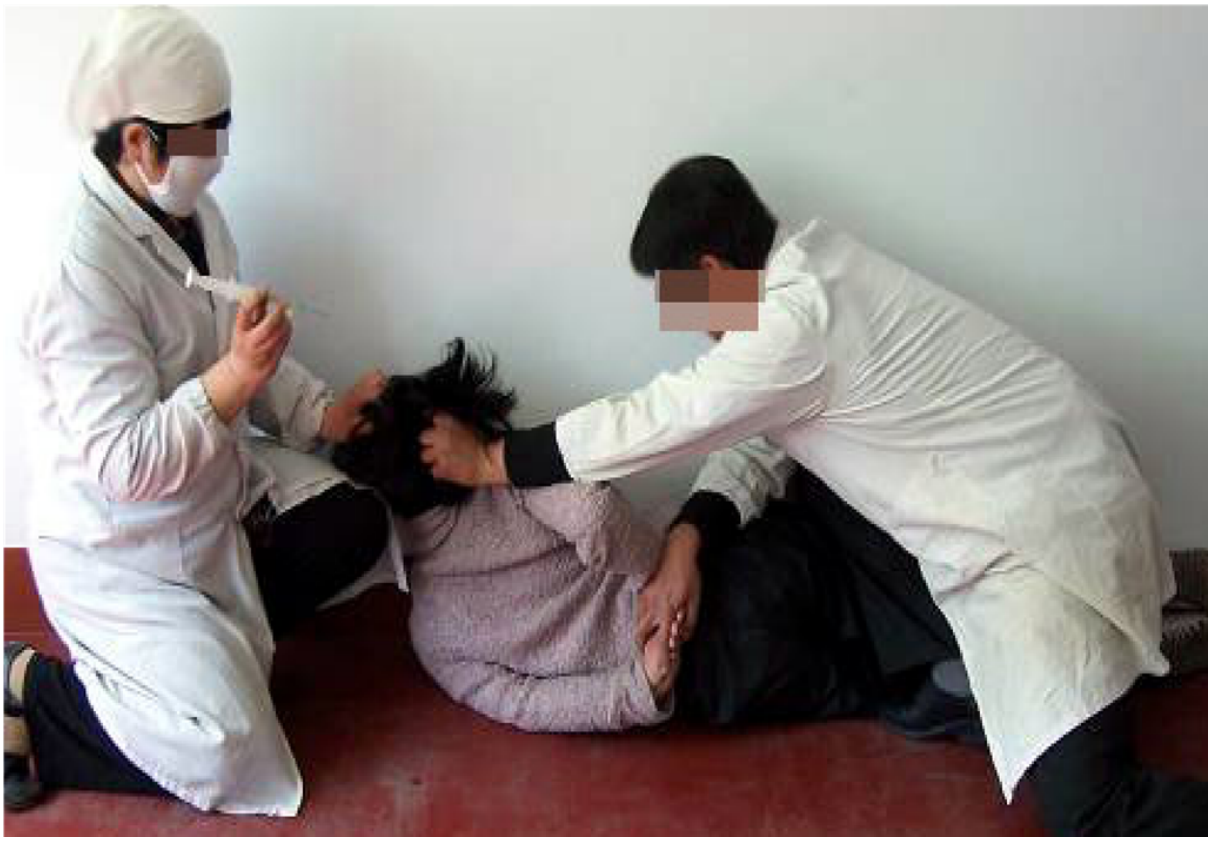
Community Treatment Orders



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Executive Summary

Community Treatment Orders ('CTOs') are legal orders for a person to receive compulsory mental health treatment, as authorised by legislation, without a person's consent. These orders have been continually rising over the years despite this form of 'treatment' generally being limited to use during arrests, hospital stays, and forced medication. This paper will argue that CTOs are ineffective, counterproductive, discriminatory and a hindrance to recovery.

Although the imposition of CTOs operates as the NSW health and criminal justice system's current response to persons seen as a threat to themselves or others, particularly in cases concerning an individual with a history of refusing treatment, their wide scope and intrusive nature enables significant opportunity for misuse and abuse. This is specifically evident in NSW where legislation and practices associated with CTOs are misaligned with those of other Australian states. A 2023 study demonstrates that NSW has one of the highest rates of imposing CTOs worldwide, with 6,767 instances of CTOs issued in 2022 alone. The broad applicability and criteria of CTOs have allowed them to be made into a tool for control rather than a method for rehabilitative recovery focusing on individual needs and the best interests of mental health consumers.

The introduction of CTOs as instruments for deinstitutionalisation is highly problematic as community services are often inadequately funded and the overarching policy lacks transparency and a comprehensive system of accountability. Further, CTOs are coercive and anti-therapeutic as they remove all elements of personal autonomy for individuals with mental illness. The real potential for discrimination and counterproductive outcomes for affected individuals is incredibly detrimental to their wellbeing. Studies have proven the ineffectiveness of CTOs; 85 orders are required in order to prevent 1 readmission, 27 orders to prevent 1 case of homelessness, and 238 orders to prevent 1 arrest. CTOs only further the misconception that mentally ill incarcerated persons are dangerous people who are behaviourally unpredictable and incapable of making decisions for themselves.

The use of CTOs in prisons, also known as Forensic CTOs ('FCTOs'), is unjustified and oppressive. Introduced into NSW in 2011, the primary purpose of legislating FCTOs is for convenience, resulting in an average annual increase of 4% since the 2017/18 period. This further demonstrates the ongoing failure of NSW public policy and practices, given that there is an obligation in NSW for affected incarcerated persons to be transferred to a hospital and receive proper care, which is not occurring due to replacement with CTOs. Prisons now have overwhelming authority to forcibly medicate incarcerated persons under the guise of a CTO, functioning as an extended form of 'prisoner punishment'. This extrajudicial punishment of incarcerated persons, aside from being highly unethical and unjust, has resulted in distrust between prison/medical personnel and incarcerated individuals. This form of coercive control should not be tolerated as it directly conflicts with fundamental human rights afforded to all persons.

Recent case studies, as discussed in this report, highlight the coercive effects of CTOs. These case studies, in the context of legal frameworks and research conducted in this area, evidence the criticisms of CTOs. The examination of CTOs in this report makes these orders' stringent and invasive nature abundantly clear. Most notably, CTOs infringe on an individual's autonomy, freedom and self-determination. Although CTOs serve as an alternative to incarceration in NSW and other Australian states, their restrictive form of compulsory treatment can be seen as a form of detention due to their ability to significantly impede upon a person's life. In addition, there is no conclusive evidence that CTOs are greatly beneficial or effective, yet it can be shown that CTOs instead encourage the stigmatisation of people with mental illness.

Alternatives to CTOs, such as access to consumer workers and the option of establishing a directive, should be considered in place of CTOs to not only work towards reducing the continued stigma that comes with mental illness but also provide the individual with an opportunity to possess some control over their impending treatment when they are of sound mind. Research derived from other countries that have successfully instituted these alternatives to CTOs evidences their effectiveness and the importance of allowing individuals a sense of autonomy as opposed to implementing means of forced medication. Therefore, CTOs in Australia are not fit for purpose and must be reevaluated in order to be used as a valuable tool in rehabilitating individuals with mental illness.

Recommendations

This paper calls for significant and urgent change to the use of Community Treatment Orders at State and Federal levels. The recommendations of this report are as follows:

- To safeguard of Community Treatment Orders to strictly life-threatening situations;
- To abolish the use of Forensic Community Treatment Orders;
- To promote alternatives to Community Treatment Orders; and
- To increase transparency and data collection.

Criticisms of Community Treatment Orders

Ineffective

Evidence regarding 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 misinformation and media fear mongering which drives the enthusiasm for support of CTO legislation. Australian jurisdictions continue to use CTOs at high and varying rates, with reports of higher than previous figures in all jurisdictions.[1] Despite the mixed evidence regarding the efficacy of these orders, NSW has some of the highest rates of CTOs worldwide.[2] In NSW, CTOs seem to be used as a 'safety valve'[3] to react to the pressure placed on the mental health and criminal justice system as a consequence of deinstitutionalisation, as well as the severe under-staffing and lack of resources available to health professionals.

Scholars have argued that the use of CTOs in freeing up expensive hospital beds is an attractive prospect. The imposition of CTOs should be made with due consideration as to the most effective course of action, not the easiest or most economic. 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.[4] 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 those who are deemed 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.[5]

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[1] Edwina Light, 'Rates of use of community treatment orders in Australia.' (2019) *Int J Law Psychiatry* 64, 83–7.
[2] NSW Mental Health Review Tribunal, *Annual Report 2022* (Report, 2022) 14 ('*NSW MHRT Annual Report 2022*').
[3] Edwina Light et al, 'Community treatment orders in Australia: rates and patterns of use' (2012) 20(6) *Australasian Psychiatry* 478, 481.
[4] 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.
[5] Ibid.

Similarly, Professor Tom Burns conducted the UK's largest randomised trial of CTOs and concluded that they are ineffective and unnecessary.[6] Although the aim of CTOs was to reduce 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.[7]

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.[8]

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 involved in CTOs that can cause stress and exacerbate existing mental health problems, often playing into existing paranoiac 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 the stated objectives and principles in sections 3 and 68 of the *Mental Health Act*.[9]

CTOs also challenge the Mental Health Review Tribunal's own recent acknowledgement and encouragement of recovery principles,[10] which seek to involve mental health service consumers in their own treatment. CTO use runs contrary to concepts such as

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[6] 'Compulsory treatment orders for mental illness need reviewing', *University of Oxford* (Web Page, March 2013) <http://www.ox.ac.uk/media/news_stories/2013/130326.html>.
[7] N Snow and 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.
[8] Ibid.
[9] *2007* (NSW) ('*Mental Health Act*').
[10] Mental Health Review Tribunal (NSW), 2012/13 Annual Report (2013).

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 due to the general increase in black and minority ethnic populations 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'.[11]

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* (2007), which maintains "Indigenous peoples are free and equal to all other peoples… and to be respected as such".[12]

The study 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%.[13] 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.

Aboriginal and Torres Strait Islanders 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. However, data specifically addressing CTO's and Aboriginal and Torres Strait Islanders is scarce or incomplete due to rurality and geographic remoteness. This has

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[11] 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.
[12] *United Nations Declaration on the Rights of Indigenous People* (2007) art 2.
[13] 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.

increased the difficulty of gathering accurate, valid and reliable data thereby preventing a true representation of First Nations communities and associated incidence of CTOs.

According to a Western Australian study, 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".[14] Also, "residential location showed a tendency for more outpatient contacts to occur in metropolitan areas than in rural or remote areas of Western Australia".[15] The increased likelihood of First Nations Australians being subject to inpatient methods rather than outpatient methods appears to be a reflection of both demographic and racial targeting.

Another study conducted in Western Australia showed that First Nations Australians viewed mental illness as an inherent characteristic of the individual and not something that can be addressed via treatment.[16] Therefore, it can be concluded that the state's mental health service would less likely 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-representation.[17]

It is also worth noting here that there is limited data on the relationship between CTOs and rural and remote communities, with a particular knowledge gap on the relationship between CTOs and First Nations peoples. More comprehensive research needs to be pursued to understand the targeted and oppressive implementation of CTOs on these groups, and to pinpoint geographical and social groups requiring greater assistance and access to CTO alternatives. However, in undertaking this research, policymakers and researchers must actively avoid furthering misrepresentations of disparity, deprivation, disadvantage, and dysfunction within these data sets. The process and outcomes of this data collection must be transparent in order to enable review and accountability.

Arguments from Stakeholders

Society should never coerce individuals to take treatment, but CTOs extend coercion to the community. The use of CTOs violates a person's human rights, including the invasion of privacy and personal autonomy. It puts people at risk of being subjected to new forms of social control without proper legal protection owing to the flaws in its application.[18] There cannot be any ethical justification to serely deprive any person of their freedom and liberty

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[14] 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.
[15] Ibid.
[16]David Vicary, Tracy Westerman, 'That's just the way he is': Some implications of Aboriginal mental health beliefs' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 103.
[17] R Churchill, 'International experiences of using community treatment orders' (Doctoral dissertation, Institute of Psychiatry, Kings College London, 2007).
[18] Reinhard Heun, Subodh Dave and Paul Rowlands, 'Little evidence for community treatment orders – a battle fought with heavy weapons' (2016) 40(3) *BJPsych Bulletin* 115-118.

without any proper evidence. There has been research examining the experience from relative stakeholders: the mental health professions, the patients and their family members about the implementation of CTOs.[19]

Many mental health professionals expressed unhappiness about forming the relationship with the patient under legislation and medications administered, which was strongly influenced by the law. Despite the coercive nature of CTOs, the implementation of such treatment requires trust between the administrator and patient. Interviews conducted in 2019 with those currently on CTO and mental health workers in Adelaide, Australia have shown patients have diverse experiences when it comes to CTOs and trust plays an important role in a patient's response to a mental health worker.[20] However, strength of trust comes with duration and experiences in interaction, and the lack of time given to mental health workers with patients hinders the opportunity of trust. Thus mental health professionals are unhappy about the lack of time they are spending with their patients[21] limiting their ability to provide treatments. More than 70% of the professionals argued that due to the policy, inappropriate patients may get released to the community and their major concerns stem from this.[22]

Although in some cases CTOs may have a beneficial outcome for the patient, many of these instances were associated with continuing medication and ill-health.[23] The patients all saw limitations from CTO, including the side-effects of forced medication, stigmatisation and lack of control. Further, many experienced an invasion of privacy due to continuous supervision and monitoring, which deprived them from their freedom as stigmatisation promoted negative emotions among individuals. A study from the 2005 New York State Office of Mental Health discusses the impact of CTOs on a person's dignity, suggesting more than half of the interviewed patients reported feeling embarrassed and angry about being put on a CTO.[24] Two large cohort studies indicated that in general there is no significant improvement of CTOs as evidence shows CTO patients were more likely to be readmitted to hospital.[25]

The family members of the patients may also be affected by the labels intrinsically attached to CTOs. A study conducted in Oregon found that some family members agree the CTO to be useful since around 50% believed that their relatives were dangerous. In addition, there seemed to be a lack of understanding of CTO from the family members, as only 44% of them were aware that CTO is an option of the state.[26] Furthermore, lack of outpatient care, fear of the mentally ill and inability to provide the care were also cited as factors against the CTOs.

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[19] Churchill (n 15).
[20] John McMillan, 'Trust and Community Treatment Orders' (2019) 10(349) *Front Psychiatry*.
[21] Gibbs et al (n 9).
[22] Glenn W Currier 'A survey of New Zealand psychiatrists' clinical experience with the Mental Health (Compulsory Assessment and Treatment) Act of 1992'(1997) 110(1036) *The New Zealand Medical Journal* 6.
[23] Gibbs et al (n 9).
[24] Churchill (n 15).
[25] Ibid.
[26] B H McFarland et al, 'Family members' opinions about civil commitment' (1990) 41(5) *Hospital & Community Psychiatry* 537, 537-540.

Legal Framework

Defining Community Treatment Orders

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. According to the *Mental Health Act*, the Mental Health Tribunal authorise medical practitioners to apply for an order on a patient they are familiar with, and who is detained or in a mental health facility.[27] Countries that have enacted legislation for community supervision orders (also called community treatment orders) usually require persons with mental disorders to reside at a specified place, and to attend prescribed treatment programs that include counselling, education and training.[28] CTOs also allow mental health professionals to have access to the individual's residence. In doing so, the affected persons have little choice but to submit to involuntary psychiatric treatment.

CTOs are only valid under certain situations. Firstly, health departments assert that people who have a severe and chronic mental illness,[29] such as schizophrenia and bipolar depression,[30] who authorities believe lack the capacity to think rationally, or are likely to put others in serious danger,[31] should accept CTOs. Secondly, the medications received by the patients were ineffective in remission and after a benefit-disadvantage evaluation, the patient refused to continue the treatment due to various reasons, such as the side effects burden, inability to prevent relapse and maintain wellbeing. Thirdly, hospital readmission is considered to be coercive in patients and they are unsuitable to be monitored in hospitals due to negative experiences. Lastly, the patients need to be fully familiar with the process of CTO's and understand the conditions when undergoing the CTO. Without any of the above conditions, CTO cannot be implemented. The imposition also 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 purported objective of a CTO is to prioritise treatment of the mentally ill while they live in the community as opposed to 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".[32] 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

[27] *Mental Health Act* (n 7).
[28] World Health Organisation <http://www.who.int/mental_health/resources/en/Legislation.pdf>.
[29] Department of Health (WA), Community Treatment Orders: A Review (December 2001) 3.
[30] Ibid.
[31] World Health Organisation <http://www.who.int/mental_health/resources/en/Legislation.pdf>
[32] Department of Health (WA), Community Treatment Orders: A Review (December 2001) 3.

life involving engagement through education and employment.[33] 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 been more prevalent and 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:

1. People on conditional release from an involuntary admission need to be treated 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 admission criteria but are at risk of meeting them are given a preventative order; or
4. Court-ordered treatment under guardianship law involving interventions like medications. Rehospitalisation may occur if the client does not adhere to treatment.[34]

Today, using CTOs has proved to be an inefficient and poorly justified means of deinstitutionalisation. The compulsory nature of treatment is 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,[35] calls for reform are not surprising.

Imposing a Community Treatment Order

In New South Wales, community treatment orders are established pursuant to Part 3, Chapter 3 of the *Mental Health Act 2007* (NSW).[36] S 51(1) of the Act gives the Mental Health Review Tribunal (MHRT) or a Magistrate the power to grant a CTO.[37] The vast majority of CTOs are made by the MHRT, rather than by a Magistrate.[38]

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[33] 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.
[34] Snow and Austin (n 5).
[35] 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.
[36] *Mental Health Act* (n 7).
[37] Ibid s 51(1) .
[38] Mental Health Review Tribunal (NSW), 2012/13 Annual Report (2013).

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.[39] Under s 51(3) an application may be made about a person who is detained in (or a patient of) a mental health facility or a person who is not in a mental health facility.[40] Under s 51(4) a CTO may also be made about someone who is subject to a current CTO.[41] A CTO may also be applied in various circumstances and may replace existing orders under s 51(5). Therefore, anyone could potentially be a subject to a CTO, including prisoners, as long as the person applying for the order meets the criteria under s 51(2).[42]

Criteria

The Mental Health Review Tribunal may issue a CTO if:

a) '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';[43]

b) The nominated mental health facility can effectively implement an appropriate treatment plan for the person;[44] and

c) The affected person has a previous history of refusing to accept appropriate treatment if they have previously been diagnosed with a mental illness.[45]

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.[46]

According to ss 4 and s 14, a mentally ill person is one who has a condition that seriously impairs their mental functioning, and where there are reasonable grounds for believing that care is necessary for that person's own protection and protections of others from serious harm.[47] 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.[48] 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 the processing and implementation of a CTO.

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[39] *Mental Health Act* (n 7) s 51(3).
[40] Ibid s 51(3).
[41] Ibid s 51(5).
[42] Ibid s 51(2).
[43] Ibid s 53(3)(a).
[44] Ibid s 53(3)(b).
[45] Ibid s 53(3)(c).
[46] Ibid s 53(2).
[47] Ibid ss 4, 14.
[48] *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315; *Mental Health* (n 7); s 53(4).

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.[49] 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*.[50] Treatments can include medication as well as therapy and other services,[51] 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.[52] 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.[53] 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.[54]

The strenuous nature of this legal process, discretionary powers granted to the Tribunal or Magistrates in determining what is 'appropriate' for an individual and harsh consequences of detainment attached to breaching a CTO further causes concern when considering the issues arising from implementing CTOs in the first place.

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[49] *Mental Health Act* (n 7) s 51(2).
[50] Ibid.
[51] Department of Health (WA), Community Treatment Orders: A Review (December 2001) 3.
[52] *Mental Health Act* (n 7) s 56(2).
[53] Ibid s 58.
[54] Ibid s 63.

Extent of Community Treatment Order Use

The use of CTOs is highest in Australia and New Zealand by world standards, even though 41 states in the USA, and the UK legislate for the use of CTOs.[55] 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 in Australia varies between states, ranging from 41 per 100,000 in Western Australia, to 108.4 per 100,000 in Victoria. South Australia has the highest rate of CTO imposition within Australia, with a rate of 112.5 per 100,000.[56] These figures for each state have significantly increased compared to 46.4 per 100,000 in 2010-11.[57] New South Wales witnessed a 6% increase, resulting in 6,767 CTOs made in 2022.[58] Scholars have argued that CTOs are overused in jurisdictions and that this has led to the reduced standard of care.[59] This is especially alarming as rates across the country continue to rise.[60]

According to the 2022 NSW Mental Health Review Tribunal Annual Report, in the year ended 30 June 2021, there were 679 new CTO applications, a 12% increase in hearings compared to the number of CTO applications (5,857 hearings) in the same period. This resulted in 6,556 applications for CTO. There was an 18% increase in the number of individual customers compared to 2021, with 4,227 individuals, resulting in a total count of 4,985 individuals. Moreover, the number of CTOs attributed to mental health inquiries has also increased since 2021. The number of CTOs rose to 896 (compared to 868 in 2021), accounting for 15.8% of all inquiries. With reference to the *Mental Health Act*, a CTO can only be imposed for up to 12 months. The data from the Annual Report revealed that the majority of CTO's lasted for six months or less (90%).[61]

The critical factor that determines the prevalence of CTOs within a jurisdiction is the sentiment of the tribunal, and medical officers that make the applications to judicial bodies. The tribunal holds the authority to determine the circumstances under which a CTO can be imposed. In 2022, there was a surge in the number of individuals being placed under such orders, reaching 3,734 compared to 3,146 in 2021, while the revocation of CTOs remained relatively low.[62] This situation raises concerns and highlights the importance of understanding the individual's needs and the need for the tribunal to exercise careful consideration when imposing CTOs. The Chief Psychiatrist of Western Australia expresses concern of the significant risks of psychiatrists holding too many CTOs, discussing "they may not have

[55] Kisely S, McMahon L and Siskind D, 'Benefits Following Community Treatment Orders Have an Inverse Relationship with Rates of Use: Meta-Analysis and Meta-Regression' (2023) 9 *BJPsych Open* 68.
[56] Light et al (n 1).
[57] Light et al (n 2) 478.
[58] NSW Mental Health Review Tribunal, *Annual Report 2022* (Report, 2022) 14 ('*NSW MHRT Annual Report 2022*').
[59] Nicholas Owens & Lisa Brophy, 'Revocation of Community Treatment Orders in a mental health service network' (2012) 21(1) *Australasian Psychiatry* 46, 46-50.
[60] Light et al (n 1).
[61] *NSW MHRT Annual Report 2022* (n 56) 24.
[62] Ibid 36.

enough time to adequately get to know their patients" and may not be able to provide effective service.[63] The rise in CTOs emphasises the urgency of ensuring thoughtful decision-making and a thorough understanding of the patient's situation.

Perceived advantages and disadvantages that such practitioners would consider includes 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;
- Expectations of the community concerning clinicians' use of the scheme;
- Administrative burdens involved in treating a patient under it;
- Liability concerns of clinicians who treat patients under it; and
- Extent to which involuntary treatment may have a negative impact on therapeutic relationships, particularly the effect of the stigma and coercion experienced by the patient.[64]

[63] Prescribed Medical Practitioners under the Mental Health Act 2014 and Mental Health Act Regulations 2015 (Report, 2022) 5.
[64] John Dawson, 'Fault-lines in community treatment order legislation' (2006) 29 *International Journal of Law and Psychiatry* 482, 482-494; 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.

Community Treatment Orders & Forced Medication

A CTO is made by the Mental Health Review Tribunal, authorising mental health officers and professionals to carry out treatments on patients without requiring consent.[65] Forced medication refers to the administration of medications to patients in order to 'temporarily' restrict the patient's 'freedom of movement'.[66]

The Tribunal can only make a CTO when the person is in a mental health facility or detained, and fulfils the requirements of being practical and feasible to apply treatment. The outcome of the CTO must be 'appropriate' for the reason of treatment and will have the least harm on the person.

Relationship Between CTOs and Forced Medication

Regarding the relationship between CTO and forced medication, CTO can be considered as a technique to treat the patients with mental disorders while forced medication can be one of the ways to implement the CTO issued by the Tribunal. When a CTO is issued, authorities are able to force the patient to consume medications to treat their mental illnesses without the patients' consent or approval.

Both of these actions are required to be performed under reasonable grounds.
CTO's are a designed treatment plan for an affected patient under the determination of application form the Tribunal.[67] Forced Medication is the act of performing an involuntary treatment in conditions which can cause serious harm and is permitted by the tribunal.

Mental Health Outcome Assessment Tool (MH-OAT)

The Mental Health Outcome Assessment Tool is used as a state-wide record to keep the progress of the clinical interaction between patients and carers. This initiative provides clinicians access to documents for triage, assessment, past history, care planning of the affected person, allowing mental health services to work more efficiently.[68] However, in accordance with s 14 of the *Mental Health Act,* this tool is not being admitted as the primary assessment of "mental illness" yet.[69] As a tool for reasoning the application for forced medication under approval of the Tribunal, it is worthwhile to consider the mechanisms restricting the power of CTO.

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[65] *Mental Health Act* (n 7) s 51.
[66] Irina Georgieva, C L Mulder and A Wierdsma, 'Patients' Preference and Experiences of Forced Medication and Seclusion' (2012) 83 *Psychiatr Q* 1, 1-13.
[67] *Mental Health Act* (n 7) s 53.
[68] 'Mental Health Outcomes and Assessment Tool (MH-OAT)', NSW Health (Web Page, November 2022) <https://www.health.nsw.gov.au/mentalhealth/professionals/Pages/mhoat.aspx>.
[69] *Mental Health Act* (n 7) s 14.

The responses of patients underscore the extent of adverse outcomes of CTO's. Patient preferences are associated with prior experiences. Patients without prior coercive experiences or who had experienced both seclusion and forced medication, favoured forced medication. Although those who had been secluded preferred seclusion as intervention in future emergencies.[70] Thus, forced medication is not the solution for CTO's, and patients preferring other mechanisms of treatment such as seclusion should not be ignored. These patients' individual choices should be considered and implemented in MH-OAT to ensure clinicians and carers provide a more appropriate and less harmful approach in assisting patients when they are unable to do so themselves. Through this it can potentially provide a better response from patients in circumstances for which CTO is administered.

[70] Georgieva et al (n 65).

Forensic Community Treatment Orders

Please be advised that this paper provides only a brief overview of FCTOs, for a more comprehensive analysis see the '**Forensic Community Treatment Order**' report prepared by Justice Action. This report places the issue of FCTOs within its broader social and legal framework, identifies the current legislative regime, explores key criticisms and findings of the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*, and examines the Queensland mental health system as a best practice model of mental health management, in order to assert the need for suitable alternatives in NSW to preserve the wellbeing and rights of individuals.

Forensic Community Treatment Orders ('FCTOs') authorise the forcible medication of individuals with mental illness within prison. These orders can apply to both incarcerated persons who develop a mental illness while in prison and to forensic patients who are detained in a prison. FCTOs raise a number of ethical issues, namely the breach of one's entitlement to equivalent treatment, the denial of the right to autonomy and bodily integrity, and the failure to properly administer care for vulnerable individuals within highly restrictive prison environments. Despite this knowledge FTCOs continue to be used in NSW, the only jurisdiction in Australia to do so.

As such, this paper calls for the withdrawal of s 99(1)(c)-(d) of the *Mental Health And Cognitive Impairment Forensic Provisions Act 2020* and consequently the cessation of FCTO administration in NSW prisons. Incarcerated people experiencing serious mental health issues should be transferred to the appropriate State or Federal Health Department, and alternative options should be considered and implemented. For those remaining in prison, formal alternatives such as counselling and complementary therapies are recommended. Additionally, informal alternatives including open dialogue, quality time with friends and families, and peer-mentoring with trained prisoners, should be implemented. Alternative options will prevent the overreliance on pharmaceuticals to treat mental health issues, and will ensure a holistic approach to the care and treatment of prisoners. Access to external services and the implementation of tablets or computers within prisons will enable individuals to take responsibility for their own health and seek appropriate support.[71]

Over the past seven years, there has been a steady rise in the application and outcome of FCTOs. From 2021, there has been a notable increase of 19% in FCTOs, and in the past five years an increase of 9%. In 2022, a total of 215 patients were detained in hospitals, with 206 being forensic patients. Additionally, 199 individuals were held in prisons such as Long Bay Correctional Complex, and Long Bay Hospital, with 65 of them being forensic patients.[72]

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[71] See 'World First: Computers in Prison Cells with Phones', Justice Action (Web Page, 27 November 2020) <https://justiceaction.org.au/world-first-computers-in-prison-cells-with-phones-2/>.
[72] *NSW MHRT Annual Report 2022* (n 56) 10.

Case Studies

Christopher Clunis

A key example of the ineffectiveness of CTOs includes Christopher Clunis. Diagnosed with schizophrenia, Clunis committed a stabbing of Jonathan Zito in the eye on the London underground in 1992. Although an inquiry found that there was a "catalogue of failure and missed opportunity"[73] by professionals who should have been monitoring Clunis, 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.[74]

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 a reason for them to be responsible and have authority over me," Chapman 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'".[75]

Malcolm Baker

In June 2011, Malcolm 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,

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[73] Ellen Widdup, 'Secret plan to move Zito killer', *Evening Standard* (Webpage, 13 April 2012) <https://www.standard.co.uk/hp/front/secret-plan-to-move-zito-killer-6814846.html>.
[74] Alison Baird et al, 'Homicide by men diagnosed with schizophrenia: national case–control study' (2020) 6(6) *BJPsych Open* 1, 4.
[75] Sanchez Manning, ''Psychiatric Asbos' were an error says key advisor', *Independent* (WebPage, 14 April 2023), <http://www.independent.co.uk/life-style/health-and-families/health-news/psychiatric-asbos-were-an-error-says-key-advisor-8572138.html>.

he discovered that his CTO had been revoked since August 2012, but appropriate 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 CTO, when in fact, the order no longer existed. As a result, the procedures surrounding CTOs appear highly ineffective.

Michael Riley

Michael Riley is currently subject to a CTO that has been consistently renewed for over 16 years despite possessing no criminal record and no history of violent behaviour. He is currently employed at a union and is the loving father of a daughter who has just started primary school this year. Riley has never agreed nor consented to the imposition of the CTO, and does not agree with his diagnosis of Schizoaffective Disorder. Riley has cited feeling like his treatment is likened to a criminal, particularly as he has faced forceful arrests leaving him with hospitable injuries. 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 proposal for an Advance Directive in November 2013 was rejected by the MHRT and a CTO enforced. For more information on Michael Riley, please read more here and watch his video.

T v South Western Sydney Local Health District[76]

The plaintiff, T, was subject to a CTO by the Mental Health Review Tribunal on 11 November 2021, despite a lack of any suggestion that they were "an involuntary patient" and thus a "person under legal incapacity" prior to the determination.[77] T was subjected to a dose of 405 milligrams of Olanzapine fortnightly by depot injection. T argued this administration was unnecessarily debilitating, resulting in various side-effects and unduly interfering with employment opportunities.[78] Instead, T argued that a smaller, equivalent dose administered orally daily would have been less debilitating.[79] The defendant accepted oral injection could be taken as an alternative for depot injection, but did not trust T to self-administer the medication.[80]

On appeal, the trial judge determined T did not meet the requirement of a CTO pursuant to ss 53(3)(a)-(b) in that 'care of a less restrictive kind' was available in the form of oral medication.[81] The judge also determined that T was not 'likely to continue in… or relapse into an active phase of mental illness' if the CTO was revoked.[82] Such statements reflect the

[76] [2022] NSWSC 1173 ('*T v South Western*').
[77] *Civil Procedure Act 2005* (NSW) s 3(1).
[78] *T v South Western* (n 75) [38].
[79] Ibid.
[80] Ibid.
[81] Ibid; *S v South Eastern Sydney & Illawarra Area Health Service* [2010] NSWSC 178.
[82] *T v South Western* (n 75) [167].

flaws evident in CTOs, particularly where less stringent aid can be provided with similar, if not better, benefits tailored to the individual.

Kerry O'Malley

Since 2017, Kerry O'Malley has been subjected to CTOs she did not consent to and has been forcibly medicated despite never exhibiting threatening behaviour to herself or to the community. As a result, she has been stripped of her dignity and autonomy, facing countless mental and physical health repercussions. These health implications include anxiety, depression, poor concentration, weight gain, and loss of hair. She is one of 17,000 Australians who are currently forcibly injected under CTOs, and her story represents the mistreatment those in the Australian mental health system and prisons face.[83] In July 2020, Kerry achieved a huge personal victory when the NSW Supreme Court accepted her case that the authorisation of forced injections was unlawful, and the court directed NSW Health to pay her legal costs. The impact that CTOs have had on O'Malley have been devastating, and only prove they fail to provide any true improvement to the health of those who suffer most.

Nathan Chetty

In 2015, Nathan Chetty was subject to forcible treatments under a CTO, which consisted of involuntary hospitalisations and monthly injections of antipsychotic medication accompanied with strict surveillance measures.[84] In 2022, Chetty's situation escalated when he was arrested and detained at the Concord Hospital for a total of six days. During this period, Chetty was repeatedly subject to his injections despite his full lack of consent, and was not being provided valid justifications other than undisclosed reasons of 'safety'. Consequently, Chetty had to undergo a completely revised treatment arrangement made at the full discretion of the Tribunal, which led them to breach Chetty's CTO conditions. Although Chetty has now been able to pursue his own medical treatment plans following the discontinuation of his CTO in April 2023, the level of force which he experienced without proper consultation highlights the dangers of lacking regulations over the implementation of CTOs and how they are enforced by authorities.

From these case studies, it is clear that CTOs are often wrongly enforced by authorities despite their allegedly 'strict' application, reflecting their harmful and lasting impact on vulnerable individuals. Thus, CTOs must be stopped as they fail to genuinely assist those who suffer from mental illnesses.

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[83] 'Responses by Mental Health Authorities and Stakeholders to the Kerry O' Malley Case', *Justice Action* (WebPage, n.d.) <https://justiceaction.org.au/responses-by-mental-health-authorities-and-stakeholders-to-the-kerry-omalley-case/>.
[84] 'Nathan Chetty' *Justice Action* (WebPage, n.d.) <https://justiceaction.org.au/nathan-chetty/>.

Alternatives to Community Treatment Orders

Viable alternatives for CTOs involving cooperative recovery approaches that engage the decisions of consumers, social support systems, and consumer workers must be implemented. Alternatives such as access to consumer workers and the option of establishing a directive, should be considered in place of CTOs to work towards reducing the continued stigma that comes with mental illness and provide the individual with an opportunity to have some control concerning the treatment they are about to receive when they are of sound mind.

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 Care Directive

An Advance Care Directive is a written document describing the medical treatment plan that someone wishes to receive if they become incapable of making decisions for themselves.[85] The directive usually indicates factors such as where they want to be cared for, by whom and what treatments they consent to. An Advance Care Directive may also express the person's wishes about any aspect of their life or affairs. Though existing uses for advance directives mainly involve situations near the end of a person's life,[86] for use as a 'living will', they are now increasingly used in mental health to enable patients to provide their own input and preferences into their care for when they may have an acute episode.

As a result, 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: (1) the instructional directive; (2) the proxy directive; and (3) the hybrid directive, which combines the advantages of instructional and proxy directives. 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 for children and financial matters.

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[85] NSW Ministry of Health, 'Making an advance care directive' (NSW Ministry of Health, May 2022) 1.
[86] 'Advance care directive', *Department of Health and Aged Care* (Web Page, July 2019) <https://www.health.gov.au/topics/palliative-care/planning-your-palliative-care/advance-care-directive>

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 consider the actual circumstances of the patient's situation once they become incompetent. This effectively substitutes the patient's judgement, rather than requiring the patient to anticipate specific, future events for giving suitable instructions. As a result, proxy directives are used more frequently than instructional directives. 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.[87]

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.[88] 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 are 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.[89] Under common law, they can be binding if the criteria of specificity and competence at the time of writing are fulfilled.[90]

The NSW Department of Health also supports the use of advance directives, providing a guideline on its use.[91] In comparison, states such as Queensland, South Australia and the Northern Territory consider advance care directives as 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.[92]

The implementation of advance care directives may also be seen in regions such as the UK, where advance refusals were statutorily enabled by the *Mental Capacity Act 2005* (UK), but

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[87] Leslie Anne Campbell and Steve R Kisely, 'Advance treatment directives for people with severe mental illness' (2008) (8) *Cochrane Database of Systematic Reviews* 1, 1-44.
[88] *Guardianship Act 1987* (NSW) s 33(3).
[89] Sarah Ellison et al, 'The legal needs of older people in NSW', 2004 1 *Law and Justice Foundation of NSW* .
[90] Advance Care Planning Australia, *Advance planning laws in New South Wales* (Webpage, n.d.) <https://www.advancecareplanning.org.au/law-and-ethics/state-and-territory-laws/advance-care-planning-laws-in-nsw#:~:text=In%20NSW%2C%20there%20are%20no,of%20a%20substitute%20decision%2Dmaker.>.
[91] NSW Department of Health, *Using Advance Care Directives* (Webpage, n.d.) <www.health.nsw.gov.au/policies/gl/2005/pdf/GL2005_056.pdf>.
[92] Fiona Morrissey, 'Advance Directives in Mental Health Care: Hearing the Voice of the Mentally Ill' (2010) 16 (1) *Medico Legal Journal of Ireland* 21.

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.[93] Furthermore, it provides that advance decisions only apply regarding refusal of treatment, and is silent on whether a patient can request particular treatment.

On the other hand, Scottish legislation 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.[94] 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.[95]

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'.[96]

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 d 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 derivative can be upheld.[97] 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 illness.[98] The patient's chance of recovery, which may have changed since the directive was made, is also considered.[99]

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 respected.[100] This

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[93] 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.
[94] Morrissey (n 91).
[95] G S Owen et al, 'Advance decision-making in mental health – Suggestions for legal reform in England and Wales' (2019) 64 *International Journal of Law and Psychiatry* 162, 168.
[96] Australian Department of Health, 'International Policy and Program Context', *Identifying the Carer Project,* 24.
[97] Nina Leo, 'Advanced Directives: The Legal Issues' (2004) *Office of Public Advocate* 42.
[98] Ibid.
[99] Ibid.
[100] *Re T (Adult Refusal of Treatment*) [1992] 4 All ER 649.

was further reinforced in 1994 with the case o*f Re C (Adult: Refusal of Treatment)*.[101] Ms B v An NHS Hospital Trust is the most recent authority for d directive cases in England.[102] 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".[103]

Similarly, there have been numerous cases in Canada that have stressed the importance of directives as a means of respecting self-determination and further one's personal autonomy which is also seen to be of high importance to English courts.[104] This is abundantly evident in the case of *Malette v Shulman*[105] and *Fleming v Reid,* which stressed the fact that a doctor, even in the case of an emergency, "is not free to disregard the patient's advance instructions".[106] Furthermore, *Nancy B v Hôtel-Dieu de Quebèc*, provides yet another example of the importance of autonomy.[107] 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 ventilator.[108]

The common law in the United States is also in support of advance directives and have emphasised the importance of autonomy. Directives are seen as a tool for ensuring a patient's wishes are met as expressed in *Cruzan v Director*, *Missouri Department of Health.*[109] 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 invalid.[110] This is evident in *Werth v Taylor,* where it was found that the patient's understanding of her condition was misjudged and failure to provide her with a transfusion would result in death.[111] As a result of her false assumptions about her condition her directive was not upheld.

By examining international common law it becomes clear that there is a willingness to enforce certain 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.

Case Study: Michael Riley

In November 2013, Michael Riley prepared an Advance Directive in an effort to avoid a CTO being placed upon him. This CTO stated that before his scheduling under the *Mental Health*

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[101] *Re C (Adult Refusal of Treatment)* [1994] 1 WLR 290.
[102] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).
[103] Ibid 94.
[104] Leo (n 96) 40.
[105] *Malette v Shulman* (1990) 67 DLR (4th) 321 at 330.
[106] *Fleming v Reid* (1991) 82 DLR (4th) 289, 310.
[107] *Nancy B v Hôtel-Dieu de Quebèc* (1992) 86 DLR (4th) 385.
[108] Ibid 40-41.
[109] *Cruzan v Director, Missouri Department of Health* (1990) 497 US 261.
[110] Leo (n 96) 41-42.
[111] *Werth v Taylor* (1991) 475 NW (2d) 426

Act,[112] 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 Mental Health Review Tribunal it was not accepted as a sufficiently effective document and his CTO was renewed.

However, according to s 14 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'.[113] Michael does not have a criminal history nor has he exhibited violent behaviour in the past. This raises concerns as to whether the Mental Health Review Tribunal's refusal of his advance directive was reasonable. Similarly, *Fleming v Reid* [114] highlights the importance of the right to personal security and autonomy.

[112] *Mental Health Act* (n 7).
[113] Ibid s 14.
[114] (1991) 82 DLR (4th) 289.