

**A POSITION PAPER ON COMMUNITY
TREATMENT ORDERS**

MENTAL HEALTH LEGAL CENTRE

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INTRODUCTION

Because the Mental Health Act, 1986 regulates the apprehension, admission and detention of persons in an approved Mental Health Service against their wishes, or their understanding, and restricts their freedom in the community, the Act must be interpreted in favour of a person affected by the provisions of the Act. The Court should be constrained to interpret the Act in a way that least infringes upon the civil rights of a person because of the stigma surrounding mental illness. '(Justice O'Bryan in R W V Mental Health Review Board and Others).

'CTOs enable people to receive treatment for their mental illness in the community as an involuntary patient. A CTO is used as an alternative to admission to a psychiatric inpatient service, or where the psychiatric service is no longer the least restrictive environment in which a person can receive care. The person to whom the CTO applies must satisfy the criteria for involuntary treatment. (Lee: 1993: P.26)

THE MENTAL HEALTH LEGAL CENTRE

The Mental Health Legal Centre was established in 1987 as part of the Victorian Cain Government's Social Justice Strategy. The Centre was initially established to give Consumers who were labelled with a psychiatric disorder the appropriate legal and educational services to redress inappropriate detention, discrimination, and stigma. The Centre has broadened its focus in the past 13 years to other areas of law where consumers experience discrimination, including criminal law, crimes mental impairment defence (the former Governor's Pleasure legislation), family law, social security law, and guardianship and administration and equal opportunity law. This has enabled broader advocacy for the rights and needs of those labelled

with a psychiatric disorder. In 1997 the Centre took a policy position that it would advocate more systemically.

CONCERNS OF THE CENTRE

The above quotes, of which the most recent comes from the Victorian Supreme Court, confirm the need for CTO's to be rights based rather than the punitive instrument many Consumers interpret them to be. The Centre has become increasingly concerned about the use of CTOs in Victoria for the following six reasons:

1. In Victoria, the duration of CTO's is amongst the longest in the country (12 months);
2. CTOS appear in many cases to be contrary to and to lead to counter therapeutic effect
3. There are high levels of Consumer concern regarding the potential for CTO's to be punitive (Ring, Brophy Gimlinger, 2001 & MHLC Annual Report: 2001;
4. That the MHRB rarely vary the length of CTOs
5. There is evidence of increasing use of such orders by area mental health services, which the centre believes creates an inappropriate therapeutic environment for many of our clients (Ring, Brophy and Gimlinger, 2001);

6. There are large numbers of people discharged from their CTO's within seven days prior to their scheduled hearings by the Mental Health Review Board. Mental Health Review Board figures suggest that this is as high as 70% of all discharges from CTOs (MHRB Annual Report 2000)

As the use of CTOs has apparently increased so the Mental Health Legal Centre has also increasingly been inundated with demand that it cannot always meet, to represent people before the Mental Health Review Board who believe that involuntary treatment in the community is inappropriate for them. The Centre is also aware, through sources such as regular consumer forums, that there is increased concern about the appropriateness of the use of CTOs.

The Centre has been committed to researching this issue and a recent project involved speaking to 19 mental health workers in the field and seeking the views of 30 Consumers about how CTOs work, how they affect peoples lives and how they can be improved. The Centre's aim is not to demonise involuntary treatment but to investigate to what extent the legal safeguards are being met in Victoria and contrast those safe guards with other similar jurisdictions. The Centre will make a series of recommendations for law reform purposes based on the research results.

THE HISTORY OF CTO'S

CTO's were not an initial part of the Mental Health Act, 1986, but were added to the Act in 1988 as deinstitutionalisation progressed and concerns about the adequacy of community based care increased. Thus CTOs have emerged within mental health law over time and have evolved with amendments to the Act from time to time (for example the Mental Health (Amendment) Act, 1996).

The Mental Health Act, 1986 represented an initiative in rights based legislation. It differed from previous legislation because of its rights based nature and its emphasis on balancing the need for care and treatment. The legislation has been reviewed on a number of occasions. In 1988 the Mental Health Act was reviewed to include a new form of involuntary treatment, entitled Community Treatment Orders. This form of treatment enabled civil detention in the community and was introduced to aid, and deal with problems associated with, deinstitutionalisation. Deinstitutionalisation was a deliberate attempt to shift care from institutional settings to 'care in the community' (Delaney, 1992). Care in the community meant an end to long stay involuntary treatment in large inpatient facilities. In 1988 the Act was amended to allow the authorised psychiatrist to make a CTO and revoke that order if that person failed to comply with the conditions of the order (Lee: 1993). The law allowed for police to apprehend a person who's CTO was revoked if they didn't stay or go to hospital or were absent without leave from an inpatient unit. However, the law made it clear that the authorised psychiatrist or their delegate should ensure that the person subject to the order is aware of the grounds for revoking the CTO.

In 1990 the Mental Health Act was again amended to allow for a person to be placed on a CTO even when the person had not been admitted to hospital but met the Section 14 (involuntary admission in the community) of the Act.

The 1995 Discussion Paper on Community Treatment Orders (Department of Health and Community Services (Vic)) recommended the following:

- The Criteria for community treatment orders should be explicitly stated. The criteria should mirror the existing criteria with the additional requirement that unless a treatment order is made the person will be unlikely to comply with the treatment;
- That the Mental Health Review Board review the making of a Community Treatment Orders within eight weeks;

- That a new category of patient be created, that of a Community Treatment Order patient;
- That the maximum period for a Community Treatment Order be reduced from 12 months to 6 months;
- That a Community Treatment Order stipulates who is to monitor and supervise treatment of a person, and
- The revoking of the Community Treatment Order is understood as the Consumer meeting the Section 12 involuntary admission criteria.

The 1996 amendments enacted a number of recommendations, including that the criteria for Community Treatment Order patients be explicit and 8-week review of Consumers by the Board take place and CTO should stipulate who would monitor the order. However, the extra criterion recommended has not included and this round of amendments did not reduce the maximum period of review.

THE CASE LAW

There has been very little higher court case law on mental health with involuntary treatment in the community being no exception. However, the recent case of RW in the Victorian Supreme Court (2000) found the earlier decisions by the Mental Health Review Board the Victorian Civil and Administration Tribunal (VCAT) to be invalid.

RW appealed when his Community Treatment order was extended after the order had lapsed. RW came to the Centre and in representing him we appealed the order on jurisdictional grounds. The Board found against RW, relying on the previous case of XY,

If the patient has been illegally admitted due to technical procedural defects but is never the less in need of care and treatment because the criteria for his or her admission have been fully applicable, the patient is not disadvantaged by technical illegality (MHRB: 110699:W61: 521689).

The Centre appealed this decision to VCAT who affirmed the order stating that;

I agree with the secretary's submission that such a person (a person with an expired CTO) is an involuntary patient quote that reflects rationale i.e.: a need for treatment where in the circumstances of the first case a decision had been made between need for treatment and 'rights objective of the Act the latter would prevail absent without leave (VCAT: Generalist No: 1999/75412).

The Centre appealed the VCAT decision to the Supreme Court. His Honour Justice O'Bryan found in favour of RW and upheld the appeal.

In rejecting the Board's and VCAT'S decision, Justice O'Bryan has arguably made rights (to protect the rights of people with mental disorder (Section 4(ac) The Mental Health Act, 1986)) to be the pre-eminent object of the Act over Care and treatment (to provide for the care, treatment and protection of the mentally ill people who do not or can not consent to that care, treatment or protection (Section 4(a) Mental Health Act, 1986)). At least where it is unclear in a particular situation which upheld should prevail this is an important victory for Consumers and advocates who believe that the spirit of the 1986 Act is right based.

A LITERATURE REVIEW ON EFFICACY OF CTO'S

There is little literature on the efficacy of CTO's and because of different jurisdiction's laws; it is hard to make generalised statements about the effectiveness of involuntary treatment in the community.

Dedman (1991) Carne (1991) Turner (1994) and Muirhead (2000) suggest that CTO's offer significant benefits to consumers compared with involuntary inpatient admissions or no treatment at all. These benefits include less hospitalisation, greater connection to services for consumers, and better familial relationships. Two reasons cited by McIvor (1998) and Freckelton (1998) in support of the use of CTO's and continued involuntary treatment were:

1. CTO's assist in the development of insight and,
2. CTO's provide protection of self or others.

Calvin, Winter & Morse (2000) found that, when comparing compliance to treatment between those mandated and those non-mandated consumers, there was no clear indicator to suggest any difference in health outcomes after 12 months. The lack of clear outcomes in research undertaken by the Mental Health Legal Centre appears to question whether mandated treatment in the community is necessary to improve health outcomes and indicates the need for further research. There is some useful literature on the use of CTO's and assertive outreach. Hiday & Scheid-Cook (1991) report that many studies rely on data from the USA where civil commitment (or CTO's) does not allow for compulsory medication and consumers cannot be readmitted to hospital for non-compliance alone. They describe the use of an assertive outreach model with mandatory powers (i.e., the ability to make a person attend a consultation with psychiatric trained staff) rather than a method of treatment that involves compliance through the threat of hospitalisation or enforced treatment, such as medication. Hiday and Scheid (1991) found that with assertive outreach methods of compulsory follow up clinicians were often successful in gaining consumer co-operation with treatment. Only 22% were non-compliant to treatment after two follow-up letters, 45% did not miss an

appointment without an appropriate excuse, and 77% met their commitments with only one failure to attend. Test and Stein (1980) have also found that the use of assertive outreach is successful.

Given these findings, it may be suggested that:

If CTOs are to be justified both clinically and from civil liberties perspectives, controlled research needs to be carried out to identify whether CTOs are more effective than comprehensive assertive community out-reach programs in reducing relapse and hospitalisation and compliance (McIvor, 1998).

THE VICTORIAN JURISDICTION

In this section of the paper the Centre will compare and contrast the Victorian Legislation with the Commonwealth Model legislation and make some general comments about other jurisdictions.

CTO's are provided for section 14 of the Mental Health Act, 1986. Section 14 states the following:

14. Community treatment orders

- (1) If a person satisfies the criteria specified in sub-section (1A) and the authorized psychiatrist considers that a community treatment order is appropriate, the authorized psychiatrist may make a community treatment order instead of confirming the admission of the person to an approved mental health service as an

involuntary patient or continuing to detain the person in an approved mental health service.

(1A) For the purposes of sub-sections (1) and (6), the criteria are that—

(a) the person appears to be mentally ill; and

(b) the person's mental illness requires immediate treatment and that treatment can be obtained by making the person subject to a community treatment order; and

(a) the person is deemed to be an involuntary patient who is absent from an approved mental health service without leave; and

(b) the authorised psychiatrist may authorise any of the persons referred to in section 43(1) to apprehend the person for the purpose of returning the person to an approved mental

(c) because of the person's mental illness, the person should be made subject to a community treatment order for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness;
and

(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

(1B) Despite anything in the **Guardianship and Administration Act 1986**, the **Medical Treatment Act 1988** or any other law, in considering, for the purposes of sub-section (1A), whether a person—

(a) in respect of whom a guardian has been appointed under the **Guardianship and Administration Act 1986** or in respect of whom a person responsible within the meaning of section 37 of that Act may make decisions relating to treatment; or

(b) in respect of whom an agent has been appointed under the **Medical Treatment Act 1988**—
has refused or is unable to consent to treatment, that person's personal refusal or consent only is relevant and not the refusal or consent of that person's guardian, the person responsible, the agent or the Tribunal.

(2) A community treatment order must specify—

(a) the authorised psychiatrist or delegate of the authorised psychiatrist who is to monitor the treatment of the patient; and

(ab) the registered medical practitioner who is to supervise the treatment of the patient; and

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

(c) the intervals at which the registered medical practitioner must submit a written report concerning the treatment of the patient to the monitoring psychiatrist; and

(d) the duration of the community treatment order which must not exceed 12 months.

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

(3) A person who is subject to a community treatment order—

(a) is deemed to be an involuntary patient detained under section 12; and

(c) the provisions of this Act, other than sections 37,

40, 41, 42 and 43 apply accordingly.

(4) The authorised psychiatrist—

(a) may vary a community treatment order; or

(b) if satisfied on reasonable grounds that a person who is subject to a community treatment order—

(i) has failed to comply with the order; or

(ii) satisfies the criteria specified in section 8(1) but no longer satisfies the criteria specified in sub-section (1A) of this section—
may revoke the order; or

(c) if satisfied that a person who is subject to a community treatment order does not satisfy the criteria specified in section 8(1) or in sub-section

(1A) of this section, must discharge the person as an involuntary patient.

(4A) If the authorised psychiatrist revokes a community treatment order to which a person is subject—

(4B) Sub-sections (5), (6) and (7) of section 9 apply to a person being returned to an approved mental health service under sub-section (4A) as if that person were a

person to whom a recommendation relates being taken to an appropriate approved mental health service.

(5) If a community treatment order is revoked the authorised psychiatrist must make reasonable efforts to inform the person—

(a) that the order has been revoked; and

(b) that the person must return to an approved mental health service as an in-patient

(6) If, after examining a person who is the subject of a community treatment order, the authorised psychiatrist considers that—

(a) the person still satisfies the criteria in sub-section (1A); and

(b) a community treatment order is still appropriate— the authorised psychiatrist may extend a community treatment order for a period which must not exceed 12 months.

(7) There is no limit to the number of times a community treatment order may be extended under sub-section

(8) For the purposes of review under section 30(1)(a), the

extending of a community treatment order is deemed to be the admitting of the person who is the subject of the order to an approved mental health service.

OTHER JURISDICTIONS

Model Legislation

The model legislation makes a number of provisions that are different to the Victorian legislation.

The relevant differences are outlined below:

Interim community treatment order

67. An authorised psychiatrist may make an interim community treatment order in relation to a person if the authorised psychiatrist is satisfied the person meets the criteria for involuntary treatment in the community.

Application for a community treatment order

68. An authorised psychiatrist or authorised medical practitioner may apply to the tribunal for a community treatment order,

- 70 A community treatment order must specify,

(a) the name and residential address of the person who is subject to the order,

- (b) the health care agency which is to implement the community treatment order,
- (c) the time and days of the week the person must attend the health care,
- (d) any medications or treatment the person receives,
- (e) any rehabilitation support or other service the person is to receive,
- (f) such others relevant information as the tribunal see fit.

Action after interim order

- 71 (1) after the authorised psychiatrist has made an interim Community treatment order, the authorized psychiatrist must lodge an application with the tribunal for a community treatment order.
- (2) The tribunal must conduct a hearing on the application in a period of not exceeding seven days from the date of the interim community treatment order.

Period of order

- 74 The tribunal may make a community treatment order for any period not exceeding six months.

Application for review

- 78 person subject to a community treatment order may apply to the tribunal for a review of that order at any time during operation of the order.

Prior orders

82 Where a person has previously been subject to a community treatment order, the psychiatric case manager must make a written report to the director of the community health care agency on the efficacy of the order.

Breach of community treatment order

85 A person is subject to a community treatment order is in breach of that order if the person refuses or fails to comply with the order and an authorised psychiatrist or an authorised medical practitioner determines that:

- (a) the health care agency has taken all reasonable steps to implement the order and obtain the co-operation, and
- (b) there is significant risk to harm to the person or another person or a significant deterioration in the mental or physical condition of the person.

Involuntary admission

86 (1) Where a breach of a community treatment order occurs, an authorised psychiatrist:

- (a) must inform the person that breach has occurred, and
- (b) may cause the person to be involuntarily admitted to a mental health facility.

(2) A person who has been informed with sub-section (1) that a breach has occurred is deemed to be a person who is absent without leave from a mental health facility

The model mental health legislation differs considerably from Victorian legislation and the Centre has a number of concerns about the Victorian legislation when compared with the model legislation. The particular concerns are as follows:

- That the order under the model legislation is only an interim order until the tribunal makes that order in full. In Victoria, the legislation only allows for review or appeal and the doctor makes the actual order.
- That the orders can be made for 12 months instead of six months as per the model mental health legislation.
- There is no requirement, as with the model mental health legislation, that a written report be made on the efficacy of the previous order so as to allow a judgment about how effective orders are for a particular person.
- Under the model legislation there is compulsion for the person to be notified that their CTO has been revoked unlike the Victorian legislation.
- Before revoking an order under the model mental health legislation the mental health agency must make reasonable steps to gain the co-operation of the Consumer and be satisfied there is significant risk to person. The Victorian legislation makes no provision for this.

THE RELEVANT UNITED NATION PRINCIPLES

The Victorian legislation fails the United Nation's Principles in two ways:

- (1) Everyone shall have the right to liberty of movement and freedom to choose his or her residence (Article 12)

The Victorian legislation allows for residence clauses for some Consumers section 14(2A),

Section 14(2A) A community treatment order may specify where the patient must live, if this is necessary for the treatment

- (2) The case of every person detained or treated involuntarily must be subject to independent review at regular intervals not exceeding 6 months.

The Victorian legislation states that,

30. Reviews

(1) Subject to sub-section (2), the Board must review the continued detention of a patient, other than a forensic patient—

(a) within 8 weeks after the patient is admitted or, in the case of a person who is subject to a restricted community treatment order, as soon as practicable after receiving a copy of the order

under section 15A(6); and

(b) thereafter at intervals not exceeding 12 months.

(2) In the case of a patient whose detention has been continued under section 12C, the Board must review the continued detention of the patient within 14 days after the day on which the committee consented under section 12B to the continued detention.

The Victorian legislation allows for mandatory 8-week review and then 12-month review, with review on appeal at any time. Whilst the Consumer can appeal at any time they are a group of highly disadvantaged people and often don't attend reviews or appeals and may have limited understanding of their rights. Furthermore it is not possible for all Consumers to have legal representation due to limited resources. Thus the Centre believes that this review procedure does not meet the United Nations principles in practice due to the length of mandatory review and the potential for Consumers to have limited awareness of their rights.

RESEARCH FINDINGS

In 2000 the Mental Health Legal Centre began a pilot study relating to the topic of Community Treatment Orders. The overall purpose of this study was to interview service providers currently employed within the mental health services sector and Consumers, to determine their views on how efficacious they believe Community Treatment Orders to be.

The aim of this study was to collate information relating to obstacles, possibilities and mechanisms relevant to the administration of CTO's, and to determine what suggestions service providers and Consumers have to improve CTO's. The overall project consisted of interviews with both service providers and Consumers to provide data for discussion on the efficacy of Community Treatment Orders. The following focuses on the data obtained via interviews with these key stakeholders.

Consumer Perspectives

Method

Thirty Consumers were interviewed in a total of three focus groups. Six questions were asked that ranged from ideas around the understanding of what a CTO is to how a CTO could be improved. Consumers were chosen from three diverse areas; rural Victoria, Outer South-East Melbourne and Inner North Melbourne. Consumers were asked a series of questions with one person facilitating the group while another recorded the responses.

Demographic data

The respondents interviewed were most likely to be male, in their early 40s, have a diagnosis of schizophrenia and be living on the Disability Support Pension. The majority of respondent's education level was of a high school standard with most people living alone or in supported accommodation. The gender was mix women n=8 and men n=22

Responses

The participants gave the following responses to six key questions:

- What do you understand the purpose of a CTO to be?

Consumers expressed the opinion that the purpose of a CTO was to ensure further treatment would be received in a crisis. One person suggested that CTO's stopped violence against family members or members of the public. Other Consumers noted that the CTO 'got you into hospital without the red tape.'

However, many Consumers felt that CTO's were punitive and a form of involuntary treatment with one Consumer saying they were like a "CBO"¹, or "like being in jail without any walls". Others focused on the issue that CTO's enforce medication and "if you did not take drugs then the police would come and take you to hospital".

- Why are people on Community Treatment Orders?

Some consumers believed that they were put on a CTO because they had been violent to other people; one specifically mentioned that this had occurred while he was in a psychiatric

¹ CBO – a Community Based Order issued within the criminal justice system

inpatient unit. Others thought there was no reason for being on a CTO; one thought he was on a CTO because 'they're fascists'. The participants didn't seem to have any consistent understanding of the five criteria and no one stated that they knew they had to meet all five of those criteria to be detained. The overall impression was that Consumers in the focus groups located the decision about whether they would be on a CTO with their treating doctor. Many of the participants acknowledged that there were times when they or other people they knew became very unwell, usually associated with not complying with treatment, and they believed that involuntary treatment, either in the form of inpatient admission or a CTO, was appropriate to deal with this crisis.

- What were or are the benefits of being on a CTO?

Some participants identified that their case manager or doctor had told them that they would be more likely to 'get into hospital' if they stayed on their CTO. That is, being fast tracked to hospital when and if required. There were a number of responses also around safety and the possibility of CTO's ensuring the safety of consumers and others.

- What are the negatives about being on a CTO?

The label of the CTO is more stigmatising than the diagnosis according to one Consumer. The CTO is also like a prison sentence with out walls was another comment. One Consumer stated that they worried their employer would find out they had been on a CTO. Consumers continually stated that they didn't like the forced nature of treatment and particularly the injections and would prefer a range of other therapeutic responses, particularly "someone to really listen".

- What do you need to do to be discharged from a CTO?

Whilst Consumers did not articulate the five involuntary admission criteria they understood a number of ways to be discharged from a CTO that are consistent with the five Criteria. One Consumer stated that, 'you had to dress up well and play the game and stay in the good books of the doctor'. Another Consumer said 'you need to let the CATT team come and speak to you'. Other Consumers suggested that people needed to articulate a requirement to receive treatment from their doctor, while another stated the Mental Health Review Board could discharge you but clarified this by saying that it was unlikely.

- How could a CTO be improved?

Consumers reported shortening the length of time before a review and better planning by the service to enable a better chance of being discharged. Only one Consumer stated that they should be removed totally from the Mental Health Act. One member of the focus group felt that the criteria for involuntary treatment were too rigid and should be changed.

Another Consumer complained that the Doctor only consulted people in working hours, which interfered with his job, and he believed there needed to be more out of hour's services.

Some Consumers saw Community Treatment Orders as punitive and highly restrictive although one Consumer said she was scared to go off her medication and she believed that the CTO enabled her to stay on the medication. The second Consumer forum could not identify any way that CTO's could be improved due to a strong belief that they could not have any valid input into CTO's because of the dominant bureaucracy.

- How do you imagine your life would be if you were not a CTO?

Consumer stated throughout the forum that the 9 to 5 hours stoped them from achieving certain goals. Another complaint of this nature suggested that Consumers could not have a normal (sic) lifestyle.

Other Consumers saw not being on a CTO as a return to normal (sic) and would have the opportunity to work and be better off.

- What other kind of Treatments do you get on a CTO?

The Centre found that Consumer mainly received medication from the Area Mental Health Services. However, some consumers reported on occasion and reported would like more of.

- Allied health Services
- Psychological Treatments
- Talking therapies
- Alternative therapies

Mental Health Worker's Views

The investigator conducted eighteen interviews with service providers randomly selected although representing the key professional groups and service regions. The centre developed a questionnaire requesting both qualitative and quantitative data. Leichhardt scales were used in conjunction with open-ended questions. The Centre sent out a copy of the questionnaire for review before the interview date, and an 'invitation to participate' letter to potential interviewees, and then interviews were conducted over a seven week period.

The subjects were chosen from a wide range of professional specialties and people interviewed were deliberately selected from regions that varied in socio-economic status so as

not to bias the sample and to give a broad-range representation of key stakeholders within the field of Mental Health. The centre chose people from government and non-government services, self-advocacy groups, peak bodies and related health professionals to ensure that all key service providers would be represented.

The types of clinicians interviewed were social workers, occupational therapists, consumer advocates, welfare workers, psychiatrists, psychiatric nurses, solicitors and medical records clerks. These people were employed by the following service types: psychiatric disability support services, community health centres, the Department of Human Services, and area mental health services which included crisis assessment teams, continuing care teams, and community care units. The demographic data compared subjects determined by age, gender, profession and number of years working in the mental health sector. The findings showed that participants tended to be female, older and experienced in the mental health field.

Method

The structure of the data analysis consisted of comparing the 18 subjects responses to find trends amongst the responses. The data had been collated initially by numbering the interviewees, then by placing a letter representing their profession next to this . The data was collated and analysed by looking for particular trends.

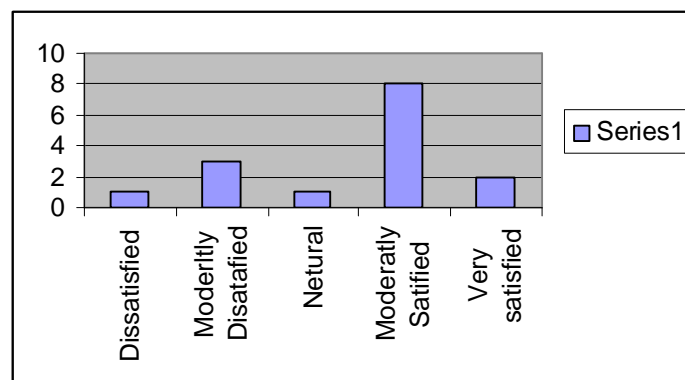
The research method used in the qualitative data analysis was to code the most common responses. The quantitative data used Leichhardt Scales from 1 to 5. The scale was reversed to avoid interviewees giving the same responses to different questions. The investigators then cross-analysed certain questions with others, as stated in the data analysis report.. Many of the questions were cross- matched to find trends.

Demographic data

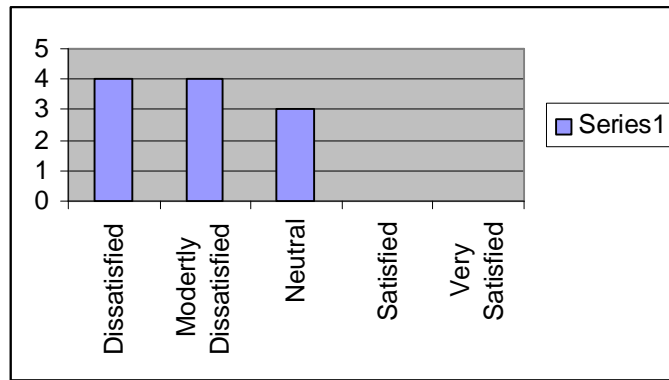
The comparison of subjects through the collation of their demographic data, found that the subjects were a mixture of ages, and experience. The representation of subjects ages are as follows: one subject under 30 years, two subjects between 30-35 years, four subjects between 35-40 years, six subjects between 40-50 years and five subjects who are 50 years and above. The mode age of subjects was between 40-50 years, 60.5% were female, professions represented are mentioned above, and they averaged ten years working in the field.

The interview question data

Comparisons were made between Question 1 and Question 2 as these dealt with clinician's level of satisfaction compared with consumer's level of satisfaction. . The data suggested that while clinicians are moderately satisfied, consumers are dissatisfied.



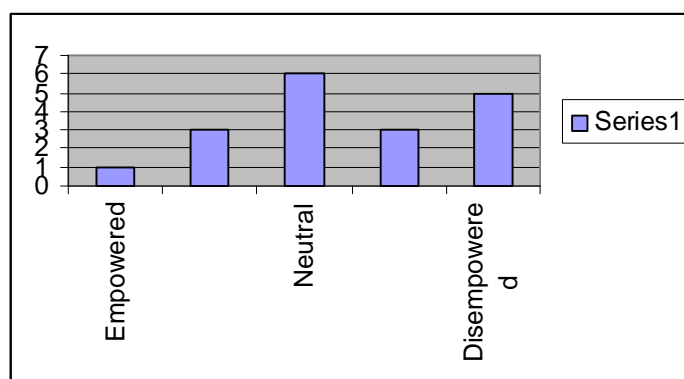
Question 1



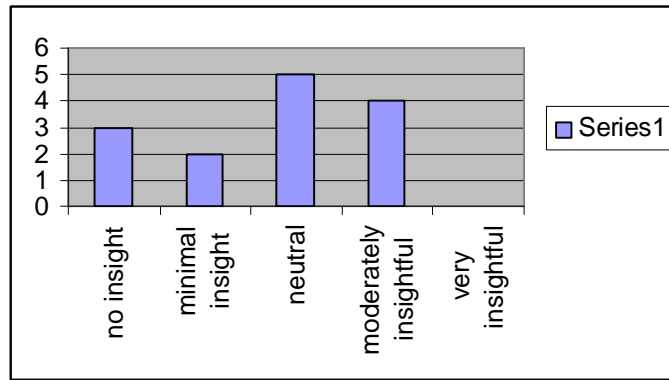
Question 2

Question 3 and Question 4 were compared with attention to how empowered a client feels after being on a CTO in relation to levels of insight into their condition after being on a CTO. When comparing the responses the data suggests that if a person is feeling disempowered, they are less likely to develop insight.

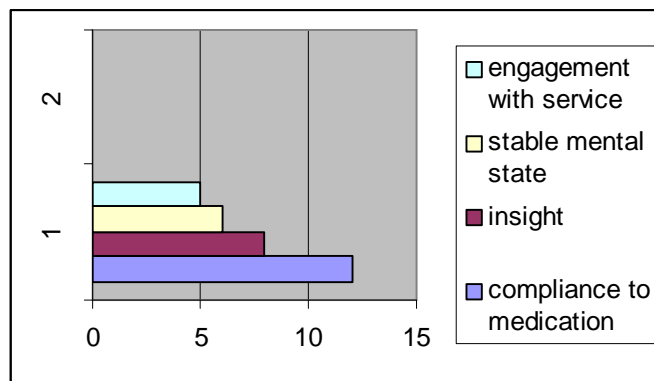
Question 5 asked what are the key indicators for discharge and this was compared with question 6 which explored the reasons why doctors discharged people from CTO's. This was to see if there were any differences in reasoning. While many of the responses were similar, the prioritising was different, and it was noted that neither mentioned the involuntary admission criteria as the most common indicator for discharge. Another point of interest to raise is that the Question 5 responses included 'engagement with service' whereas the Question 7 responses made no reference to this as a consideration for discharge by doctors.



Question 3



Question 4



Question 5

Of the clinicians interviewed in regards to relapse rates, 7 claimed that clients on a CTO do not relapse more frequently than those not subject to a CTO, which may suggest that they are fulfilling their function. On the other hand 5 interviewees claimed 'Yes', that clients do relapse more than those not subject to a CTO.

When asked regarding the number of hospital admissions a person on a CTO may have in a 12-month period, over 50% (9 of the 18 interviewed) of the respondent's predicted one admission. One social worker responded with no admissions, two respondents were unable to say, and the remaining 6 interviewees were between two to five hospital admissions.

Mental health workers questioned (N=9) (Question 14) found that CTO's for Consumers were in fact disempowering, oppressive, restrictive and stigmatising Mental health workers (n=10) found that CTO's gave limited. Life options for the people receiving treatment. Mental health

workers further found that CTO's result in a lack of choice about treatment (N=4), which the consumers found difficult to understand and except.

The data on how CTO's can be improved suggests that the most popular response is to 'improve administration of CTO's' however; respondents were unclear as to how this could be achieved. However, other matters mentioned were improved psychosocial supports and shorter review periods.

CONCLUSION

The Centre is concerned that the Consumers interviewed apparently did not understand the five criteria or its necessity to be met before involuntary detention can take place. The Centre is also concerned that there is a perception that people risk access to crisis treatment services if they do not remain on their CTO. It is of interest to note that while Consumers could not articulate that the mental health service had to meet five criteria to place a person on a CTO however, they understood the implications for discharge, which tended to be located within conformist behaviour (eg. Dressing well).

If CTO's are to be effective both Consumers and Carers should find them an effective tool, however the data questions whether CTO's reduce relapse rates although this is currently one of the most important predictors of success in psychiatric treatment (McIvor, 1998).

Perhaps there have been reductions in the number of relapses when consumers are compared before and after being placed on a CTO. Or conversely, being on a CTO may not affect the number of relapses a person experiences despite the expectation that engagement with the service and assertive outreach would result in significant reduction in relapses.

The service provider responses regarding the impact of CTO's correlates with the consumer experience of CTO's in terms of how punitive they are seen to be and the feelings of disempowerment they generate.

-

RECOMMENDATIONS

- That Doctor make interim Community Treatment Orders that only the Board can confirm to enable greater accountability.
- That the Board have increased powers to change or alter treatment if Consumers are poorly progressing towards being treated in a less restrictive environment.
- That Board no longer is able to make residency clauses because of the significance this has in contributing to the current punitive nature of CTO's
- That there be Consumer positions made available on the Board to enable a stronger consumer voice in external review.
- That there be a two week automatic review and then review every six months of all CTO's by the Mental Health Review Board
- That CTO's be limited to a six month period
- That the service be required to write a report on the continued benefit for a person being on a CTO and present this to the MHRB prior to any extension being granted.
- That services be monitored regarding the number of people being discharged just prior to MHRB hearings and that this phenomena be reviewed in the context of its potential indication that CTO's are not being adequately reviewed by service providers.

APPENDICIS

Appendix One

Date of Birth

Postcode

Gender M/F

Education- what year did you leave school?

High school VCE TAFE University

Do you have dependants?

Accommodation and Do you live with other people

Friends Family Relatives Shared Housing Partner

Income support Social Security Work retired none

DSP Sickness benefit Unemployment Benefit Sole support parent benefit

What label does the system give you?

No of Times before the Board

Appendix Two

FORUM: With 3 PDSS's

What do you understand is the purpose of a CTO

Have you ever been aware of a CTO being helpful for someone?

Why

What are some of the feelings you have on a CTO?

What is the impact of the CTO on people?

If you were not on a CTO how would you imagine your life?

What do you need to do to be discharged from a CTO?

How could a CTO be improved?

What are the alternatives to a CTO?

APPENDIX THREE

*Community Treatment Order Project
by Mental Health Legal Centre*

INVITATION TO PARTICIPATE IN INTERVIEW

Principal Investigator, David Ring, Lisa Brophy, and Amanda Gimlinger.

The interview is part of a pilot study for the Mental Health Legal Centre.

The overall purpose of this study is to identify the efficacy of Community Treatment Order's and make recommendations for Law Reform, and to present information at the International Social Work in Health and Mental Health Conference.

INTERVIEWS

We would like to invite you to participate in an interview to discuss your views on the provision of Community Treatment Orders by interviewing professionals in the mental health field.

In this stage of the project we are seeking the views of key stakeholders concerned with Community Treatment Orders.

Our aim is to collate the views of major stakeholders on issues, obstacles, possibilities, and mechanisms relevant to Community Treatment Orders. To this end interviews are being held across the state with consumers, self-advocacy groups, peak bodies, government and non-government service providers and related health professionals.

Information from the interviews and other parts of the project will be compiled into a final report to State Governments, it may also be used to publish articles in academic journals, and no individual or service will be identified in the final report unless their specific permission is given. Copies will be available when the research is completed via the Mental Health Legal Centre website at <http://www.vicnet.au/~mhlc>.

The interviews give an opportunity for stakeholders to be involved in commenting on current issues, relating to the efficacy of Community Treatment Orders, and to suggest directions for future development. The results will inform policy for the Mental Health Legal Centre and the Community Treatment Order project.

Any questions regarding the CTO project can be directed to the Committee of Management at the Mental Health Legal Centre on (03) 9629-4422.

If you have any complaints or queries that the researcher has not been able to answer to your satisfaction, you may contact the Mental Health Legal Centre at 4/520 Collins St, Melbourne 3000, (03) 9620-4422

CONSENT FORM FOR INTERVIEWED PARTICIPANTS.

I.....have read and understood the information sheet about this project and the letter above and any questions I have about this project have been answered to my satisfaction. I agree to participate in the project realising that I may withdraw at any time. I agree that research data collected during the project may be included in a report, presented at conferences and published in journals on the condition that my name or any other identifying data is not used.

Name of Participant.....

Date

Signature

APPENDIX FOUR

CONSENT FORM

I consent to take part in the Mental Health Legal Centre forum at PDSS on Community Treatment Orders. I understand that I can withdraw from this forum at any time and that my responses to questions are confidential. I understand that non-identifying data will be used for research purposes including reports to government, academic journals and conferences. I further understand that all publications will be published on the World Wide Web (<http://www.vicserv.net.au/~mhlc>).

NAME ...

SIGNATURE ...

WITNESS ...

DATE ...

APPENDIX FIVE

Aims and Brief Description of Project

Aims:

To investigate the efficacy of CTO's and to undertake research that informs the Centre on appropriate law reform which promotes the least restrictive practice.

Analyse the existing human rights for Consumers on CTO's and identify the human rights and social justice issues which would enhance the appropriate use of involuntary treatment in the community.

General Inquiries:

- Undertake research on existing rights
- Review research on what rights would enhance CTO's
- Review obstacles to appropriate use of CTO's by mental health service providers and the effect on Consumers
- Undertake a investigation of the Justice related questions
What's good for Consumers?
What's good for service providers/agencies?
What's good for policy/law/society?

Objectives:

1) Develop glimpses/snapshots of what currently represents good practise, efficacious treatment and justice for Consumers

- Interview practitioners on 'Best Practise' methods in regards to Consumer rights
- Investigate the theories, methods and values which contribute to what is understood to be best practice for service providers when working with people on CTO's
- Identify the justice issues from the Consumers perspectives

2) Gain an overview of Consumer's perspective on CTO's

- Undertake a review of Consumer literature involuntary treatment
- Interview consumers both individually and in forums to hear their views regarding:
 - The current Victorian model of CTO's
 - The lived experience of people on CTO's
 - What is helpful/unhelpful

3) Gain an overview of mental health service provider perspectives on CTO's

- Investigate Clinicians perspectives on the current Victorian model of CTO's
- Gain a service provider perspective on why and when CTO's appropriate
- Interview mental health service providers both individually and in forums
- Investigate what service providers believe is helpful/unhelpful when working with people on CTO's and what contributes to good practice.

4) Review the relevant Legislation on CTO's

- Review Model legislation
- Review Victorian legislation
- Review other states legislation
- Review international law on CTO's

5) Explore alternatives to CTO's

- Review alternative models of involuntary community treatment
- Undertake research on Consumer based alternatives with peak bodies and individual Consumers
- Identify other interventions which would enable less restrictive treatment options

6) Give recognition to the issue of who gains from CTO's, if any one?

Analyse the data in regards to interviews and focus group of Consumers and mental health service providers and reach conclusions about the following, which will include potentially contrasting perspectives:

- When are CTO's generally considered to be efficacious and why?
- What contributes to positive attitudes towards the use of CTO's

- What contributes to negative attitudes towards the use of CTO's
- What other issues impact on the efficacy of CTO's?
- What changes/reforms have been suggested by participants in the research regarding:
 - Service Delivery
 - Policy
 - Law
 - Consumer Involvement

A) Participants

Number of Participants 20 Consumer 16 mental health service providers

B) Age Adult 16-64

C) Will any be frail

Yes

Some of the participants who will participate in the interview will have experienced or currently been experiencing serious psychotic symptoms or have serious depressive (dis) orders.

D) Recruitment Method

Consumers will be recruited through the Victorian Mental Illness awareness Council and through the Area Mental Health Services. A letter inviting Consumers to attend will be sent to Consumers home address.

Mental Health Service Providers have been invited randomly from the Human Services Mental Health Directory taking into account all parts of the service system including statutory authorities and Human Services. Participants will be given an invitation on interview.

E) Compensation

None

F) Special interest groups

Not applicable

7) Dissemination of results

Participants will review a copy of the discussion paper and the discussion and the paper will be posted to our website. No identifying information will be included in the documentation produced by this research.

BIBLIOGRAPHY

Calsyn, Robert, J., Winter, Joel, P. and Morse, Gary, S. (2000) "Do Consumers Who Have Choice Have Better Out-Comes", *Community Mental Health Journal*, 36 (3)
Carne, Jonathan, M. (1991) *A Study of the Effect and Outcome of the Use of Community Treatment Orders in New South Wales*, 1991, unpublished papers

Department of Health and Community Services Psychiatric Services Division, (1996) *Community Treatment Orders and Restricted Community Treatment Orders: Guidelines and information*, Victoria: Psychiatric Services Division, Dept of Health and Community Services

Dedman, Paul (1990) "Community Treatment Orders in Victoria, Australia", *Psychiatric Bulletin*, 14

Freckelton, Ian. (1998) "Decision making about Involuntary Psychiatric Treatment: An Analysis of the Principles of the Board behind the Victorian Practice" *Psychiatry, Psychology and the Law*, 5 (2)

Hiday, Virginia & Scheid-Cook, T. (1991) "Outpatient Commitment for 'Revolving Door' Patient 'Compliance and Treatment'", *Journal of Nervous and Mental Disease*, 179 (2)

McIvor, Ronan. (1998) "The Community Treatment Order: Clinical and Ethical Issues" *Australian and New Zealand Journal of Psychiatry*, 32.

Mental Health Act 1986 (Vic)

Mental Health Act 1990 (NSW)

Mental Health Act 1993 (SA)

Mental Health Act 1996 (Tas)

Mental Health Act 1996 (WA)

Mental Health Act 2000 (Qld)

Mental Health and Related Services Act 1998 (NT)

Mental Health (Treatment and Care) Act 1994 (ACT)

Mental Health Legal Centre (2000) *Annual Report 2000*, Mental Health Legal Centre

Mental Health Review Board (2000) *Annual Report 2000*, Mental Health Review Board

Model Mental Health Legislation (1995) *Report to the Australian Health Ministers Advisory Council Working Group on Mental Health*, Australian Health Ministers Advisory Council, Mental Health Branch, Canberra, ACT

Muirhead, David, R. (2000) *Involuntary Treatment of Schizophrenia in the Community: Clinical Effectiveness of Community Treatment Orders with Oral or Depot Medication in Victoria*, Unpublished Dissertation for Section 11 Examination: RANZCP.

O' Reilly Richard, I., Komer, William & Dunbar, S. (1999) "Why are Patients Discharged by Review Boards?" *Canadian Journal of Psychiatry*, 44.

Stein, L.I & Test, M.A. (1980) "An alternative to mental hospital treatment: 1. Conceptual model, treatment program and clinical evaluation", *Archives of General Psychiatry*, 37, 392-397

Turner, Trevor (1994) "Compulsory treatment in the community: Some debating issues" *Psychiatric Bulletin*, 18.

