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Fault-lines in community treatment order legislation

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Abstract

This article discusses the major tension points in the legislation that authorises involuntary outpatient treatment for mental disorder in six British Commonwealth jurisdictions. Particular attention is paid to the role of competence (or capacity) principles in the ruling legal criteria, to the precise powers of community treatment conferred, and to the potential impact of the legislation on clinicians' liability concerns. It is argued that the conferral on clinicians of a power to administer 'forced medication' in community settings is not required to promote active use of involuntary outpatient care, and that such a power should not be provided. The article concludes with discussion of the reasons why community treatment orders are used more frequently in some jurisdictions than others.

1. Introduction

This article surveys the fault-lines in the community treatment order (CTO) legislation of six British Commonwealth jurisdictions with a shared common law tradition. So far, much of the debate about CTO schemes (or outpatient commitment schemes, as they are called in the United States) has focused on their ethics, their constitutionality and their efficacy. Those are all important matters, but it is still necessary to pay close attention to particular legislative schemes. The two issues that will receive the most attention here, because they seem the most troubling across the jurisdictions studied, are the role of capacity (or competency) principles in the legal criteria governing involuntary outpatient care, and the precise powers the legislation confers on health professionals to 'enforce' treatment in the community.

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2. Methods

Since the late 1990s, the author has studied, with colleagues, the operation of New Zealand's CTO regime.[1] In addition, during 2003, the author travelled for several months, in Australia, Canada and the United Kingdom, collecting material concerning their involuntary outpatient schemes.[2]

The main methods followed in each place were:

- to visit and interview key professionals involved in the study or implementation of CTOs, especially those who had researched the local scheme, members of mental health review tribunals, and psychiatrists;
- to collect and study local legislation, case law and law reform materials; and
- to study the literature found in journals, theses and local policy guidelines.

As an example, the research in the Australian state of Victoria involved study of: the Victorian Mental Health Act 1986 (and amendments); the published decisions and annual reports of the Victorian Mental Health Review Board which reviews the status of patients under CTOs; the CTO Guidelines issued by the Chief Psychiatrist of Victoria;[3] a law reform Discussion Paper on CTOs circulated in 2003;[4] three unpublished theses;[5] and 11 journal articles that were found.[6] A three week site visit was made to Melbourne, where 17 interviews were conducted with senior psychiatrists, health administrators, lawyers and members of the Mental Health Review Board. In addition, the author had previously visited Melbourne on several occasions to attend local conferences on mental health law.

[1] See Dawson, J. and Romans, S. (2001). Use of community treatment orders in New Zealand: early findings. *Australian and NZ Journal of Psychiatry*, 35, 190–195; Dawson, J., Romans, S., Gibbs, A. and Ratter, N. (2003). Ambivalence about community treatment orders. *International Journal of Law and Psychiatry*, 26, 243–255. Romans, S., Dawson, J., Mullen, R. and Gibbs, A. (2004). How mental health clinicians view community treatment orders: a national New Zealand survey. *Australian and New Zealand Journal of Psychiatry*, 38, 836–841. Gibbs, A., Dawson, J., Forsyth, H., Mullen, R. and Te Oranga Tonu Tanga (the Maori Mental Health Team) (2004). Maori experience of community treatment orders in Otago, New Zealand. *Australian and New Zealand Journal of Psychiatry*, 38, 830–835; Gibbs, A., Dawson, J., Ansley, C. and Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, 14, 357–368; Gibbs, A., Dawson, J. and Mullen, R. (2006). Community treatment orders for people with serious mental illness: a New Zealand study. *British Journal of Social Work* (in press); Mullen, R., Gibbs, A. and Dawson, J. (2006). Family perspective on community treatment orders: a New Zealand study. *International Journal of Social Psychiatry* (in press); and see the Otago Community Treatment Order Study Website: http://www.otago.ac.nz/law/otagoCTO/index.html.

[2] Further material was collected during 2004 and 2005, while the work was written up. The full report of this project is published in Dawson, J. (2005). *Community Treatment Orders: International Comparisons*. Dunedin: Otago University Print: available at the website above. The law in Switzerland was also studied, to consider the position in a civil law jurisdiction: see 'Switzerland' in Dawson (2005), 80–92.

[3] Chief Psychiatrist (2001). *Community Treatment Order Guidelines*. Melbourne: Department of Human Services. A new version of these excellent guidelines has recently been published: Chief Psychiatrist (2005). *Community Treatment Orders*. Melbourne: Department of Human Services; www.health.vic.gov.au/mentalhealth/cpg/index.htm.

[4] Mental Health Branch (2003). *Community Treatment Orders: Discussion Paper.* Melbourne: Department of Human Services.

[5] Cooper, H. (1992). *Involuntary Treatment in the Community.* MPsychMed Thesis, Monash University, Melbourne; Power, P. (1998). *Outpatient Commitment — Is it Effective?* MD Thesis, School of Medicine, University of Melbourne, Australia; Muirhead, D. (2000). *Involuntary Treatment of Schizophrenia in the Community: Clinical Effectiveness of Community Treatment Orders with Oral and Depot Medication in Victoria.* Dissertation submitted to the Royal Australasian College of Psychiatrists, Melbourne.

[6] Dedman, P. (1990). Community treatment orders in Victoria, Australia. *Psychiatric Bulletin,* 14, 462–464; Power, P. (1999). Community treatment orders: the Australian experience. *Journal of Forensic Psychiatry,* 10, 9–15; McDonnell, E. and Batholomew, T. (1997). Community treatment orders in Victoria: emergent issues and anomalies. *Psychiatry, Psychology and Law,* 4, 25–36; Jaworowski, S. and Guneva, R. (2000). Integrating community treatment orders into best clinical practice. *Australasian Psychiatry*, 8, 59–62; Ring, D., Brophy, L. and Gimlinger, A. (2001). Examining community treatment orders in Victoria: a preliminary inquiry into their efficacy. *Health Issues*, March, 13–17; Systema. S., Burgess, P. and Tansella, M. (2002). Does community care decrease length of stay and risk of rehospitalization in new patients with schizophrenic disorders? *Schizophrenia Bulletin*, 28, 273–281; Brophy, L. Campbell, J and Healy, B. (2003). Dilemmas in the case manager's role: implementing involuntary treatment in the community. *Psychiatry, Psychology and Law*, 10, 156–163; Brophy, L. and McDermott, F. (2003). What's driving involuntary treatment in the community? The social, policy, legal and ethical context. *Australasian Psychiatry*, 11 (Supplement), 84–88; Burgess, P., Bindman, J., Lees, M., Szmukler, G. and Henderson, C. (2003). *Do community treatment orders for mental illness reduce readmission to hospital: an epidemiological study.* Policy & Analysis Group, Mental Health Research Unit, Parkville, Melbourne; Wallace, P., Mullen, P. and Burgess, P. (2004). Criminal offending in schizophrenia over a 25 year period marked by deinstitutionalization and increasing prevalence of comorbid substance abuse disorders. *American Journal of Psychiatry*, 161, 716–727; Brophy, L. and Ring, D. (2004). The efficacy of involuntary treatment in the community: consumer and service provider perspectives. *Social Work in Mental Health*, 2, 157–174.

Similar research was conducted in Sydney, in New South Wales, although less extensive local materials were found.[7] A month was spent in Toronto, investigating the new Ontario CTO scheme and general principles of Canadian mental health law;[8] and a further month was spent in the United Kingdom, where the emphasis was on the newly-enacted Scottish CTO scheme, which has since come into force, and on the proposals for the enactment of a 'non-resident' treatment scheme under revised legislation for England and Wales.[9]

During this work the CTO provisions of the following statutes were scrutinised:

- in New Zealand, the Mental Health (Compulsory Assessment and Treatment) Act 1992
- in Australia, the Victorian Mental Health Act 1986 and the New South Wales Mental Health Act 1990
- in Canada, the Ontario Mental Health Act (as amended in 2000 to insert a CTO regime)
- in Scotland, the Mental Health (Care and Treatment) (Scotland) Act 2003 (implemented in late 2005)
- in England and Wales, the Mental Health Act 1983, the Mental Health (Patients in the Community) Act 1995, and the Draft Mental Health Bill 2004 (Department of Health, 2004).

The primary focus of the work was therefore the law governing CTOs and professionals' views of the operation of involuntary outpatient care, not the perspectives of consumers or families.[10]

There are therefore important limitations to these methods, especially when several sites were visited for limited periods. In some jurisdictions, little sustained research was found on the local CTO scheme. Not all the conclusions that are reached here can therefore be grounded in hard data or published work. They are simply the best conclusions I feel able to draw from the materials collected and the inquiries made. The advantage of the methods followed, however, is the breadth of the inquiries made, across a range of jurisdictions, in a single year. This permits a wide-angled view to be gained.

[7] See 'New South Wales' in Dawson (2005), 62–79; and Carne, J. (1996). *A Study of the Effect and Outcome of the Use of Community Treatment Orders and Community Counselling Orders in New South Wales in 1991*. MPH Thesis, University of Sydney; Ozgul, S. and Brunero, S. (1997). A pilot study of the utilisation and outcome of community orders: client, care, case manager and Mental Health Review Tribunal perspective. *Australian Health Review*, 20, 70–83; Vaughan, K., McConaghy, N., Wolf, C., Myhr, C. and Black, T. (2000). Community treatment orders: relationship to clinical care, medication compliance, behavioural disturbance and readmission. *Australian and NZ Journal of Psychiatry*, 34, 801–808; Legislative Council of NSW (2002). *Inquiry into Mental Health Services in NSW of the Select Committee on Mental Health: Final Report*, Parliamentary Paper No 368: Sydney.

[8] See 'Canada' in Dawson (2005), 116–139; Gray, J., Shone, M. and Liddle, P. (2000). *Canadian Mental Health Law and Policy*. Vancouver: Butterworths; O'Reilly, R., Brooks, S., Chaimowitz, G., Neilson, G., Carr, P., Zikos, E., Leichner, P., and Beck, P. (2003). CPA position paper: mandatory outpatient treatment. *Canadian Journal of Psychiatry*, 48 Insert, 1–6; O'Reilly, R. (2004). Why are community treatment orders controversial? *Canadian Journal of Psychiatry*, 49, 579–584; Gray, J. and O'Reilly, R. (2005). Canadian compulsory community treatment laws: recent reforms. *International Journal of Law and Psychiatry*, 28, 13–22.

[9] See 'Scotland, England and Wales' in Dawson (2005), 93–115. On the existing legal regimes for involuntary community care in the UK, see: Bartlett, P. and Sandilands, R. (2003). *Mental Health Law: Policy and Practice (2nd ed)*. Oxford: Oxford University Press; Atkinson, J., Harper Gilmour, W., Dyer, J., Hutcheson, F. and Paterson, L. (1997). Consultants' views of leave of absence and community care orders in Scotland. *Psychiatric Bulletin*, 21, 91–94; Atkinson, J., Harper Gilmour, W., Dyer, J., Hutcheson, F. and Paterson, L. (1999). Retrospective evaluation of extended leave of absence in Scotland 1988–94. *Journal of Forensic Psychiatry*, 10, 131–147; Atkinson, J., Harper Gilmour, W. and Garner, H. (2000). Views of consultant psychiatrists and mental health officers in Scotland on the Mental Health (Patients in the Community) Act 1995. *Journal of Mental Health*, 9, 385–395; Atkinson, J., Garner, H., Harper Gilmour, W. and Dyer, J. (2002). The introduction and evaluation of Community Care Orders following the Mental Health (Patients in the Community) Act 1995. *Journal of Mental Health*, 11, 417–429; Atkinson, J., Garner, H., Harper Gilmour, W. and Dyer, J. (2002). The end of indefinitely renewable leave of absence in Scotland: the impact of the Mental Health (Patients in the Community) Act 1995. *Journal of Forensic Psychiatry*, 13, 298–314; Pinfold, V., Bindman, J., Friedli, K., Beck, A. and Thornicroft, G. (1999). Supervised discharge orders in England. *Psychiatric Bulletin*, 23, 199–203; Pinfold, V., Bindman, J., Thornicroft, G,, Franklin, D., Hatfield, B. (2001). Persuading the persuadable: evaluating compulsory treatment in England using Supervised Discharge Orders. *Social Psychiatry and Psychiatric Epidemiology*, 36, 260–266.

[10] Our group has studied consumer and family perspectives of CTOs in New Zealand: see Gibbs, A., Dawson, J., Forsyth, H., Mullen, R. and Te Oranga Tonu Tanga (the Maori Mental Health Team) (2004). Maori experience of Community Treatment Orders in Otago, New Zealand. *Australian and New Zealand Journal of Psychiatry*, 38, 830–835; Gibbs, A., Dawson, J. and Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health,*14, 357–368; Gibbs, A., Dawson, J. and Mullen, R. (2006). Community treatment orders for people with serious mental illness: a New Zealand study. *British Journal of Social Work* (in press); Mullen, R., Gibbs, A. and Dawson, J. (2006). Family perspective on community treatment orders: a New Zealand study. *International Journal of Social Psychiatry* (in press).

3. The criteria for a CTO

In the jurisdictions studied, two distinguishable sets of criteria are usually established by the relevant legislation to govern a person's placement on a CTO: first, general criteria that govern a person's placement under the mental health legislation as a whole; and, secondly, more specific criteria that govern the use of involuntary *outpatient* care.[11] The general criteria usually specify the forms of mental disorder for which involuntary treatment may proceed, and the necessary 'harms', 'dangers', or 'risks' the person must pose, to their own health or safety, or that of others. The more specific criteria will then usually require that outpatient treatment be 'appropriate' or 'viable', and that adequate community services be 'available' to meet the person's needs.[12] In some statutes, the latter criteria are very precise. They may specify that involuntary outpatient treatment may only be used as an alternative to hospital, or that a certain number of recent hospital admissions is required.[13] Perhaps the most troubling issue, in the design of these criteria for the use of CTOs, is the role played by competency (or capacity) principles.

3.1. The role of competency (or capacity) principles

The place of competency principles in involuntary treatment legislation is perhaps *the* major question of principle facing mental health law throughout the western world. It is a particularly significant issue for the law governing involuntary outpatient care.

Now that most mental health service systems in the western world have been largely deinstitutionalised, and the number of psychiatric hospital beds available has dramatically declined, those psychiatric patients who are still hospitalised involuntarily are often acutely unwell, and many would, for that reason, lack the capacity to consent to treatment at that time. For involuntary outpatients, however, this is less likely to be true. Outpatients are considered well enough to live outside the hospital, after all, and they may remain under treatment for lengthy periods of time. Some involuntary outpatients may lack the competence to consent to psychiatric treatment throughout their time on the CTO, but not all will. Some are likely to regain their competence to consent while still under the order, or their competence may fluctuate during the course of their care. The right of these latter patients to refuse further psychiatric treatment, when their competence returns, is the principal fault-line dividing the CTO statutes in North America from those in Australasia and the UK.

The central question of principle is whether the involuntary psychiatric treatment of a person who retains their competence to consent (or their capacity; the terms are used here interchangeably) should ever be permitted under a CTO regime. The trend in the North American jurisdictions, and in some parts of Europe, is to apply to psychiatric treatment the same general rule applied to other forms of medical care: that only incompetent patients may be treated without their consent.[14] In Ontario and in many states of America, this rule is applied even to the psychiatric treatment of patients lawfully placed under a civil commitment scheme, including patients under CTOs.[15]

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[11] For details of the relevant legislative criteria, see, Dawson (2005): for NZ, 20; Victoria, 34; NSW, 64; Scotland, 99; the Bill for England and Wales, 112; Ontario, 129.

[12] See, for example, New Zealand's Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28(4).

[13] See, for example, Saskatchewan's Mental Health Services Act, S.S. 1984–85 c. M-13.1, s 24.3(1)(a)(ii); and Ontario's Mental Health Act, R.S.O. 1990 c. M.7, s 33.1(4).

[14] On the position in the USA, see particularly Appelbaum, P. (1994). *Almost a revolution: mental health law and the limits of change*. New York: Oxford University Press; Winick, B. (1997). *The right to refuse mental health treatment.* Washington, DC: American Psychological Association; Saks, E. (2002). *Refusing care: forced treatment and the rights of the mentally ill*. Chicago: University of Chicago Press. For Canada, see Gray, J., Shone, M. and Liddle, P. (2000). *Canadian Mental Health Law and Policy.* Vancouver: Butterworths; Downie, J., Caulfield, T. and Flood, C. (2002). *Canadian Health Law and Policy.* Toronto: Butterworths.

[15] For Ontario, see: Bay, M. (2004). Lessons from 70 years of experience with mental health, capacity and consent legislation in Ontario, *Health Law in Canada,* 24, 36; Hiltz, D'A. and Szigeti, A. (2005). *A guide to consent and capacity law in Ontario.* Markham, Ontario: LexisNexis Butterworths. For the USA, see: Gerbasi, J., Bonnie, R. and Binder, R. (2000). Resource document on mandatory outpatient commitment. *Journal of the American Academy of Psychiatry and Law*, 28, 127–44; Kress, K. (2000). An argument for assisted outpatient treatment for persons with serious mental illness illustrated with reference to a proposed statute in Iowa. *Iowa Law Review*, 85, 1269–1386; Saks, E. (2003). Involuntary outpatient commitment. *Psychology, Public Policy and Law*, 9, 94–106; Winick, B. (2003). Outpatient commitment: a therapeutic jurisprudence analysis. *Psychology, Public Policy and Law*, 9, 107–144.

Applying this rule to all forms of medical treatment reflects the central role of autonomy and competency principles in contemporary health care ethics; it recognises that non-psychiatric treatment is already covered by competency principles, even in the case of patients who are simultaneously receiving involuntary psychiatric care; and it removes the suggestion that the law discriminates against mentally disordered people when it applies less favourable rules to their psychiatric treatment than to other forms of medical care (Dawson & Szmukler, 2006).

The main practical effect of applying this rule in the mental health context is to prohibit the involuntary psychiatric treatment of a patient who regains their competence and refuses further treatment. In addition, it requires clinicians to assess the competence of involuntary patients on a regular basis, to ensure competent patients are not being treated without their consent.

In North America, the general (though not universal) position is that psychiatric treatment cannot be provided without consent to a competent patient, even a patient lawfully placed under a civil commitment scheme.[16] This is not the legal position in Australasia or Scotland, however, nor will it be the position in England and Wales if the mooted 'non-resident' treatment scheme is implemented there in the form in which it is currently proposed.[17]

Under the Australasian statutes, in particular, the general position is that psychiatric treatment may be provided without consent to a patient for as long as they remain lawfully under the CTO regime. To remain lawfully under it, they must continue to be mentally disordered in the necessary sense, and they must present one of the necessary threats of harm, to themselves or others, and no doubt many patients who meet those criteria would be found to lack the competence to consent to their psychiatric treatment, if that matter was specifically assessed. But an involuntary outpatient's resumption of competence does not suspend the responsible clinician's authority to treat that patient without consent, in Australasia, as a matter of law. That would be an important ethical consideration for the clinician, who may choose not to treat a competent patient without their consent, but no direct link is established in the law between an involuntary outpatient's competence and their right to refuse psychiatric treatment. Nor does return of the patient's competence trigger an immediate right to their discharge from a CTO. In short, the Australasian mental health statutes are not based on competency principles. They are based primarily on the twin concepts of mental disorder and the continuing threat of harm.[18]

This position has advantages, of course. It permits the continuing treatment of patients with severe and continuing mental disorders, whose competence may fluctuate, but for whom a sustained course of medication may be thought required. The condition of these patients may be viewed in a longitudinal manner, taking into account their full psychiatric history and their likely prognosis if treatment were withdrawn. A predictive and preventive approach to their treatment is authorised, and that approach may provide greater opportunities to stabilise their condition and to establish a proper structure for their long-term community care.

The pre-eminent question of legal principle facing the various jurisdictions in Australasia and the UK, therefore, is whether that 'clinical' approach to treatment without consent in psychiatry (as it might be called) should continue to prevail, or whether the North American trend, which draws more heavily on legal and bioethical reasoning,[19] should be adopted instead, to recognise more firmly a competent person's autonomy over their mental health care.

If the North American approach were adopted, it might significantly reduce both the rate of use, and the typical length of use, of the Australasian CTO schemes. Those changes would in turn put pressure on other social systems, and greater use might be made of the criminal justice system (and of specialised mental health courts, within the criminal jurisdiction) as an alternative mechanism of social control.

[16] Supra n 14 and n 15.

[17] See Dawson (2005), 98–102, concerning Scotland; and 111–114, for England and Wales.

[18] See, for example, Bell, S. and Brookbanks, W. (2005). *Mental Health Law in New Zealand (2nd ed).* Wellington: Brookers; Hoggett, B. (1996). *Mental Health Law (4th ed)*. London: Sweet and Maxwell; Richardson, G. (1999). *Report of the Expert Committee: Review of the Mental Health Act 1983*. London: Department of Health; Millan, B. (2001). *Review of the Mental Health (Scotland) Act 1984*. Edinburgh: Scottish Executive; Jones, R. (2002). *Mental Health Act Manual (8th ed)*. London: Sweet and Maxwell; Bartlett, P. and Sandilands, R. (2003). *Mental Health Law: Policy and Practice (2nd ed).* Oxford: Oxford University Press.

[19] See, for example, Buchanan, A. and Brock, D. (1989). *Deciding for others: the ethics of surrogate decision-making*. New York: Cambridge University Press.

3.2. The English approach

The position likely to be adopted on these questions in England is perhaps the most critical from the Australasian point of view. Many core principles of Australasian mental health law have been derived from English models in the past. So, if competency (or capacity) principles were to be adopted into English mental health law, perhaps under the influence of developments in European human rights law, that might tip the balance in the same direction in Australasia. It is therefore highly significant for Australasia that the adoption of competency principles into mental health legislation has not been accepted by the British government so far. The adoption of such principles was recommended by the Expert Committee convened to review English mental health law in the early stages of the current law reform process (Richardson, 1999). But that recommendation was not accepted by the British government when it placed its own Draft Mental Health Bill before the UK Parliament in 2004. Nor has the right to refuse psychiatric treatment of every competent patient (including those lawfully placed under a civil commitment scheme) been recognised as an overriding requirement of European human rights law.[20]

The incorporation of capacity principles into mental health legislation has been resisted by the British government so far due to the barriers it could pose to the sustained treatment of people with severe but fluctuating mental conditions who pose significant threats of harm (Department of Health, 2005). Permitting an involuntary patient to refuse medication immediately, if they temporarily regain their capacity, may prevent that person receiving a sustained course of treatment, even if their condition poses a serious threat of harm, and even if their condition might improve substantially if treated effectively for a reasonable period of time. This is because it may not be safe or viable to stop and start a person's medication regime as their capacity (and therefore their right to refuse treatment) fluctuates from time to time. This is the familiar dilemma posed by the application of capacity principles to people with severe but fluctuating mental conditions (Appelbaum, 1994).

The new Scottish legislation has attempted to finesse this dilemma by incorporating into the legislation a 'significantly impaired capacity' test.

3.3. The 'significantly impaired capacity' test in Scotland

On the recommendation of the Millan Committee, the new Scottish mental health legislation has included a test of significantly impaired capacity to consent to treatment for mental disorder within the base criteria for involuntary treatment under that Act.[21] This modified capacity test governs both detention and treatment decisions. This may surmount some of the difficulties encountered when 'pure' capacity principles are applied to patients with severe but fluctuating mental conditions.

The 'significantly impaired capacity' test retains some advantages of the 'clinical', or longitudinal, approach to assessing a person's need for mental health care, because its language is sufficiently flexible to accommodate fluctuating mental states. A person who lacked the capacity to consent to treatment much of the time could be considered to have significantly impaired capacity to consent to treatment overall. Their sustained community treatment could therefore proceed under the Scottish legislation.

This approach affirms to some extent the central role of capacity (and autonomy) principles in the law governing consent to treatment, and it responds, to some degree, to the suggestion that mental health law discriminates against

[20] Harding, T. (1989). The application of the European Convention on Human Rights to the field of psychiatry. *International Journal of Law and Psychiatry, 12,* 245–262; Gostin, L. (2000). Human rights of persons with mental disabilities: the European Convention on Human Rights. *International Journal of Law and Psychiatry, 23*, 125–159. Wicks, E. (2001). The right to refuse treatment under the European Convention on Human Rights. *Medical Law Review, 9*, 17–40; Salize, H., Dressing, H. and Peitz, M. (2001) (eds). *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients— Legislation and Practice in EU—Member States* (a report to the European Commission). Mannheim: Central Institute of Mental Health; Lewis, O. (2002). Protecting the rights of people with mental disabilities: the European Convention on Human Rights. *European Journal of Health Law, 9,* 293–320; Gevers, J. (2004). The European Court of Human Rights and the incompetent patient. *European Journal of Health Law*, *11*, 225–229; Kingdon, D., Jones, R. and Lonnqvist, J. (2004). Protecting the human rights of people with mental disorder: new recommendations emerging from the Council of Europe. *British Journal of Psychiatry, 185*, 277–279; Richardson, G. (2005). The European convention and mental health law in England and Wales: moving beyond process? *International Journal of Law and Psychiatry*, *28*, 127–139.

[21] See Millan, B. (2001). *Review of the Mental Health (Scotland) Act 1984*. Edinburgh: Scottish Executive; and now Mental Health (Care and Treatment) (Scotland) Act 2003, s 64(5).

people with mental disorders when it fails to apply capacity principles to involuntary psychiatric treatment, when those principles are applied to all other forms of medical care.

Under the Scottish approach, there would be three main criteria for intervention under mental health legislation. It would have to be shown that:[22]

- the person was mentally disordered in the necessary sense; and
- they presented a serious threat of harm to themselves or others; and
- their capacity to consent to treatment for mental disorder was significantly impaired.

As a whole, those criteria would be different, but arguably no less demanding, than the legal tests applied to other forms of non-consensual medical care. When non-psychiatric treatment was contemplated, 'pure' capacity principles would apply. When involuntary psychiatric treatment was contemplated, only watered-down capacity principles would apply. But, in the latter case, the further criteria of serious mental disorder and potential for harm would also apply, before involuntary treatment could proceed.

In Scotland, that significantly impaired capacity test will apply to the psychiatric treatment of both involuntary inpatients and outpatients.

3.4. Previous hospitalisation

The second major fault-line concerning the criteria for involuntary outpatient care, in the jurisdictions studied, concerns whether a person must have a history of prior hospitalisation to be eligible for a CTO.

The question is not so much whether the person must have been hospitalised on this occasion to be placed on a CTO, because, in practice, virtually all patients placed on them have just passed through some period of inpatient care, whether that is required by the legislation or not. The more pressing question is whether a CTO can be lawfully employed following a person's first admission to psychiatric care.

For a CTO to be employed, the Saskatchewan legislation requires, for instance, that 'during the immediately preceding two year period' the person must have 'been detained in an in-patient facility for a total of 60 days or longer', or have 'been detained in an in-patient facility on three or more separate occasions'.[23] The Ontario legislation requires the person to have been hospitalised at least twice, or for more than 30 days, in the last 3 years.[24]

Neither of these requirements prohibits the use of a CTO following a first admission to psychiatric care, but only a lengthy first admission (and in Saskatchewan an involuntary one) would meet the prior admission requirements laid down. The New South Wales legislation, on the other hand, expressly permits a person to be placed on a CTO following their first psychiatric admission, if this constitutes a less restrictive alternative to their hospital care;[25] while in Victoria, New Zealand and Scotland the legislation makes no reference to prior hospitalisation at all.

In some jurisdictions, CTOs are applied to patients following their first psychiatric admission. From my interviews with clinicians using CTOs actively in Victoria, Australia, for instance, it was clear they sometimes relied on involuntary outpatient treatment in these circumstances, when it was considered necessary to stabilise the patient's condition and ensure their continuing medication.

This is a controversial use of a CTO, because in such cases there can be no established pattern of treatment refusal or relapse, following the patient's discharge from hospital. When discharged from their first admission, such patients might accept voluntary care. Once placed on a CTO, however, they may remain on it for a considerable time. As one case manager put it to me in Victoria: 'The patient stays under the CTO for a year when all they really needed was another week in hospital'.

Many clinicians in Victoria still argued that placing first admission patients on CTOs could be justified, when the patient remained very unwell on discharge from hospital, they lacked insight into their need for treatment, and they could not be relied upon to take continuing medication. The benefits of early intervention in promoting recovery from

[22] Mental Health (Care and Treatment) (Scotland) Act 2003.

[23] Mental Health Services Act, S.S. 1984–85 c. M-13.1, s 24.3(1)(a)(ii). See O'Reilly, R., Keegan, D. and Elias, J. (2000). A survey of the use of Community Treatment Orders in Saskatchewan. *Canadian Journal of Psychiatry*, 45, 79–81.

[24] Mental Health Act, R.S.O. 1990 c. M.7, s 33.1(4).

[25] Mental Health Act 1990 (NSW), s 133.

schizophrenia were frequently cited (RANZCP, 2005). In short, the prevailing view seemed to be that the decision to use a CTO should be based on a current assessment of the severity of the patient's illness, the potential for harm to befall them or others, their likely compliance with medication, and their current treatment needs. The clinicians encountered did not think involuntary outpatient treatment should be prohibited just because the patient did not have a lengthy history of hospitalisation.

This use of CTOs seems particularly associated with the dramatic shortening of hospital admissions that is now typical of radically deinstitutionalised mental health systems, like that in Victoria, where the average length of a psychiatric admission is now something like 8 days (Burgess, Bindman, Lees, Szmukler, & Henderson, 2003). In such circumstances, patients are frequently discharged from the hospital at an early stage in their treatment, to be followed up under a CTO by a mobile community mental health team.

4. Powers to 'enforce treatment' in community settings

Another major question of principle troubling the various jurisdictions is the precise scope of the treatment powers to confer on community clinicians. Can a CTO regime be devised that is sufficiently enforceable to attract the confidence of clinicians but is still consistent with the protection of patients' human rights?

In the jurisdictions studied, two general approaches have been adopted by legislatures when specifying the scope of community treatment powers. The first is for the legislation to address the matter directly, by explicitly conferring on health professionals a package of powers that may be used at their discretion to facilitate the treatment of any patient under a CTO.[26] In that manner, powers may be directly conferred: to enter private premises, provide treatment, recall the patient to hospital, use reasonable force in that process, obtain police assistance, and so on; and these powers could be applied to any patient under the scheme. This is the general approach taken in the 'first generation' CTO statutes, like those originally enacted in Victoria and NSW. It has the advantage of being both transparent and simple.

The second approach is taken in more recent, 'second generation' CTO statutes that require the formulation for each patient of a statutory treatment plan. Under this approach, the precise powers conferred on health professionals to enforce community treatment are specified indirectly. Instead of providing a list of powers in the legislation that may be applied to any involuntary outpatient, a court (or tribunal) is empowered to specify the particular means that may be used to enforce treatment in the individual case, when it approves the contents of that patient's treatment plan.[27]

This approach may be less transparent, particularly if the kinds of enforcement mechanisms the courts may approve are described in vague or general terms in the legislation. In that case, only subsequent research into the orders actually made could reveal the precise enforcement mechanisms that were being authorising in different categories of case. On the other hand, this approach is more sophisticated and calibrated. It permits a court to specify the particular means to enforce treatment that are 'proportionate' to the circumstances of the individual case, as may be required in jurisdictions governed by European human rights law.[28]

As to the specific powers to enforce community treatment that are being conferred by CTO legislation on health professionals: great care is taken in some statutes to provide enforcement mechanisms that give some 'teeth' to the outpatient regime, without going so far as to authorise the administration of medication without consent in circumstances that would be unsafe for the patient or the health professionals concerned. The line that emerges from study of the statutes, and from the law reform debates, as the Rubicon that should not be crossed, is the authorisation of 'forced medication' in community settings. This is the point on which virtually all commentators and statutes seem to agree: that forced medication of involuntary outpatients in community settings is unacceptable if all citizens are to be guaranteed the levels of privacy, dignity and personal security required by human rights norms.

Virtually every other practical means to enforce outpatient treatment is authorised by law in one or other jurisdiction studied, except that one. Even the NZ statute, which may contain the most explicit treatment powers,[29] does not expressly authorise health professionals to 'restrain and medicate' a patient in a community setting. Instead, that kind of authority is explicitly disavowed in the statutory Guidelines to the NZ scheme (NZ Ministry of Health, 2000).

[26] As in New Zealand and New South Wales; see Dawson (2005), 18–28 for NZ; and 62–79 for NSW.
[27] See, for example, the treatment plan provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003.
[28] Supra n 20; and *A v Secretary of State for the Home Department* [2004] UKHL 56; [2005] 2 WLR 87 (HL).
[29] Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), ss 29, 122B and Part V.

In my opinion, this consensus is correct. If we are to take patients' human rights seriously, the administration of medication by force in a community setting, outside a properly supervised clinic or hospital, should never be authorised by a CTO regime.

4.1. The alternative package of powers conferred in Australasia

What the experience in Australasia demonstrates, nevertheless, is that conferring precisely that kind of power on health professionals is not necessary to encourage the active use of a CTO scheme.[30] The argument that is sometimes heard — that unless 'forced medication' in community settings is authorised the scheme 'cannot work' and will not be used — is disproved by the experience in NZ, Victoria and NSW. The conferral on community teams of another carefully-designed package of powers, and the imposition of certain duties on the patient and treatment providers, in a statute that walks right up to the line of forced medication in the community, but does not walk over it, has proved sufficient, in the Australasian context, to give health professionals the confidence to use these schemes (Dawson, 2005).

It has proved sufficient to provide the following mix of duties and powers:

- to direct the kind (or 'level') of accommodation at which the patient must reside[31]
- to place a duty on the patient to accept psychiatric treatment (subject to the same limits as apply to treatment in hospital), even if that duty is not matched by a power to 'restrain and medicate' the patient in a community setting[32]
- to direct the patient to accept visits from health professionals and to attend outpatient appointments
- to recall the patient swiftly to hospital and to take them there[33]
- to enter the patient's place of residence to activate that recall process
- to obtain police assistance in that process
- to provide treatment without consent in a hospital, or in a clinic that is continuously staffed by properly qualified health professionals.

None of these provisions is quite explicit enough to authorise the restraint and forced medication of a patient in a community setting and there is considerable agreement that that kind of power should not be conferred.[34]

Perhaps the most contentious point, in relation to the powers that are sometimes conferred, is whether an express power of entry should be provided into private premises, to obtain access without consent to the patient for the purposes of their treatment or rehospitalisation. Here a spectrum of approaches is evident in the jurisdictions studied. In NZ, an express power of entry is conferred on community mental health teams to enter the patient's residence 'at all reasonable times' for the purpose of providing treatment.[35] In NSW and Victoria, such powers of entry appear only to exist for the purposes of returning the patient to hospital.[36] While under the Bill for England and Wales, entry to a patient's private residence without consent would seem to be limited to crisis intervention situations, where entry would be independently authorised by law.[37] The British Parliament may be more constrained than Australasian legislatures in this respect by the requirement to respect privacy and family life imposed by European human rights law.[38]

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[30] On rates of use of CTOs in various jurisdictions, including Australasia, see Lawton-Smith, S. (2005). *A question of numbers: the potential impact of community-based treatment orders in England and Wales*. London: King's Fund.

[31] The Victoria legislation provides an explicit power of this kind: Mental Health Act 1986 (Victoria), s 14(3); in other parts of Australasia residence requirements may be imposed in practice by clinicians as a condition of the patient's community tenure or as a requirement of their community treatment plan.

[32] See, for example, Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), ss 29; Mental Health Act 1986 (Victoria), ss 12AD and 14(2); Mental Health Act 1990 (NSW), ss 145, 146.

[33] See, for example, Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), ss 29(3), 41; Mental Health Act 1986 (Victoria) ss 9A, 9B; Mental Health Act 1990 (NSW), ss 137–143A.

[34] See, for example, the discussion in the Victorian CTO Guidelines: Chief Psychiatrist (2005). *Community Treatment Orders*. Melbourne: Department of Human Services, 14; www.health.vic.gov.au/mentalhealth/cpg/index.htm.

[35] Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), s 29(2).

[36] Mental Health Act 1986 (Victoria) ss 9A and 9B; Mental Health Act 1990 (NSW), ss 137–143A; and see the *Community Treatment Order Guidelines,* supra n 3.

[37] Mental Health Bill 2004, clauses 225–228.

[38] European Convention on Human Rights, Article 8(1): 'Everyone has the right to respect for his private and family life, his home and his correspondence'.

NSW treads perhaps the finest line, by expressly authorising community clinicians to 'enter the land, but not the dwelling' of the patient, to facilitate treatment, and by stating that medication may be administered to involuntary outpatients in a community setting without consent 'if it is administered without the use of more force than would be required … if the person had consented'.[39]

Even those powers might be challenged in North America or Europe as contrary to constitutional or human rights norms, but it is doubtful whether such challenges would be successful when the overriding purpose of the CTO regime is to authorise the least restrictive form of mental health care.

Perhaps an adequate compromise can be found, therefore, that confers sufficient authority on health professionals to ensure they use the scheme, without the unjustifiable infringement of patients' human rights.

4.2. Recall to hospital

The single most important power in the enforcement of CTOs seems to be the power to recall the patient swiftly to inpatient care, while by-passing the usual complexities of the certification process. These recall (or 'revocation', or 'breach') powers are not frequently used in practice,[40] but there appears to be widespread agreement among community clinicians who administer CTOs that the credible threat of their use, and their ready availability in a crisis, are central to the successful operation of such schemes. A recall power that is burdened by procedural requirements that are too demanding to be followed in a mental health emergency is not seen to contribute anything positive to the scheme. If the recall power cannot be activated at sufficient speed, the likely outcome is that the patient will be certified afresh, and will be put back through the 'front door' of the civil commitment process, to become an involuntary inpatient again, only by a different route. There is no obvious advantage in that for the patient, but it substantially reduces the value, for clinicians, of the CTO regime.[41]

An associated pitfall in the design of recall powers is to require non-compliance by the patient with the terms of their CTO before they can be recalled.[42] The effect of that requirement is to prohibit use of the recall power if the patient relapses despite their compliance with treatment, as may occur. In that case also, the patient would have to be recommitted afresh, even if already under the CTO regime.

5. Liability concerns

A further set of legal issues concerns the potential for civil liability to be imposed on health professionals (and health authorities) who manage involuntary outpatients under a CTO scheme. The usual range of issues concerning professional negligence in treatment may obviously arise in the treatment of involuntary outpatients, but, in addition, new malpractice issues may also arise specifically related to community treatment powers.

These new liability issues seem to be of two main kinds. First, it may be alleged that health professionals have been negligent, in some cases, in failing to invoke the CTO regime following a person's discharge from inpatient care; and, secondly, it may be alleged they were negligent in the exercise of their powers to control a person under the CTO scheme: failures in supervision, for instance, or failure to recall the patient to hospital when there was clear evidence they had relapsed into an acute phase of their illness and again required inpatient care.

Particularly difficult questions may arise, in such cases, concerning liability to pay damages to third parties who have been injured by the patient following professional lapses of that kind. There are clear analogies here with *Tarasoff* liability,[43] for failure to warn third parties of a patient's potential for violence, even if that kind of liability has not been widely recognised outside the United States.

[39] Mental Health Act 1990 (NSW), s 146.

[40] On breach practices in Victoria, for example, see Dawson (2005), 40–41; for NSW, 73. In Victoria, it seems that an average of less than one revocation to hospital occurs per involuntary outpatient year; the rate in NSW seems even lower.

[41] See Dawson (2005), 73, and 134–135.

[42] See, for example, Mental Health Act 1990 (NSW), s 137.

[43] *Tarasoff v. Regents of the University of California* (1976) 551 P 2d 334.

The second of these two forms of liability specific to the use of CTOs — failure to properly exercise statutory powers of supervision and control — is perhaps the most significant, as community mental health professionals would be exposed to it whenever they were managing a patient under the CTO scheme.

Fortunately, there is not much evidence that these new forms of liability are likely to be imposed in the jurisdictions studied. There are no cases of which I am aware in which the litigants have directly alleged negligence in the use of the powers provided by a CTO scheme. There are some analogous cases. In the English case of *Clunis*, for instance, it was held that a rule in the English Mental Health Act 1983, requiring local authorities to provide after-care services to discharged patients, did not give rise to a private law action for damages if that duty was not fulfilled.[44] And, in the recent decision of the NSW Court of Appeal in *Presland*, the majority of the Court determined that a health authority was not liable to pay damages to a mentally ill man who killed another person immediately after his discharge from a brief hospital admission, and who was then confined in a forensic facility, restricting his liberty, even though the health professionals owed him a duty of care, had been negligent, and could have lawfully detained him in hospital at the time.[45] Santow JA, in particular, was concerned that expansive rules of liability for negligent failure to control a patient would threaten health professionals' impartiality in the discretionary exercise of their statutory powers, and that to impose liability might produce overly defensive medical practices and a bias towards detention of patients that was not consistent with the general principles behind the statutory scheme.

These decisions do not therefore suggest that unreasonable forms of liability are likely to be imposed in these jurisdictions on the members of community mental health teams for failure to control, or failure to deliver scarce resources to, patients under a CTO scheme.

5.1. Liability and legislation

Nevertheless, specific provisions of CTO legislation could enhance such liability concerns, and the obligations imposed by the legislation should be carefully scrutinised in this light. The precise language used could affect the circumstances in which liability would be imposed.[46] The potential for liability could be enhanced, for instance, if it were stated that 'treatment must be provided in accordance with the patient's treatment plan', or that 'the patient must be recalled to the hospital whenever outpatient treatment is no longer viable'.

Provisions in the legislation that impose such strong duties on health providers to deliver community services might appear to create a desirable form of reciprocity (or quasi-contract) between them and involuntary outpatients; and provisions demanding close supervision might appear to allay wider societal concerns about the risks posed by unsupervised mentally ill persons in the community. But if such provisions contribute to fears on the part of health professionals about the unreasonable imposition of liability, the most likely outcome is that those professionals will refuse to accept responsibility for patients under CTOs, leading to disuse of the scheme.

The CTO statutes in the jurisdictions studied appear to be carefully drafted with a view to minimising these concerns.[47] The obligations to deliver services to involuntary outpatients are not stated in such strong terms that they would seem to support private actions for damages for failure to comply, because there is insufficient evidence that the legislature intended that outcome. And the powers to supervise and control outpatients tend to be conveyed in discretionary, not mandatory, terms.

The possibility that liability might be imposed unfairly on health professionals can be anticipated, of course, when designing the statutory scheme. A special kind of immunity from liability to third parties might be conferred on clinicians who are responsible for the management of patients under CTOs.[48] They might be protected from liability as long as they acted in 'good faith', or 'with reasonable care', in the exercise of their powers. An example is clause 298 of the Mental Health Bill for England and Wales.

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[44] *Clunis v. Campden and Islington Health Authority* [1998] 3 All E R 180.

[45] *Hunter Area Health Authority v. Presland* [2005] NSWCA 33.

[46] See, for example, the Mental Health (Care and Treatment) (Scotland) Act 2003, ss 25–27; and Dawson (2005), 100–104.

[47] The NZ legislation, for example, refers to the availability of outpatient services and adequate social support for the patient as *criteria* for making a CTO, but imposes no explicit statutory duty on health or social service providers to meet that level of care: Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), s 28.

[48] See, for example, the former Mental Health Act 1969 (NZ), s 124(6).

6. Other fault-lines in the design of CTO schemes

Several other pitfalls in the design of CTO legislation have emerged from this study of the various jurisdictions' schemes.[49] There is disquiet about the character of the independent review procedures both in those jurisdictions in which reviews occur frequently before under-resourced tribunals that must adopt expedited procedures due to their burden of work,[50] and in those jurisdictions where the hearings are so lengthy and adversarial that they constitute a 'virtual discharge' mechanism for the patient.[51] Regimes are also considered unsatisfactory that permit the CTO to be cancelled, or its duration to be automatically extended, by the patient's brief readmission to hospital care. There is also concern in some places about the confusion of roles and responsibilities between various administrators of the scheme.[52] Finally, there is doubt whether family members, who may have a conflict of interest with the patient, should have full veto or approval powers concerning a patient's involuntary treatment under a CTO. The preferable solution may be for family members to have significant entitlements to be consulted and to receive information about their relative's care,[53] when this is not contrary to the patient's interests, but for final decisions about involuntary treatment to remain in the responsible clinician's hands, subject to the usual requirement of independent review of the continuing need for the order as a whole.

7. The varying rates at which CTOs are used

In conclusion, it is worth drawing attention to the widely varying rates at which CTOs are used in the different jurisdictions studied (Lawton-Smith, 2005). These rates are very difficult to compare due to differences in the legislation and in the context for its implementation, but one may still ask why CTOs seem to be used more frequently in Victoria and NZ, for instance, than in Ontario or most other parts of North America.

In my view, having spoken to dozens of clinicians who use CTOs in different parts of the world, and having surveyed psychiatrists on their use in NZ (Romans, Dawson, Mullen, & Gibbs, 2004), the critical factor in determining the rate of use of CTOs is the perception of clinicians concerning the advantages of the local scheme. CTOs will only be used actively, it seems, when they are viewed positively by the clinicians who must drive their procedures forward. The clinicians must decide to initiate the CTO process, rather than discharge the patient outright from hospital; and they must complete the necessary documents, put the evidence before courts or tribunals, propose the order's renewal, and so on. In making these decisions, the clinicians must assess the effort required to continue the CTO process in light of other calls on their time. In those circumstances, they must believe that use of the CTO in a particular case would confer significant advantages. The central point is that use of a CTO scheme is largely discretionary from the clinician's point of view. They must decide, in each case, whether to initiate or continue a patient's treatment under the scheme.

In my view, the main factors that influence clinicians' views concerning the advantages of using CTOs are as follows:

- the marginal authority the scheme confers on them to treat outpatients, in comparison with other lawful approaches to treatment they could employ
- the value for the patient's treatment of the community mental health services that are available to be delivered under the scheme
- the expectations of the community concerning clinicians' use of the scheme

[49] For more critical perspectives on CTOs in general, see Mattinson, E. (2000). Commentary: the law of unintended consequences. *Journal of the American Academy of Psychiatry and the Law*, 28, 154–158; Hoge, M. and Grottole, E. (2000). The case against outpatient commitment. *Journal of the American Academy of Psychiatry and the Law*, 28, 165–170; Allen, M. and Fox Smith, V. (2001). Opening Pandora's box: the practical and legal dangers of involuntary outpatient commitment. *Psychiatric Services*, 52, 342–346; Pinfold, V. and Bindman, J. (2001). Is compulsory community treatment ever justified? *Psychiatric Bulletin*, 25, 268–270; Winick, B. (2003). Outpatient commitment: a therapeutic jurisprudence analysis. *Psychology, Public Policy and Law*, 9, 107–144. One important criticism of CTOs is that patients who would accept treatment voluntarily may be placed under them simply to claim services on their behalf, if some services (like case management) are only available to involuntary patients.

[50] In New South Wales, for example; see Dawson (2005), 77.

[51] In Ontario, for example; see Dawson (2005), 133.

[52] In Victoria, for example; see Dawson (2005), 35–36.

[53] See, for example, the strong family consultation provisions of the NZ legislation: Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), ss 5(2), 7A.

- the administrative burdens involved in treating a patient under it
- the liability concerns of clinicians who treat patients under it
- the extent to which involuntary treatment may have a negative impact on therapeutic relationships, particularly the effect of the stigma and coercion experienced by the patient (Gibbs, Dawson, Ansley, & Mullen, 2005).

To give an example of such a calculation in an individual case: if the clinician believed that the local CTO regime conferred significant marginal authority, to provide a helpful and available community service to a particular patient, and believed that use of the scheme in those circumstances was within the expectations of the community, they would tend to use it in that case, unless its use would expose that clinician to excessive administrative burdens, or unacceptable liability concerns, or they think it would be counter-productive for their long-term relations with the patient.

On this view, any significant change in the perceptions of the relevant group of clinicians concerning these indicators would have a significant effect on the overall use of the scheme. So, an increase in the scope of the powers conferred on clinicians, or in the available community services, or in the expectations of the community concerning the scheme's use (in response, perhaps, to a highly-publicised tragedy), would tend to increase clinicians' use of the scheme. On the other hand, increasing the frequency of external reviews, or any other administrative burden on clinicians, or the occurrence of a celebrated case in which a clinician was sued for the conduct of their patient in the community, or the development of greater sensitivity to the coercion likely to be experienced by patients on CTOs, would tend to decrease clinicians' use of the scheme.

Similarly, if any of these factors were to go awry, that could totally subvert the utility of the scheme: if, for instance, clinicians generally considered the scheme provided no more authority than the voluntary approach to treatment, or that it imposed intolerable administrative burdens, or no adequate community service was available.

If this view is correct — that clinicians' perceptions of the balance of advantage are the key to the rate at which CTOs are used — it would impose important constraints on the capacity of legislatures to design useful CTO schemes. A scheme that seemed impeccably fair to the legislature, and fully consistent with human rights norms, may still turn out to be largely inoperative in practice if it is viewed in a negative light by the clinicians who must drive its process forward. There is therefore little point in legislatures enacting CTOs for political reasons if they do not have the relevant professional groups on their side.

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