Ethics and law

Out of sight, out of mind: making involuntary community treatment visible in the mental health system

Edwina M Light
BA(Comms), GradCertJournalism, GradCertBioethics, PhD Candidate[1]

Ian H Kerridge
MPhil, FRACP, FRCPA, Director and Associate Professor of Bioethics,[1] and Staff Haematologist/BMT Physician[2]

Christopher J Ryan
MB BS(Hons), MHL, FRANZCP, Senior Clinical Lecturer,[1,3] and Consultation–Liaison Psychiatrist[4]

Michael D Robertson
MB BS(Hons), FRANZCP, PhD, Clinical Associate Professor[1,3]

1 Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney, NSW.
2 Royal North Shore Hospital, Sydney, NSW.
3 Discipline of Psychiatry, University of Sydney, Sydney, NSW.
4 Department of Psychiatry, Westmead Hospital, Sydney, NSW.
edwina.light@sydney.edu.au

MJA 2012; 196: 591–593
doi: 10.5694/mja11.11216

Summary

- Most specialised mental health services in Australia are delivered in community settings and one in six services comprise involuntary treatment.
- Despite a growing demand for community treatment orders (CTOs) worldwide — and comparatively high rates of use in Australia — the clinical, legal and ethical aspects of CTOs remain contentious.
- This article examines federal, state and territory mental health policy documents and discovers little reference to CTOs.
- The "invisibility" of CTOs in mental health policy raises questions about the transparency and accountability of the mental health system, and about whether this policy silence ultimately entrenches the marginalisation of, and discrimination against, people living with mental illness.

Improving community services for people with severe and persistent mental illnesses is the focus of the mental health reform package announced in the 2011 federal Budget and reiterated in the 2012 Budget.[1] Over a third of the $1.5 billion package was allocated to fund multidisciplinary care coordination and structured social activity programs for this group.[2] Introducing the reforms, the Minister for Mental Health and Ageing acknowledged the well documented problems associated with the move of psychiatric services from hospitals to the community,[1] including inadequate resourcing of community services and high rates of unmet need, disadvantage, homelessness and imprisonment among people living with mental illness.[3]

The package highlighted the fact that most psychiatric care for some of our most severely affected people is provided in the community, but it failed to shine similar light on another by-product of deinstitutionalisation — the use of involuntary treatment in the community setting. In the 2007–08 financial year, more than a million of the 6.27 million community mental health services were applied under an involuntary order.[4]

Involuntary community treatment is authorised and regulated through community treatment orders (CTOs). These legislated orders (sometimes referred to as community management or involuntary treatment orders) are made by tribunals and clinicians and set out the terms under which a person with a mental illness must accept (non-consensual) treatment[5] — including medication and therapy or other services — while living in the community. A person who breaches a CTO may be taken to a mental health facility and be forced to have treatment, including medication. In Australia, and around the world, the people most likely to be subject to CTOs are those with severe and persistent mental illness.[6]

CTO use is on the rise, but remains contentious

Since the 1980s, CTOs have been introduced in all Australian states and territories, as well as in Israel, New Zealand, Canada, 44 states of the United States, Scotland, England and Egypt.[6-9] However, rates of use vary considerably and, compared with international standards, are high in some Australian states. In 2005, a review noted rates per 100 000 population of 55 in Victoria, 43 in Queensland, 37 in NSW and 10 in Western Australia. This compared with low rates in Canada — around 2 per 100 000 in Saskatchewan and 6 per 100 000 in Ontario — and mixed rates in the US, from 2 per 100 000 in New York State to 26 per 100 000 in Nebraska.[10]

In the face of growing demand worldwide,[11] CTOs remain one of the most contested issues in psychiatry,[12,13] and their efficacy is unclear. An international review of empirical data on CTOs concluded that it was not yet possible to state whether CTOs are beneficial or harmful, that there was inconsistent evidence about the effects of CTOs on clinical and quality-of-life outcomes, and that stakeholder perceptions were mixed.[6] A Cochrane review concluded that CTOs might not be an effective alternative to standard care.[14] Even if CTOs are effective, it is not clear whether any benefit is due to their compulsory nature or simply a result of the intensity of treatment that they facilitate.[6,13,14]

In addition to the uncertainties about efficacy, the ethical justification of CTOs is also far from clear. CTOs raise a number of ethical dilemmas for practitioners concerning consent, autonomy, coercion, paternalism and beneficence, as well as confidentiality, agency and privacy, and the accountability of the state to provide appropriate and quality services.[12,13] Criticisms of CTOs include their potential to undermine non-coercive efforts to engage patients, and the inappropriateness of any attempts to increase coercion to compensate for underresourced services.[12]

There are also concerns about the impact of CTOs on fundamental human rights and about the legal criteria and scope conferred by different CTO systems.[15-17] CTOs are intrusive and grant professionals powers to monitor a person's condition, provide non-consensual treatment, and take a person to a psychiatric facility for treatment. Such powers have an enormous impact on the privacy and autonomy interests of patients.[15] Operating at, or beyond,

the boundaries of human rights, CTOs place significant duties on governments to provide adequately resourced community mental health and accommodation services.[16] Another problem is that CTOs are based principally upon considerations of risk, dangerousness or harm, as opposed to a person's capacity to consent to treatment.[5,17] This is problematic for several reasons: we cannot usefully categorise people with mental illness as of high or low probability of future harm; the application of risk criteria may actually worsen the prognosis of some illnesses; and failure to take account of capacity may compel treatment on a person who could make a competent decision to refuse treatment.[5,16]

The invisibility of CTOs in policy

With more than a million involuntary community services provided in Australia each year, it would be reasonable to expect that there would be rigorous and publicly accessible information about the policy principles and objectives related to CTOs. However, a review of mental health policies reveals little information about the operation of CTOs in Australia.

The *National mental health report 2010* details trends in the resources, structure and activities of the mental health system since the National Mental Health Strategy commenced in 1993.[18] Although it notes the challenges facing community-based mental health care, it makes no mention of involuntary treatment of patients with mental illness in the community. This seems a remarkable absence, particularly as the National Mental Health Strategy (most recently articulated in the *Fourth national mental health plan*) provides the framework that is supposed to guide the organisation and delivery of mental health services across Australia.[19] Individually, the strategy documents also say little about involuntary treatment, only broadly identifying that people may receive treatment under provisions of mental health legislation and flagging procedural issues to do with "civil and forensic orders". The 1991 *Mental health: statement of rights and responsibilities*[20] is the only strategy document that explicitly articulates that some people may be involuntarily treated. A careful review of state and territory mental health policy documents finds mentions of care in least-restrictive environments or subject to provisions of mental health legislation, but reveals few references to CTOs. In New South Wales, for example, key mental health policy documents, including the *Community mental health strategy 2007–2012*[21] and *NSW: a new direction for mental health*,[22] provide no information about CTOs, their organisation or role in the state's mental health system. Victoria has reviewed its Mental Health Act, and the *Victorian mental health reform strategy 2009–2019* is the only state or territory policy to detail a position on CTOs. The Victorian strategy notes that although CTOs are "an important element of community-based treatment, their increasing use is a cause of some concern", and that further work will be undertaken to determine the factors driving their increasing use and how to reduce any overuse.[23]

State and territory mental health tribunals and departments publish information about procedures under mental health laws, including chief psychiatrist guidelines, and provide data on statutory activities, such as the total number of orders made. In NSW, for example, there were 4772 CTOs made in the 2009–10 financial year.[24] There are, however, no comprehensive or uniform national data regarding the number of CTOs or the number of people subject to CTOs.[10] Likewise, while regulatory statements, such as the *National standards for mental health services 2010*,[25] provide information about the service frameworks in which CTOs operate, none of these documents really provide a clear picture as to where CTOs fit into mental health policy frameworks and what contribution CTOs make, or should make, to the care of people with mental illness. None clarify how CTOs are functioning and whether they require reform.

The price of invisibility

There are at least three reasons why it is important to make CTOs more "visible" and embed them within broader mental health policy.

Marginalisation and stigma

Failure to take account of CTOs in mental health policy marginalises people who are subject to involuntary orders, by entrusting them to a system that is not publicly acknowledged and may be relatively less open to assessments of quality and accountability. People living with mental illnesses already face disadvantage and unmet need because of the unresolved problems of a neglected mental health system. Isolating policy attention and responsibility for CTOs risks further inequity for people subject to such orders, and perpetuates a lack of knowledge about mental illness and treatment that contributes to its stigmatisation. The CTO policy silence is inconsistent with the principles detailed in the mental health policies themselves, which prioritise social inclusion and equity, recognise diversity of illness experiences and care needs, and aim to reduce the effects of stigma and enhance system quality and accountability.[21,22]

Transparency and accountability

Including involuntary treatment policy and activities in regular policy statements and reporting — such as Budget policies or the *National mental health report* — would provide a more comprehensive, transparent and accurate account of the operation of the entire mental health system, without which it will be impossible to build confidence in the system and in the progress of mental health reforms.[19] Current policies give the impression that there is little involuntary community treatment in Australia and that policymakers have no role or responsibility in this area. The incorporation of CTO information — including tribunal and involuntary psychiatric service data — in mental health policies and reviews would make clear the existence, extent and utility of CTOs. This will enable the community to make informed judgements about their use and the reform of mental health services in general.

System access and quality

If governments are to understand how the health system is functioning and whether it is providing equitable and

timely access to care, they must include information about CTOs in health policy planning and deliberations. An inadequate health system may hinder people's access to services and voluntary choices.[12] On the other hand, CTO systems may facilitate some people's access to appropriate treatment.[26] Keeping CTOs invisible in the public policy agenda limits our understanding of whether variations in CTO use[10] relate to individual laws, local implementation practices, or the general functioning of the mental health system. It also confines rigorous clinical, legal and ethical analyses of the use and impact of CTO systems to the domain of specialist literature and practice — rather than making them accessible for debate in the wider community.

Improving the involuntary treatment of patients with mental illness in the community

In the process of reform, it is not possible or practical to simultaneously bring to the fore every single issue for attention. However, meaningful reform is only possible where one has an accurate picture of the entire mental health system. This demands that we recognise involuntary treatment as a substantial aspect of community psychiatric services, and that we know something about why and how CTOs are being applied. Opportunities to do so continue to emerge as part of the ongoing activity in mental health policy reform. Discussion about how the Budget's plans for care coordination by Medicare Locals and non-government organisations will work with existing case management for people on CTOs should be an important element of understanding how these proposed reforms will function and should raise awareness of involuntary treatment issues. Other opportunities for comprehensive policy making that could take account of CTOs include the 10-year "roadmap" for national mental health reform to be finalised in 2012–13, the current review of the *Mental health: statement of rights and responsibilities*, and the planned development of nationally consistent mental health legislation.[19] These activities could enable the explicit inclusion of CTOs in mental health policy frameworks, during relevant public consultation and in their final outcomes. The creation of mental health commissions at federal and state levels also present additional policy leadership prospects. If governments deliver on mental health reforms, there will be a significant opportunity to constructively and respectfully include CTOs in the public and political discussion of mental illness and society's responses to it.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed.

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