

Community Treatment Orders



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Introduction

Community Treatment Orders (CTOs) are a frequently used tool in mental health legislation that authorise the compulsory treatment of a person without their consent. This treatment is generally reduced to nothing more than arrest and forced medication. This is counterproductive and should be stopped.

Although the imposition of a CTO is the health profession's current response to people diagnosed with mental illness and who may have a history of refusing treatment, its broad scope and intrusive nature allows great room for abuse. The wide-ranging applicability of CTOs has shaped them as a tool for control, rather than the recovery method of listening that is in the best interests of mental health consumers.

The introduction of CTOs as a tool for deinstitutionalisation is problematic, as community services are often inadequately funded. Social support and counselling is less used as CTOs are much simpler and cheaper. The overall policy lacks transparency and a clear system of accountability, and raises questions regarding respect for the autonomy of the mentally ill. CTOs are coercive and anti-therapeutic as they remove all elements of personal autonomy and responsibility for affected individuals. The potential for discrimination and counterproductive outcomes for affected individuals have also prompted calls for reform.

There is already a stigma surrounding the mentally ill, and a CTO only furthers the misconception that they are dangerous people who are unbalanced and are likely to attack others at any given moment.

The use of CTOs in prisons is also highly contentious. A recent introduction in 2011, the main purpose of legislating for CTOs in prisons is purely for convenience. Instead of having to take mentally ill inmates to a mental health facility, prisons now have the authority to forcibly medicate prisoners under the guise of a CTO for a "treatment". Not only is it convenient, it is easy, cheap and can be used as a form of 'prisoner punishment' as prison authorities hold even more power over inmates. This coercive measure should not be tolerated as it goes against the basic human rights of liberty and security of the person, especially when no personal crisis exists. Prisoners say they fear the doctors more than the guards.¹

For these reasons, CTOs must be abandoned. Experiences like that of Michael Riley's (<http://www.justiceaction.org.au/cms/mental-health/cases/michael-riley>) have highlighted the above critiques and the urgency for change. Furthermore, there is a need for alternatives to CTO's to be adopted such as recovery approaches that work cooperatively with the consumer and social support including consumer workers.

What is a CTO?

A CTO is a legal order made by a judicial body that obligates an individual to accept compulsory treatment provided by a nominated mental health facility. Countries that have enacted legislation for community supervision orders (also called community treatment orders) usually require

¹ *Universal Declaration of Human Rights* Article 3

persons with mental disorders to reside at a specified place, and to attend specified treatment programs that include counseling, education and training.² CTOs also allow mental health professionals to have access to the persons' homes. In this way, the affected persons have little choice but to submit to involuntary psychiatric treatment.

Health departments assert that people who have a severe and chronic mental illness,³ such as schizophrenia and bipolar depression,⁴ who authorities believe lack the capacity to think rationally, or are likely to put others in serious danger,⁵ should accept CTOs. The imposition of such an order entails constant monitoring and regulation of the subject's activities, as well as frequent intervention to deal with breaches of any of its terms.

The objective of a CTO is to prioritise treatment of the mentally ill while they live in the community over treatment performed in institutions. CTOs attempt to ensure public safety, the availability of treatment and its provision "in the least restrictive environment consistent with the needs of the individual."⁶ They were first introduced in Australia in 1986 in Victoria as a method for deinstitutionalisation that would provide a less restrictive, community-based environment for involuntary treatment.

One reason for deinstitutionalisation was renewed clinical optimism during this time that receiving treatment in the community would enable individuals to lead a relatively balanced life involving engagement through education and employment.⁷ However, economic and political imperatives such as the reluctance of state governments to upgrade mental health facilities and the increasing burden on the public health sector were just as responsible for this trend, if not more so.

The application of CTOs have the potential to be flexible depending on the personal circumstances of an individual. For example, in Canada, a person's situation determines which one of four types of CTOs is utilised:⁸

1. People who are on conditional release from an involuntary admission need to be treated whilst in the community where hospitalisation is unnecessary.
2. People who meet the hospitalisation criteria, but can be treated in the community involuntarily instead.
3. People who do not meet the criteria for admission, but are at risk of meeting them, so they are given a preventative order.
4. Court-ordered treatment under guardianship law involving interventions like medications. Rehospitalisation may occur if the client does not adhere to treatment.

² World Health Organisation <http://www.who.int/mental_health/resources/en/Legislation.pdf>

³ Department of Health (WA), *Community Treatment Orders: A Review* (December 2001) 3.

⁴ Ibid.

⁵ World Health Organisation <http://www.who.int/mental_health/resources/en/Legislation.pdf>

⁶ Department of Health (WA), *Community Treatment Orders: A Review* (December 2001) 3.

⁷ A Rosen, 'The Australian experience of deinstitutionalization: interaction of Australian culture with the development and reform of its mental health services' (2006) 113(429) *Acta Psychiatrica Scandinavica* 81, 83.

⁸ N Snow, W J Austin, 'Community treatment orders: the ethical balancing act in community mental health' (2009) 16(2) *Journal of Psychiatric and Mental Health Nursing* 177, 177-186.

Today, the use of CTOs has indeed proved to be an inefficient and poorly justified means of deinstitutionalisation. The compulsory nature of treatment almost always forced medication stipulated in CTOs and the potential for their implementation without the individual's consent challenges fundamental notions of autonomy and privacy. The existence of such concerns calls for a critical consideration of all factors before the imposition of a CTO and consideration of social support alternatives. Since the decision process for granting a CTO often lacks transparency,⁹ calls for reform are not surprising.

Legal Framework

In New South Wales, community treatment orders are sanctioned under Part 3, Chapter 3 of the *Mental Health Act 2007* (NSW).¹⁰ s 51(1) of the Act gives the Mental Health Review Tribunal (MHRT) or a Magistrate the power to grant a CTO.¹¹ Statistically speaking, the vast majority of CTOs are made by the MHRT, rather than by a Magistrate.¹²

Although the Act limits who may make an application for a CTO under s 51(2), it does not limit who may be the subject of such an order.¹³ Under s 51(3) an application may be made about a person who is detained in or a patient in a mental health facility or a person who is not in a mental health facility,¹⁴ and under s 51(4) it may be made about someone who is subject to a current CTO.¹⁵ Potentially, anyone could be subject to a CTO, including prisoners, as long as someone under s 51(2) makes the application.

Criteria

A CTO may be made if:

- “no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care.”¹⁶
- the nominated mental health facility can actually implement an appropriate treatment plan for the person, and
- the affected person has a previous history of refusing to accept appropriate treatment if they have been diagnosed with a mental illness previously.¹⁷

Evidence for determining these points consist of the proposed treatment plan itself, reports made by the psychiatric case manager, the efficacy of any existing or previous CTOs, and any other information placed before the Tribunal.¹⁸

⁹ Edwina Light et al, 'Out of sight, out of mind: making involuntary community treatment visible in the mental health system' (2012) 196(9) *Medical Journal Of Australia* 591-593.

¹⁰ http://www.austlii.edu.au/au/legis/nsw/consol_act/mha2007128/

¹¹ *Mental Health Act 2007* (NSW), s 51(1)

¹² Mental Health Review Tribunal (NSW), *2012/13 Annual Report* (2013).

¹³ *Mental Health Act 2007* (NSW), s 51(3)

¹⁴ *Mental Health Act 2007* (NSW), s 51(3)

¹⁵ *Mental Health Act 2007* (NSW), s 51(5)

¹⁶ *Mental Health Act 2007* (NSW), s 53(3)(a)

¹⁷ *Mental Health Act 2007* (NSW), s 53(3)(c)

According to s 4 and s 14 of the Act, a mentally ill person is one who has a condition that seriously impairs his/her mental functioning, and there are reasonable grounds for believing that care is necessary for that person's own protection and protections of others from serious harm. However, while s 53(4) states that a CTO may not be made unless the Tribunal is of the opinion that the person is mentally ill, court decisions have shown that the Tribunal does not necessarily need to make that finding.¹⁹ This demonstrates that the granting of a CTO incorporates elements of discretion on behalf of the MHRT, and that there is no uniform standard to CTO processing and implementation.

The legal process

An authorised medical officer, medical practitioner, Director of Community Treatment and/or the primary carer of the person can apply to the Tribunal for a CTO.²⁰ When successful, the psychiatric case manager will present a treatment plan to the Tribunal or Magistrate who will determine how the individual will be treated and managed whilst under a CTO.

These treatment plans are tailored to the specific individual so that it suits the circumstances of the individual and also complies with the *Mental Health Act 2007* (NSW). Treatments can include medication as well as therapy and other services,²¹ but the Tribunal has discretion to order individuals to receive treatment at a mental health service.

Once under a CTO, its conditions apply to the individual for any period up to 12 months, as dated on the order, or ends 12 months after the order was made.²²

If a person breaches the CTO, they may be taken to a mental health facility where they will undergo involuntary treatment and may be detained under s 58. If the individual is detained, within the following 3 months, the authorised medical officer must bring the person before the Tribunal to be reviewed under s 63.

Extent of CTO Use

The use of Community Treatment Orders is prevalent in Australia, New Zealand, 41 states in the USA, and in the UK since 2008. The only other jurisdictions that utilise CTOs are Israel, Scotland and nine provinces in Canada, all of which have adopted the legislation since late 2005. The rate of CTOs imposed range from an average of 2 per 100,000 in Canada, to 40-60 per 100,000 in Australia.²³ The rate of CTO imposition varies within Australia, with 46.6 per 100,000 people in

¹⁸ *Mental Health Act 2007* (NSW), s 53(2)

¹⁹ *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315.

²⁰ *Mental Health Act 2007* (NSW), s 51(2)

²¹ Department of Health (WA), *Community Treatment Orders: A Review* (December 2001) 3.

²² *Mental Health Act 2007* (NSW), s 56(2)

²³ Edwina Light et al, 'Community treatment orders in Australia: rates and patterns of use' (2012) 20(6) *Australasian Psychiatry* 478, 478-482.

New South Wales in 2012 and only 30.2 in Tasmania. Victoria has the highest rate of CTO imposition within Australia, with a rate of 98.8 per 100,000.²⁴

Scholars have argued that CTOs are overused in the Victorian jurisdiction and that this has led to the reduced standard of care.²⁵ This is especially alarming as rates across the country continue to rise.²⁶ Lawton-Smith's analysis recorded a CTO usage rate of 37.4 per 100 000 people in 2003 in NSW. According to Light et al, this rate has now risen to 46.4 per 100 000 in 2010-11, and in comparison, Victoria's rate has nearly doubled, going from 55 per 100 000 in 2003 to 98.8 per 100 000 in 2010-11.²⁷

More recently, the number of CTOs made in NSW increased by 10.3% over 2012-13 as compared to the previous year, corresponding with 483 additional hearings to reach a total of 5180 over the year.²⁸ Out of these hearings, 3253 hearings concerned males and 1927 hearings concerned females, as compared with 2998 and 1699 hearings respectively from 2011-12.

On the other hand, the number of CTOs being made for a longer duration (more than 6 months) is steadily decreasing, and now only comprises 8.2% of all cases.²⁹

Nevertheless, the number of people subject to an Order at 30 June 2013 was higher than the figure recorded at the same date in the previous year, signifying an increase from 2709 individuals to 2763 individuals.³⁰ More worryingly, 1125 CTOs were made from 1233 applications for people not detained or on an existing CTO, relative to 1063 Orders made from 1156 applications from a year earlier.³¹

The critical factor that determines the prevalence of CTOs within a jurisdiction is the sentiment of medical officers that make the applications to judicial bodies. The perceived advantages and disadvantages that such practitioners would consider, include:³²

- The potentially large amount of authority CTOs confer upon them to treat outpatients, in comparison with other lawful approaches to treatment they could employ
- Potential reductions in cost for the patient's treatment in using mainly community mental health services, rather than formal health institutions
- The expectations of the community concerning clinicians' use of the scheme
- The administrative burdens involved in treating a patient under it
- The liability concerns of clinicians who treat patients under it
- The extent to which involuntary treatment may have a negative impact on

²⁴ Ibid.

²⁵ Nicholas Owens & Lisa Brophy, 'Revocation of Community Treatment Orders in a mental health service network' (2012) 21(1) *Australasian Psychiatry* 46, 46-50.

²⁶ Edwina Light et al, 'Out of sight, out of mind: making involuntary community treatment visible in the mental health system' (2012) 196(9) *Medical Journal Of Australia* 591-593.

²⁷ Edwina Light et al., 'Community treatment orders in Australia: rates and patterns of use' (2012) 20(6) *Australasian Psychiatry* 478, 478-482.

²⁸ Mental Health Review Tribunal (NSW), *2012/13 Annual Report* (2013).

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Dawson, 'Fault-lines in community treatment order legislation' (2006) 29 *International Journal of Law and Psychiatry* 482, 482-494.

therapeutic relationships, particularly the effect of the stigma and coercion experienced by the patient.³³

Criticisms of CTOs

While research has shown that the use of CTOs has been effective in reducing vulnerability and improving psychosocial functioning, the challenge such orders pose to an individual's autonomy prompts a critical consideration.

Ineffective?

Evidence regarding the effectiveness of CTOs remains contentious and inconclusive worldwide. As the sanction of CTOs is a discretionary process, many have concluded that it is largely public opinion and a fear of "stranger danger" which drives the enthusiasm for CTO legislation. In NSW, CTOs seem to be used as a 'safety valve'³⁴ to react to the pressure placed on the mental health and criminal justice systems as a consequence of deinstitutionalisation.

Scholars have argued that the use of CTOs in freeing up expensive bed use is an attractive prospect, and wrongfully so. The imposition of CTOs should be made with due consideration as to the most effective course of action, not the easiest. Reliance on CTOs shifts the community's focus and resources from exploring voluntary avenues of treatment, and establishes coercion rather than trust and voluntariness as the basis for treatment.

A 2011 study conducted by the University of Queensland found that although the risk of victimisation decreases with court-ordered Outpatient Commitment (OPC), the equivalent of CTOs in the USA, it would take 85 OPCs to prevent one readmission, 27 to prevent one case of homelessness and 238 to prevent one arrest.³⁵ Countries with a long history of CTOs such as Australia, New Zealand and Canada, have had no significant decrease in the overall rates of homicides by the mentally ill.

Legislation on outpatient commitment schemes in the United States is also frequently used as an "extension of the state's powers" to treat individuals whilst they are in the community through involuntary medication. It is argued that such provisions are necessary to achieve deinstitutionalisation and the need to supervise those who need medical attention in the community. However, little evidence supporting the benefits and effectiveness of mandatory community treatment has been found, specifically in relation to health service use, social functioning, mental state and quality of life, when compared to standard care.³⁶

Similarly, Professor Tom Burns conducted the UK's largest randomised trial of CTOs and concluded that they are ineffective and unnecessary.³⁷ Although the aim of CTOs was to reduce

³³ A Gibbs et al, 'How mental health clinicians view community treatment orders: a national New Zealand survey' (2004) 38(10) *Australian And New Zealand Journal Of Psychiatry* 836, 836-841.

³⁴ Edwina Light et al., 'Community treatment orders in Australia: rates and patterns of use' (2012) 20(6) *Australasian Psychiatry* 478, 481.

³⁵ S R Kisely, L A Campbell, N J Preston, 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders' [2011] (2) *Cochrane Database of Systematic Reviews* 1, 1-44.

³⁶ Kisely, SR, Campbell LA & Preston NJ 2011. Compulsory community and involuntary outpatient treatment for people with severe mental disorders.

³⁷ <http://www.ox.ac.uk/media/news_stories/2013/130326.html>

the number of patients being readmitted to hospital when they failed to continue taking their medication, it was found that similar rates of patients were readmitted within the year regardless of whether they were under a CTO or not. These findings support the argument that CTOs alone are insufficient and largely dependent on adequate community support networks.³⁸

Counterproductive?

The stigmatisation and labelling of persons with mental illness is another main driver for the use of CTOs. These practices contribute to the view of mental illness as something to be feared, avoided and ruthlessly monitored withstanding any incursion on the individual's liberty and autonomy. Such views not only increase public support for the legislation, but can also deter the mentally ill from seeking voluntary help and treatment.³⁹

CTOs have been found to reinforce these stigmas and cause patient dissatisfaction, which can cause individuals to stop seeking help, and taking medication once the order ends. The individual's situation is worsened by the constant surveillance encouraged by CTOs that can cause stress and exacerbate existing mental health problems, often playing into existing paranoid tendencies. Although some patients are able to live in the community, this only provides an appearance of freedom. In reality, feelings of entrapment are rife.

Hindrance to Recovery?

CTOs offend recovery principles sanctioned by international and domestic governing bodies. The removal of a person's agency and self-determination, the sanction of forced treatment and their use to compensate for an under-resourced mental health system undermine the United Nations' Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991) and even the stated objectives and principles of the *Mental Health Act 2007* (NSW).⁴⁰

CTOs also challenge the MHRT's own recent acknowledgement and encouragement of recovery principles,⁴¹ which seek to involve mental health service consumers in their own treatment. CTO use runs contrary to concepts such as self-management, effective advocacy, self-determination and the ability for consumers to lead lives that are meaningful and free.

Discriminatory?

In the UK, concerns have been raised regarding a disproportionate number of black and ethnic minority patients under CTOs. According to the British Labour government's 2005 "Count Me In" census, black men and mixed race men are three or more times likely than the general population to be admitted to a psychiatric unit. Women are two or more times likely to be admitted. The 2011 "Count Me In" census found that 23% of the 32,799 people receiving inpatient care belonged to ethnic minority groups, a 3% increase from 2005. However, this could be partially

³⁸ Snow, 'Community treatment orders: the ethical balancing act in community mental health', (2009), *Journal of Psychiatric and Mental Health Nursing*, 16, 177-186

³⁹ Ibid.

⁴⁰ *Mental Health Act 2007* (NSW), ss 3 and 68.

⁴¹ Mental Health Review Tribunal (NSW), *2012/13 Annual Report* (2013).

due to the general increase in black and minority ethnic population in England and Wales during the years.

In Otago, New Zealand, 14% of patients under CTOs were found to be of Maori descent according to a study done in 2004. At that time, the indigenous people of New Zealand were overrepresented by a 'factor of more than 2 compared with their census numbers in the region'.⁴²

Furthermore, another study asserts that Indigenous populations such as Maori have a historical experience of coercion and misuse of power through government systems including the health system. Racial discrimination against Maori within the New Zealand mental health service is evident, and was reported in a survey of psychiatrists' beliefs about Maori mental health in the *Journal of the Royal Australian and New Zealand College of Psychiatrists*. This is against the United Nations' Declaration on the Rights of Indigenous People, which maintains "indigenous peoples are free and equal to all other peoples... and to be respected as such".⁴³

It was also found that nearly 20% of male psychiatrists surveyed at this time held racist beliefs, and among male New Zealand born psychiatrists with 10 or more years experience, the figure increased to more than 50%.⁴⁴ However, New Zealand already has a strong "treatment" focus on CTOs when compared to other countries, which heightens the concern that CTOs may potentially lead to discrimination and abuse of power in Australia.

Indigenous Australian data regarding Community Treatment Orders is scarce or incomplete due to the nature of Aboriginal communities often being in rural and remote locations, increasing the difficulty of gathering data accurate enough to be a true representation. Indigenous Australians as a whole are generally over-represented in the health system with a higher proportion being affected by a mental illness when compared to the rest of the population.

According to a study done in Western Australia, although 'CTO status did not significantly predict subsequent inpatient admissions', 'Aboriginal ethnicity showed a tendency for Aboriginal people to be admitted more frequently than non-Aboriginal people'⁴⁵. Also, 'residential location showed a tendency for more outpatient contacts to occur in metropolitan areas than in rural or remote areas of Western Australia'⁴⁶. The increased likelihood of Indigenous Australians being subject to inpatient methods rather than outpatient methods appears to be a reflection of both demographic and racial differences.

Another study conducted in Western Australia showed that Indigenous Australians viewed mental illness as an inherent characteristic of the individual and not something that can be addressed via treatment⁴⁷. Therefore, it can be concluded that the state's mental health service

⁴² A Gibbs et al, 'Maori experience of community treatment orders in Otago, New Zealand.' (2004) 38(10) *Australian And New Zealand Journal Of Psychiatry* 830, 830-835.

⁴³ *United Nations Declaration on the Rights of Indigenous People* art 2.

⁴⁴ G Newton-Howes et al, 'Community treatment orders: The experiences of non-Maori and Maori within mainstream and Maori mental health services' (2014) 49(2) *Social Psychiatry and Psychiatric Epidemiology* 267, 267-73.

⁴⁵ N J Preston et al, 'Assessing the outcome of compulsory psychiatric treatment in the community: Epidemiological study in Western Australia' (2002) 324(7348) *BMJ: British Medical Journal* 1244.

⁴⁶ *Ibid*.

⁴⁷ David Vicary, Tracy Westerman, "That's just the way he is': Some implications of Aboriginal mental health beliefs' (2004) 3(3)

would be less likely to be involved and a comparison between Indigenous and non-Indigenous individuals under CTOs would be inaccurate

Despite these conjectures, census data in 2004 recorded 3.2% of Western Australia's population as being Aboriginal, yet 6.8% of CTO patients were Aboriginal, a clear over-representation⁴⁸.

However, it is uncertain whether over-representation of the indigenous population of Australia and New Zealand in the number of patients under CTOs is a reflection of the high numbers of Indigenous peoples who are mentally ill or the discretionary nature of CTOs paving the way for racial discrimination regarding mental health.

Case Studies

In countries that have recently implemented CTOs into their mental health system, a key trigger was a spike in the number of homicides committed by mentally ill people. However, in some nations, a high profile case involving a mentally ill perpetrator has not caused significant shifts in public sentiment.

Christopher Clunis

A key example was the stabbing of Jonathan Zito in the eye by Christopher Clunis, a schizophrenic, on the London underground in 1992. Although an inquiry found a "catalogue of failure and missed opportunity" by professionals who should have been monitoring Clunis,⁴⁹ there is little evidence in support of CTOs as a method of reducing homicide rates perpetrated by the mentally ill. A study in England found that many perpetrators had not previously been in contact with services or had last been assessed as being at low risk.

Paul Chapman

Paul Chapman, a UK resident, was placed under a CTO in 2009, and felt that it affected his relationship with his family and carer. "Instead of them being concerned out of care and compassion for the problem I was having, there was reason for them to be responsible and have authority over me," he says. "It was the mental health equivalent of having a tag. If I became unwell again or stopped taking my medication – like re-offending – I would have gone straight back into hospital." After a few months, he inquired about being taken off the CTO but was turned down: "I felt stigmatised by it. Because of the nature of my condition, I felt other people might know and think, 'He must be bad, he's on a CTO'."⁵⁰

Malcolm Baker

Indigenous Mental Health 103, 103-112.

⁴⁸ R Churchill, *International experiences of using community treatment orders* (Doctoral dissertation, Institute of Psychiatry, Kings College London, 2007).

⁴⁹ <<http://www.standard.co.uk/news/secret-plan-to-move-zito-killer-6814846.html>>

⁵⁰ Sanchez Manning, "Psychiatric Asbos' were an error says key advisor' <<http://www.independent.co.uk/life-style/health-and-families/health-news/psychiatric-asbos-were-an-error-says-key-advisor-8572138.html>>

In June 2011, Malcolm George Baker was placed on a CTO while serving a sentence. Although the primary purpose of a CTO is to allow people to receive the necessary treatment, care and support in a less restrictive environment, for Malcolm, this 'less restrictive setting' is the High Risk Management Unit of Goulburn Jail, a maximum-security prison. In February 2014, he discovered that his CTO had been revoked since August 2012, but the authorities had not notified him of this change. During the intervening period, Malcolm has been forced to accept treatment and medication which caused severe side effects in the belief that he was compelled to undergo this under a Community Treatment Order, when in fact, the order no longer existed.

Michael Riley

Michael Riley, a gentle man with no criminal record and no history of violent behaviour is subject to a CTO that has been consistently renewed for 14 years. He is currently employed at a union and is the loving father of a daughter who has just started primary school this year. He does not agree nor consent to this order, nor does he agree with his diagnosis of Schizoaffective Disorder.

For more information on Michael Riley, please read more [here](#) and watch his [video](#).

In light of the contentious nature of CTOs and their power to strip away the dignity and rights of those that are subject to them, it is imperative that people like Michael be supported in their own personal views for recovery. His proposed for an Advance Directive in November 2013 was rejected by the MHRT and a CTO enforced.

Alternatives to CTOs

Before the creation of CTOs, mentally ill persons were commonly subject to detainment in a specialised facility known as institutionalisation.

Consumer Workers

Consumer workers are people with 'lived experiences' and can identify with the 'person in question', that is, the mentally ill person. This means that they themselves have or had a mental illness, which allows them to empathise with the 'person in question'. A consumer worker would be able to assist the mentally ill person by providing support with an intimate understanding of what they are facing, not just the difficulties of the illness itself but also the social stigma that comes with it.

Advance Directive

An Advance Directive is a written document describing what someone wants to happen to them if they become incapable of making decisions for themselves. It usually refers to medical treatment and care and stipulates where they want to be cared for, by whom and what treatments they consent to. An Advance Directive may also express the person's wishes about any aspect of their life or affairs.

Existing uses for advance directives mainly involve situations near the end of a person's life,⁵¹ for use as a 'living will', but they are now increasingly used in mental health to enable patients to provide input, namely their preferences, into their own care for when they may have an acute episode.

This means that physicians have a means of respecting the patient's prior competent instructions when these conflict with instructions expressed while incompetent. Three main forms of advance directive exist: the instructional directive, the proxy directive and the hybrid directive, which combines the advantages of the former two.

Instructional directives directly communicate instructions to the treatment providers in the event of a mental health crisis, and could contain decisions about hospitalisation, methods for handling emergencies, and people to be given responsibility of children and financial matters. Proxy directives are health care power of attorney documents, which are legal documents allowing the patient to designate someone else to make decisions on their behalf if they become incompetent.

Proxy directives are used more frequently than instructional ones, as the proxy can consider the actual circumstances of the patient's situation once they become incompetent. This effectively substitutes the patient's judgment, rather than requiring the patient to anticipate specific, future events for giving suitable instructions.

Hybrid directives name an individual who is authorised to make treatment decisions on behalf of the patient while also providing instructions to that person. This combines the specificity of the instructional directive with the flexibility of the proxy directive.⁵²

In NSW, advance directives do not directly derive their legal force from legislation, and the *Guardianship Act 1987* (NSW) only implies that a person who lacks capacity may refuse treatment in advance.⁵³ In NSW they may take one of two forms, either incorporated in an *Appointment of Enduring Guardian* or in a separate more informal document. The issue however, is if the wishes of the subject is in conflict with the guardian's authority, the guardian is able to make the ruling decision. Although not legally binding under statute law, they are seen as strongly persuasive especially if consistent, specific and up to date.⁵⁴ Under common law, they can be binding if the criteria of specificity and competence at the time of writing are fulfilled.

The NSW Department of Health also supports the use of advance directives, providing a guideline on its use.⁵⁵

⁵¹ <http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-carer-toc~mental-pubs-i-carer-3~mental-pubs-i-carer-3-4>

⁵² SR Kisely, LA Campbell, 'Advance treatment directives for people with severe mental illness' [2008] (8) *Cochrane Database of Systematic Reviews* 1, 1-44.

⁵³ *Guardianship Act 1987* (NSW), s 33(3).

⁵⁴ Ellison, S, Schetzer, L, Mullins, Perry, J & Wong, K 2004, *The legal needs of older people in NSW*, Law and Justice Foundation of NSW, Sydney

⁵⁵ www.health.nsw.gov.au/policies/gl/2005/pdf/GL2005_056.pdf

In comparison, in states such as Queensland, South Australia and the Northern Territory an advance care directive is a legally binding document.

There is now widespread international support building up for the use of advance directives, especially in the United States, where their use in mental health is widely recognised. Twenty-five states have created statutes explicitly authorising psychiatric advance directives, while nearly all the others permit them through health care advance directives or power of attorney statutes.⁵⁶

In the UK, advance refusals were statutorily enabled by the *Mental Capacity Act 2005* (UK), but treatment deemed necessary for the health and safety of the patient or others is excluded from such refusals under the *Mental Health Act 2007* (UK). While the 2005 Act does not require a record of assessment of capacity, it also states that an advance decision is not applicable if there are reasonable grounds for believing that circumstances have arisen that the person did not expect and that would have affected his/her decision had he/she expected them.⁵⁷ Furthermore, it provides that advance decisions only apply regarding refusal of treatment, and is silent on whether a patient can request particular treatment.

Scottish legislation, on the other hand, includes a comprehensive set of ethical and human rights principles promoting good practices, as exemplified by *The Mental Health (Care and Treatment)(Scotland) Act 2003* (UK), which recognises advance mental health directives through a provision for non-binding advance statements.⁵⁸ The clinician can only override these statements after reasons have been provided to the patient, the patient's guardian, legal representative and the Scottish Mental Welfare Commission.

In Canada, more limited steps have been taken. The Senate Standing Committee on Social Affairs, Science and Technology published a 2006 report recommending that all provinces and territories 'empower mentally capable persons, through legislation, to appoint substitute decision makers and to give advance directives regarding access to their personal health information'.⁵⁹

International Common Law Perspectives on Advanced Directives:

International jurisdictions provide numerous common law examples where the courts have upheld the validity of a patient's directive. However although international cases provide a willingness to accept the implementation of directives many factors need to be considered by the court before the directive can be upheld⁶⁰. It has been suggested that the courts will consider advances in medicine which were not available at the time the directive was fashioned and the imperative requirement that the individual has comprehensive knowledge of their

⁵⁶ Fiona Morrissey, 'Advance Directives in Mental Health Care: Hearing the Voice of the Mentally Ill' (2010) 16 (1) *Medico Legal Journal of Ireland* 21.

⁵⁷ C Johnston, J Liddle, 'The Mental Capacity Act 2005: a new framework for healthcare decision-making' (2007) 33(2) *Journal of Medical Ethics* 94, 94-97.

⁵⁸ Fiona Morrissey, 'Advance Directives in Mental Health Care: Hearing the Voice of the Mentally Ill' (2010) 16 (1) *Medico Legal Journal of Ireland* 21.

⁵⁹ Australian Department of Health, 'International Policy and Program Context', *Identifying the Carer Project*, 24.

⁶⁰ Nina Leo, 'Advanced Directives: The Legal Issues' (2004), *Office of Public Advocate*, 42.

illness⁶¹. The patient's chance of recovery, which may have changed since the directive was made, is also considered⁶².

The English case of *Re T (Adult Refusal of Treatment)* affirmed the importance of d directives stating that while the patient is "competent and properly informed about the consequence of refusing or agreeing to treatment" their direction is binding and should be respected⁶³. This was further reinforced in 1994 with the case of *Re C (Adult: Refusal of Treatment)*⁶⁴. *Ms B v An NHS Hospital Trust* is the most recent authority for d directive cases in England⁶⁵. It was held that her directive should be upheld as a result of her wide-ranging knowledge of the illness and the potential consequence of not being kept on a ventilator so as to respect her "personal autonomy"⁶⁶.

Similarly, there have been numerous cases in Canada that have stressed the importance of directives as a means of respecting self-determination and further ones personal autonomy which is also seen to be of high importance to English courts⁶⁷. This is abundantly evident in the case of *Malette v Shulman*⁶⁸ and *Fleming v Reid* which stressed the fact that a doctor, even in the case of an emergency, "is not free to disregard the patients advance instructions"⁶⁹. Furthermore, *Nancy B v Hôtel-Dieu de Québec*, provides yet another example of the importance of autonomy⁷⁰. It was suggested here that the right to refuse treatment is analogous to the right to be treated and thus, an injunction was provided that ordered the treating doctor to take Nancy off her ventilator⁷¹.

The common law in the United States is also in support of advance directives and have emphasised the importance of autonomy. d directives are seen as a tool for ensuring a patient's wishes are met as expressed in *Cruzan v Director, Missouri Department of Health*⁷². However, although much importance is given to this right where a directive is misinformed or fails to acknowledge the seriousness of the consequences of refusal to accept treatment it will be deemed invalid⁷³. This is seen the case of *Werth v Taylor* where it was found that the patients understanding of her condition was misjudged and failure to provide her with a transfusion would result in death⁷⁴. As a result of her false assumptions about her condition her directive was not upheld.

Though an examination of international common law it becomes clear that there is a willingness to enforce d directives so long as they comply with the requirements outlined above, as notions of autonomy and self-determination are seen as paramount within the international community.

⁶¹ Ibid.

⁶² Ibid.

⁶³ *Re T (Adult Refusal of Treatment)* [1992] 4 All ER 649.

⁶⁴ *Re C (Adult Refusal of Treatment)* [1994] 1 WLR 290.

⁶⁵ *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).

⁶⁶ Ibid, at 94.

⁶⁷ Nina Leo, 'Advanced Directives: The Legal Issues' (2004), *Office of Public Advocate*, 40.

⁶⁸ *Malette v Shulam* (19990) 67 DLR (4th) 321, at 330.

⁶⁹ *Fleming v Reid* (1991) 82 DLR (4th) 289, 310.

⁷⁰ *Nancy B v Hôtel-Dieu de Québec* (1992) 86 DLR (4th) 385.

⁷¹ Ibid & Nina Leo, 'Advanced Directives: The Legal Issues' (2004), *Office of Public Advocate*, 41.

⁷² *Cruzan v Director, Missouri Department of Health* (1990) 497 US 261.

⁷³ Nina Leo, 'Advanced Directives: The Legal Issues' (2004), *Office of Public Advocate*, 41-42.

⁷⁴ *Werth v Taylor* (1991) 475 NW (2d) 426.

Case Study: Michael Riley

In November 2013, Michael Riley prepared an Advance Directive in an effort to avoid a CTO being placed upon him. It essentially stated that before his scheduling under the *Mental Health Act 2007* (NSW) ('*Mental Act*'), one of his three delegates should be contacted for the purposes of devising a substitute plan with a community-based, supportive and therapeutic alternative to the strict and overly intrusive CTO. Despite having presented his directive to the MHRT it was not accepted as a sufficiently effective document and his CTO was renewed. According to the *Mental Act* (NSW) however, s 14 states that coercive treatment is only necessary: a) for the person's own protection from serious harm or b) protection of others from serious harm. This section also states that there must be 'reasonable grounds for believing that care, treatment or control of the person is necessary'.⁷⁵ Michael does not have a criminal history nor has he exhibited violent behaviour in the past. This questions whether the MHRT's refusal of his advance directive was reasonable.

Similarly, *Fleming v Reid*⁷⁶ highlights the importance of right to personal security and autonomy.

Conclusion

This examination of CTOs makes the stringent and invasive nature of the order abundantly clear. It can essentially be seen an infringement on an individual's autonomy, freedom and self-determination. Although an alternative to incarceration in Australia, its restrictive form of compulsory treatments can potentially be seen as a form of detention in that it significantly impedes a person's life. In addition to this, there is no conclusive evidence in regards to their effectiveness, yet they can encourage the further stigmatisation of people with mental illness.

Alternatives to CTOs such as access to consumer workers and the option of establishing an d directive should be considered in place of CTOs to not only work towards reducing the continued stigma that comes with mental illness but also providing the individual with an opportunity to have some sought of control in relation to treatment – when they are of sound mind. Research of other countries that have instituted such alternatives evidence their effectiveness and the importance of allowing individuals have a sense of autonomy as opposed to forced medication.

⁷⁵ *Mental Health Act 2007* (NSW) s 14.

⁷⁶ (1991) 82 DLR (4th) 289.