sanctions to patients who are non-compliant and
re-hospitalisation procedures can be cumbersome (McIvor 1997). The American
Medical Association guidelines recommend against forced medication of patients on
outpatient commitment, however some states allow treatment with the requirement
of separate court order. As well as a very vocal consumer movement who are
extremely critical of enforced community treatment some groups like mental health
nurses are also against the concept (Smith, 1995).

Some American commentators such as Tavalaro (1992) in looking at the tradition of
civil liberties conclude that the conflict between the state’s authority to treat a person
against their will and the patient’s right to refuse treatment can be reconciled from a
civil liberties perspective. Others go further and are convinced that coercion is a
logical component of care in severe mental illness (Geller, 1995).

North Carolina was one of the first states to experiment with outpatient commitment.
Their 1984 legislation allowed outpatient commitment either after hospitalisation or
as an alternative to in-patient care. Courts make the orders and patients automatically had representation. Furthermore psychiatrists could be cross-
examined at the hearing regarding their recommendations. However, and this was seen as one of pitfalls of the legislation, treatment can not be forced. If a patient failed to attend for treatment despite all reasonable efforts by the psychiatrist then the psychiatrist could ask the sheriff to take the person into custody and bring him or her to the treatment centre for examination and hopeful persuasion to compliance. But treatment could still not be forced on the patient, and therefore the legislation was widely criticised as suffering from 'lack of teeth'. The legislators did not anticipate much need for forced treatment because they did not anticipate many refusals to comply. Non compliance was attributed to issues such as transportation to the mental health centre or the cost of medication as opposed to recalcitrance (Hiday & Schied-Cook 1987). Despite these difficulties further research in North Carolina confirmed that the revolving door syndrome was significantly reduced by outpatient commitment legislation. (Fernandez & Nygard, 1990) Success therefore seemed to be premised on having the commitment to a system rather than having draconian powers to enforce.

In Tennessee post-hospital mandatory outpatient treatment commenced in 1981 whereby patients could be discharged on to a program of community treatment indefinitely but which was reviewed regularly by the courts. The criteria was a lesser degree of mental illness or anticipated dangerousness than in-patient care, however it did require a past history of repeated serious incidents and non-adherence to follow-up plans (Bursten 1986).

Munetz et al. (1996) report on community treatment in Ohio where there is no formal outpatient commitment, however the Summit County Mental Health Services Board can using the least restrictive option place people on out-patient civil commitment. The criteria is the same as for hospitalisation, medication is not enforceable, non-compliance does not automatically mean re-hospitalisation however patients on civil commitment are brought into hospital quicker when decompensating.

The Canadian Experience

O'Reilly and his colleagues (2000) report on the introduction of CTOs into Saskatchewan in 1995. For patients to be eligible for an order beside having a
mental illness and evidence of possible harm to self or others, the patient in the previous 2 years must also have spent at least 60 days as an involuntary patient in a psychiatric facility or an involuntary patient on three or more separate occasions or previously been on a CTO. However CTOs are used very sparingly due to concerns of liability and civil liberties and psychiatrists are quite circumspect in their use. Nevertheless they are viewed as a valuable tool in treatment of people with a serious mental illness. Most patients are treated for limited periods though research indicates that the longer duration of the CTO the more efficacious it is.

In 1995 Brian Smith, a popular sports commentator was killed by a man suffering from a severe mental illness who lived in the community. At Mr Smith’s inquest the jury recommended that the Ontario mental heath reform initiative should incorporate a community-based treatment program. In December 2000 the Mental Health Legislative Reform Bill was introduced against a great deal of consumer resistance. This legislative reform, known as Brian's Law, is part of the government's plan to create a comprehensive, balanced and effective system of mental health services that provides a continuum of community-based, outpatient and in-patient care. The Ontario Government states that Brian's Law is in keeping with the government's commitment to ensure that people with serious mental illness get the treatment they need. The government is committed to providing the most appropriate treatment possible to those with serious mental illness. The police may take patients who do not comply with their community treatment plan to their physician who may order enforced medication. Brian’s Law is under close scrutiny in Canada and no doubt will be the target of a great deal of investigation and commentary.

The New Zealand Experience

The Mental Health (Compulsory Assessment and Treatment) Act 1992 established a CTO regime under which outpatients may be required to accept psychiatric treatment as directed and to receive visits from health professionals (Dawson & Romans, 2001). They may also be returned at the discretion of clinicians to in-patient care. Patient's are subject to 6 monthly formal reviews of the involuntary status the CTO may be extended for an indefinite period. Patients are required to ‘attend for treatment’ and ‘accept that treatment’. Staff are authorised to enter private premises
for the ‘purposes of treating the patient’. Dawson and Romans study showed that clinicians considered CTOs a useful strategy in managing the transition between hospitals and community of long-term patients with psychotic disorders. Patients with the risk factors of violence were kept on CTOs longer. It was evident that a significant group of long-term patients with schizophrenia, delusions, alcohol abuse and aggression were maintained in community settings for more than a year without in-patient care.

Australia

While mental health legislation has traditionally, and constitutionally been regarded as a state matter in Australia with each state and territory introducing different mental health law, the impact of federal initiatives and international bodies have been significant (Boerma et al, 1995). The justification for this derives from the federal parliament’s constitutional ‘external affairs’ powers, which supported federal legislation implementing international treaties and obligations including obligations in the area of human rights. The National Mental Health Statement of Rights and Responsibilities (1991) and the United Nation’s Principles for the protection of persons with a mental illness and the improvement of mental health care (1991) have helped shape the development of CTOs in Australia. Also significant has been Part 9 of the Model Mental Health Legislation (1994) document which has detailed expectations of what an Australian CTO should look like. According to Boerma et al. (1995) despite the best endeavours of the Commonwealth an unfortunate mismatch of incompatible legal provisions for CTOs between the eight different states and territories has developed.

Victoria was the first state to introduce CTOs in 1986 (including later restricted CTOs for forensic patients) with NSW later bringing in 2 types of community treatment (CTOs and Community Care Orders). Currently all six states and two territories either have or, in the case of Queensland in the process of, CTO legislation.

A review of Australian Legislative provisions with regard to CTOs was prepared by Mr Simon Cooke in December 2000 (Mental Health Legal Centre Inc, Victoria) and that review is attached with permission as Appendix 1.
Victoria

Power (1999) states that the Victorian model of CTOs has inherent advantages for psychiatric services in that the procedure is driven by medical rather than judicial concerns. Victorian CTOs according to Dedman (1990) were a late addition to the 1986 Victorian Act and this is evident in the minimal mention in the Act itself. CTOs may be issued only by authorised psychiatrists of gazetted in-patient facilities and requires the agreement of the community-based doctor. Psychiatrists in the community may also issue CTOs. The duration of the order is up to 12 months and can be renewed. The conditions of the CTO are attendance at the nominated community service and adherence to (pharmacological) treatment. Place of residence may be specified but this is very rarely undertaken in practice. Enforcement mechanisms allow for coerced treatment in the community and revocation and readmission to hospital if the patient fails to comply with the conditions of the CTO or if in-patient treatment or care is required. Revocation requires the authorisation of the issuing psychiatrist or delegate. CTOs are automatically reviewed within 4 weeks of issue or renewal by the Mental Health Review Board, which may discharge the CTO if the criteria are not met. Patients may appeal to the Board at any time.

Protheroe and Carroll (2000) note that CTOs enable the Victorian clinician to insist on clinic attendance and the patient’s acceptance of oral or intra muscular medication. If the patient refuses to comply then the CTO may be revoked and the patient admitted to hospital, usually for a brief period. However they suggest that this ultimate sanction is rarely used. Both these community psychiatrists see good advantages in having CTOs as part of community options.

Leonard and Ventress (2000) who both have clinical experience in Victoria though now living in the UK, state that CTOs do not confer any advantage to the patient in comparison with comprehensive community care. In fact, they state that they observed that the frequent use of CTOs served to alienate patients from mental health services. They pose the conundrum of whether a patient can and should be subject to a CTO in the absence of proven efficacy.
Hardman (1993) contends that CTOs are not fully used in Victoria but that most psychiatrists agree that it has an important place in the community management of those patients with a chronic psychosis who suffer from severe loss of volition and energy, lowered motivation, limited insight and poor cooperation with treatment plans. It is useful in persuading patients to accept depot neuroleptics and day care on a regular basis. He agrees that there is an obvious potential for abuse but asserts interestingly that this is not an issue that patient's rights groups have taken up with any vigour.

A complaint by two psychiatrists who work in a community mental health service in Melbourne is that the clinical role of the CTO is often overshadowed by administrative issues relating to implementation and review. (Jaworowski & Guneva, 1999) The legislation dictates a number of reviews by the psychiatrist and the Mental Health Review Board and these legislative requirements become the focus of the community care rather than comprehensive clinical management. Certainly this point was echoed by a number a clinicians who responded to the West Australian survey who felt the requirements under the Act of monthly reviews and reports to the Board distracted from the job of caring for the patient.

**New South Wales**

Community treatment orders have been used in New South Wales since 1990 and were introduced with the intention of reducing the re-hospitalisation rate for patients who have an established history of exacerbation of symptoms due to non-compliance (Vaughan et al., 2000). It was hoped that CTOs would encourage patients to comply with the maintenance phase of treatment and so remain out of hospital long enough to experience the positive aspects of social and community life that stability can bring. Hambridge and Watt (1995) note that in keeping with the philosophy of least restriction two provisions of the NSW Act 1990 make it possible to compel some individuals to receive treatment in the community from gazetted community mental health services. These provisions are a community treatment order and a community counselling order. If a client does not comply with the conditions of either order there are a range of warnings and sanctions which can be
sequentially applied. However they note that Community Care Orders are basically paper tigers and infrequently used.

A study done in New South Wales by Vaughan et al. (1999) indicated that 33% of patients on CTOs were readmitted while on the orders and a further 17% following termination. There was a high level of compliance with depot medication and formal breaching was seldom necessary, suggesting that the threat of breach was sufficient to promote compliance. Depot medication had significant advantages in terms of re-hospitalisation compared with oral medication during the period the CTO was in existence. Re-hospitalisations occurring during CTOs were of a shorter duration, with less police involvement than involuntary admissions. The suggestion was that patients were admitted at an earlier stage of relapse when they were more amenable to treatment. Duration of non-compliance and disturbed behaviour was reduced in the period prior to hospitalisation while on a CTO compared to index admissions. The researchers showed that CTOs enable closer monitoring of patients and the establishment of more clinical contact as symptoms of relapse became more apparent. Hospitalisation appears to have been reduced by the existence of a CTO, which ensures depot medication but may have been brought forward or even increased by earlier intervention during exacerbations in disturbed behaviour.

Vaughan et al. note that before the introduction of CTOs patients reduced the frequency of, or withdrew from, seeing their case managers and doctors, so reducing the efficacy of assertive case management. When patients refused to see mental health workers they were obliged to withdraw until the level of the patients disturbance resulted in a risk of harm to themselves or others such that they required admission under the Act.

**Western Australia**

Community treatment orders were introduced into Western Australia with the *Mental Health Act 1996*, which came into force on 13 November 1997. Statistics obtained from the Mental Health Review Board indicate that between the commencement of the Act and 30 September 2001, 1947 CTOs have been made. Of these 1344 were made when a detained patient was being discharged from an authorised hospital into
the community. 603 were made on persons who were either voluntary patients in hospital or persons living in the community. CTOs are made for an initial period of up to 3 months with the possibility of an extension for a further 3 months. Over this period, 575 CTOs were extended for a further period of up to 3 months. Community treatment orders may be revoked because the person no longer requires the involuntary status and this occurred on 52 occasions in the time period. They may also be revoked because the person has become unwell again and requires a period of detention in an authorised hospital and this occurred on 382 occasions.

Date (1998) surveyed a number of psychiatrists on some issues regarding the Act and specifically asked questions regarding their experiences using CTOs. Twenty-eight of the respondents (42% of total respondents) had been involved in administering CTOs. Fifty per cent of respondents either disagreed or strongly disagreed that CTOs improved patient compliance while 57% disagreed or strongly disagreed that CTOs improved patient care. Respondents were almost evenly divided on whether CTOs result in-patients being treated in less restrictive settings. Of note however was that 50% of those who responded disagreed or strongly disagreed with the statement that CTOs are unnecessary. When the results for having experience with a CTO were stratified by involvement with public or private practice, by nature of practice, and by location of practice, it was clear that psychiatrists working only in public practice were significantly more likely to have used a CTO than their colleagues in either private only or mixed private public practices.

This research was completed not long after the introduction of CTOs into Western Australia and the negative responses could reflect difficulties psychiatrists were having in operating under a new legislative system and managing involuntary patients in the community. Despite the difficulties they envisaged and their lack of a firm conviction that CTOs could improve community care, it is significant that many still felt that CTOs could be a useful option in the armoury of the community psychiatrist.
Preston and his colleagues (2001) set out to examine whether CTOs reduce subsequent health service use compared to controls that were not placed on a CTO. They state that ‘CTOs or other forms of compulsory treatment in the community have been suggested as effective for reducing service utilisation of patients with mental health disorders’. Using standard multiple regression they attempted to control for socio-demographic variables, clinical features and previous psychiatric history. All patients who were made subject to a CTO in the first year of the implementation of the Act were extracted from the Mental Health Information System using an epidemiological sampling frame. Patients on CTOs and a similar number of patients not on CTOs were compared for the effects on subsequent in-patient admissions, bed days and outpatient contacts. 228 patients on CTOs were matched with a similar sample not on CTOs giving a total subject population of 456. All subjects had reduced in-patient admissions and hospital bed days, however CTO subjects also recorded significantly higher outpatient contacts. The researchers indicate that the study suggests that the introduction of compulsory treatment in the community does not lead to reduced health service use.

This is not a surprising result as one of the reasons CTOs were introduced as a community care option was to ensure that those chronic patients who were not complying with treatment and therefore becoming unwell again would receive a treatment even if it was without their consent. The fact that the number of outpatient contacts increased along with a reduction in re-admissions indicates that CTOs are achieving their aim of increasing contacts between service providers and patients while preventing further re-admissions.
West Australian Survey

In September/October 2001 a survey was conducted across the metro and rural and remote services. A questionnaire (Appendix 2) was distributed via e-mail and through the post to all clinical services and individual psychiatrists requesting feedback either through e-mail or hardcopy. A similar questionnaire was sent to consumer groups including the Mental Health Law Centre and the West Australian Association of Mental Health (WAAMH). Another questionnaire was sent to the Mental Health Review Board and the Council of Official Visitors. The primary purpose of the survey was to elicit peoples experiences and ideas about CTOs in order to inform the development of good practice guidelines.

Clinicians Response

37 written replies were received from clinicians and also a few verbal discussions. The information was collated under the headings in the questionnaire and appears as Appendix 3.

The main issues raised by clinicians include the following-

1) Some clinicians felt that the medical/nursing practitioner had to prove that a person has a mental disorder sufficient to be an involuntary patient and yet manage the patient in the least restrictive way by a CTO. This raised ethical issues and the rights of the patient to make his or her own decisions;

2) Concern expressed about the quality of care received on a CTO and that placing a person on a CTO does not ensure follow-up by community staff;

3) Insufficient liaison and consultation with the supervising psychiatrist and responsible practitioner before a person who is a detained patient is placed on a CTO;

4) Difficulties regarding the requirement that the CTO specify the exact date and time of the first appointment; particularly when the form is completed by the treating psychiatrist;

5) That it was preferable to hospitalise the patient and then put him/her on a CTO rather than attempt to manage medication against a person’s will;
6) CTOs are primarily a preventive strategy and there is the problem of clients who certainly suffer from psychotic illness, but may not present a danger to themselves or others;

7) The difficulty of clients living a nomadic existence, moving between communities and towns which may have vast distances between them, and having to wait for a visiting psychiatrist to review;

8) A major issue identified was the length of the order with a preference for longer time limits;

9) Difficulty of incorrectly completed CTOs and the logistical problem of the delivery of the CTO to the patient;

10) Organisational difficulties in getting a patient seen at the right time before expiry of a CTO;

11) The difficulty of a patient who does not attend follow-up yet it is not appropriate to admit them into involuntary detention; compounded by the problem that some psychiatrists are reluctant to enforce treatment until patients are obviously unwell;

12) The length of time before a review by the Mental Health Review Board was identified as too short;

13) CTOs are only one part of case management and there is insufficient regard to overall responsibilities and pressure of work;

14) CTOs are only effective for people who respect authority and are ineffectual for those who scoff at such restrictions;

15) The need for a written treatment plan stipulating the consequences if the patient fails to return for review or depot medication; and the lack of clarity regarding the extent of the management plan. For example can the plan direct where the individual lives;

16) Difficulties in giving information to patients when they are in the community as many lead quite unstructured lives or are difficult to get hold of to notify of changes in their treatment;

17) Community staff not been involved with the construction of the treatment plan but then expected to implement it;

18) Chronic under resourcing of the community which results in ‘treatment’ in the community being merely a code for the administration of medication.
19) Many clients do not believe that the CTO is in his or her best interest and hence are resistant to complying with it;
20) Grave concerns about the expectation for community nurses to enforce the CTO by administering depot injections or having to bring the patient in for treatment. As well as safety issues this damages the therapeutic alliances;
21) Important to assess the level of family and community support for a CTO
22) Treatment such as psychological or social treatments can not be enforced unless the person is subject to a Guardianship Order;
23) Second opinion after extending a CTO places an extra burden on psychiatrists especially considering the patient would have had a MHRB review a few weeks before;
24) Process of breach is bureaucratic and not practical, it is too involved, wastes staff time, and is predicated on being able to access the patient when that is often not possible; Furthermore busy community staff have other duties which have to be neglected to meet breach requirements and when should a CTO be breached. Should it be when the care plan is not adhered to, or if there is a failure to attend scheduled appointments;
25) Clinicians felt revoking a CTO was cumbersome, as it is often difficult to locate the supervising psychiatrist in an emergency;
26) Clinicians also felt it is important that the client’s views are listened to. Negotiation may enable a less restrictive outcome;
27) The difficulty that every change in medication is supposed result in a variation order;
28) Unrealistic expectations from carers and families who may feel they have quick access to psychiatric service which is not always so. Families expect more than the instrument can deliver. Additionally there may be pressure from the family to preserve involuntary status when that is not really justified;
29) Pressure from the legal profession, particularly during reviews to discharge patients on CTOs;
30) Perceived lack of information for clients, particularly culturally specific information and lack of education on the whole CTO process for clinicians;
31) Need to have telepsychiatry recognised as a legitimate assessment tool and the problem of after-hours assessment by medical practitioners who have limited understanding of the Act;
32) Forms were badly designed and the expectations of documentation do not reflect the fluidity of clinical situations;
33) Confidentiality was identified as a concern attempting to balance the needs of carers with the patients preferred outcome;
34) CTOs damages therapeutic relationships as well as increasing administration time;
35) Patients who are determined to evade the provisions of the order invariably change address to do so;
36) Reduce the avenues of appeal;

**Consumer Feedback**

The Director of WAAMH and the Mental Health Law Centre (MHLC) also responded. No replies were received from either the Mental Health Review Board or the Council of Official Visitors.

The issues of concern identified by WAAMH and the MHLC include:

**The length of CTOs**

It was noted that the possibility of continuing on CTOs indefinitely could be distressing for some consumers with persistent mental illness. Consumers have hopes that their involuntary status and treatment will end and become distressed when this does not happen. The view of the MHLC was that it would be more humane for a consumer to know that the initial CTO is for a three month period and that it can then be extended or renewed on a 6 monthly basis if the psychiatrist believes that the involuntary criteria continue to be satisfied.

**Review Process**

There should continue to be strict accountability requirements. The consumer needs to be reviewed by a medical practitioner on a monthly basis with a requirement that the practitioner discharge (or recommend that the psychiatrist discharge) the consumer from involuntary status unless the involuntary patient criteria are satisfied.
Invalid CTOs.
The MHLC is concerned that CTOs which do not comply with the requirements set out in section 68 of the Act continue to be issued by psychiatrists.

The Mental Health Review Board and CTO’s
The MHRB has the power when carrying out a review to “vary the order and to give such directions in relation to the order as it thinks fit”. The Board has not taken a pro-active stance to make sure that CTO’s are in accordance with section 68 of the Act or in accordance with the decision of EO vs MHRB. The MHRB has the power to order that a CTO be made (s145), however the Board has made clear its position that it will not order a CTO unless the consumer has organised all aspects of the proposed CTO including supervision and treatment. This in effect reverses the onus of proof by effectively requiring the consumer to show why he or she ought not remain in hospital rather than requiring the treating psychiatrist to prove why detention in hospital is the least restrictive alternative available. The Act needs to be amended to clarify whether the Board can order a psychiatrist to supervise and treat a consumer pursuant to a CTO.

The Treatment Plan
There is considerable concern about the lack of specificity in CTOs including the inadequacy of treatment plans. Consideration needs to be given to the inclusion of psychiatric rehabilitation in treatment plans, rather than the almost total focus on medication.

It is the view of the MHLC that CTOs need to be more widely written to include different types of treatment options not just focusing on medication.

Revocation
The MHLC is of the view that the revoking procedures are used more often than the breach provisions. This practice has significant consequences for a consumer. If ‘breached’ then the consumer is provided with a breach notice, they are given the opportunity to comply with the order and if they do not comply then they are sent an order to attend. If the consumer still does not comply with the order to attend, then they can be taken to a clinic or hospital by the police for treatment.
When a consumer’s CTO is revoked, they are immediately taken to hospital for treatment and are not given the opportunity to comply with their order. The MHLC is of the view that that revocation under section 70 of the Act should only be allowed in cases of physical danger to the consumer or another person (s).

**Notification of consumer at end of CTO**
A mental health service is not required to advise a patient that their CTO has finished. In practice this can mean that, even though a CTO has expired a consumer can be still under the impression that they are an involuntary patient and may be given treatment without their consent. The Act requires amendment so that a consumer is informed that they are no longer an involuntary patient as soon as their CTO has ended.

**The apparent lack of psychiatric services available to support CTOs**
It was noted that consumers often have difficulty complying with the requirements of a CTO due to lack of support services and or psychiatrists willing to supervise the order.

**The apparent difficulty of people in hospital accessing CTOs**
It was noted that consumers and carers have raised concerns about the difficulties that arise when a consumer in hospital wants to be discharged to a CTO rather than remain in hospital.

**Planning**
It was felt important to involve consumers in the planning process of instigating a CTO.

**Carers and family members**
Relatives and carers have raised concerns about the lack of understanding regarding the operations of a CTO and the expectations placed upon them to assist the consumer in meeting the requirements of the CTO. Carers and families wish to be involved in the process and their cooperation should not be assumed. It is important to provide information education, advice and support to families.
Advantages
Consumers recognise the advantages of CTOs such as living in familiar surroundings rather than the alien world of a hospital. They also recognise that the networks of family and friends are more accessible as well as increased social opportunities.

Disadvantages
Consumers also recognise the disadvantages, which include the uncertainty of when someone will gain control over their lives and the pressure of being continuously monitored. Also CTO may be used to relieve pressure on beds and this could mean people are being discharged into the community prematurely.

Other consumer submission
The author was also contacted by one consumer who wanted to relay her story. She states she had a difficult time in hospital and was placed on a CTO because she refused her medication. However being on a CTO meant she had her issues dealt with and although she is no longer on a CTO she continues to have contact with the community clinic and take medication. She states that while on the CTO she felt it was imposed on her and she was concerned not to break the rules of the order and end up back in hospital, however looking back she feels that the outcome was good even though the process was not ideal.

Although there was limited response to the survey a number of important issues were raised and the concerns of clinicians and consumers were aired. A number of the concerns can only be managed by a review of the Act and changes in the legislation, however there was clear indication that guidelines to practice were required and would assist in making sure that the legal requirements were met within a framework of good practice.
Summary

The purpose of this review was to present a comprehensive overview of the history and current status of CTOs. It presented a number of perspectives, from clinicians, consumers and researchers. Clearly the use of CTOs is a contentious practice and there are a variety of views depending on a person’s experience of using CTOs or being subject to a CTO. Not all clinicians are in favour of compulsory community treatment and not all consumers are against the idea. For many clinicians and consumers it is not the legislation which is the issue but rather the manner in which the legislative processes are managed which causes consternation.

The main points that are highlighted in the review centre around the rationale for CTOs; which patients would benefit the most if they are made subject to a CTO; the ethical issues of balancing human rights with the need for compulsion; the variety of research questions which arise regarding the efficacy of compulsory community treatment including issues of coercion, health and safety and treatment; alternatives to CTOs including guardianship and the use of CTOs in jurisdictions all around the world. The review finally gave the results of a survey conducted in Western Australia.

It is clear that the main reason for the introduction CTOs was to manage people with a chronic mental illness who live in the community and often have a tendency to relapse if non-compliant with medication. However, the use of CTOs has now expanded to manage a number of people with less chronic illnesses but who would relapse without close community care. As a replacement to aftercare the general view is that CTOs will allow people with a mental illness to survive longer in the community as well as encourage compliance with medication.

The review looked in some detail the ethical issues involved and considered the requirement to generate a balance between total non-interference and the need for compulsion. The views of consumers and consumer groups were examined in detail and their very persuasive arguments as to why CTOs for them are an infringement on human rights. These ideas were also examined from the perspective of therapeutic jurisprudence. The therapeutic jurisprudence lens enables an
examination of the issues from a position, which recognises the necessity for legislation yet proposes that a beneficial outcome for consumers and service providers may be possible depending on how the legislation is framed and enacted.

The main focus of the review was to examine a number of questions that arise when CTOs are utilised. These questions include whether involuntary treatment in the community is more efficacious than hospital treatment and do CTOs keep people out of hospital. The question of compliance was examined and whether CTOs are effective in reducing violence. It is clear from the research that there are no definite answers to these questions and although some research indicates approval as to the effectiveness of CTOs there is criticism of the research methodology. Other research is more equivocal and if the future of CTOs depended solely on research outcomes then there would be a much more vigorous debate as to whether CTOs should have been introduced in the first place and whether they should now be abandoned. However it is apparent that, particularly in Australia, the debate is not whether CTOs should continue but rather how could they be improved to uphold human rights and still prevent relapse by promoting treatment in the community.

The utility of CTOs raise other questions such as the legislative criteria and whether CTOs damage therapeutic relationships. It is clear that CTOs require alternative criteria which is less stringent than criteria for involuntary detention as the aim is prevention from relapse rather than managing relapse itself. The question of therapeutic relationships highlights the changing role of the community clinician with the closure of large institutions and the recognition that in the future the community will be the main focus for patient care. This expansion of the role of community clinicians from offering a voluntary treatment service to being involved with involuntary care and perhaps uncooperative clients, is a new experience, which may require a revision of clinical skills. The issue about treatment and what treatment can encompass such as lifestyle directives was also considered.

As CTOs have been available for a number of years, some guidelines have been developed as to how best to manage them and the review considers a number of suggestions from Geller (1990) and Diamond (1996).
The review briefly considered alternatives to CTOs and there is evidence that alternatives such as assertive community treatment might be preferable to legislative requirements. Guardianship as an alternative to or in conjunction with CTOs is examined and it is clear that this is a subject of continued debate.

The review considers the experience of the use of CTOs in other countries and it is clear a great deal can be learnt by examining the management of CTOs in these jurisdictions. Community treatment orders come in a variety of forms and are managed very differently in different parts of the world and it is evident that tragic events in the community can be the basis of legislative changes, which deeply effect the lives of people with a mental illness living in the community.

The final section of the review reports on the West Australian survey, which indicates that clinicians and consumers have a variety of experiences in using or being subject to CTOs. Many of the benefits and drawbacks are articulated though there seems a general consensus that for particular patients who require particular mental health services and who live in particular places, the CTO is a viable option for maintaining people with a mental illness living in the community.
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Appendix 1- Review of Australian Legislative Provisions
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Relative CTO Rights Research Project

All Australian States and mainland Territories have provision for community-based care and treatment in their mental health legislation. During the 1990s, all other States and mainland Territories developed legislation to provide for compulsory community-based treatment. The most recent Act to make such provision, the Queensland Mental Health Act, received assent on 8 June 2000.

The relevant legislation and the orders that may be made under the Acts are:

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Legislation</th>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>Mental Health (Treatment and Care) Act 1994</td>
<td>Mental Health Order (Involuntary Psychiatric Treatment Order or Community Care Order)</td>
</tr>
<tr>
<td>NSW</td>
<td>Mental Health Act 1990</td>
<td>Community Counselling Order Community Treatment Order</td>
</tr>
<tr>
<td>NT</td>
<td>Mental Health and Related Services Act 1998</td>
<td>Community Management Order</td>
</tr>
<tr>
<td>Qld</td>
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</tr>
<tr>
<td>SA</td>
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<td>Treatment Order</td>
</tr>
<tr>
<td>Tas</td>
<td>Mental Health Act 1996</td>
<td>Community Treatment Order</td>
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<tr>
<td>Vic</td>
<td>Mental Health Act 1986</td>
<td>Community Treatment Order</td>
</tr>
<tr>
<td>WA</td>
<td>Mental Health Act 1996</td>
<td>Community Treatment Order</td>
</tr>
</tbody>
</table>

Despite the similarity in the aims of these Acts and orders, the legislative provisions by which they are carried into effect differ from jurisdiction to jurisdiction.

This review of Australian legislation that creates compulsory community-based treatment orders excludes provision that is made for offenders in some legislation.

A summary of some features of the legislation follows:

Who may create an order?
An order may be made by authorised practitioners in the following jurisdictions:

- Northern Territory (interim order only)
- Queensland
- Tasmania
- Victoria; and
- Western Australia.

In each of these jurisdictions, there is an automatic review of the making of the order by a tribunal or board upon the creation of the order.

Orders may only be made by a tribunal, board or magistrate in the following jurisdictions:

- Australian Capital Territory
Conditions to be met before an order is made

The criteria upon which a person may be made subject to an order differ from Act to Act. Some differences between the Acts are:

Refusal or inability to consent to treatment

The refusal of a patient to agree to voluntary treatment is implicit in the making of an order for treatment. Nevertheless, a number of the Acts (New South Wales (in relation to the Community Counselling Order), Northern Territory, Queensland, Victoria) make refusal or inability to consent to treatment a pre-condition for making an order.

Requirement for mental illness

In most cases ‘mental illness’ (however defined) is required for an order to be made. However, in New South Wales a Community Counselling Order may be made if the person is likely to become a mentally ill person within 3 months. Legislation in the Australian Capital Territory provides order for people suffering ‘mental dysfunction’ (which is defined differently to ‘mental illness’).

Likely efficacy of treatment

A number of the Acts make the likelihood that treatment will result in improvement a condition of making an order (Australian Capital Territory, South Australia, Tasmania).

Duration

In all jurisdictions other than Queensland, orders for community-based treatment must have a specified duration. Orders may be made for the following periods:

- 3 months with a single 3 month extension by supervising psychiatrist (Western Australia)
- 6 months (Australian Capital Territory, New South Wales)
- 6 months with extension for another 6 month on application by an authorised psychiatric practitioner (Northern Territory)
- 12 months (South Australia, Tasmania, Victoria)

In Queensland, involuntary treatment orders continue (with regular reviews) until revoked.

Review of orders

All jurisdictions allow appeals to be made for a review of an order on an ad hoc basis. In New South Wales this is restricted to cases where there has been significant change in the condition of the patient or new information is presented.
All jurisdictions that allow authorised practitioners to make orders have provisions requiring review of these decisions upon the creation of the order.

**Powers in breach**
Jurisdictions differ in the extent to which the legislation prescribes the lengths to which agencies are expected to go prior to a patient being apprehended and forced to undergo treatment (whether outpatient or in-patient).
The most extensive procedures are set out in the New South Wales, Queensland and West Australian legislation. Each requires a variation of the following:
- patient non-compliant
- agency must take reasonable steps to ensure compliance
- significant risk that non-compliance will result in deterioration of the patient’s condition
- written warning concerning breach and the possible consequences provided to the patient
- further non-compliance
- written order commanding the patient to attend for treatment
- assistance may be sought from police in enforcing the order for treatment

**Legislative Provisions for Community-Based Care and Treatment**
The following sections provide a detailed review of the legislative provisions in each jurisdiction that has orders for community based care and treatment. A table summarising the legislative provisions in all jurisdictions follows is provided at the end.

**Australian Capital Territory: Mental Health Order**
**Legislation**
Mental Health (Treatment and Care) Act 1994 (ACT)

**Summary**
‘Mental health orders’ directing that a person undergo involuntary treatment can be made by the Mental Health Tribunal under the Mental Health (Treatment and Care) Act 1994. A mental health order may be either an involuntary psychiatric treatment order or a community care order.
Features of particular interest include:
- community care order for mentally dysfunctional persons
- restriction orders
- balance to be struck between benefits of psychiatric treatment and the stress and deprivation that results
Process for making a mental health order

An assessment must be made before the Mental Health Tribunal can make a mental health order (s. 23). Assessments are carried out following an order from the Tribunal (s. 16).

The Act distinguishes between two cases:

‘mental dysfunction’, which means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion; and

‘mental illness’, which means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:

(a) delusions;

(b) hallucinations;

(c) serious disorder of thought form;

(d) a severe disturbance of mood;

(e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d);

The Tribunal can make two different orders: an involuntary psychiatric treatment order or a community care order.

The Tribunal may make an involuntary psychiatric treatment order in respect of a person if (s. 26 (1)):

(a) the person has a mental illness;

(b) the Tribunal has reasonable grounds for believing that, by reason of that illness, the person is likely to do serious harm to himself or herself or others, or is likely to suffer serious mental or physical deterioration unless subject to involuntary psychiatric treatment;

(c) the Tribunal is satisfied that psychiatric treatment is likely to reduce the harm referred to in paragraph (b) and result in an improvement in his or her psychiatric condition; and

(d) the treatment can not be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.

An involuntary psychiatric treatment order may:

- specify a health facility to which the person to whom the order relates may be taken (s. 28(2));
• specify that the person is required to undergo psychiatric treatment, other than convulsive therapy or psychiatric surgery (s. 28(4)(a)(i));

• specify that the person is required to undertake a counselling, training, therapeutic or rehabilitation program (s. 28(4)(a)(ii)),

but must specify whether the person concerned has refused consent or is incapable of giving consent (s. 28(5)).

The Tribunal may make a *community care order* in respect of a person if (s. 26(2)):

(a) the person is mentally dysfunctional;

(b) the Tribunal has reasonable grounds for believing that, by reason of that dysfunction, the person is likely to do serious harm to himself or herself or others;

(c) satisfied that care and support is likely to reduce the harm referred to in paragraph (b);

(d) in the circumstances, an involuntary psychiatric treatment order should not be made; and

(e) the community care can not be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.

A community care order may specify that the person is to:

• be given or provided care and support (s. 28(4)(b)(i));

• undertake a counselling, training, therapeutic or rehabilitation program (s. 28(4)(b)(ii)),

but must specify whether the person concerned has refused consent or is incapable of giving consent (s. 28(5)).

In making a mental health order, the Tribunal must take into account the following matters (s. 25):

(aa) whether the person consents, refuses to consent or is capable of making a decision to consent, to a proposed course of treatment, care or support;

(a) the views and wishes of the person, so far as they can be ascertained;

(b) the views and wishes of the persons responsible for the day-to-day care of the person who is the subject of the proceeding, so far as those views and wishes are made known to the Tribunal;

... 

(e) that the person’s welfare and interests should be appropriately protected;
that the person’s rights should not be interfered with except to the least extent necessary;

that the person should be encouraged to look after himself or herself;

that, as far as possible, the person should live in the general community and join in community activities;

that any restrictions placed on the person should be the minimum necessary for the safe and effective care of the person.

The Tribunal must confirm with service providers that they are capable of providing the service that the Tribunal orders (s. 24A(2)).

The chief psychiatrist or care coordinator (as the case requires), is responsible for determining the details of treatment, care and support, in consultation with the Tribunal, community advocate and, whenever practicable, the subject of the order (s. 29(1-2)). A determination of these matters must be in writing (s. 29(3)).

In determining any psychiatric treatment that will be administered, the chief psychiatrist or care coordinator (as the case requires) shall not determine treatment that has, or is likely to have, the effect of subjecting the person to whom it is administered to undue stress or deprivation, having regard to the benefit likely to result from the administration of the treatment (s. 29(4)).

**Restriction order**

The Tribunal may make a restriction order, if satisfied that, in the interests of his or her health or safety or public safety, which:

- requires that the person should not be discharged from an involuntary psychiatric treatment order or a community care order under section 26 unless the Tribunal has reviewed that order (s. 27(1));

- may require a person with a mental illness to reside at a specified place (s. 27(2)(a));

- may require a person with a mental dysfunction, other than a mental illness, to reside at a community care facility (s. 27(s)(b));

- may require the person not to approach a specified person or specified place or undertake specified activities (s. 27(2)(c)).

A restriction order expires after 3 months (s. 28(7)).

**Duration**

Mental health orders may be made for a period of up to six months (s. 30).

**Breach**

Failure to comply with a treatment order will result in the following:

- an oral warning that refusal to comply may result in apprehension and enforced treatment (s. 32A(1)(a));

- a written warning following further non-compliance (s. 32A(1)(b));
apprehension (by police, mental health officer or doctor) and detention in an approved mental health facility to ensure compliance (s. 32A(1)(c)).

**Discharge**
The chief psychiatrist or care coordinator (as the case requires) shall discharge the person from a mental health order if satisfied that the person no longer meets the criteria for an order (s. 29(5)). If the person is subject to a restriction order, then the matter must be referred to the Tribunal (s. 28(8) and s. 29(7)).

**Review, variation and revocation**
A review of a mental health order can be carried out by the Tribunal on application or of its own motion.
If, following a review, the Tribunal is satisfied that a person is no longer mentally dysfunctional or mentally ill, then the Tribunal must revoke the order (s. 36(2)(a)). If the Tribunal is satisfied that a person remains mentally dysfunctional but:
(i) the person’s health or safety would not be, and would be unlikely to be, substantially at risk; and

(ii) the person is not likely to do serious harm to others;

and is satisfied that it is otherwise appropriate to do so, the Tribunal may vary, revoke or make additional orders (s. 36(2)(b)). Finally, if the Tribunal is satisfied that it would be appropriate to do so, the Tribunal may vary, revoke or make additional orders (s. 36(2)(c)).

**New South Wales: Community Counselling Order and Community Treatment Order**

**Legislation**
Mental Health Act 1990 (NSW)

**Summary**
The Mental Health Act 1990 provides for two types of compulsory community-based treatment: the community counselling order and the community treatment order. Both orders permit the administration of medication. However a community counselling order may be made in a wider range of circumstances that a community treatment order. The scope and operation of this legislation was examined and clarified in *Harry v. Mental Health Review Tribunal* (1994) 33 NSWLR 315. Features of particular interest include:

- distinction between community counselling order and the community treatment order
- extensive procedures in case of breach
- right to obtain information about medication
COMMUNITY COUNSELLING ORDER

Circumstances in which a Community Counselling Order may be made
A Community Counselling Order may be made by the Mental Health Review Tribunal, or a Magistrate holding an inquiry into whether a person should be detained involuntarily, upon application by (s. 118(1)):
(a) the affected person, or
(b) a near relative of, or a relative nominated by, the affected person, or
(c) a medical practitioner who is familiar with the clinical history of the affected person, or
(d) a person prescribed by the regulations as being authorised to make such an application (definition ‘authorised applicant’, (Sch. 1 and s. 3).

Criteria for a Community Counselling Order
The Mental Health Review Tribunal or Magistrate may not make a community counselling order unless satisfied on the balance of probabilities:
(a) that the affected person is likely to become a mentally ill person within 3 months (s. 120(a));
(b) the person:
   (i) is not detained (except in the case of an order made by a Magistrate) (s. 120(2)(a))
   (ii) has, on more than 1 occasion, refused to accept appropriate treatment, which refusal was followed by relapse into an active phase of mental illness and mental or physical deterioration justifying involuntary admission to hospital (s. 120(2)(b-d));
(c) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery from, the debilitating symptoms of a mental illness or the short-term prevention of deterioration in the mental or physical condition of the affected person (s. 120(2)(e));
(d) the health care agency which is to implement the order:
   (i) has made reasonable attempts to maintain contact with the affected person and to have the affected person consent to treatment, counselling or rehabilitation within the community, (s. 120(3)(a)) and
   (ii) has an appropriate treatment plan which it is capable of implementing (s. 120(3)(b)).

1 Based on the evidence of a psychiatrist or of a medical practitioner appointed by an order under section 123.
Content of Community Counselling Orders
The Community Counselling Order must:
(a) nominate the health care agency which is to implement it (s. 118(2));
(b) require the affected person to be present at a specified place, at such
reasonable times as are stated in the order, and there receive such
medication and therapy, and such rehabilitation and other services, as
are provided in accordance with a treatment plan approved by the order
(s. 118(2)(a-b)).

Duration of Community Counselling Orders
Community Counselling Orders may be specified to run for up to six months (s. 124).
A Community Counselling Order expires if the subject of the order is detained in
hospital under the Act or becomes a forensic patient (s. 124(1)(c)).

Discharge
The Director of a health care agency may discharge a person from a Community
Counselling Order at any time if appropriate to do so (s. 124(4)).

Renewal
Any number of orders may be made in relation to the same person (s. 124(3)).

Breach of a Community Counselling Order
Breach of a Community Counsellor Order occurs where:
(a) the affected person refuses or fails to comply with the order (s. 127(1));
    and
(b) the agency has taken all reasonable steps to implement the order (s.
    127(1)(a)); and
(c) there is a significant risk of deterioration in the mental or physical
    condition of the affected person (s. 127(1)(b)).

Breach must be followed by a written report of the breach and notification of the
person affected that further refusal or failure to comply with the order will result in the
person being required to attend the health care agency for counselling or the
administration of medication, or both (s. 127(2)).
Further refusal or failure to comply may result in written notice requiring the affected
person to attend the agency and warning them that the police may assist in enforcing
the Order (s. 128(1)). A person apprehended by police for breaching a Community
Counselling Order must be transported to the health care agency without undue
delay and may only be kept there for up to two hours (s. 130).

2 Except where an order is made for less than 14 days on adjournment (s. 121).
Revocation or Variation of Community Counselling Order
An application may be made to the Mental Health Review Tribunal for the variation or revocation of an Order by the affected person, the psychiatric case manager implementing the order, or a person who could have applied for the order (s. 148(3)). An application may be made only if there has been a substantial or material change in the circumstances surrounding the making of the order, or if relevant information not available when the order was made has become available (s. 148(2)).

Revocation of Community Counselling Order by the Director
The Director of a health care agency may revoke an order if of the opinion that the affected person is not likely to benefit from a continuation of the order (s. 149).

Information about medication administered under a Community Counselling Order
The Director of the health care agency implementing the order must provide particulars of the kind and dosages of medication which are being administered, or have recently been administered, to the affected person at their request (s. 147).

COMMUNITY TREATMENT ORDER

Circumstances in which a Community Treatment Order may be made
The Mental Health Review Tribunal may make an order on the application of a medical superintendent or upon review of a patient who has been detained involuntarily (s. 131(1)). A magistrate holding an inquiry into whether a person should be detained involuntarily (s. 131(2)) following application by:
   (a) the affected person, or
   (b) a near relative of, or a relative nominated by, the affected person, or
   (c) a medical practitioner who is familiar with the clinical history of the affected person, or
   (d) a person prescribed by the regulations as being authorised to make such an application (definition ‘authorised applicant’, (Sch. 1 and s. 3).

Criteria for a Community Treatment Order
The Mental Health Review Tribunal or Magistrate may not make a community treatment order unless satisfied that:
   (a) the person:
      (i) has been for the first time diagnosed as suffering from a mental illness (s. 133(1)(b); or
      (ii) the affected person has previously refused to accept appropriate treatment, which refusal was followed by relapse into an active phase of mental illness and mental or physical deterioration justifying involuntary admission to hospital (s.
133(2)(a-c)) and care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery from, the debilitating symptoms of a mental illness or the short-term prevention of deterioration in the mental or physical condition of the affected person (s. 133(2)(d)) (s. 133(1)(b)).

(b) the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care (s. 133(1)(c)), and

(c) a health care agency has an appropriate treatment plan which it is capable of implementing (s. 133(1)(d)); and

(d) in the case of an order made by a Magistrate, the Magistrate would otherwise make an order detaining the person as a temporary patient for up to three months under section 51 (3) (s. 133(1)(a)).

Content of Community Treatment Orders
The Community Treatment Order must:
(a) nominate the health care agency which is to implement it (s. 131(3));

(b) require the affected person to be present at a specified place, at such reasonable times as are stated in the order, and there receive such medication and therapy, and such rehabilitation and other services, as are provided in accordance with a treatment plan approved by the order (s. 131(3)(a-b)).

Duration of Community Treatment Orders
Community Treatment Orders may be specified to run for up to six months (s. 135). A Community Treatment Order expires if the subject of the order is detained in hospital under the Act (except in the enforcement of Community Treatment Orders) or becomes a forensic patient (s. 135(1)(c)).

Renewal
Any number of orders may be made in relation to the same person (s. 135(3)).

Breach of a Community Treatment Order
Breach of a Community Treatment Order occurs where:
(a) the affected person refuses or fails to comply with the order (s. 137(1)); and

(b) the agency has taken all reasonable steps to implement the order (s. 137(1)(a)); and

(c) there is a significant risk of deterioration in the mental or physical condition of the affected person (s. 137(1)(b)).

Breach must be followed by a written report of the breach and notification of the person affected that further refusal or failure to comply with the order will result in the
person being required to attend the health care agency or appropriate hospital for treatment (s. 137(2)).
Further refusal or failure to comply may result in written notice requiring the affected person to accompany a staff member of the agency or treatment or attend a specified hospital and warning them that the police may assist in enforcing the Order (s. 138(1)). A person apprehended by police for breaching a Community Counselling Order must be transported to the health care agency or specified hospital without undue delay (s. 130). If the person is transported to a health care agency and continues to refuse treatment, then they may be taken to hospital by the Police (s. 141).
On arrival at a hospital (s. 142):
(a) the person is to be given notice of his or her right to apply for a review of the order, to lodge an appeal and to apply for discharge, and
(b) the medical superintendent must review the person's mental condition, and
(c) if the medical superintendent considers it appropriate, the person is to be given treatment in accordance with the community treatment order.

The review by the medical superintendent may result in:
(a) detention as a 'mentally ill person' until the expiration of the community treatment order or the person is released following review by the Mental Health Review Tribunal under section 143A, whichever is the earlier (s. 143(1)(a) and s. 51(3)), or
(b) detention in the hospital as a 'mentally disordered person' for up to 3 working days or until the community treatment order expires (s. 143(1)(b) and s. 35).
(c) release from hospital (s. 143(2)).

Revocation or Variation of Community Treatment Order
An application may be made to the Mental Health Review Tribunal for the variation or revocation of an Order by the affected person, the psychiatric case manager implementing the order, or a person who could have applied for the order (s. 148(3)). An application may be made only if there has been a substantial or material change in the circumstances surrounding the making of the order, or if relevant information not available when the order was made has become available (s. 148(2)).

Revocation of Community Treatment Order by the Director
The Director of a health care agency may revoke an Order if of the opinion that the affected person is not likely to benefit from a continuation of the order (s. 149).

Information about medication administered under a Community Treatment Order
The Director of the health care agency implementing the order must provide particulars of the kind and dosages of medication which are being administered, or have recently been administered, to the affected person at their request (s. 147).
Northern Territory: Community Management Order Legislation
Mental Health and Related Services Act 1998 (NT)

Summary
An interim community management order is made in the first instance by an authorised psychiatric practitioner. The interim order must then be confirmed by the Mental Health Review Tribunal.

Features of particular interest include:
- limits on the kind of treatment that may be administered under an interim order
- medication and treatment must be specified in the order
- a report on the efficacy, appropriateness and effectiveness of the order must be made on its conclusion and may inform any decisions to continue or renew the order

Process
The process for making a community management order begins with the making of an interim community management order by an authorised psychiatric practitioner (s. 45(1)). The practitioner must not make an interim community management order unless the person-in-charge of an approved treatment agency agrees that the treatment proposed for the person is appropriate and able to be implemented by the agency (s. 45(1)(a)). The interim order remains in force for seven days (s. 45(3)). The psychiatric practitioner must notify the following people that an interim order has been made as soon as practicable:
- the subject of the order,
- the Mental Health Review Tribunal
- a legal practitioner prepared to act on the person’s behalf,
- the person’s primary carer or other person closely involved with treatment (where the person consents, or where it is reasonably believed to be in the best interests of a person unable to consent or who has unreasonably refused consent as a result of their mental illness), and
- the principal community visitor (s. 47(1-2)).

The only treatment that may be given under such an interim order is treatment that will (s. 45(4)):
(a) prevent the person causing imminent harm to himself or herself, or another person;
(b) prevent behaviour that is likely to cause imminent harm to himself or herself, or another person;
(c) prevent any further physical or mental deterioration;
(d) relieve acute symptomatology.

The interim order must specify (s. 46):
(a) the name and address of the person to whom it relates;
(b) the approved treatment agency that is to supervise and review the order;
(c) the name of the approved treatment agency that is to implement the order;
(d) other organisations or persons treating or caring for the person under the order;
(e) the times when treatment will be administered;
(f) the mediation or treatment the person is to receive under the order;
(g) the rehabilitation, support and other services the person is to receive under the order;
(h) any other information the authorised psychiatric practitioner thinks fit.

The Mental Health Review Tribunal must review the interim community management order as soon as practicable, but not more than 7 days after it was made (s. 48 and 123). If the Tribunal is satisfied that the person fulfils the criteria, it may make a community management order for a period of no longer than six months and fix a date for a subsequent review.

Criteria
The criteria for involuntary treatment in the community are (s. 16):
(a) that the person has a mental illness;

(b) as a result of the mental illness:
   (i) the person requires treatment;
   (ii) the person:
      (A) is likely to cause imminent harm to himself or herself, a particular person or any other person; or
      (B) is likely to suffer serious mental or physical deterioration unless he or she receives treatment or care; and
   (iii) the person is not capable of giving informed consent to the treatment or care or has unreasonably refused to consent to the treatment or care; and

(c) the treatment or care is able to be provided by a community management place that has been prepared and is capable of being implemented.
**Content**
The order must specify (s. 49):

- (a) the name and address of the person to whom it relates;
- (b) the approved treatment agency that is to supervise and review the order;
- (c) the name of the approved treatment agency that is to implement the order;
- (d) other organisations or persons treating or caring for the person under the order;
- (e) the times when treatment will be administered;
- (f) the mediation or treatment the person is to receive under the order;
- (g) the rehabilitation, support and other services the person is to receive under the order;
- (h) any other information the Tribunal thinks fit.

**Conduct of the order**
A psychiatric case manager must be appointed to monitor the progress of the treatment, care and rehabilitation of the person under the order (s. 51). An authorised psychiatric practitioner must examine the person at least once every 6 weeks (s. 50(1)).

**Revocation**
A community management order must be revoked if the authorised psychiatric practitioner is satisfied, following an examination of the person, that they no longer meet the criteria for involuntary treatment in the community (s. 50).

**Extension**
A community management order may be extended for a period of up to six months after consideration of an application by an authorised psychiatric practitioner made prior to expiry (s. 123(11)).

**Review**
The Tribunal may review an order if requested to do so by the person on the order or a person who has a genuine interest in, or a real and immediate concern for the welfare of the person (s. 123(4)).

If the Tribunal finds that the person fulfils the criteria for involuntary treatment in the community, it may make a community management order in relation to the person for not longer than 6 months and, where it does so, it must fix a date for the order to be reviewed again (s. 123(5)(c)).

If the Tribunal finds that the person does not fulfil the criteria for involuntary treatment in the community, it must revoke the order or interim order (s. 123(7)).
Variation
The Mental Health Review Tribunal may vary a community management order upon review, where it is satisfied that there has been a significant change in the condition of the person (s. 123(12)).

Expiry
The person in charge of an approved treatment agency must report to the Tribunal as soon as practicable after the expiry or revocation of an order as to the efficacy, appropriateness and effectiveness of the order. The Tribunal is to have regard to this report when considering placing the person on a further community management order (s. 52).

Suspension
An order may be suspended by an authorised psychiatric practitioner. The practitioner and the psychiatric case manager must be satisfied that the person has failed to comply with the order and that (s. 53(12)):
   (a) all reasonable steps have been taken to implement the order and to obtain the person’s co-operation; and

   (b) as a result of the person’s failure to comply with the order, there is a significant risk of the person:

   (i) causing harm to himself or herself or to another person; or

   (ii) suffering serious mental or physical deterioration.

The person subject to the order and his or her representative must be informed of the reasons for the suspension of the order (s. 53(3)(a)). The person must be assessed by the authorised psychiatric practitioner suspending the order, who may either admit the person to an approved treatment facility as an involuntary patient (s. 53(3)(b)(i)) or treat the person and revoke the suspension (s. 53(3)(b)(ii)). The Tribunal must be notified of a suspension within 24 hours (s. 53(3)(b)(ii)).

Queensland: Involuntary Treatment Order
Legislation
Mental Health Act 2000 (Qld)

Summary
The Mental Health Act 2000 (Qld) had received assent at the time of writing. The Act will commence on proclamation. The previous Act, the Mental Health Act 1974 did not have any provision for compulsory community-based treatment. The new Act provides for an ‘involuntary treatment order’ which may classified as either ‘in-patient’ or ‘community’. Features of particular interest:
   • patients subject to an ‘involuntary treatment order’ may classified as either ‘in-patient’ or ‘community’ according to need;
the order is of an indefinite duration, but expires if no treatment is provided for a period of 6 months

the Tribunal may seek a second opinion after a patient has been under an order for more than 6 months

**Process for making an involuntary treatment order**
An authorised doctor making an assessment for an authorised mental health service must be satisfied that all the following treatment criteria apply before making an involuntary treatment order (sections 108 and 14):

(a) the person has a mental illness;

(b) the person’s illness requires immediate treatment;

(c) the proposed treatment is available at an authorised mental health service;

(d) because of the person’s illness—
   (i) there is an imminent risk that the person may cause harm to himself or herself or someone else; or
   (ii) the person is likely to suffer serious mental or physical deterioration;

(e) there is no less restrictive way of ensuring the person receives appropriate treatment for the illness;

(f) the person—
   (i) lacks the capacity to consent to be treated for the illness; or
   (ii) has unreasonably refused proposed treatment for the illness.

A second examination by a psychiatrist within 72 hours will be necessary if the involuntary treatment order was made by an authorised doctor who is not a psychiatrist or solely on the basis of an audiovisual link assessment.

**Categorisation as community patient**
The authorised doctor making the order must decide whether the patient will be categorised as an in-patient (if they 'need' to be treated as an in-patient) or, otherwise, community (s. 109). In making this decision, the authorised doctor must take into account the general principles for exercising powers and performing functions under the Act listed in sections 8 and 9. Section 8(f) requires that the following be taken into account:

The importance of a person’s continued participation in community life and maintaining existing supportive relationships are to be taken into account to the greatest extent practicable, including, for example, by treatment in the community in which the person lives.
Section 9 provides that powers or functions exercised under the Act relating to a person who has a mental illness must be exercised or performed so that:

(a) the person’s liberty and rights are adversely affected only if there is no less restrictive way to protect the person’s health and safety or to protect others; and

(b) any adverse effect on the person’s liberty and rights is the minimum necessary in the circumstances.

The category of an involuntary treatment order must be changed if it is necessary to do so because of the patient’s treatment needs, to give effect to an order of the Mental Health Review Tribunal or where a person becomes classified patient (s. 119).

The doctor must make a written record of the change of category and the reasons for it, and, unless impracticable or against interests of the health or safety of the patient or the safety of others, talk to patient about the reasons for the change (s. 119(3-4)). Where the change is from community to in-patient, the doctor may take the patient to an authorised mental health service and seek assistance from the police in doing so (s. 119(5-6).

Notice of a change in category must be given within 7 days to the patient, the Mental Health Review Tribunal and the patient’s ‘allied person’ (a person chosen to help the patient represent the patient’s views, wishes and interests relating to the patient’s assessment, detention and treatment under the Act). Where the change is from community to in-patient, the notice to the Mental Health Review Tribunal must include the reasons for the change (s. 120).

Notice
Notice of the making of an involuntary treatment order must be given within 7 days to the patient, the Mental Health Review Tribunal and the patient’s ‘allied person’ (s. 113).

Treatment plan
The treatment plan for a community involuntary patient must state—

1. in general terms, an outline of the proposed treatment, rehabilitation and other services to be provided (124(1)(a));

2. in specific terms, the method by which, the frequency with which, the place where, the duration of and the persons by whom, the services are to be provided (124(1)(b));

3. the intervals for the patient’s regular assessment (124(1)(c));

4. state the health service, if the patient is to be treated at a health service other than an authorised mental health service (124(2)(a)); and

5. state the name of the practitioner, if the patient is to be treated by a health practitioner who is not an employee of a public sector mental health service and who has agreed to treat the patient (124(2)(b) and 124(3)).
The treatment plan must take into account any existing plan or advance directive given under the *Powers of Attorney Act 1998* (s. 124(4)). Changes may be made to the treatment plan by an authorised doctor on their own motion or to give effect to a change of categorisation for the patient or decision or order of the Mental Health Review Tribunal or Mental Health Court (s. 125-127).

**Regular assessment**

The authorised psychiatrist in a health service must carry out 'regular assessments' of the patient, including whether the treatment criteria continue to apply to the patient (s. 116).

**Non-compliance**

Where the authorised doctor is of the opinion that:

(i) the patient has not complied with the patient’s treatment plan; and

(ii) reasonable steps have been taken to obtain compliance with the treatment plan without success; and

(iii) there is a significant risk of deterioration in the patient’s mental or physical condition because of the non-compliance,

then the doctor must make a written record of this opinion and the reasons for it, and, where practicable, tell the patient about the non-compliance and the consequences of further non-compliance (s. 117(1-2)).

Further non-compliance may result in written notice being served on the patient by the health service ordering attendance at a stated authorised mental health service on a stated day (s. 117(3)). Failure to comply with the notice may lead to detention for treatment and may involve the police (s. 117(4)).

**Duration**

Involuntary treatment orders continue indefinitely until revoked (s. 118(1)). Orders also end if the patient does not receive treatment under the order for 6 months (s. 118(2)).

**Reviews**

The Mental Health Review Tribunal must review treatment orders:

1. within 6 weeks of the order being made (s. 187(1)(a));

2. thereafter, at intervals of not more than 6 months (s. 187(1)(a)); and

3. on application in writing at any time by:

   (i) the patient;

   (ii) a person on behalf of the patient; or

   (iii) the Director of Mental Health (s. 187(1)(b) and s. 188)

If an order has been in force for more than 6 months, the Tribunal must consider whether an opinion from a second psychiatrist should be sought (s. 190). The Tribunal must provide a copy of its decision (s. 192).
Revocation
The Director of Mental Health may, and an authorised doctor for an involuntary patient’s treating health service must, revoke an order if satisfied that the treatment criteria no longer apply (s. 121-122). Written notice of revocation must be given within 7 days to the patient, the patient’s allied person, the Mental Health Tribunal and (in limited circumstances) the Director of Mental Health (s. 123).

South Australia: Treatment Order
Legislation
Mental Health Act 1993 (SA)

Summary
The Act does not contain the phrase ‘community treatment order’ or similar, but does permit the making of a treatment order that will allow treatment to take place in the community without the consent of the person being treated. (The Guardianship Board refers to making community treatment orders under this power).
Features of particular interest include:
• the provision of a 2 month warning that an order is about to expire

Process for obtaining a treatment order for a person who refuses or fails to undergo treatment
An application for a treatment order may be made by (s. 20(2)):
1. the Public Advocate;

2. a medical practitioner; or

3. a guardian, relative or medical agent of the person.

If, following an application, the Guardianship Board may make a treatment order if the following criteria are satisfied (s. 20(1)):
(a) that a person has a mental illness that is amenable to treatment; and

(b) that a medical practitioner has authorised treatment for the illness (not being prescribed psychiatric treatment) for the person but the person has refused or failed, or is likely to refuse or fail, to undergo the treatment; and

(c) that the person should be given treatment for the illness in the interests of his or her own health and safety or for the protection of other persons; and

(d) that an order under this section should, in all the circumstances, be made.

Duration
Treatment order may be for a period not exceeding 12 months. The period must be specified in the order (s. 20(1)).
Warning that order is about to expire
Where an order is made for six months or more, the Registrar of the Board must send notice to the applicant not less than two months before the expiry of an order reminding him or her of the date on which the order will expire.

Revocation
The Guardianship Board may revoke a treatment order upon application from one of the following (s. 21):
(a) the person to whom the order relates; or

(b) the Public Advocate, on his or her own initiative, or at the request and on behalf of the person to whom the order relates; or

(c) a medical practitioner; or

(d) a guardian, relative or medical agent of the person; or

(e) any other person who satisfies the Board that he or she has a proper interest in the welfare of the person.

Breach
A person subject to a treatment order who has, without reasonable excuse, refused or failed to comply with the order may be apprehended by the police and taken to the practitioner or clinic specified in the order for treatment (s. 23(4)).

Appeal
Appeals may be made from decisions of the Guardianship Board to the Administrative Appeals Court, with the leave of the Board or the Court (Guardianship And Administration Act 1993, s. 67(g)). On appeal, the Court may substitute, or make in addition, any decision, direction or order that could be made by the Board (Guardianship And Administration Act 1993, s. 68(c)).

Tasmania: Community Treatment Order
Legislation
Mental Health Act 1996 (Tas)

Summary
The Mental Health Act 1996 (Tas) commenced on 1 November 1999, introducing provisions for community-based compulsory treatment. Features of particular interest:

- medication and treatment to be administered must be specified in the order;

- no specific provisions for dealing with breach of the community treatment order.
Making a Community Treatment Order
A Community Treatment Order may be made by two approved medical practitioners (s. 41). Practitioners making an order must inform the Mental Health Tribunal within 48 hours of making an order (s. 70(1)).
A community treatment order may be made for the treatment of a person only if (s. 40):
(a) the person has a mental illness; and
(b) there is, in consequence, a significant risk of harm to the person or others unless the mental illness is treated; and
(c) the order is necessary to ensure that the illness is properly treated; and
(d) facilities or services are available for the care and treatment of the person.

Content
A community treatment order must specify (s. 42):
(a) the name and address of the applicant;
(b) the name and address of the person in respect of whom the order is made;
(c) the name and address of each medical practitioner making the order;
(d) if appropriate, the name of the treatment centre at which the person is intended to be treated;
(e) the date and time of the making of the order;
(f) any medication and treatment required,
and must refer to the criteria which must established for an order to be made (referred to above).
A community treatment order may require the patient to (s. 43):
(a) undergo medical treatment as specified by the order or as decided by a nominated medical practitioner; or
(b) attend as an outpatient at a nominated treatment centre at specified intervals or as directed by a nominated medical practitioner; or
(c) comply with other specified requirements or with the requirements of a specified person.

Duration
A Community Treatment Order remains in force for up to one year (s. 44 (1)).

Renewal
A Community Treatment Order may be renewed by two approved medical practitioners (s. 44 (2)).
Revocation
A Community Treatment Order is revoked when (s. 44(4)):
(a) one of the approved medical practitioners who made the order subsequently discharges the order;
(b) the Tribunal, on review of the order, discharges it;
(c) the order is not renewed at the end of the term of the order; or
(d) the patient remains in an approved hospital as a patient for three months.

Review
The Mental Health Tribunal must review a community treatment order within 28 days of its creation (s. 52(1)) and renewal (s. 52(2)), as well as on application by the patient, a person responsible for the patient or another person who has, in the opinion of the Tribunal, a proper interest in the patient's welfare (s. 52(4)).

Breach
There are no specific provisions dealing with breaches of community treatment orders.

Victoria: Community Treatment Order
Legislation
Mental Health Act 1986 (Vic)

Summary
The scope and operation of this legislation was examined and clarified in Wilson v. Mental Health Review Board [2000] VSC 404.

Criteria for making a community treatment order
A community treatment order may be made by an authorised psychiatrist instead of confirming the admission\(^3\) (or continued detention) of the person to an approved mental health service as an involuntary patient if the psychiatrist considers such an order is appropriate and the following criteria are met (s. 14(1)):
(a) the person appears to be mentally ill;
(b) the person's mental illness requires immediate treatment and that treatment can be obtained by making a community treatment order;
(c) because of the person's mental illness, the person should be made subject to a community treatment order for his or her health or safety or for protection of members of the public;

\(^3\) Note that admission does not require a person to be taken to the service: s12(4A).
(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.

**Content of the order**

A community treatment order must specify (s. 14(2)):

(a) the authorised psychiatrist (or delegate) who will monitor the treatment;

(ab) the registered medical practitioner who will supervise the treatment;

(b) where the patient is to receive the treatment;

(c) the intervals at which the registered medical practitioner must report to the monitoring psychiatrist; and

(d) the duration of the order.

An order may also specify where the patient must live, if this is necessary for the treatment of the patient's illness (s. 14 (2A)).

A community treatment order must not exceed 12 months (s. 14(2)(d)).

**Extension**

The order may be extended for a period of up to 12 months by the authorised psychiatrist if the person continues to meet all the relevant criteria (s. 14(6)). Such extensions may be repeated indefinitely (s. 14(7)).

An order extending a community treatment order must be reviewed by the Mental Health Review Board within 8 weeks of extension (secs 14(8) and 30).

**Revocation**

An order may be revoked by the authorised psychiatrist if satisfied on reasonable grounds that the patient has failed to comply with the order or no longer meets the criteria for a community order (while still meeting the criteria for involuntary detention) (s. 14(4)).

If a community treatment order is revoked, the authorised psychiatrist must make reasonable efforts to inform the person that the order has been revoked and that they must return to an approved mental health service as an in-patient. (s. 14(5)). Revocation means that the person is deemed to be an involuntary patient who is absent from an approved mental health service without leave and may be apprehended (s. 14(4A)).

**Review**

A person who is subject to a community treatment order is deemed to be an involuntary patient and the provisions of this Act, (other than those sections that deal specifically with detention as an in-patient4) apply accordingly (s. 14(3)).

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4 Sections 37, 40, 41, 42 and 43.
An order extending a community treatment order must be reviewed by the Mental Health Review Board within 8 weeks of its creation or extension (secs 14(8) and 30).

**Appeal**
An appeal may be made to the Mental Health Review Board at any time against the detention of a person as an involuntary patient by the patient, a community visitor or any other person with a genuine concern for the patient (s. 29).

**Discharge**
If the authorised psychiatrist is satisfied that a person who is subject to a community treatment order does not satisfy the criteria specified in section 8(1) or in sub-section (1A) of this section, he or she must discharge the person (s. 14(4)(c)).

**Western Australia: Community Treatment Order**

**Legislation**
Mental Health Act 1996 (WA)

**Summary**
Features of particular note include:
- Orders under the West Australian legislation have the shortest period of any in Australia.

**Making an order**
A psychiatrist who has examined a person and believes that they should be made an involuntary patient (having regard to general criteria in s. 26) may make a community treatment order in relation to that person (s. 67). A community treatment order will only have effect if the order is confirmed within 72 hours by another psychiatrist or an authorised person (s. 69). This confirmation is not necessary if the person is already detained as an involuntary patient or was referred under s. 43 (s. 69(2)). A community treatment order does not have to be confirmed in this manner if the person was given involuntary status after referral for examination while detained under s. 29, or referred for examination while a voluntary patient under s. 30, or is a prisoner about to be discharged under s. 56: s. 43.

A psychiatrist may not make a community treatment order unless satisfied that (s. 66):

(a) treatment in the community would not be inconsistent with the objectives for involuntary treatment in general, as set out in section 26 (1) (b);

(b) suitable arrangements can be made for the care of the patient in the community;

(c) a medical practitioner or mental health practitioner will be available to ensure that the patient receives the treatment; and

(d) a psychiatrist will be available to supervise the order (who may be the treating psychiatrist or psychiatrist who made the order (s. 74)).
Section 26(1) provides that a person should be an involuntary patient only if:

(a) the person has a mental illness requiring treatment;

(b) the treatment can be provided through detention in an authorised hospital or through a community treatment order and is required to be so provided in order:

(i) to protect the health or safety of that person or any other person;

(ii) to protect the person from self-inflicted harm of a kind described in subsection (2); or

(iii) to prevent the person doing serious damage to any property;

(c) the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment; and

(d) the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.

Content of orders
The order must specify (s. 68(1)):

(a) a psychiatrist who will be responsible for supervising the carrying out of the order;

(b) a treatment plan, including the time and location of treatment and other appropriate matters:

(c) a medical practitioner or mental health practitioner who will be responsible for ensuring that the treatment plan is carried out; and

(d) the duration of the order, which must not be more than 3 months.

The supervising psychiatrist must review the patient at least once every month (s. 75). The supervising psychiatrist may extend an order once for up to three months (s. 76). In the case of such an extension, the patient may request a second opinion (s. 76).

Breach
A breach occurs where the patient is non-compliant and the supervising psychiatrist believes that all reasonable steps have been taken to obtain compliance without sufficient success and that a significant risk of the condition of the person deteriorating arises from the non-compliance (s. 80). The supervising psychiatrist must make a written record of the breach and give it to the patient, unless impractical to do so. This notice must inform the patient that continued non-compliance will result in an order requiring attendance for treatment (s. 81). If the supervising psychiatrist is not satisfied that the patient has begun to comply with the order, the psychiatrist may make an ‘order to attend’, specifying a time and place for treatment.
(s. 82), which treatment may be given without consent (s. 83) and with the assistance of the police (s. 84).
Alternatively, the supervising psychiatrist may revoke a community treatment order (with or without making an order that the patient be detained in an involuntary patient) if the patient fails to comply (s. 70).

**Reviews**
A review of the community treatment order must be made within 8 weeks of the order being made (s. 138). A review is not necessary if the person was already an involuntary patient when the community treatment order was made, has continued to be an involuntary patient, and a review was held previously (s. 138(4)). Should a person remain an involuntary patient continuously, reviews must be held at least every six months (s. 139). Reviews of the order may be sought the patient concerned, an official visitor, or any other person who the Board is satisfied has a genuine concern for the patient (s. 142).

**Table of Legislation**
- Mental Health (Treatment and Care) Act 1994 (ACT)
- Mental Health Act 1986 (Vic)
- Mental Health Act 1990 (NSW)
- Mental Health Act 1993 (SA)
- Mental Health Act 1996 (Tas)
- Mental Health Act 1996 (WA)
- Mental Health Act 2000 (Qld)
- Mental Health and Related Services Act 1998 (NT)

**Table of Cases**
- Harry v. Mental Health Review Tribunal (1994) 33 NSWLR 315

**Bibliography**
Jordan, Margaret; Sheard, Natalie E. and Errington, Michael R., “Mental Health and the Intellectually Disabled”, in *The Laws of Australia*, Law Book Co., as at 31 April 1999
Evans, Michael; Took, Andrew and Lloyd, Diane, “Mental Health”, in *Halsbury’s Laws of Australia*, as at 1 July 1997
Appendix 2- WA Survey- Questionnaire

Community Treatment Order Project- Survey for Mental Health Practitioners

As a mental health or responsible practitioner, who has been involved with a person on a CTO, The Chief Psychiatrist is interested in your experiences. He is interested in what has worked and what has not worked and how you would like CTO’s to be different. Your feedback will not only inform the Guidelines for CTO’s but will also contribute to the review of the Mental Health Act which will commence at a later stage.

This survey can either be completed in hardcopy and returned by post or as a word document and returned by e-mail. (Note that if you are completing this survey in hardcopy to leave space for your replies when you are printing the document.) The survey is confidential and although the survey requests personal details there is no requirement to complete them.

CTO’s have a number of components and to assist with the feedback the survey is divided into different headings, however if you wish you could just reply in any format such as a report or memo about your opinions and experiences with CTO’s.

If you would prefer a face to face meeting or telephone link-up to discuss the issues rather than completing this survey then contact Tim Rolfe and such a meeting can be arranged. (see contact details below)

This is your opportunity to influence practical guidelines and the Chief Psychiatrist cannot overemphasise the importance of your contribution to this initiative.

This survey will be distributed by e-mail and hardcopy. Thank you for completing this survey and please return it as soon as possible and the latest by 25 September 2001 to-

Contact: Tim Rolfe
Mental Health Division
Department of Health
COMMUNITY TREATMENT ORDERS SURVEY

Personal Information (optional)

Name:
Work Address:
Work phone number:
E-mail address:

Approximately how many CTO’s have you been involved with since November 1997:

1. **Placing a person on a CTO** - What are the issues which most concern you and how have these issues been managed?

2. **Managing a CTO** - What are the issues which most concern you and how have these issues been managed? Are there any specific constraints you have identified?

3. **Treatment Plan on a CTO** - What are the issues which most concern you and how have these issues been managed?

4. **Compliance with a CTO** - What are the issues which most concern you and how have these issues been managed?

5. **Extending a CTO** - What are the issues which most concern you and how have these issues been managed?

6. **Breach of a CTO** - What are the issues which most concern you and how have these issues been managed?

7. **Revoking a CTO** - What are the issues which most concern you and how have these issues been managed?

8. **Variation of a CTO** - What are the issues which most concern you and how have these issues been managed?

9. **Working with the family or carers of a patient on a CTO** - What are the issues which most concern you and how have these issues been managed?

10. **The Legal (Mental Health Act) Framework** - What are the issues which most concern you and how have these issues been managed?

11. **In your opinion what are some of the Advantages of having CTO’s as an intervention option:**
12. In your opinion what are some of the Disadvantages of using CTO’s:

13. What ideas have you or your team introduced or thought about introducing in managing CTO’s which you feel should be included in Guidelines to practice?

14. What changes in the Mental Health Act do you think are necessary to make CTO’s a more viable community treatment option?

15. Any other comments-

Thank you for completing this survey.

Please return it to-

Tim Rolfe
Mental Health Division
Department of Health
189 Royal Street
EAST PERTH 6004
Or
tim.rolfe@health.wa.gov.au
Appendix 3- WA Survey: Results

Results of the Survey Questionnaire to Clinicians

The questionnaire was a series of 15 questions and a summary of the responses are as follows:

1. **Placing a person on a CTO** - What are the issues which most concern you and how have these issues been managed?

Some of the issues raised include:

- A major concern was the criteria for placing a person on a CTO. Some clinicians felt that the medical/nursing practitioner had to prove that a person has a mental disorder sufficient to be an involuntary patient and yet manage the patient in the least restrictive way by a CTO. This raised ethical issues and the rights of the patient to make his or her own decisions. It was proposed that the clinician needs to ask him or herself questions such as 'Does the person need an involuntary order?', 'Is it practical and will it be enforceable if push comes to shove?', and 'What are the implications for community and family relationships?'. Each of these are a judgement call and often result in not commencing a CTO. The problem identified was the difficulty in trying to emphasise a treatment program which is basically a legal contract with obligations on both sides.

- There was concern expressed about the quality of care received on a CTO. Some clinicians stated there was a reluctance by community psychiatrists to accept patients on CTOs and that placing a person on a CTO does not ensure follow-up by community staff.

- There was also problem of the time taken before a CTO can be acted upon. The time from writing, to confirmation, to serving, means that CTOs in their current state can never be used as an alternative to admission. One alternative suggestion could be a provisional CTO which would allow acute treatment in the community to commence, with review by the appropriate service within 72 hours.

- From the community clinics perspective there was a feeling that there was insufficient liaison and consultation with the supervising psychiatrist and responsible practitioner before a person who is a detained patient is placed on a CTO.

- Another issue identified by community staff was the requirement that the CTO specify the exact date and time of the first appointment which appears to be unreasonable and time consuming.

- The difficulty of imposing involuntary status on a person living in the community with implications of safety for the client and his social network was identified. Some clinicians suggested that it was preferable to hospitalise the patient and then put him/her on a CTO rather than attempt to manage medication against a person’s will. Another alternative would be to set up a case review and canvass opinion from all potential participants in the client’s ongoing care.

- Clinicians identified that the use of CTOs was primarily a preventive strategy and there was the problem of clients who certainly suffer from psychotic illness, but may not presents a danger to themselves or others.

- Clinicians from the rural sector identified a number of issues such as clients living a nomadic existence, moving between communities and towns which may have vast distances between them, having to wait for a visiting psychiatrist to review monthly or for a second psychiatrist to give a second opinion and the fact that
some GPs do not want to be involved. Some rural clinicians felt that the
difficulties in arranging reviews results in a waste of consultants time which
deprives other needy individuals of treatment. One solution suggested was being
able to impose a CTO by telepsychiatry. One radical suggestion was predicated
on the fact that AMHPs can not initiate a CTO but they can initiate admission to
hospital and if CTOs are seen as a less restrictive alternative, then AMHPs
should be able to get a CTO started.

2 Managing a CTO- What are the issues which most concern you and how
have these issues been managed? Are there any specific constraints you have
identified?

Some of the issues raised include-

- A major issue identified was the length of the order. Clinicians felt that there was
  a problem with CTOs lapsing after 6 months, as the process of making a new
  order can be very cumbersome and in rural areas impossible as lapsing may not
  coincide with a visit by a psychiatrist. One clinician stated that a 6 month period
  should be the optional for length of CTOs in selected cases with reviews then
  essential. Some clinicians felt that the short timeframe resulted in CTOs being
  under utilised. One stated that their short time duration is predicated on an
  administrative fantasy that patients have brief illnesses not chronic ones, and that
  they will gain insight and voluntarily take medication. Many do not achieve this
  status.

- An administrative difficulty identified was the requirement on the Form 10 to state
  where and when treatment is to commence. The form is completed by the
  treating psychiatrist and the community clinic may be unable to give specific
details. At times responsible practitioners are nominated on the form for the role
  without his or her consent. Alternatively an unnamed individual such as CMHN is
  nominated as responsible practitioner. There were also the difficulty of incorrectly
  completed CTOs and the logistical problem of the delivery of the CTO to the
  patient.

- A number of issues were raised regarding follow-up appointments. One was that
  the need for the psychiatrist to review a patient can be difficult when many of the
  patients are actually treated on a day to day basis by the registrars. There are
  also organisational difficulties in getting a patient seen at the right time before
  expiry of a CTO. One suggestion was a central registry be kept and the
  psychiatrist and patient be notified one month and one week prior to an order
  lapsing.

- There was also the difficulty of a patient who does not attend follow-up yet it is
  not appropriate to admit them into involuntary detention. One clinician stated that
  there appears to be some reluctance to enforce treatment until people are
  obviously unwell, however another recognised that changes to stated
  appointment dates may lead to confusion and patients not attending. In situations
  such as this what did not help was the fact that different psychiatrists handle the
  situation differently when a patient does not attend monthly review appointments.
  Some psychiatrists are not concerned while others would breach the patient.

- The length of time before a review by the Mental Health Review Board was
  identified as too short as treatment of people who require ongoing involuntary
care, such as the maintenance treatment with depot neuroleptics may only show
  positive results at a later stage.
Some clinicians pointed out that CTOs are only one part of case management and there is insufficient regard to overall responsibilities and pressure of work. For example ensuring there is sufficient time for the supervision psychiatrist to review a patient on a CTO is difficult.

For the Psychiatric Emergency Team knowing who is on a CTO, as the register is often not up to date or unable to be accessed through Graylands after hours was an issue.

Some clinicians pointed out that CTOs are only effective for people who respect authority. They are ineffectual for those who scoff at such restrictions and only depot is effective in such cases. There are also difficulties for clients understanding what a CTO means and indicated that culturally appropriate information on CTOs and the Mental Health Act is required.

A view from a psychiatrist in Graylands is that in reality it is far too easy for patients to elude the follow up. He was of the opinion that a system to be useful it must be instituted for good reason; must be for 12 month periods or multiples thereof; must include control of finances and place of abode, however this does not mean they cannot relocate, rather it means if they do it has to be sanctioned; and follow up will be by a designated facility and the management will be determined by that facility or another designated by them in the case of relocation.

3 Treatment Plan on a CTO- What are the issues which most concern you and how have these issues been managed?

Some of the issues raised include-

- Clinicians identified a number of problems regarding written treatment plans as directed by the Act. One clinician stated that there is a need for written treatment plan stipulating the consequences if the patient fails to return for review or depot medication, however it was also pointed out that it was impossible to state on the treatment plan what other services will and will not need be provided including what is feasible and what can be enforced. Furthermore treatment changes and doses alter from time to time and one question raised is whether every time these treatments vary does a form need completion. The need to be specific regarding treatment can be a problem because it is difficult to inform the patient by variation of CTO every time something changes. There are difficulties in giving information to patients when they are in the community as many lead quite unstructured lives or are difficult to get hold of to notify of changes in their treatment. A further issue identified was that many patients have substance abuse as a major complicating factor in their illness and it is difficult to include treatment for drug problems as part of treatment plan on a CTO.

- As a responsible practitioner one clinician mentioned the difficulties in not been involved with the construction of the treatment plan but then expected to implement it. Also identified was that sometimes treatment plans are not explicit enough for the client or the treating team. Clinicians identified the lack of clarity regarding the extent of the management plan. For example can the plan direct where individual lives. One suggestion was that given the high degree of detail now required on the treatment plan more space on the form 10 is required.

- One psychiatrist wrote at length about the chronic under resourcing of the community which results in ‘treatment’ in the community being merely a code for the administration of medication. He felt that truly integrated packages for this
disturbed population had to include the options of psychological work with patients and “family”, suitable supportive accommodation and some day therapy which is not available throughout the metro area. Thus the truly least restrictive option, particularly one which deals with the entire patient’s needs cannot be offered. Community treatment has come to mean just the administration of medical treatment. Another psychiatrist pointed out that it is difficult to use CTOs for oral atypicals. It is only useful for depots but that brings with it side-effects problems.

- Other issues raised were that the time frame for first contact is not always appropriate. For example the indigenous concept of time and there was lack of clarity regarding how to use CTOs with Guardianship administration orders.

4 Compliance with a CTO- What are the issues which most concern you and how have these issues been managed?

Some of the issues raised include-

- A number of clinicians complained that CTOs are toothless. It’s a paper mechanism rather then true enforcement of compliance and breaching a patient is a very bureaucratic process. The outcome can be a very time consuming and traumatic process of revoking the order and taking the patient to hospital for a very short time in order for them to receive treatment. In some cases this is a process which may be repeated on a fortnightly basis.

- It was pointed out that unfortunately many clients do not believe that the CTO is in his or her best interest and hence is resistant to complying with it. Where there is resistance from a client the responsible practitioner has a ‘social control function’. A number of clinicians had grave concerns about the expectation for community nurses to enforce the CTO by administering depot injections or having to bring the patient in for treatment. As well as safety issues this damages the therapeutic alliances.

- The theme of how practical would it be to supervise compliance if the person is going to be uncooperative was raised by a number of respondents. For example it would be important to assess the level of family and community support for a CTO. If the support isn’t there then one clinician stated there is no point in going ahead with it. A strong point made is that compliance is always a relationship issue ultimately.

- Other problems identified include that the resources required to ensure that treatment is carried out such as psychological or social treatments can not be enforced unless the person is subject to a Guardianship Order. Furthermore if the treatment plans are too prescriptive then non-compliance would increase and indirectly create administrative work. There was also the issue of a lack of insight due to the illness and in the end what may be needed is a Guardianship order.

- The issue of co-morbidity was raised and there was concern that compliance with abstention from drugs is a problem. Patients mostly do not abstain from drugs, even when it is part of the treatment plan. The question is whether you revoke the CTO and send them back to hospital, even though their illness has not relapsed yet. Sometimes it is the logical thing to do, but pressure for beds makes this difficult.
5 Extending a CTO- What are the issues which most concern you and how have these issues been managed?

Some of the issues include-

➢ A number of clinicians identified the requirement for a second opinion for extending a CTO after 3 months if the patient makes such a request places an extra burden on psychiatrists especially considering the patient would have had a MHRB review a few weeks before.

➢ Again a major issue was the length of time a CTO lasted. It was pointed out that most patients who need a CTO need it for an extended period (more than a year). In Victoria CTOs can be made for up to a year before extension and then after review can be extended indefinitely a year at a time. In WA CTOs are rarely extended beyond 3 months and often result in non-compliance and readmission. It was felt preferable to have a 6 month extension. Most patients do not need extension but those who do tend to need more long-term CTOs than 3 month extension allows.

➢ Some clinicians felt there was a lack of coordination by psychiatrists where there is often an expectation that case managers/ responsible practitioners will make arrangements for extensions. However it is only consultant psychiatrists who have responsibility for the organisation of this. It was felt that a bit of leeway to fill in the extension form a few days before or after the expiry date would be helpful (grace days).

6 Breach of a CTO- What are the issues which most concern you and how have these issues been managed?

Some of the issues include-

➢ A number of clinicians felt the process was bureaucratic and not practical as there are no guidelines to practice. The complaints were that it is too involved, wastes staff time, and is predicated on being able to access the patient when that is often not possible, unless the patient is immobile or infirm and lives in a nursing home. One clinician stated that the bizarre process includes completing a Form 13, then form 14, then maybe a form 3, then finally form 11 and all have to be presented to the patient. Who if they have any sense are well hidden by this time. Beside this many of the busy community staff have other duties which have to be neglected to meet these requirements.

➢ A further issue was that some breaches have no consequences. The question was raised whether a need for stricter enforcement should be employed to avoid several relapses resulting in long admission periods.

➢ Then there was the issue as to when should a CTO be breached. Should it be when the care plan is not adhered to, or if there is a failure to attend scheduled appointments. Treatment plans are not detailed enough and some patients are too distracted or though disordered to appreciate ramifications of CTO non-compliance. Clearly deciding when to act on a breach can be difficult. Clinicians stated a need to balance therapeutic alliance by staff with patients with an authoritarian approach.

7 Revoking a CTO- What are the issues which most concern you and how have these issues been managed?
Some of the issues include-

- A major issue for clinicians is the process for revocation of a CTO. Some clinicians felt it was cumbersome, as it is often difficult to locate the community psychiatrist in an emergency to revoke the CTO. Therefore it should be possible for any qualified psychiatrist rather than the supervising psychiatrist to revoke a CTO when needed, particularly during out of work hours when community staff have to use Forms 1 & 3.
- From the Psychiatric Emergency Treatment perspective it is unclear in the Act as to how long a revocation can remain revoked if transport orders are completed over and over. Psychiatrists are also unclear about whether they need to do forms 3’s if they are not supervising psychiatrists.
- From the rural perspective one question was when a clinician from another service asks the rural service to revoke a CTO and the rural service feel the person could be managed in the least restrictive option. This echoed some concern expressed regarding the reasons stated for revocation and whether it would be accepted by Board or the Mental Health Law Centre.
- An administrative issue was a perceived need for a new information system to flag revoked CTOs so that the information is automatically given to anybody who looks the patient up on the computer.
- One radical suggestion was that in order to be useful the power of revocation should be available for Authorised Mental Health Practitioners.
- Some clinicians also felt it is important that the client’s views are listened to. Negotiation may enable a less restrictive outcome.

8 Variation of a CTO- What are the issues which most concern you and how have these issues been managed?

Some of the issues include-

- There was concern with the inexpert way CTOs are completed, which some clinicians felt was an indication of poor communication between community and treating team.
- Some clinicians were concerned about the detail required feeling it is nonsense that every change in medication should result in a variation order.
- Clinicians identified problems with the forms such as is room on the form for change of responsible practitioner, but not of the supervising psychiatrist, even though this is a fairly common occurrence.

9 Working with the family or carers of a patient on a CTO- What are the issues which most concern you and how have these issues been managed?

Some of the issues include-

- Clinicians felt there were unrealistic expectations from carers. The family may feel they have quick access to psychiatric service which is not always so. Families expect more than the instrument can deliver and they may be put in danger or under duress by the need to be explicit in the forms. The need to give the forms to the patient and the Mental Health Law Centre’s conduct of reviews where they insist that all ‘evidence’ is placed before the tribunal, places families in difficult situations. Most families want to keep their loved ones at home,
however extended family members are sometimes very frightened by some side effects of medication if not taken on time.

- Clinicians need to explain the limitations of a CTO and clients rights to least restrictive options when recovered. Questions such as are the family in agreement to the person being on the CTO and will they therefore be cooperative with it, need clarification. There is a need to involve the family to obtain reports regarding the patients mental state. Often these reports are needed to support a CTO and this can cause problems as the family does not want to be seen as the ‘dobber’ or ‘bad guy’.

- An important issue is whether involving the police will be counterproductive to family and community relationships.

- Clinicians felt that often community staff are too poorly trained and have inadequate time deal with families needs, particularly if there is no immediate crisis. As a consequence families are under utilised, poorly informed, and “under treated” due to the chronic under resourcing of services. This impairs the efficient application of the CTO. What does not assist is the lack of consultation prior to implementation of CTO and inadequate explanation.

- Sometimes there was pressure from the family to preserve involuntary status when that is not really justified and it was difficult in being clear with families regarding the power (or lack of power) of a CTO. Although most families supported the use of CTOs this lead to some families feeling frustrated by the limitations of a CTO.

10 The Legal (Mental Health Act) Framework- What are the issues which most concern you and how have these issues been managed?

Some of the issues include-

- Some clinicians felt there was pressure from the legal profession, particularly during reviews and this persuaded the Mental Health Review Board to discharge patients on CTOs. One clinician suggested that sometimes lawyers called on by patients obviously do not understand the complexities of mental illness and are hostile and act as if in court.

- Education and Information was a major issue with perceived lack of information for clients, particularly culturally specific information and lack of education on the whole CTO process for clinicians.

- The importance of involving the family in the legal process was seen as an important issue which was not adequately addressed in the Act.

- From the rural perspective there was a perceived need to have telepsychiatry recognised as a legitimate assessment tool and the problem of after-hours assessment by medical practitioners who have limited understanding of the Act and tend to send patients to Perth rather than attempting to manage them locally.

- A number of clinicians felt that there was extensive bureaucracy. For example the number of copies and the number of avenues of appeal, the requirement for a second psychiatrist to authorise a CTO when a voluntary patient had just been discharged, and the process of revocation and readmission.

- There was concern that the Forms were badly designed and the expectations of documentation do not reflect the fluidity of clinical situations.

- Some clinicians felt the Act gives more responsibility with no corresponding power and that patients could equally well be treated without the need for a CTO.
The issue of confidentiality was identified as a concern attempting to balance the needs of carers with the patients preferred outcome.

11. In your opinion what are some of the Advantages of having CTO’s as an intervention option:

Some of the issues included-

- That the proper use of CTOs minimises the use of expensive and more restrictive option of involuntary detention and commits some clients to ongoing treatment. Some clinicians viewed this enforcing of compliance a positive action as it resulted in stabilising a patient’s mental state to a safe functioning level. The consequence is that compliance kept clients ‘well’ for longer.
- Clinicians pointed out that CTOs allow clients that are a risk to themselves or others in the community to be monitored very closely and managed in the community aggressively. This monitoring could reduce the need for in-patient admission.
- Some clinicians felt CTOs were a progressive step in mental health as it provided an alternative to admission and also allowed doctors to see patients outside clinics. For many it was an example of the least restrictive principle.
- A rural clinician pointed out that although CTOs enforce medication without it some people would relapse which may mean they be sent to authorised hospital a long way from home. Furthermore every relapse means the return to the best level of functioning never quite reaches previous levels. There is also there is the drama involved for carers and families.
- One clinician took an optimistic view, seeing the CTO as a time of opportunity. A time to do some compliance training and education while the person is maintained on treatment and time to establish rapport and trust if the patient was new to the service.
- Apart from the difficult to manage chronic patient one clinician felt that the reasonably stable patient who lacks insight is sometimes better managed with a CTO, because some clients do respect the law and comply to their advantage. It was also pointed out that CTO were a great help to carers and families as it does maintain compliance with medication.
- Overall many clinicians felt CTOs are a useful addition to the range of (involuntary) treatment options we have even though they have their limitations. One clinician stated she was sure that it keeps many patients out of hospital.

12. In your opinion what are some of the Disadvantages of using CTO’s:

Some of the issues include-

- That the time frame was too short.
- That the requirement of 2 psychiatrists to institute a CTO in the community was too cumbersome.
- That the automatic expiry without notification lead to difficulties.
- That CTOs were perceived as coercive.
- That there was inadequate staffing at community mental health clinics which prevented CTOs to be used appropriately.
- That it was not effective for clients who are not responsive to rules and laws.
- That psychosocial and oral medication can’t be enforced.
That there were numerous moral and ethical issues

That CTOs were a paper tiger and the patient in the system knows well about the toothlessness of the law.

That CTOs damages therapeutic relationships.

That there is an emphasis on compliance rather than concordance.

That there was lack of knowledge of the process.

That systems are not in place to support the use of CTOs.

That there is a danger of alienating patients, their families and the greater community if the process isn’t fully explained and understood.

That CTOs increased administration time.

That patients who are determined to evade the provisions of the order invariably change to do so. They may frequently change address, leave the state, go up north and go on the streets to avoid contact.

That at the crunch most reasonable clinicians will not revoke unless the patient is ill and that is often too late. Needs clarity that it is OK to take well people into hospital for treatment

That CTOs can be resource intensive and useless for some patients.

That CTOs are potentially dangerous because it insists on attendance and if the patient did not attend it may be necessary to put staff at risk to admit patients involuntary

That many patients do not like CTOs as it removes an individuals level of empowerment.

13. What ideas have you introduced or thought about introducing in managing CTO’s which you feel should be included in Guidelines to practice?

Some of the issues include-

Some clinicians state they are highly selective in their use of CTOs and it is important to have a case conference with all parties which should be common practice and standards should be evaluated at local level. For example extensive assessment as to the suitability and practicality of using the CTO in a remote Aboriginal community or even a predominantly Aboriginal town has different implications to other areas.

Clinicians felt it was important to discuss with clients and carers the aims of the CTO, including what would allow a CTO to be cancelled. In the rural areas there should be co-case management between indigenous and non-indigenous workers to manage indigenous clients as well as co-case management between different sites.

From a Community Clinic perspective it was stated that there should be no more than 20 CTOs on at a time, distributed amongst the consultant staff.

From an administrative viewpoint one clinician uses a pro-forma for his written reports to the MHRB and this ensures that he address the requirements for the CTO.

14. What changes in the Mental Health Act do you think are necessary to make CTO’s a more viable community treatment option?
Some of the issues include-

- Have option of 3, 6 month or one year CTOs with extension by one psychiatrist as in Victoria and reduce the amount of paperwork needed to maintain people on a CTO. It is then more likely that people will receive adequate treatment.
- In the case of patients with an acute organic psychosis who only need treatment in a General Hospital it should be possible to make a CTO in the community by one psychiatrist specifying involuntary treatment for underlying medical problem.
- If a breach occurs there should be automatic detention and a review by the Review Board within a few days.
- Treatment plan should be specific but limited to next appointment.
- If patients do not comply with their CTO, maybe there should be some provision for it to continue rather than just lapse. For example, a lot of patients ‘disappear’ or avoid community nurses until the CTO period lapses because they know that if they are not able to be reviewed and assessed by the psychiatrist, their CTO just lapses. Maybe if patients do not attend their appointments, they continue to be on a CTO until the Mental Health Review Board makes a decision for them to be discharged from the CTO or a review occurs by the psychiatrist.
- The power for Community Mental Health Nurses to revoke CTOs with return to hospital for review by duty consultant during out of hours.
- From a rural perspective there should be more leeway for country CTOs so that the expiry date can be matched with a visit by the psychiatrist. Also organising two doctors in the community is sometimes very difficult and a psychiatrist’s time is very tight. Furthermore that telepsychiatry be allowable under the Act.
- That Authorised Mental Health Practitioners being able to place people on CTO’s. It seems ludicrous that they can send people to an authorised hospital but they can not authorise them to receive least restrictive option.
- Simplify the process of breach and revocation.
- Reduce the avenues of appeal. This should only be through the Review Board.
- Reduction in the number of copies of forms that have to be distributed.
- Revocation for readmission by any zonally available psychiatrist so that review and management could start early.
- There should be more proof to refer a person to an authorised hospital and some doctors write inadequate Form 1’s. This is an abuse of position, and the less people brought unnecessarily into mental health services the better.
- There are potential problems with the patients making repeated requests for 2nd opinions, and a limit to the number thought reasonable would be helpful.
- There is no responsibility placed on a person to attend for review following the expiry of a CTO. It would be useful if this were a requirement, particularly as a new CTO cannot be written while a person is currently subject to one.
- The forms could probably be simplified, eg the initial order having sections for treatment details, and for first and subsequent appointment dates. The breach and order to attend could almost be combined as a two-step form.
- One psychiatrist recommended a whole new system starting with the treating Team determining as soon as possible after admission those patients will be going out on a CTO, preferably with discussion with the referring clinic. Then that application for hearing at the Board made, the Board comprising, representatives of the Guardianship Board and if necessary Social Security/ Welfare and Community Corrections if they are involved. If a CTO is then granted it should be for 1 to 5 years, finances managed by Public Trustee, Clinical Management by
the designated Clinic and should the patient attempt to escape the CTO by geographic displacement their Social Welfare payments should cease immediately. Finally, he re-iterates that revocation should be simple and the task of any Authorised Mental Health Practitioner that assesses their relapse, non-compliance or increasing risk in the community.

16. Any other comments-

- One psychiatrist noted that compared to Victoria CTOs in WA require more time and staff resources. The result of this is that CTOs are not often used when they should be resulting in unnecessary relapse of mental illness and admissions.
- Another psychiatrist felt that they have not been given an adequate extensive trial as a first line treatment with intensive community follow-up.
- One hospital psychiatrist stated that until the matter of enforcement is dealt with, until community services are adequately resourced, and until treatment of the whole person is a real option, little will change.
- One psychiatrist felt that a lot of patients were being taken off their CTO's, particularly if they had a litigious, articulate lawyer, and it is unclear what consequence this has for treatment outcomes.
- Clinicians stated that they accepted the CTO as a framework or principles of ongoing treatment contract and it is not a prescription which will solve all the problems.