Community Treatment Orders and Human Rights

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This article discusses the widespread use of community treatment orders (CTOs) in Australasia, in light of international trends towards the constitutionalisation of human rights. It argues that, in the absence of entrenched human rights instruments governing their law-making powers, Australasian legislatures have considerable freedom in the design of CTO regimes, and they have used that freedom to enact reasonably enforceable regimes. These have attracted the confidence of clinicians and are therefore widely used, compared with less enforceable regimes operating in many other parts of the world. This reveals a major dilemma concerning CTOs: that, in order to attract the confidence of clinicians, and be a useful element in the delivery of mental health care, they may have to operate at the boundaries of human rights concern.

Introduction

Community Treatment Orders (CTOs) authorise the provision of psychiatric treatment outside hospital, without the patient's consent, under the authority of mental health legislation. Patients under CTOs will usually be required to keep taking medication for their illness following discharge from a compulsory hospital admission, and be required to accept home visits from a community psychiatric nurse, who will monitor their condition. If treatment is refused, the patient may be returned to hospital for medication to be administered there. Involuntary treatment in the community pursuant to a CTO is clearly an intrusive form of intervention in a person's life and a proper focus of human rights concern. Nevertheless, provisions authorising this kind of intervention are now a standard feature of mental health legislation in Australia and New Zealand (Dawson, 2005).

It is no coincidence that the main criticism of CTOs made in recent times, in New Zealand, alleging their over-use, has been couched in the language of human rights (Mental Health Commission, 2006; Dawson, 2006a). The more absolute one's conception of human rights, and the more extensive the zone of negative liberty one thinks such rights cast around an individual – requiring them to be left alone, even if they have a serious, continuing mental illness – the greater will be the threat perceived to human rights from a CTO regime.

This article focuses on certain features of the CTO regimes found in New Zealand, Victoria and New South Wales. The legislation in these jurisdictions takes a distinctive approach to authorising involuntary outpatient care, particularly with regard to the scope of the community treatment powers it confers on mental health teams. One major reason why these jurisdictions have taken this approach, it will be argued, is because they do not have an entrenched bill of rights within their constitutions that controls the content of the legislation their Parliaments may lawfully enact.[1] As a consequence, their Parliaments have considerable freedom in the design of CTO legislation, and they have used that freedom to enact reasonably enforceable outpatient treatment schemes. Because these regimes are reasonably enforceable they have been widely used by clinicians. In this manner, CTO regimes have become *the* major vehicle for 'leveraging' people into psychiatric care in Australasia. This has all taken place under the authority of *civil* mental health law. Ultimately, therefore, the practice of community psychiatry in Australasia has been significantly influenced by the region's distinctive constitutional arrangements.

There are many other legal mechanisms that can be used to 'leverage' people into psychiatric care (Monahan et al, 2005). In North America, for instance, greater reliance may be placed on the criminal law: that is, on the arrest of mentally disordered persons (often for minor crimes) and their subsequent diversion to mental health care through the vehicle of specialised mental health courts, established for this purpose, within the criminal justice system (Schneider et al, 2007; Griffin et al, 2002). Alternatively, the receipt of housing and social welfare entitlements may be premised on 'voluntary' acceptance of mental health care.

These alternative approaches may sit more comfortably with the libertarian political culture found in North America. That political culture, and the associated constitutional entrenchment of civil rights, obviously imposes important constraints on the kind of mental health laws that North American legislatures can enact, and every country must design its own mental health laws in light of its own political culture and constitutional arrangements.

Further, when mental health laws are designed, the structure and availability of the local psychiatric services must be taken into account, so a proper fit can be established between those services and the ruling legal regime. If no comprehensive network of community-based psychiatric services were available, for instance, that would prevent any effective use of a CTO regime.

For these kinds of reasons, many different approaches are bound to be taken to the use of involuntary outpatient treatment in different parts of the world. Nevertheless, the overall weight of evidence

concerning the value of well-embedded and adequately resourced CTO regimes is reasonably positive, as special committees established to review the evidence by both the Canadian and the American Psychiatric Associations have found (CPA, 2003; Gerbasi et al, 2000; cf Churchill et al, 2007). There is no strong case therefore for disestablishing the CTO regimes that are currently operating within the particular constitutional arrangements, and particular mental health service environment, now found in Australasia.

The Distinctive Australasian CTO Regimes

The regions considered here – New Zealand, Victoria and New South Wales – are the most heavily populated regions of Australasia. Their CTO regimes have been in force for more than a decade (*Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ); *Mental Health Act 1986* (Vic); *Mental Health Act 1990* (NSW)). These regimes are widely used. The figures concerning their use, in 2003, have been estimated as 2700 for a total population of 4.9 million people in Victoria, 2500 for 6.6 million people in New South Wales and 1700 for 4 million people in New Zealand (Dawson, 2005; Lawton-Smith, 2006).

Roughly one person in 2000 (or 50 persons per 100,000) was therefore under a CTO, on any day, in 2003, across these regions as a whole, which contained about 15 million people: well over half the population of Australasia. This is undoubtedly a high rate of use of CTOs compared with many other parts of the world (Dawson, 2007).

This high rate of use is occurring within a particular service environment which is characterised by thorough-going deinstitutionalisation of mental health service delivery and by a strong degree of professional commitment to community-based mental health care. This care is provided through an extensive network of mobile community teams, whose nursing staff, in particular, are willing to enter patients' homes to deliver treatment there. Moreover, this system operates within a wider social welfare context, one that is still characterised by significant levels of state-subsidised housing for the mentally ill, and by the operation of publicly funded psychiatric services, delivered mainly through the salaried employees of regionally organised health authorities, that provide both inpatient and outpatient care. All these elements of the service environment may be vital to the success of a CTO regime.

In addition, there are distinctive features of the Australasian constitutional systems that seem to exert an influence on the design of the region's mental health laws. This is explored in the following section.

The Constitutionalisation of Human Rights

One distinctive aspect of the Australasian constitutional arrangements, already mentioned, is the absence of an entrenched bill of rights.[2] The constitutions of Canada and the United Kingdom, in contrast, have now moved significantly towards the position long followed in the United States, whereby certain declared rights, that are given an entrenched or 'supreme law' status, have a controlling effect on the capacity of the legislature to enact laws.

The Canadians adopted their entrenched *Charter of Rights and Freedoms* in the early 1980s, and now the United Kingdom has taken a somewhat similar approach, directly incorporating into its legal system the *European Convention on Human Rights*. It has also submitted its laws to the overriding scrutiny of the European Court of Human Rights, which can declare laws of the United Kingdom Parliament incompatible with European human rights law.

Such critical developments give human rights a superior legal status and therefore a controlling effect on other laws. This empowers the courts to strike down offending aspects of legislation, and – perhaps even more importantly – it has a pre-emptive (or preventive) effect on Parliament's willingness to pass certain laws in the first place. To avoid the embarrassment of having its statutes struck down, Parliament tends to avoid enacting any legislation that might be considered contrary to human rights principles. Parliament is bound by the constitutional (or supranational) human rights instrument, and the legal advice to Parliament, and to the ministries that develop legislation, will be that they cannot lawfully enact legislation that is inconsistent with guaranteed rights.

The lesser, statutory Bills of Rights that have been adopted in New Zealand, the Australian Capital Territory and Victoria (*New Zealand Bill of Rights Act 1990* (NZ); *Human Rights Act 2004* (ACT); *Charter of Rights and Responsibilities* (Vic)) may have similar preventive effect, but this effect is less powerful, because a statutory Bill of Rights of this kind has a lesser constitutional status: that of ordinary legislation. So it does not render other statutes invalid, such as mental health statutes, that the courts might consider inconsistent with the Bill of Rights' norms. These lesser, statutory Bills of Rights have, primarily, an interpretive effect: that is, they require other legislation to be interpreted, where possible, in a manner that is consistent with the declared rights, but they do not empower the courts to strike down offending legislation.

The Parliaments of New Zealand, Victoria and New South Wales therefore retain the power to enact mental health legislation of their choice. In contrast, the new Canadian and British constitutional

arrangements may preclude their Parliaments lawfully enacting the extensive kinds of powers to enforce community psychiatric care that are now authorised by statute in Australasia. The clear implication is that, if the Australasian jurisdictions were to adopt equivalent constitutional arrangements, this could lead to a substantial weakening of the community treatment powers that could be included lawfully within an Australasian CTO regime; and this, in turn, could significantly affect clinicians' views about the usefulness of such schemes, especially when additional administrative burdens are imposed on clinicians who activate these powers.

The overall outcome of such developments might be that both the overall *rate* at which CTOs are used, and the *length of time* for which they are used in individual cases, in Australasia, would significantly decline. If that happened, rights-conscious community treatment provisions might sit on the statute books virtually unused, because the psychiatrists, who drive the CTO process, might think the overall balance of advantage – between additional powers to treat and additional administrative burdens – no longer favoured active use of involuntary outpatient care (Dawson, 2007).

Greater use might then be made of alternative mechanisms to 'leverage' people into psychiatric treatment. Such mechanisms include the criminal law, the imposition of treatment conditions on housing and social welfare entitlements, and greater use of adult guardianship schemes. Alternatively, a reduction might occur in the number of people with serious mental illness who receive adequate continuity of care, leading perhaps to greater rates of imprisonment, alienation from families, and homelessness. If that happened, many people in Australasia would doubt that was an overall advance in human rights terms.

Community Treatment Powers

The kinds of powers and duties that are central to the enforcement of the Australasian CTO regimes include the following:

- a duty placed on the patient to accept psychiatric treatment (even if this duty is not matched by a correlative power to 'restrain and medicate' the patient for treatment purposes in a community setting);
- a duty to accept visits from health professionals and attend outpatient appointments;
- a power to direct the 'level' (or kind) of accommodation at which the patient shall reside (even if not the precise address);

- a power to enter the patient's residence for treatment and monitoring purposes;
- a power swiftly to recall the patient to hospital, avoiding the complexities of the usual certification process;
- a power to obtain police assistance in that process;
- a power to provide treatment without the patient's consent in a hospital or in a properly staffed clinic (subject, in some cases, to the requirement of a second psychiatric opinion, approving the proposed treatment, if the patient does not consent).

Providing this particular mix of duties and powers has, in the Australasian service environment, been sufficient to give most clinicians, in the relevant areas of practice, the confidence to make active use of the CTO regime. The further power of 'forced medication' in community settings is often talked about, and is an important part of the rhetoric surrounding these schemes: the notion of 'holding the patient down and giving an injection on the kitchen table'. The spectre of that is powerful, but this is not a power the Australasian schemes expressly convey, nor one that many nurses would be prepared to use. Further, there is widespread consensus that no such power should be conferred, and that any such power would contravene human rights norms (Dawson, 2006b).

The legal position in Australasia is that a CTO imposes a duty on the patient to accept psychiatric treatment on an outpatient basis, but no correlative power is expressly provided to restrain the patient to administer medication in a community setting. This is an interesting legal position, which leads some people to say that such regimes are 'very intrusive' and others to say they are 'toothless', and, in a sense, both positions are right.

It is the other powers listed above that constitute the legal engine room of the Australasian CTO regimes. Even these powers may not be exercised fully in practice, but they sit in the background and can be brought to the patient's attention. The threat of their use may be very powerful indeed, especially to a patient who has been forcibly taken to hospital several times before.

The full use of these powers would not necessarily be inconsistent with patients' human rights. This is a contested issue that has not been fully addressed in the superior courts of the common law world (the most notable decision being that of the New York Court of Appeals upholding that State's outpatient commitment statute in *In re KL* (2004)). The outcome is likely to depend on the kinds of 'justified limitations' on articulated rights that the courts will permit. Human rights are not absolute, even in entrenched constitutional systems. Some limits on

them can be justified, to promote other 'compelling' interests, especially when the least restrictive approach is employed.

Nevertheless, the exercise of community treatment powers is clearly a matter of human rights concern. The rights of patients to be left alone, to security of their person, and to privacy of their person and property, may clearly be implicated, even if they are not actually 'detained' when receiving compulsory community care. Whether the courts, in constitutionalised legal systems, would consider a CTO regime to be a 'justified' limitation on such rights is likely to depend on the precise scope of the treatment powers conferred and the circumstances in which those powers may operate: that is, it will depend on the fine print of the ruling legal regime.

There are many fine gradations in the scope of the powers conferred by different CTO regimes (Dawson, 2005). Section 146 of the *Mental Health Act 1990* (NSW) provides, for instance, that medication may be administered without consent to a patient under a CTO in a community setting 'if it is administered without the use of more force than would be required … if the person had consented'; and it provides that clinicians may 'enter the land, but not the dwelling' of the patient to facilitate treatment.

Fine lines are being drawn there. The New South Wales statute does not say that 'no force' may be used to administer treatment. As some very minimal degree of force would be required to administer an injection of medication, even to a patient who had given consent, it would not be wise for the legislation to be drafted in such absolute terms. Instead, the New South Wales legislation authorises the use of the same degree of force as 'would be required … if the patient had consented'.

The position under New Zealand's mental health legislation is very similar, even if different language is employed. Section 29(1) of the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) provides that a CTO 'shall require the patient … to accept … treatment' as directed by the Responsible Clinician. In addition, s 122B(3) states that '[a] person treating a patient … may use such force as is reasonably necessary in the circumstances'. The degree of force that is authorised by these provisions therefore depends on what is considered 'reasonably necessary' to administer treatment (including injections of medication) in a community setting. The *New Zealand Bill of Rights Act 1990* requires the scope of these powers to be interpreted in a 'rights-centred' way, so it is doubtful whether it should be considered 'reasonably necessary' to use force to restrain and medicate a patient under a CTO who is refusing treatment in a community setting, without proper medical back-up being available and without adequate supervision of the patient afterwards, as that would not be a safe health practice. In such cases, the additional

powers provided by the CTO, to return the patient to hospital for a short period for treatment to be administered, should be used instead.

The New Zealand Ministry of Health is therefore right to state in its official Guidelines, issued under the authority of the statute, that a CTO itself 'does not authorise detention *in any way*' – not even short-term detention of the person in a community setting for treatment to be imposed (revised NZ Guidelines (2006): para 12.2). The same point is made in the Victorian CTO Guidelines (2005: para 6.1.2) that:

> It is not acceptable to use physical force to impose treatment in any community setting. Similarly, it is not acceptable to use the presence of others (especially Police) to coerce a person to take treatment in the community. If such a degree of force or coercion is considered necessary … the [order] should be revoked, whereafter the person must be admitted to an inpatient unit. This allows … reconsideration of their clinical state, treatment needs, and treatment regime.

There is no clear power, therefore, under the Australasian statutes, to 'restrain and medicate' a patient in the community, but it would be lawful to medicate a patient without consent where no restraint, or significant force, was employed.

Powers of Entry

With regard to the power of entry into the residence of a patient provided under a CTO, it is said in the New South Wales statute that the clinicians may enter the land but not the private dwelling of the patient without consent. This power might not therefore permit contact to be maintained with a patient who declined to answer their telephone or open their door. The New South Wales legislation (ss 137-143A) goes on to provide, however, that entry into the patient's residence may still occur, without consent, when the community clinicians activate the additional power to return a patient under a CTO to hospital care.

In a study on the use of CTOs in New Zealand, psychiatrists surveyed about their reasons for using involuntary outpatient care rated maintaining contact with the patient, so negotiations could continue about treatment, the most important factor (Romans et al, 2004). From this contact many other benefits, such as promoting medication compliance and early identification of relapse, were seen to follow. The power of entry for community nurses therefore seems critical to the effective use, and clear enforcement, of a CTO regime (Mullen et al, 2006).

The various CTO statutes provide powers of entry of different kinds, some stronger than others. Community mental health teams may be provided with a general power to enter private premises 'for treatment purposes', at 'all reasonable times' (*Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s 29(2)). Alternatively, entry without

consent may only be lawful when clinicians activate the further power to recall a compulsory outpatient to hospital. In that case, it may be necessary to invoke both the power of entry and the power of recall simultaneously, requiring the patient to be returned to hospital whenever entry without consent is obtained. This practice is not necessarily to the patient's advantage. A third possibility is that entry without consent may only be authorised following the activation of an independent judicial process, or in circumstances that would justify the activation by the clinicians, or some other person, of a general crisis intervention power.

In this third situation, the CTO would provide no independent power of entry. The community clinicians dealing with a patient under this kind of regime would then be in more or less the same position as if they were dealing with a voluntary patient: in both cases, an independent legal process, or an independent power of entry, would have to be invoked for lawful entry, without the patient's consent, to occur.

The question such an approach presents is this: would community mental health teams be prepared to make active use of that kind of lightly powered CTO regime? Would they think it sufficiently useful to place a patient under it, instead of allowing reversion to voluntary status, if the CTO provided no independent power of entry that would permit the mental health team to maintain contact with a patient who declined to open the door, when using the CTO also imposes additional administrative burdens on clinicians, such as extra appearances before a court or tribunal to justify continuing the patient's involuntary care? The danger is that where the CTO regime is weakly powered (and therefore more respectful of patients' rights) it will be very little used, and so will make very little impact on the overall delivery of mental health care.

Clearly, strong powers of entry may be considered inconsistent with patients' privacy and property rights. The *European Convention on Human Rights* provides, for instance, in Article 8(1), that: 'Everyone has the right to respect for … private and family life, his [or her] home and his [or her] correspondence'. This is not an absolute guarantee. Some compelling and 'proportional' limits on it can be justified. But a Parliament bound by European human rights law may – understandably – back away from enacting strong powers of entry in the face of that provision.

In a similar vein, s 7 of the *Canadian Charter of Rights and Freedoms* provides: 'Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice'. The Supreme Court of Canada has held that the concept of 'security of the person', in that section, incorporates personal privacy rights (*R v O'Connor*, 1995; *A(LL)*

v B(A), 1995). Those rights can therefore be invoked, with the force of a constitutional guarantee, in the context of mental health law.

Conclusions

The community treatment powers provided by a clearly enforceable CTO regime therefore operate at the boundaries of human rights concern. If a strongly rights-centred approach is taken to the design of a CTO statute, however, this may lead to the enactment of moribund legislation that will not make any significant difference to the delivery of mental health care. In Australasia, where Parliaments' hands are not tied by a constitutional human rights instrument, the choice faced is therefore a stark one. The futility of enacting weakly powered CTO regimes means that the real choice is between the continued operation of the current, reasonably enforceable CTO regimes, and their repeal. There is little point in having a weakly powered CTO regime on the statute books that is not used. That is simply another way effectively to abolish the regime. It is best to opt firmly one way or the other, and that is a very difficult choice to make.

If use of CTOs is to continue, in order to support the far-reaching deinstitutionalisation of mental health services, to bring relief to families, to encourage use of less restrictive forms of treatment, to prevent unnecessary criminalisation, and to bring greater stability to the lives of the seriously mentally ill, then CTO regimes should be maintained that walk right up to the line of human rights concern. This will leave Australasian jurisdictions increasingly exposed to criticism on human rights grounds.

If such criticisms are to be accepted, CTO regimes should be repealed. Alternatively, the difficult decision should be taken to support legislation that contains clear powers to obtain access to patients and to facilitate their treatment by community mental health teams. What should not be done, however, is to cross the line to use of 'forced medication' – by physical restraint of the patient – in a community setting.

If the current Australasian approach is to continue, one further policy should be pursued in tandem, and that is accepting the responsibility to fund, train, retain, support and value the community mental health professionals, and the accommodation services, that are needed to provide effective community care. This responsibility must be taken very seriously if the intrusive powers provided by Australasian CTO regimes are retained.

Notes

1 Under New Zealand's unitary constitutional structure, the relevant legislation is enacted by the national Parliament, while under Australia's federal system it is enacted by State legislatures, in this case the legislatures of Victoria and New South Wales.

2 The New Zealand constitution, in particular, is characterised by a number of constitutional voids. New Zealand has no entrenched constitution, no federal system, no upper house of Parliament, no executive presidency and no standing system of binding, citizens-initiated referenda. Nevertheless, it is one of the most stable and long-standing democracies in the world, having operated an uninterrupted parliamentary system since 1853.

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