

**COMMUNITY TREATMENT ORDERS:
INTERNATIONAL COMPARISONS**

John Dawson

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INTERNATIONAL COMPARISONS**

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Community Treatment Orders: International Comparisons

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Chapter 1

Overview

This is a comparative study of the law in several jurisdictions concerning involuntary outpatient psychiatric treatment. It is particularly a study of legislation that governs the use of Community Treatment Orders (CommTOs). These orders authorise the provision to unwilling patients of continuing medication for the treatment of a serious mental condition after discharge from hospital. Many of the central legal issues concern the scope of the powers to confer on community mental health teams, to monitor the patient's condition, enter private premises, provide treatment without consent, and take the patient to a clinic or hospital for treatment. The law in this area is reviewed in Victoria, New South Wales, Switzerland, the United Kingdom and Canada, with a view to assessing the adequacy of NZ's CommTO regime.

The common issues

What this comparative study has revealed above all is the similarity of the issues facing the various jurisdictions. They are facing:

- *the ethical question*, whether an involuntary outpatient regime ought to be enacted
- *the constitutional question*, whether such a regime can be lawfully enacted, in light of contemporary human rights norms
- *political questions*, that go to the will of parliaments to enact such schemes
- *legal questions*, concerning the detailed design of the legislation; and
- *empirical questions*, concerning the operation of established CommTO schemes, particularly questions about the categories of patient placed under the scheme; the services they receive; the consequences of their treatment; the frequency of the scheme's use; and the manner in which it interacts with other social systems, like the criminal justice system.

The major fault-lines in the design of CommTO legislation

The two issues of legal principle that seem to be most troubling across the jurisdictions are the role of competency (or capacity) principles in the criteria governing involuntary outpatient care, and the precise powers to confer on clinicians to 'enforce treatment' in community settings.

On the first point, the conclusion will be reached that NZ should include capacity principles within its mental health legislation, although it should include them in modified form. It will be argued that a test of ‘substantially diminished capacity to consent to treatment for mental disorder’ should be added to the legal criteria governing all involuntary intervention under NZ’s mental health legislation. This would have the effect of harmonising, to a significant degree, the rules governing consent to psychiatric treatment with the rules governing consent to other forms of medical care.

On the second point, the conclusion will be reached that the administration of medication by force in a community setting, outside a properly supervised clinic or hospital, should *not* be authorised by a CommTO regime. Nor should the law confer on community clinicians an overly-broad power of entry into the residence of a patient under a CommTO, to avoid excessive violation of patients’ privacy. Nor is it necessary to confer an additional power on the courts to order an outpatient to reside at a specified address.

Subject to those conditions, however, NZ law should continue to encourage the use of CommTOs, particularly to avoid the unnecessary ‘criminalisation’ of the mentally ill .

The experience gained in Australasia in the last decade shows it is sufficient for the adequate operation of a CommTO regime to provide in the law the following mix of duties and powers:

- to place a duty on the patient to accept psychiatric treatment (subject to the same limits as govern treatment in hospital)
- to direct the patient to accept visits from health professionals and attend outpatient appointments
- to direct the kind (or ‘level’) of residence at which the patient must reside
- to enter the patient’s place of residence at reasonable times and for purposes directly related to enforcement of the community treatment regime
- to recall the patient swiftly to hospital, and to transport them there
- 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.

In addition, to clarify the precise scope of the authority conferred on health professionals to treat patients in the community, it might be useful to adopt the following rule from NSW: that medication may be administered without consent to a patient under a CommTO ‘if it is administered without the use of more force than would be required ... if the person had consented’.

A number of further fault-**lines** in the law have been identified from study of the various jurisdictions’ legislation. These include:

- whether use of CommTOs ought to be limited to patients with a history of prior hospital admissions, or whether patients on their first admission should also be eligible
- whether family members should be granted veto powers over the patient’s treatment, in addition to consultation and information entitlements, when they may have a conflict of interest with the patient
- the frequency and intensity of tribunal review procedures
- the value of statutory treatment plans, to be approved by a court or tribunal, when they may confuse lines of responsibility for the treatment of the patient
- the tendency to impose strong statutory duties on health providers to furnish treatment to involuntary patients, when that may enhance providers’ liability concerns.

The empirical research

From the empirical evidence some clear trends were also found. The use of CommTO schemes often increases significantly after an initial ‘bedding in’ period, particularly if a simultaneous reduction occurs in the number of hospital beds, and there is an associated build-up of community mental health teams. When the average length of involuntary hospital stays falls below some critical length (perhaps 2-3 weeks), the use of CommTOs seems to jump significantly, due to the early stage in treatment at which many patients are then discharged. The upward trends in the use

of CommTOs also suggest that increasing the availability of community resources increases their use, instead of decreasing the need for their use, as some may suggest.

Well-embedded CommTO schemes usually focus on certain categories of patient. Male patients tend to outnumber females, by a ratio of about 60:40; and most involuntary outpatients are in the middle phase of their illness, have a diagnosis of schizophrenia, several prior hospital admissions, and a recent history of non-compliance with outpatient care. A considerable proportion are found to have concurrent problems with substance misuse, and a significant minority have experienced imprisonment or forensic care. In most jurisdictions, only a minority live in group homes or supported accommodation; most live alone in rented accommodation, or with their families. Power's research in Melbourne, in particular, suggests that CommTOs can be successfully targeted in practice on those patients who are identified in the psychiatric literature as the primary candidates for involuntary outpatient care.

Although there are limitations in the evaluation studies of CommTO regimes, the results of those reviewed almost always revealed: significant therapeutic benefits for patients; greater compliance without outpatient treatment, especially medication; and reduced rates of hospital admissions. Some also revealed: better relations between patients and their families, or enhanced social contacts; reduced levels of violence and self-harm; and earlier identification of relapse. These findings are consistent with the evaluation studies conducted of well-embedded regimes in the United States.

The empirical research also suggests, however, that the use of CommTOs is strongly linked to the use of depot (or injectable) medication, which is disliked by many patients, and that it is a common complaint of patients that their treatment is dominated by the use of medication, and that they have little access to alternative forms of care. CommTOs also tend to be issued for the maximum period permitted by law. Discharge from the order is likely to come shortly before an independent review hearing would be held, and many orders are renewed for a further term. In addition, when the patient's treatment is proceeding satisfactorily under the order clinicians seem to have a strong preference for maintaining the status quo. Discharge

may not therefore be easy for the patient to achieve, and there may be a tendency for CommTOs to be used for too long, and as a form of defensive medical practice.

It is also widely believed that patients under CommTOs get some priority for care, that they receive more intensive treatment, that the order may help direct resources to them at an earlier stage in their relapse, and that it may facilitate their smooth readmission to hospital care.

The context for the use of CommTOs

The use of CommTOs seems most likely to produce positive outcomes when:

- the regime is well-embedded and has the full support of clinicians
- a reasonably intensive level of community services is provided, by clinicians who visit the patient at their residence and are committed to enforcement of the scheme
- a good range of supported accommodation is available, plus a range of additional health services, beyond the provision of medication, including ready access to treatment for substance misuse
- the local inpatient and outpatient services are well-coordinated, permitting rapid access for involuntary outpatients to hospital
- there are no financial barriers, or problems in reimbursement systems, discouraging use of the scheme
- there is considerable continuity of staff in therapeutic relationships, and the staff are experienced and assertive, have sound relations with well-trained Police, and have a high degree of cross-cultural capability
- the independent review procedures are not so frequent or intensive as to act as a virtual discharge mechanism, and do not overly discourage long-term use of the scheme.

On the other hand, some pitfalls clinicians should try to avoid include:

- assuming that all patients on CommTOs must be administered medication by injection, rather than in oral form
- the de facto confinement of CommTO patients in sub-standard accommodation

- over-use of CommTOs for patients with affective disorders, for whom their efficacy is uncertain, and who may swiftly resume their capacity to consent after initial treatment
- over-use of CommTOs with younger, male patients, with concurrent substance abuse disorders, as an alternative to the criminal justice system, as there is also less evidence for positive outcomes in this group
- over-use of CommTOs when there is extreme pressure on hospital beds
- failure to review actively the need for the CommTO with patients who have been on them for long periods of time.

The rate of use and the balance of advantage

Finally, the critical factor in determining the rate at which CommTOs are used in different jurisdictions seems to be *the perception of clinicians concerning their advantages*, because it is clinicians who play the vital role in driving the process forward.

The main factors influencing clinicians' views as to the balance of advantage seem to be:

- the *marginal authority* the scheme provides to treat outpatients, in comparison with other lawful approaches to treatment that could be employed
- 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
- the *administrative burdens* involved in treating patients 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* that may be experienced by the patient.

Because the CommTO schemes in Australasia are generally viewed positively on these parameters by clinicians, they are extensively used by most international standards. Even so, a range of other formal and informal mechanisms may be used to similar effect in other places, including greater use being made of leave and adult

guardianship schemes, and of mental health courts operating within the criminal jurisdiction.

Nevertheless, even if all the indicators and practices were to fall in line, implementing a CommTO scheme is unlikely to be straight-forward. The entire focus of such schemes should be on patients who are difficult to engage voluntarily in their care.

Chapter 2

Introduction: Community Treatment Order Regimes

Community treatment orders (CommTOs) authorise the continuing provision, to ambivalent and even unwilling patients, of community mental health care. They establish a legal framework within which people with a serious mental disorder may be required to accept psychiatric treatment, including medication, while living outside hospital. This is a controversial approach to treatment because it overrides a person's usual right to refuse unwanted mental health care.

This report is a comparative study of the law in this area in a number of jurisdictions, notably the eastern states of Australia, Switzerland, the United Kingdom, and Canada. It considers how the law in those jurisdictions has responded to the deinstitutionalisation of mental health care. The intention is to describe the structure and content of their laws concerning involuntary outpatient treatment; to consider their debates and difficulties in the field; and to provide an account of empirical research conducted into the operation of their legal schemes. The ultimate aim is to assess, against that international backdrop, the adequacy of New Zealand's CommTO regime.

Most of the existing research in this field has been conducted in the United States, where CommTOs are usually called outpatient commitment regimes (eg, Geller, 1990; Dennis & Monahan, 1996; Swartz et al, 1999; Hiday, 2003). This report supplements that American research, by describing the laws governing this kind of treatment in a number of other countries with a relatively similar legal tradition.

The central legal questions

CommTOs operate under the authority of mental health legislation. The principal obligations usually imposed on a patient by such an order are to accept continuing medication for their mental disorder and to maintain contact with the members of a community mental health team. The order thereby provides the foundation for a therapeutic relationship to be maintained with a person who is not consistently willing to accept psychiatric care.

Many of the central legal issues in this field concern the scope of the powers that will be conferred by law on the members of community mental health teams, especially the scope of their powers to monitor the patient's condition, provide treatment without consent, enter private premises for these purposes, and take the patient to a clinic or hospital for treatment, if they refuse. These are intrusive powers for the law to provide. Obviously their exercise may affect the privacy and autonomy interests of the patients concerned. The patient loses the right to determine their own psychiatric treatment. Two central questions about CommTOs are, therefore, whether the law should confer such powers at all; and, if it does confer them, whether such powers can be exercised in a manner that is minimally consistent with the protection of human rights.

These are very difficult questions for any society to resolve, and their resolution is made particularly difficult by the changing shape of the mental health service system with which the law must interact. In many jurisdictions, this service system, which is a vital part of the context for the implementation of CommTOs, has been going through a difficult period of transition, from a system based on the institution of the hospital to one based on the provision of community mental health care. During this difficult period, great pressure is often placed on a dwindling number of hospital beds, as the institutional system of treatment is scaled down, but is not yet sufficiently supplemented by a comprehensive system of community mental health care.

It is often in those circumstances that a CommTO regime is enacted, in an attempt to manage the treatment in the community of seriously ill people who have been discharged from hospital but who have not complied with outpatient care. In such

cases, people's views on the legitimacy of the CommTO regime are likely to depend on two main factors: first, the design of the CommTO legislation; and, secondly, the adequacy of the local system for providing community mental health care.

The methods followed and their limitations

To conduct this survey of CommTO schemes, I travelled for about 5 months in the countries selected for study in 2003. This travel was made possible through the financial support of the New Zealand Law Foundation, for which I am most grateful.

The principal subjects of the research conducted during this period were:

- the well-established CommTO regimes in Victoria and New South Wales
- the law governing outpatient treatment in the civil law jurisdiction of Switzerland
- current developments concerning CommTOs in the United Kingdom
- the interesting CommTO regime in the Canadian province of Ontario.

The main methods followed in each place were:

- to visit and interview key professionals involved in the implementation of CommTOs, especially members of mental health review tribunals and community psychiatrists
- to collect and study local legislation, case law and law reform materials
- to study the literature found in journals, theses and local policy guidelines.

There are important limitations to these methods, especially when several sites were visited for limited periods of time. In many places, little sustained research has been conducted on the local CommTO scheme. The conclusions I have reached cannot therefore be fully grounded in hard data or published research. They are simply the best conclusions I feel able to draw from the materials collected and the limited inquiries made. These limitations should be borne in mind by all readers of this report.

The aims and limits of CommTOs

Although this report is mainly concerned with the details of legislation, it is useful to consider at the outset the general objectives, and likely problems, of CommTO schemes.

As the site of psychiatric treatment has shifted from hospitals to the community, compulsion in treatment has, for better or worse, followed some patients into the community under the aegis of ‘conditional leave’ or CommTO schemes. A major aim of these schemes is to avoid the so-called ‘revolving door’ syndrome, by ensuring greater continuity of treatment for people with severe mental disorders who would not otherwise comply with outpatient care. The primary hope is that the treatment provided will produce greater quality of life for such people, when their capacity to make decisions about their own treatment is substantially impaired. Requiring such persons to maintain contact with a community mental health service may prevent relapse in their illness, or reduce the severity of its consequences, while their treatment may still proceed in a less restrictive environment than hospital care. The principal aim is therefore to confer sufficient benefits on patients placed under CommTOs to outweigh the sense of coercion they may also experience.

It would be idle to claim, however, that conferring benefits on patients is the only objective of CommTO schemes. Conferring benefits on other people is clearly another motive for their use. In particular, it may be intended that a person’s treatment under the scheme will reduce the stress imposed by their illness on their immediate family and friends, or that it will reduce their potential to cause harm to other people. In addition, placing a person under a CommTO may, on occasions, prevent their arrest, or it may avoid their being processed further through the criminal justice system with the result that they might be imprisoned or be directed into forensic mental health care.

There are therefore many motives for the use of CommTO schemes. Whether they achieve their objectives in practice, however, and precisely *how* they might achieve them, are still matters of continuing professional debate. It seems likely that CommTOs may work by affecting *both* the conduct of patients placed under them *and*

the conduct of the health professionals involved. The order may act as wrap around the therapeutic relationship between them. It may provide a structure for their relationship, or it may bind them into a kind of compulsory contract for care, a contract that commits health professionals to the treatment of the patient as much as it commits the patient to their care (Romans et al, 2004). In particular, a CommTO may achieve these aims by clarifying the authority of the health professionals to maintain contact with the patient, permitting continuing negotiations to proceed about their treatment and care.

Whether these kinds of mechanisms are translated into satisfactory outcomes for patients is still a matter to be determined by empirical research. They may not be achieved if the necessary community resources are not available, or if the members of mental health teams are not prepared (or able) to treat patients assertively under the scheme.

Even if the aims of these schemes were met, however, there is still the possibility that they might be met at unacceptable social cost. It might be thought that too much coercion will be imposed on patients under the scheme; or that these patients will absorb an excessive amount of clinical time, at the expense of others; or that 'queue-jumping' will occur, whereby patients who would accept treatment voluntarily are placed under the regime solely to give them priority for care. CommTOs may be used too readily, or for too long, or they may be imposed on inappropriate categories of patient, or their use may become a form of defensive medical practice designed to deflect public concern about the closure of psychiatric hospitals or about the risk of violence posed by the mentally ill. Overall, their existence may prevent greater professional efforts being made to engage patients voluntarily in their care. There are therefore many potential pitfalls in CommTO schemes, just as there are in involuntary hospitalisation schemes.

Above all, if such schemes are to have a chance of success, it seems clear that the right context must be established for their implementation. In addition to well-designed legislation, a community mental health service must be available that can provide the necessary intensity of treatment; there must be sufficient supported

accommodation for patients with complex needs; and there must be considerable commitment among the health professions to vigorous implementation of the scheme. It can never be assumed, in any time or place, that that alignment of supporting structures will be achieved.

For these kinds of reasons, the passage of CommTO legislation should be approached with some scepticism, and the use of these orders, in individual cases, should be the subject of regular, independent review.

A central aim of this comparative survey is to try to identify the factors that are most likely to contribute to the effective operation of such schemes, particularly the factors that must be present for health professionals to have the confidence to make use of the scheme.

Major legal issues in the design of CommTO schemes

If the conclusion is reached that a CommTO scheme should be enacted, there are still many ways for that scheme to be designed.

The issues that will usually have to be addressed include:

- the criteria for a person's cover by the scheme
- the structure for its administration
- the procedures to be followed
- the documents to be completed
- the allocation of powers and responsibilities under it
- the consequences for patients of being placed under the scheme.

The criteria for a CommTO

The criteria for placing (and keeping) a person under a CommTO must be clearly established by law. Two distinguishable sets of criteria usually apply. First, the law usually requires the person to meet an initial set of standards that apply to involuntary psychiatric treatment in general. Then the law will require the person to meet further standards applying specifically to involuntary *outpatient* care.

The initial criteria usually specify the forms of mental disorder for which involuntary treatment may proceed, and the relevant ‘harms’, ‘dangers’, or ‘risks’ the person must pose. In some jurisdictions, it is also specified that the patient must lack the capacity (or competence) to make decisions about their mental health care.

These general criteria governing involuntary psychiatric treatment are then supplemented by rules governing involuntary *outpatient* care. These rules usually require, at a minimum, that the patient’s treatment outside hospital is ‘appropriate’ or ‘viable’, and that the necessary outpatient service will be ‘available’ to meet the person’s needs.

In some regimes, the outpatient treatment criteria are very precise. They may say that outpatient treatment may only be used as an alternative to hospital, for instance, or that a certain number of recent hospital admissions is required before a person could be a candidate for the CommTO regime.

Administration

Clear administrative arrangements must be established for the scheme. A regional system of administration is usually preferred, not one based on the institution of the hospital, as was the norm under the older civil commitment schemes.

A regional administrator is commonly designated, who is often a senior psychiatrist. Their main function is to audit the compliance of other health professionals with their obligations under the scheme. This regional administrator usually acts as a custodian of the documents to be completed by those directly responsible for the patient’s treatment, and acts as a conduit to courts or tribunals of the documents associated with their review functions under the scheme.

In addition, the specific powers and responsibilities of health professionals involved in the care of patients under CommTOs must be allocated. A particularly important issue concerns the precise allocation of the power to direct (or consent to) the treatment of a patient under the scheme. That power of treatment may be conferred on a psychiatrist (or a ‘responsible clinician’), or it may be conferred on some other

substitute decision-maker. It may be conferred on a member of the patient's family, for instance, or it may be conferred on a person specifically designated by the patient, to perform this role, in advance. That choice, between possible decision-makers about the patient's treatment, will significantly affect the practical operation of the scheme.

In addition, all the limits applied to involuntary psychiatric treatment in hospital will usually be applied to involuntary outpatient care. So, special limits will usually be placed on highly intrusive forms of treatment, such as psychosurgery and ECT, and a mandatory system of peer review may be established to audit the long-term use of medication without the patient's consent.

Procedures

The legislation must specify the procedures to be followed at various points in the progress of a patient under a CommTO. These procedural rules will usually cover:

- the means by which a patient may be placed under a CommTO in the first place
- the manner in which the order's continuation is periodically reviewed, both by the responsible clinicians and by an independent body, such as a court or tribunal
- the means by which the order may be renewed for a further term
- the means through which the order may be terminated or 'discharged'.

In particular, the law should state clearly the maximum term of a CommTO, which is often 6 months, and it should state the obligations of those responsible for the patient's care to release them from the order whenever the ruling legal criteria no longer apply.

Powers of mental health professionals

The potential consequences for the patient of being placed under the scheme must be carefully specified: whether they can be required to accept certain kinds of treatment, for instance, or to attend outpatient appointments; whether their place of residence may be controlled; whether health professionals have a power of entry into that residence; the circumstances in which reasonable force may be used; and so on.

Special attention must be directed to the ‘recall’ or ‘revocation’ process, under which an outpatient may be swiftly returned to hospital under the scheme. Here the legislation will usually cover:

- the circumstances and the manner in which a patient under a CommTO may be taken to a clinic or hospital for treatment
- the powers of crisis intervention teams, and the Police, in this process
- whether the patient’s return to hospital terminates or suspends their CommTO
- whether the patient is entitled to independent review of their return to inpatient care.

Collateral legal issues

A number of ancillary legal issues must also be addressed, particularly the interaction between CommTOs and parallel legal regimes. The interaction between the CommTO regime and any adult guardianship (or incapacity) regime in force needs careful handling. The law must state the role to be played by any adult guardian already appointed for the patient, for instance, in relation to their later treatment under the CommTO regime. In addition, attention must be paid to the position of a patient under a CommTO who is subsequently arrested, and who proceeds down one of the many pathways through the criminal justice system. What effect would that have on their treatment under the CommTO? It is commonly specified, for instance, that the CommTO is extinguished if the patient is imprisoned or directed into forensic care. Many technical questions of this kind must be addressed in the design of the statutory scheme.

Liability and immunity

Finally, many wider questions may arise concerning the potential for civil liability to be imposed on health professionals who manage patients under the regime. Particularly difficult questions may arise concerning their liability to pay damages to third parties who have been injured by a patient under a CommTO who has not received adequate treatment under the scheme. The general principles of tort liability would usually apply in such cases, particularly the law of professional negligence or professional malpractice, although precisely *how* those principles apply in these circumstances may not be entirely clear.

The precise obligations imposed on health professionals by the CommTO statute need to be carefully scrutinised in this light. The precise language used to express the statutory obligations of health professionals could affect the circumstances in which they would be held liable. The potential for liability may be enhanced, for instance, if strong duties are imposed upon them to deliver treatment to involuntary outpatients under the scheme: if the statute were to state expressly, for instance, that ‘treatment must be provided in accordance with the patient’s treatment plan’.

On the other hand, the risk of that kind of liability being imposed unfairly on health professionals can also be anticipated, and could be addressed specifically in the statutory scheme. A special kind of immunity from liability to third parties might be conferred on clinicians who are responsible for the treatment of patients under CommTOs. They may perhaps be protected from liability as long as they have acted in ‘good faith’, or ‘with reasonable care’, in the exercise of their powers.

The method for the comparative analysis

Provisions of this kind provide the legal core of a CommTO scheme. The legislation of particular jurisdictions can therefore be analysed on this basis, by reference to the positions adopted in relation to these central elements of the scheme. That is the method followed in the following chapters of this report: the CommTO regimes of the jurisdictions selected for study are analysed under these central legal themes.

In addition, attention will be directed to:

- the context for the implementation of each jurisdiction’s scheme
- the extent and scope of that scheme’s use
- the results of any empirical research conducted on its operation
- current debates about its implementation.

The most extensive account will be provided of the Victorian CommTO scheme. This scheme is widely used; it has been in operation for nearly 20 years; it has been the subject of considerable research; and it appears to operate within a context that most closely resembles that found in NZ.

Chapter 3

New Zealand

The aim of this report is to try to assess, in light of other jurisdictions' experiences, the adequacy of NZ's CommTO scheme. A short account is therefore required of the NZ scheme.

The introduction of CommTOs in NZ

NZ's scheme was formally introduced, in the early 1990s, by the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ). This scheme is largely administered by psychiatrists, community psychiatric nurses, and other members of NZ's community mental health teams. The staff of these teams usually visit the patient at their place of residence, to monitor their condition, and they may personally administer the medication prescribed. The members of these community teams work as the salaried employees of NZ's public sector mental health services. Those services are organised on a regional basis and are provided without charge to the patient. The same regional health authority provides both the inpatient and the outpatient service, an arrangement that may promote a relatively smooth transition for the patient between hospital and community care.

Under NZ's constitutional arrangements, the courts have no clear authority to strike down legislation they consider inconsistent with human rights norms. There is no entrenched constitutional bill of rights in NZ, and the human rights treaties to which NZ is a party are not directly enforceable against the NZ Parliament in the courts of the national legal system. NZ is therefore said to have an uncontrolled or 'sovereign' Parliament, with the 'full power' to pass laws. In those circumstances, a clearly enforceable (and therefore potentially intrusive) CommTO scheme was enacted in NZ, without fear that it would be struck down in the courts.

As a consequence, perhaps, of the significant powers provided, the NZ scheme has been widely used throughout the country, and for many years there have been more people under CommTOs in NZ than under involuntary hospital care. The

introduction of this CommTO scheme could therefore be said to have deinstitutionalised NZ's mental health law.

The introduction of this scheme did not involve a radical break with past practices, however. The introduction of CommTOs in NZ simply replaced the well-established prior practice of granting involuntary patients 'trial leave' from hospital care. That kind of leave had been granted for some years on rather similar conditions to those that would later be imposed on patients under the CommTO regime (Dawson, 1991). In those circumstances, the main effect of introducing CommTOs in NZ was to inject greater formality and transparency into that prior leave process. Under the new scheme, clearer criteria were established for the use of involuntary outpatient care, and patients obtained better access to independent review of their involuntary status. The introduction of CommTOs therefore attracted little opposition at the time on human rights grounds.

The administrative infrastructure

The NZ CommTO scheme is not structured around the institution of the psychiatric hospital. Instead, its general administration is now the responsibility of regional officials, called Directors of Area Mental Health Services (DAMHS), who are usually senior psychiatrists. They manage the flow of documents and the accountability processes required by law, and they are responsible for compliance on the part of the regional mental health service with *its* obligations to patients under the scheme. In particular, these regional officials act as intermediaries between the clinicians responsible for the patient's treatment and the courts and tribunals that review their status.

In addition, a Responsible Clinician must be designated for each patient under the scheme. That clinician exercises the central legal powers provided by law over the patient's treatment and management, in consultation with other members of a community team. The members of that team are required to consult fully with the patient's family about the treatment proposed. But the power to consent to the patient's treatment is not transferred to family members or another substitute

decision-maker under the NZ regime. The power to direct the patient's treatment 'for mental disorder' is retained in clinical hands.

Nevertheless, that power of treatment is subject to the same limitations as are imposed on the treatment of involuntary patients in hospital. Special limits are placed on the use of ECT with both involuntary inpatients and outpatients, and mandatory peer review is periodically required of the medication regime.

The criteria and the process

The legal criteria for placing a patient under a CommTO in NZ focus on (ss 2, 27, 29):

- serious mental disorder (of either a 'continuous' or an 'intermittent' nature)
- serious dangers to the health or safety of the patient, or of others, or the patient's seriously diminished capacity for self-care
- the availability of appropriate outpatient care and social support.

Three mechanisms exist through which a CommTO can be made. Two of these may be described as civil routes of entry to the scheme. The other falls within the jurisdiction of the criminal courts.

Under the civil route of entry, a CommTO may be made:

- by a District Court Judge, after a hearing; or
- by a clinician, who may switch a patient to a CommTO from an involuntary Inpatient Order, previously made by a Judge.

Within the criminal process, a Judge may place a person under a CommTO, either:

- following their conviction for an imprisonable offence (provided the usual criteria for the order are met); or
- when the person has been found not guilty by reason of insanity or unfit to stand trial.

In such cases, placing the person under a CommTO may be considered a less restrictive alternative to their imprisonment or their disposition to forensic mental health care.

The subsequent procedures for review of involuntary outpatient status include:

- mandatory clinical reviews, conducted at specified intervals by the Responsible Clinician and reported to the regional administrator
- mandatory reviews conducted by the District Court during the first year of the CommTO
- elective reviews conducted by a multi-disciplinary mental health review tribunal, on the application of the patient or other persons.

Initially, the CommTO has a maximum duration of 6 months, but it may be renewed by the District Court. If the order is renewed again (after a year), it becomes indefinite in duration. Thereafter, the patient or other concerned persons may still initiate its review periodically by the tribunal, but no continuing, *mandatory*, independent review process is provided. This could be considered a particular weakness of the NZ scheme.

At any time, the patient must be discharged (or ‘released’) from the CommTO if they cease to be ‘mentally disordered’ in the necessary sense, or if they no longer pose one of the necessary threats of harm.

The consequences for the patient

The main consequences of the order are to require the patient to accept treatment as directed by their Responsible Clinician and to accept visits at their residence from designated health professionals.

The specific clause about outpatient treatment in the NZ Act is expressed in terms of a *duty imposed on the patient* to accept treatment. This states that the CommTO ‘shall require the patient ... to accept ... treatment’ as directed by their Responsible Clinician: s 29(1). Using analytical legal reasoning, NZ’s Southern Review Tribunal has determined that that statutory duty to accept treatment, imposed on the patient via a court order, necessarily confers a correlative *power* on the clinicians to provide treatment without the patient’s consent (*MJO*, 1998). As long as the patient continues

to meet the criteria for a CommTO, therefore, ongoing assessment of their capacity to consent to psychiatric treatment would not be required by law.

No limits are stated in the NZ Act on the range of locations at which treatment may be provided. It might therefore be thought that treatment could be provided *at any location* under the NZ scheme, and that it might even be lawful to administer medication forcibly to a patient in their own home. It is doubtful whether that would be lawful, however, as no express power is provided to restrain or detain a patient for that purpose. It is not surprising, therefore, that the Guidelines to the NZ Act, issued under the authority of the statute by the NZ Ministry of Health (2000), state that ‘no power to detain the patient for the purposes of treatment’ in a residential setting is provided by law.

I am assured by health professionals who operate the NZ scheme that medication is not administered to patients under CommTOs over their objection in community settings, both because of its doubtful legality and because that is not considered a safe or ethical practice. Nevertheless, if the patient does not comply with treatment, or if they refuse to engage with the members of the community team, the legislation permits their rapid return to hospital, and their medication may be lawfully administered without the patient’s consent.

Treatment plans

The NZ legislation does not specifically require a treatment plan to be prepared for each involuntary patient, nor does it expressly require a treatment plan to be placed before the judge or tribunal whenever a CommTO is made or reviewed. Nevertheless, the Guidelines to the Act say a treatment plan must be prepared for each involuntary patient under the scheme. The Responsible Clinician’s application to the court for a CommTO is to be accompanied by a written statement as to ‘what exactly is sought in the proposed order’. It should cover: the proposed type and method of treatment; the location at which it will take place; the services or institutions responsible for delivering it; the monitoring arrangements; and an indication of any other services or support that will be available to meet the patient’s needs. The Guidelines state that

these matters should be specified in writing in the order and be given to the patient: para 12.3.

In addition, the Guidelines state that a CommTO ‘should not be used as a basis for de facto detention in a community facility’, and the NZ courts have held that a patient under a CommTO cannot be directed to live at a specified place (*D*, 1999). The patient may still be required to live in *certain kind* (or ‘level’) of supported accommodation, if that is considered necessary for their treatment as an outpatient to proceed.

The precise conditions of the CommTO will be set by the responsible clinical team. The patient will usually be required to:

- permit visits to their residence by members of the team (often weekly)
- attend outpatient appointments as required (often a monthly appointment with a psychiatrist)
- take medication as prescribed
- remain at a specified kind of residence (eg, a group home)
- not travel beyond certain boundaries without permission
- avoid substance misuse.

Whether a patient would be returned to inpatient care for breach of those conditions is still a matter of discretion for the clinical team. Return to hospital is *permitted* whenever ‘the responsible clinician considers that the patient cannot continue to be treated adequately as an outpatient’: s 29(3). Designated health professionals, called Duly Authorised Officers, are available to assist in that process, and Police assistance may be obtained.

Reciprocal duties imposed on health professionals

The extent of the reciprocal duties imposed on the health services to provide treatment to involuntary outpatients is not clearly specified in the NZ Act. A duty of care to the patient could be grounded in common law principles, under the law of professional negligence or malpractice. In addition, a duty to provide treatment could be implied from the statement, in a separate part of the NZ Act, that all

involuntary patients are ‘entitled to medical treatment and other health care appropriate’ to their condition: s 66. It is doubtful whether that statement alone would support an action for damages brought by the patient, or by some other injured person, however, if no adequate treatment has been provided, and harm has been suffered as a result. The intention of Parliament to create a remedy in damages for breach of that provision is probably not sufficiently clear for a court to take that step, particularly when another mechanism for making complaints about breaches of involuntary patients’ rights is specifically provided by the Act.

The effect of NZ’s ‘accident compensation’ scheme

As to the potential liability of the responsible clinicians for the conduct of a patient under a CommTO who might cause harm to someone else: this is fundamentally affected by the existence of NZ’s unique accident compensation scheme. This scheme has superseded the usual tort-based systems for imposing civil liability for causing personal injuries to others in NZ. It provides, instead, a form of no-fault insurance cover for all persons whose ‘personal injuries’ are caused by ‘accident’ or ‘medical misadventure’. Under NZ law, the injured person is not able to sue the person responsible to recover damages for their personal injuries. Instead, they are entitled to seek compensation from the Accident Compensation Corporation that is established under the scheme.

It is therefore an important consequence of the accident compensation scheme that it provides health professionals in NZ with a general form of immunity against civil liability for causing personal injuries for which they might otherwise be held responsible under general principles of tort law. Except in rare cases, such as where property damage has been caused by a health professional’s negligence, or where a health professional has been ‘grossly’ negligent in the provision of care, an injured person cannot successfully sue a negligent health professional in NZ. The corollary is, however, that the injured person may claim compensation under the statutory insurance scheme.

These unusual principles of NZ law make it very unlikely, at present, that a responsible clinician could be successfully sued in the rare case in which a patient

under a CommTO inflicted personal injuries on a third party, following failure by the clinicians to provide the patient with adequate treatment or care. In most cases, the only chance the injured third party would have to obtain compensation for their personal injuries would be to make a claim under the no-fault insurance scheme.

Other aspects of the NZ regime

As to relations between CommTOs and parallel legal regimes:

- in NZ, the conferral on the Responsible Clinician of the power to authorise a patient's treatment supersedes any conflicting authority already conferred on a substitute decision-maker under the country's adult guardianship scheme
- a CommTO is suspended if the patient is charged with an offence and is remanded to hospital for their assessment prior to trial
- a CommTO is terminated if the patient is sentenced to imprisonment or is directed into forensic care.

These are the central legal elements of the NZ scheme.

The rate of use of CommTOs

This scheme is used frequently, by most international standards. Figures provided to me informally by the NZ Ministry of Health suggest that roughly 1700 people were on a CommTO on any day in NZ in 2003 (or were in the similar position of being 'on leave', for up to 6 months, from involuntary inpatient status, an option that still exists in parallel with the CommTO scheme). NZ's population was about 4 million in 2003. So roughly 1 person in 2350 was on a CommTO in NZ at that time.

These numbers seem to be relatively stable, as there were very similar numbers of 'committed patients on leave' in NZ during the 1980s, when the deinstitutionalisation process was already well-advanced, but the CommTO regime had not yet been established (Dawson, 1991). In the interim, NZ's population has slightly grown.

In a study conducted in the NZ province of Otago, we found that one quarter of patients placed under involuntary psychiatric assessment in hospital during the mid-

1990s were placed on a CommTO following their discharge from that admission (Dawson and Romans, 2001).

The placement of a patient on a CommTO in NZ almost always takes place after they have been admitted to hospital, although prior hospitalisation is not required by law. In principle, even the patient's involuntary assessment can take place outside hospital.

Clinicians' views of the NZ regime

This CommTO regime appears to largely acceptable to NZ psychiatrists and other health professionals directly involved in its implementation. A recent published report of a national survey of NZ clinicians concerning their views of this regime reached the following conclusions (Romans et al, 2004):

Our central finding is the high level of endorsement of CommTOs by NZ mental health clinicians. Most see the CommTO as a useful tool in pursuit of core clinical goals for the seriously mentally ill....

The prevailing view appears to be that CommTOs work in a largely structural and indirect fashion. They are considered to bind into place the necessary community service, and to facilitate contact with the patient, medication compliance and early identification of relapse. They may support the involvement of families and other agencies in care and may have a significant impact on a patient's attitude to their illness. These complex effects may lead in turn to clinical improvement and enhanced insight, reducing harm. If that is so, CommTOs may be part of the solution to a major failure of deinstitutionalisation: lack of continuity of care.

Compulsion was not seen by respondents as a substitute for adequate service provision. On the contrary, success was seen to depend on the quality and extent of the community services provided. There is even the perception that compulsion may enhance service provision, with those under CommTOs receiving priority in poorly resourced systems. The order was seen by many to commit service providers to patients' care. "*It is not clear*", said one

respondent, "*who is under the order, the patient or the nurse*". Perhaps an order should not be required for this purpose, but if it does focus attention on patients most in need of treatment, despite their reluctance, it may correct a tendency of mental health services to shift their focus to those less difficult to engage.

With regard to the impact on the therapeutic alliance, the predominant view of respondents was that, while compulsion can harm relations with patients in the short term, the advantages of continuing treatment usually outweigh this problem, and that where greater insight follows treatment, therapeutic relations will often improve in the end....

The existence of a small minority of clinicians with strong reservations about CommTOs suggests considerable variation in clinical practice is likely to occur. This should be accepted, in our view, until the efficacy of CommTOs is better established, in light of the complex ethical questions involved [13, 14]. To that end, the law should leave considerable discretion concerning precise use of CommTOs in clinical hands.

Policy-makers, on the other hand, who favour CommTOs principally for the control of violent behaviour, or for control of patients not considered treatable by most clinicians, will derive little support from this study. Our respondents saw reducing violence to others as a matter of some importance in key decisions, but they seem to view it mainly as a desirable secondary outcome of properly-targeted clinical care.

We consider, in light of the views expressed by the majority of our respondents, that until the debate about efficacy is more clearly resolved, New Zealand law should continue to authorise compulsory outpatient care, provided it is carefully targeted on the seriously mentally ill and an adequate community service is available in each case.

Very similar views have been expressed by task forces established by the American and the Canadian Psychiatric Associations in recent years (Gerbasi et al, 2000; O'Reilly et al, 2003).

Chapter 4

Victoria

Summary

Victoria operates a widely-used and accepted CommTO regime, under the authority of civil mental health legislation, and in a manner largely independent of the criminal justice system. This regime is implemented in a radically deinstitutionalised service environment through an extensive network of community mental health teams. The regime is characterised by significant elements of clinical discretion and by a tribunal process of review. Adoption of this model authorises a more predictive and preventive approach to be taken to involuntary outpatient care than may be possible in highly-constitutionalised legal systems. Use of the Victorian regime increased rapidly during the 1990s as the number of psychiatric beds fell rapidly in the state. This put great pressure on the remaining inpatient facilities and substantially reduced the average length of hospital stays. The research suggests that the Victorian CommTO regime is reasonably well-targeted on patients identified in the psychiatric literature as suitable for involuntary outpatient care, and that the regime is effective in producing positive outcomes for patients' health, particularly for those in the middle phase of their illness. There are still concerns that CommTOs may be used too widely in Victoria, and for too long, that it may be assumed too readily by clinicians that patients under them must receive depot rather than oral medication. Patients also have relatively infrequent access to tribunal reviews and there may be insufficient continuity in doctor-patient relationships. Recent reforms have required the preparation for each patient of a statutory treatment plan.

The Australian context

Australia operates a federal legal system, under which the nation is divided into nine separate jurisdictions, one at the federal level and one for each state or territory. Each state and territory has its own mental health legislation and its own criminal laws.

The Australian legislatures are in a distinct position concerning their capacity to pass mental health legislation. Under the Australian constitution, the federal system and the separation of powers are entrenched aspects of government that cannot be altered

by the passage of ordinary legislation. But there is no constitutional bill of rights that is legally entrenched in a manner that limits the powers of the federal or state Parliaments to enact mental health legislation, or that permits the courts to strike down legislation that is considered inconsistent with civil or human rights norms. Nor are the international human rights treaties to which Australia is a party directly enforceable against its legislatures in the courts of the domestic legal system in the absence of legislation to that effect. CommTO legislation may not be inconsistent with human rights norms, in any case, but in these circumstances Australian legislatures have a fairly free hand, and all states and territories have now enacted involuntary outpatient treatment schemes. They have enacted them either as an aspect of their mental health legislation, or, in the case of South Australia, under the aegis of an adult guardianship scheme.

The focus here will be on the CommTO regimes in the eastern Australian states of Victoria and New South Wales (NSW). These are the most heavily-populated regions of Australia. They contain the major cities of Melbourne and Sydney, both of which have more than 3 million people and substantial immigrant communities.

In the last decade, the Australian federal government, in consultation with the states and territories, has promoted a National Mental Health Strategy. That Strategy declares Australia's public policies concerning the treatment of mental illness. It emphasises the benefits of deinstitutionalisation, and the need for greater development of community services and the adequate protection of patients' rights. Under this Strategy, an attempt is being made to provide total cover of the population by mobile community mental health teams. Whether these policies are adequately backed by resources is doubtful. A recent report of the national Mental Health Council of Australia argues that the implementation of the Strategy has been inconsistent, funds intended for mental health services are still siphoned to other areas of medicine, and much of the increase in the mental health budgets is being spent on the rising costs of anti-depressant medication (Robotham, 2003). Nevertheless, there is significant support, at both national and regional levels in Australia, for mental health policies that promote the use of CommTOs, where adequate resources are available.

The Victorian context

Victoria had population of just under 5 million people in 2003, roughly 60% of whom live in Melbourne. It has centrally organised and publicly funded health services and strong social welfare traditions, which no doubt contribute to its ability to coordinate the development of community mental health care.

The Victorian CommTO scheme was enacted through the *Mental Health Act 1986* (Vic). This was one of the first schemes of its kind in the world, particularly outside the USA. That is not surprising, as Victorian psychiatrists have been international leaders in the field of community care (eg, Hoult, 1986).

The Victorian regime is based on a model of clinical discretion and tribunal review. It deliberately gives priority to the use of outpatient care. Patients are placed on CommTOs exclusively by psychiatrists. In practice, this almost always follows a period of hospital care, though that is not required by law. The time patients spend in hospital may be brief, however, as the deinstitutionalisation process has been far-reaching in Victoria. Most mental health care is delivered through outpatient appointments, and through a well-established network of mobile community mental health teams that operate out of general hospital psychiatric units or community mental health centres. As a result of these developments, there is considerable pressure on the remaining hospital beds.

Mental health services

A recent review of psychiatric services in Australia shows that Victoria and South Australia generally provide the most intensive level of services to their populations, and have the highest proportion of psychiatrists (14.4 per 100,000 population in Victoria in 1999) (AHIW, 2003). From the mid-1980s, Victoria's services were rapidly deinstitutionalised. Systema and colleagues report that, in the decade from the mid-1980s to the mid-1990s, there was a 'major shift from hospital-based to community-based care in Victoria within a relatively short period of time' (at 274). The number of psychiatric hospital residents in the state peaked in 1964 at 7500, but by 1991-92 it had fallen to 3100 (McDonnell & Bartholomew, 1997). By the mid-1990s the number of psychiatric hospital beds had dropped to roughly 2-3 per 10,000

population, and it continued to fall, it seems, throughout that decade (Power, 1998; Systema et al, 2002; Wallace et al, 2004; AHIW, 2003).

By 1995, Victoria had the lowest per capita beds of any Australian state, although it still spent more than other states on mental health care and most of that funding was being spent in the community. By the year 2000, the average length of an acute psychiatric admission in the state had fallen to 8 days (Burgess et al, 2003). Many people interviewed considered this rapid reduction in psychiatric beds and the associated shift in resources to the community would not have been possible without the introduction of CommTOs.

Following their introduction, use of the scheme grew rapidly, especially in the early 1990s, after some teething problems were fixed by an early amendment to the law (Power, 1998). The number of patients per year placed under CommTOs within 7 days of discharge from hospital more than doubled between 1992 and 1998, from 919 to 2277 (Burgess et al, 2003). Increasing numbers of patients on CommTOs therefore appeared before the Victorian Mental Health Review Board (the Board). It experienced a 45% increase in its case load between 1995 and 2000.

In the 1990s, there was a series of Coroner's inquiries into suicides by discharged psychiatric patients in Melbourne. These inquiries attracted considerable media attention. A number of the people who died were apparently under a CommTO at the time, but they may not have been receiving adequate mental health care. That was the subject of criticism in a number of Coroner's reports. These events seem to have influenced the Victorian government to direct greater resources towards community care.

No-one spoken to believed the introduction of CommTOs was a successful way to save public money, because, to work effectively, the regime must be backed by well-resourced systems of community mental health care.

Services in Melbourne

The services in Melbourne are divided between a number of 'areas' of the city. Each area contains roughly 250,000 adults between the ages of 18 and 65, and each is said to have about 600-800 severely mentally ill people on its case register. Roughly 150-250 of these patients (about 15-25%) are usually on a CommTO (Trauer & Sacks, 1998; confirmed by several senior psychiatrists).

Muirhead (2000) gives the following brief description of the mental health service in one area, serving a population of approximately 250,000 people, of whom 39% were from non-English-speaking backgrounds:

The North Western Area Mental Health Service consists of a 21 bed acute inpatient ward, 20 bed Community Care Unit (CCU), two Continuing Care Teams (CCTs), a Crisis Assessment and Treatment Team (CATT) and a Mobile Support Team (MST). The CCU is a residential rehabilitation facility operating in a separate location to the inpatient unit. The two CCTs are located at two mental health clinics, one in each city council area, and provide psychiatric follow up for most of the outpatients of the service. CATT provides emergency and acute treatment and crisis intervention and is based at the innermost mental health clinic. MST is also based at this clinic and provides ongoing intensive assertive outreach treatment to a number of the service's patients (at 22).

Another feature of the Victorian situation, according to several senior psychiatrists, is that the great majority of patients in acute psychiatric wards are now treated involuntarily, perhaps 70-80%, and a voluntary admission is hard to secure.

In short, with the possible exception of forensic care, admission to inpatient mental health facilities in Victoria now seems mainly limited to the acutely mentally ill.

The Victorian public mental health system provides far more residential psychiatric beds in community settings, however, than the other states (AHIW, 2003). Beds are provided for longer-term psychiatric rehabilitation through Community Care Units

(CCUs), and some patients under CommTOs live there. ‘Silting-up’ of these facilities is considered to be a problem, as is the gap between the level of care these units provide and that available in the private sector accommodation to which most patients are discharged. No specialised psychiatric services are provided in that private accommodation, and its quality may be poor.

Gaps in suitable accommodation were generally identified as a major weakness in the Victorian system that may subvert patients’ rehabilitation.

The CommTO legislation

An excellent account of the Victorian legislation is provided in the *Community Treatment Order Guidelines*, issued by the Mental Health Branch of the Victorian Department of Human Services (Chief Psychiatrist, 2001; downloadable from the Web). These Guidelines indicate that the general intention of the Victorian scheme is to ensure that involuntary psychiatric treatment is provided in the least restrictive environment. This treatment should be based, it is said, on ‘a mutually respectful relationship between the persons on the [order] and the treating practitioners’. Establishing this relationship is said to require ‘time, consistency of staff, information sharing and negotiation’ (at 1).

Criteria

As is usual, two sets of criteria apply to the use of CommTOs in Victoria: one covering the circumstances in which a person may be placed under involuntary psychiatric treatment in general, the other covering outpatient care.

In combination, the focus of these criteria is upon:

- mental illness on the part of the patient, indicated by a medical condition characterised by a significant disturbance of thought, mood, perception or memory
- the prospect of relapse occurring in their illness, including its likelihood, and potential severity, and the consequences for the patient’s health or safety
- the need for involuntary treatment for the protection of other people
- the need for immediate treatment to proceed, on an involuntary basis
- refusal of treatment by the patient *or* their inability to give consent

- the inadequacy of less restrictive alternatives
- the availability of suitable outpatient care.

Overall, the potential benefits of treatment for the patient are to be assessed in light of their attitudes to receiving mental health care. A wide range of information is considered relevant to this assessment, including information about the levels of social support available to the patient, and their full psychiatric history.

A feature of these criteria is that they do not require a finding that the patient lacks the capacity to consent to their psychiatric treatment before their involuntary treatment may proceed. Many CommTO patients in Victoria may lack that capacity in fact, but the patient's inability to consent to treatment is still only an *alternative legal criterion* to refusal of treatment on the part of the patient. If all the other legal criteria are met, refusal of treatment is therefore sufficient to bring a person within the ambit of the scheme, whether they currently lack the capacity to consent or not. Once placed under the CommTO, they may be treated without consent as long as it remains in force. This is typical of CommTO schemes in Australasia. Their inclusion criteria are largely based on the concept of serious mental disorder plus its potential consequences. They are not based directly on the patient's incapacity (or incompetence) to consent to psychiatric treatment. They differ in this important respect from many similar schemes in North America.

Administration

The responsibilities for patients under CommTOs are shared between:

- senior psychiatrists, who exercise many key legal powers
- supervising medical practitioners, who are usually psychiatrists-in-training and make many of the day-to-day clinical decisions
- case managers, who are often social workers, nurses, or other non-medical members of a community team, who co-ordinate the patient's care.

The senior psychiatrists have the major responsibilities for initiating and extending CommTOs, although the order's continuation is then reviewed by the Board. The immediate responsibility for the patient's care is carried by the supervising medical

practitioner and the case manager, supposedly guided by an individualised treatment plan. These arrangements appear to reflect the typical division of labour established between consultants, psychiatrists-in-training and non-medical staff within clinical teams.

The total arrangements seem designed to provide senior oversight of the exercise of key statutory powers, multi-disciplinary input into decisions, and access for patients to independent review. The dynamics of practice with CommTOs in Victoria then seem to depend very much on the quality (and continuity) of the relationships established between these health professionals, and on their relationships with the patient and others engaged in their care. Organising the division of labour between the different health professionals has presented some difficulties. Problems have arisen concerning the clear allocation of responsibilities between them, ensuring completion of the necessary documentation, and maintaining adequate information flows.

Nor are these arrangements entirely satisfactory for the Board, which tends to receive evidence in its proceedings mainly from junior doctors, who work on rotations and often have limited knowledge of the patient who is appearing before the Board. Case managers may know more, especially about the patient's social circumstances, but they are not required by law to attend the hearings of the Board.

The Mental Health Review Board

When a CommTO is issued or extended by a psychiatrist in Victoria it has a maximum life of 12 months. It is then reviewed within 8 weeks, and at least annually thereafter, by this multi-disciplinary tribunal. If the patient 'appeals', more frequent review hearings may be held. About a third of the patients seem to be discharged from the CommTO by clinicians shortly before their annual review hearing is due. This is much higher than the proportion of patients discharged by the Board (Brophy and Ring, 2004). It has discharged 6-7% of the patients appearing before it in recent years.

Considerable expertise goes into the work of the Board. Its annual report for 2002 lists 26 lawyers, 34 psychiatrists and 22 community members who sit as part-time members of its panels, including well-known members of the Victorian medico-legal community. Its workload is heavy. It conducted 4140 hearings concerning involuntary patients, for example, in the 2001/02 year. Roughly 70% of its hearings concern CommTOs.

The Board operates in an inquisitorial fashion, under comprehensive procedural rules, but only a small proportion of the patients appearing before it are legally represented.

In accordance with the stated objectives of the Victorian statute, the Board's decisions reveal that it applies the CommTO provisions in a predictive and preventive manner, particularly when the patient has a lengthy history of hospitalisation, or is considered to 'lack insight' into their need for care.

Procedures

The procedures under which CommTOs are made and renewed emphasise:

- the need for full consultation between clinicians and patients
- the need for consultation with patients' families and carers, although usually with the consent of the patient
- the use of interpreters
- provision of plain-language explanations
- provision of rights advice to patients
- consultation between the different clinicians involved
- regular review by clinicians of the patient's condition
- the duty to terminate the order if its criteria no longer apply.

Treatment plans

The Victorian legislation was recently amended to require the preparation, for each involuntary patient, of a treatment plan. An inquiry by the Victorian Auditor-General had found that treatment plans were not being formulated in most cases. The plan is to provide an 'outline' of the treatment the patient is to receive. The Board must then consider whether that plan is capable of being implemented by the mental health

service when reviewing the CommTO, and it may direct clinicians to revise the treatment plan. In exceptional circumstances, if the treatment plan does not substantiate the case that the person's illness requires immediate treatment that is available, the Board may order the patient's discharge from the order. But the Board cannot 'rewrite the plan' or directly impose its own views about treatment on clinicians.

The consequences for the patient

The principal obligations imposed on the patient are:

- to comply with the treatment listed in the plan
- to maintain contact with the mental health service
- to be available for regular assessment by clinicians.

The same powers of treatment without consent apply to all involuntary patients, whether in the hospital or the community. Special limits are placed on the use of psychosurgery, ECT, restraints and seclusion, but not on the use of medication.

These powers of treatment are expressed in a manner that appears to impose an obligation both on the health service to provide treatment and on the patient to comply.

Section 12AD of the Victorian Act states: 'An involuntary patient is to be given treatment for his or her mental illness'. That rule might be considered to impose an obligation on the service to provide involuntary patients with treatment, as well as to impose an obligation on the patient to accept the treatment the service provides.

Section 12AD(2) then states: 'If an involuntary patient refuses to consent to the necessary treatment or is unable to consent to treatment for his or her mental illness, consent in writing may be given by the authorised psychiatrist'. Treating the patient on that basis would then be lawful.

The provisions concerning outpatient care also state: ‘A community treatment order is an order requiring the person to obtain treatment for their mental illness while not detained’ (s 14(2)).

The Guidelines state, however, that:

it is not acceptable to use physical force to impose treatment in any community setting, whether this is a person’s home, a GP’s surgery, or in a community mental health service. 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 to ensure adherence... the [order] should be revoked, whereafter the person must be admitted to an inpatient unit. This allows the opportunity for the reconsideration of their clinical state, treatment needs, and treatment regime (at 13).

It therefore seems reasonably clear that it is not acceptable to ‘enforce medication’ in community settings. This was confirmed by the clinicians interviewed. The only exception is where the patient is resident in certain public sector residential facilities where clinical staff are employed for 24 hours. In these clinical settings:

after alternative strategies have been exhausted, and after discussion with a senior clinician, staff may use minimal force to ensure adherence to the [order]. Appropriate consideration must be given to the intrusion the use of force would represent, the ability of the service to safely manage the event, and whether or not revocation and inpatient review would be more appropriate. In the event that force is used, it is expected that staff will discuss the proposed course of action with the person ... both before and after the event. It is not appropriate to use police to enforce treatment in these settings (at 13).

Residence requirements

The CommTO may also specify the precise location at which the patient must live, if that is ‘necessary for the treatment of the person’s illness’: s 14(3). This power is said to be rarely used in practice, however, because it is too inflexible. If the residential circumstances of the patient were to become inadequate, due to changes in the management of their residence, for instance, it would be necessary to go back to the Board to have their place of residence changed. That takes too much time and effort, especially when the same objectives can be achieved more informally by making ‘satisfactory accommodation’ a condition of the patient’s treatment plan.

The recall (or revocation) process

The CommTO may be revoked, and the patient recalled to hospital, if:

- they continue to meet the criteria for involuntary treatment as a whole; and
- their outpatient treatment is considered no longer viable; *or*
- they have not complied with the order and certain risks to health or safety are posed.

Before this power can be used, the clinicians must try to ensure the patient is aware of the requirements of their treatment, investigate the reasons for their non-adherence, and ensure reasonable efforts have been made to assist them to comply.

Comprehensive powers are provided to activate this recall process (ss 9A and 9B):

- recall may be authorised by telephone
- a designated range of health professionals, and the Police, may assist
- entry both on to and into private property is authorised
- the patient may be transported to a mental health facility
- in specified circumstances, reasonable force, restraint and sedation may be used.

No express power of entry seems to be conferred by the CommTO, except in the context of exercising this recall power.

On arrival at the inpatient service, the patient must be examined and a decision made about their admission. Medication without consent could then be administered.

Extensive advice is provided on recall practices in the Guidelines. These state (at 19-21):

The decision to revoke a Community Treatment Order is a clinical judgement that should take into consideration a number of factors, including the person's mental state, their longitudinal history, and the potential risk they might pose to themselves or others....

The experience of being apprehended and transported following revocation ... can be quite traumatic for the individual, and every effort should be made to involve the person in a negotiation about their return, and to transport them in the least restrictive manner. In many instances, the person can be eventually be persuaded to accompany the apprehending person in an agency vehicle. Should this not occur, ambulance transport should be sought in the next instance. The use of restraint, assistance of police, and transport in police vehicles should be avoided where alternatives are available and appropriate.

Clinical staff should attend to any need the person may have to discuss the reasons for the revocation, and the circumstances surrounding their apprehension and transport, and where possible and appropriate, accompany the person to the approved mental health service.

When individuals are recalled to hospital and treated without consent in this way, I was informed that the usual clinical practice is to keep them in hospital overnight. This permits their observation and assessment and they may then be discharged back to their residence the following day. Booking systems are used, and agreements reached between psychiatric units in adjacent parts of Melbourne, to ensure a bed is always available, at 24 hours' notice, for a patient's recall.

As to the frequency with which this practice occurs: a recent Discussion Paper on the Victorian legislation reports there are nearly 2000 recalls per year in the state (Mental Health Branch, 2003). It also says there were roughly 2700 people on CommTOs in

Victoria at that time. This suggests that somewhat less than one revocation occurs, on average, per involuntary outpatient year.

The CommTO is terminated by the patient's recall to hospital, but it may be re-issued immediately when the patient leaves hospital again. Recall does not prejudice the patient's right to a periodic review before the Board, because that right is based on the time they spend under involuntary treatment as a whole, whether in hospital or the community.

Diversion from the criminal courts

A special form of Restricted Community Treatment Order is also available in Victoria for patients placed under a hospital order following their conviction by a criminal court. These orders must be confirmed by the Board, however, and it is responsible for their review.

Reasons for use of CommTOs

The most common reasons advanced to me for placing patients under CommTOs in Victoria concerned the clinical indications for their use, the effect of the order on the health services, and the advantages for patients' families. They did not reveal a marked focus on the reduction of 'risk'.

These principal reasons advanced were:

- to ensure continuity of treatment for the most severely mentally ill
- to ensure compliance with depot (or injectable) medication
- to engage, stabilise and monitor patients discharged from very short in-patient stays
- to track and monitor patients in a large urban area to ensure they receive services
- to enhance the sense of responsibility of service providers for severely ill patients
- to counter-act the reluctance of health professionals to engage with difficult patients
- to reduce the burden imposed on other social service providers in the community
- to reduce the burdens imposed on patients' families, who often provide their major source of social support.

Numbers of patients under CommTOs

The most useful figure for measuring the extent to which CommTOs are used is a census figure stating the number of patients on a CommTO at one time. A figure of this kind, provided in the Victorian Discussion Paper, says that roughly 2700 people were on a CommTO in the state in 2003 (Mental Health Branch, 2003). As the Victorian population was roughly 5 million at that time, this means roughly 1 person in 1850 was on a CommTO. This suggests CommTOs are used extensively in Victoria, and somewhat more frequently than in NZ or NSW.

It is also said in the Discussion Paper that ‘many people remain on CTOs beyond the initial order and beyond 12 months’ (at 3). This is confirmed by Power (1998), and Brophy and Ring (2004), and is illustrated by the large number of annual CommTO reviews conducted by the Board.

Looking at the matter another way, Burgess et al (2003) report that approximately 13% of all psychiatric patients discharged from hospital care in Victoria between 1992 and 2000 were placed on a CommTO. At some units, the figure is clearly higher. Power (1998) reports that 27% of all patients discharged from acute psychiatric admission wards in Victoria were placed on CommTOs as early as 1992.

The number of patients under CommTOs in Victoria appears to have increased steadily during the early 1990s, as the scheme bedded in. The number reached a plateau in the mid-1990s, then started increasing again in the 2000s.

Several reasons were advanced for this continuing trend:

- further reductions in hospital beds, which had further reduced the length of hospital stays, causing more patients to be discharged on CommTOs
- greater public and media concern about ‘risks’ and threats to community safety
- better resourcing of community mental health services in Victoria, which made it possible to manage more patients under CommTOs
- the introduction of new medications, like Clozapine, that require close monitoring in the community of the patient’s condition.

The characteristics of CommTO patients

The characteristics of patients under the Victorian scheme have been studied at several points in the life of the regime, and at several sites in Melbourne, particularly by Cooper (1992), Power (1998) and Muirhead (2000).

These studies consistently show:

- a high proportion of patients under CommTOs have a diagnosis of schizophrenia or schizoaffective disorder: 70-80% in most samples
- only a small proportion have other diagnoses; eg, about 10% have a diagnosis of bipolar disorder or severe depression, and 5% delusional disorder
- a large minority have a concurrent diagnosis of drug or alcohol dependence or abuse
- a majority are men: more than 60% in most samples
- the mean age of patients is about 40 years, although male patients tend to be younger than females
- most patients are single and have never been married
- they are virtually never employed and are supported by social security benefits
- most live in private, rented accommodation, or with their families, only a minority in group homes or other forms of supported accommodation; very few are homeless
- most have a lengthy history of psychiatric treatment: eg, a mean duration of illness of at least 10 years, and numerous prior hospital admissions (a mean number of 9.5 in Cooper's sample in the early 1990s, and of 6.6 in Muirhead's in the mid-1990s)
- a significant proportion are of immigrant origins and from non-English-speaking backgrounds, but no greater than the proportion in the relevant populations as a whole
- a high proportion receive depot medication, by injection, when on the order (eg, 60-90%), although some receive oral medication alone.

The dominance of schizophrenia as the diagnostic category among CommTO patients is confirmed by the figures presented in the annual reports of the Board. These indicate that roughly 75% of involuntary patients appearing before it have a diagnosis of a schizophrenic disorder, and 10% a bipolar disorder. It is also confirmed by Burgess et al's large study of the Victorian case register (2003), which found that a much higher proportion of patients with schizophrenic disorders were placed on CommTOs during the 1990s than patients with a manic depressive disorder.

The clinicians interviewed informed me that CommTOs were used for patients with bipolar or other severe mood disorders only in exceptional cases, such as when the patient's illness was compounded by severe substance abuse, or they had a forensic history or a severe relapse profile. The clinicians did not consider patients with affective disorders benefited greatly from CommTOs, either because they tended to relapse regardless, or because the usual form of treatment is oral medication, and many doubted whether CommTOs could enhance compliance with oral medication at all (Muirhead, 2000). In any case, patients with affective disorders were generally considered competent to determine their own treatment when not in an acute phase of their illness.

In the well-known study of outpatient commitment in North Carolina, by Swartz et al (2000), it was also found that the outcome for patients with bipolar disorder or major depression was no different to that of controls.

This diagnostic profile of CommTO patients in Victoria is consistent with the patterns found in other parts of the world (Dawson and Romans, 2001).

The psychiatrists interviewed distinguished several categories of patient who are treated under CommTOs in Victoria.

By far the largest group were commonly described as patients who were 'chronically and seriously mentally ill', who often remained on CommTOs for lengthy periods of time. Perhaps some 60-70% were said to be in this category, most being diagnosed with schizophrenic disorders.

In a further proportion of cases, perhaps 15-25%, the order appears to be used for the purpose of stabilising the patient, and ensuring their compliance with treatment, following their discharge from a first admission to hospital for psychiatric care. This is a more controversial use of the order. In such cases, there may be no established pattern of treatment refusal or relapse. When stabilised, such patients may accept voluntary care. But, once placed on the CommTO, they may stay on it for a year. As

one experienced case manager put it: ‘The patient stays under the CommTO for a year when all they really needed was another week in hospital’.

Many clinicians still argued that this use of the order was justified, on occasions, 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 medication. The benefits of early intervention in schizophrenia were frequently cited.

This use of CommTOs seems particularly associated with the dramatic shortening of hospital admissions typical of radically deinstitutionalised mental health systems. It would not be permitted under some North American statutes that require patients placed on CommTOs to have had multiple prior admissions to hospital.

There seems to be a further small proportion of CommTO patients in Victoria, perhaps 10-15%, who are characterised only by their diversity. They might be called the miscellaneous group. They have less typical diagnoses, such as a delusional disorder or a drug-induced psychosis.

Two special uses of CommTOs, overlapping with these categories, were said to be:

- their use to permit close monitoring of patients being introduced to the drug Clozapine, to ensure its safe administration
- their use with former forensic patients who have been reclassified to civil status (perhaps 15-20% are in this last group).

Recent legal issues

The Victorian CommTO legislation was recently amended by the *Mental Health (Amendment) Act 2003* (Vic). The main focus of these changes was to insert the requirement into the law for the preparation of treatment plans. The legal criteria governing recall to hospital were sharpened and the requirement was added that the death of a patient under a CommTO be reported to the Coroner.

The frequency of review proceedings

Another matter of debate in this law reform process was the duration of CommTOs and the frequency of their review by the Board. If the maximum life of a CommTO had been reduced from one year to 6 months, as is common elsewhere in Australia, that change would probably require the Board to review the order every 6 months as well, instead of the annual reviews usually conducted at present. That would greatly increase the number of hearings of the Board. This was a particularly difficult matter to resolve because the Victorian government had firmly indicated that it would not provide more funds for that purpose to the Board. Arguments may be made both for and against increasing the frequency of reviews in those circumstances.

If independent review of the need for CommTOs was *more frequent*:

- the compulsory status of patients would probably be scrutinised more regularly by clinicians
- patients might then be discharged from CommTOs earlier by the clinicians, in anticipation of the hearing
- considerably more review hearings would still have to be held
- these hearings would tend to be more superficial, if no more resources were available to the Board
- greater administrative burdens, associated with those reviews, would be imposed on clinicians.

On the other hand, if independent reviews remained *less frequent*:

- the bias towards the status quo might mean CommTOs would last longer
- the need for CommTOs to continue might be less frequently scrutinised by clinicians
- the administrative burdens imposed on clinicians would be less
- they might then have more time to devote to patient care
- the less frequent hearings might be more intensive and meaningful as a result.

These arguments are finely balanced. The best approach may be to adopt a sliding timetable for reviews, whereby patients newly placed under CommTOs are entitled to more frequent reviews than those whose orders have been extended, and to grant more frequent reviews to patients who apply.

Following a debate on these lines, the Victorian government made no change to the maximum 12 month term of a CommTO, or to the frequency of reviews, in the amending legislation.

Other debates

Some other contentious issues have concerned:

- whether legal representation of patients should be mandatory at review board hearings, when that might substantially increase their length and the costs of legal aid
- the need for better information to be put before the Board about the patient's social circumstances
- whether the Board should have the power to release a patient from a CommTO when no adequate community service is being provided
- whether the Board should have a power to make recommendations (eg, about the transfer of patients between community and in-patient orders), and what the legal effect of those recommendations would be
- how to ensure access for community teams to patients under CommTOs who are arrested and remanded to prison prior to trial
- the legal position of patients under CommTO who 'abscond' to other parts of Australia; inter-state extradition procedures; and the enforceability of CommTOs in other states
- the 'liability' of clinicians at Coronial inquiries and in the media, especially when patients under CommTOs commit suicide
- the effect on relationships between the members of the different professions within community mental health teams of conferring on *doctors* the legal authority to direct the treatment of patients under CommTOs
- proper relations between CommTOs and the adult guardianship scheme, particularly concerning the duty to monitor the residential circumstances of a person who is under both schemes at the same time, when those administering both schemes would happily shift that burden to the other agency.

Research on efficacy

A significant body of evaluation research is now emerging concerning the Victorian regime. In particular, three unpublished theses were found in Melbourne medical libraries that attempt to evaluate the outcome for patients of the scheme. As this may be the most widely-used CommTO regime in the world, and the findings of these theses have not been published, except for a brief note by Power (2000), a reasonably full account of them will be provided.

Cooper's study

Cooper (1992) retrospectively studied the files of 53 patients consecutively placed under CommTOs at one Melbourne hospital in the early years of the scheme.

The common characteristics of these patients were studied and described by Cooper. They tended to be single, middle-aged males, receiving government benefits and living in private accommodation, with 'a psychotic illness'. They showed 'major impairments in daily functioning' and had required extensive psychiatric assistance in the past. There was 'little distinctive' about them, compared with other psychiatric patients in public hospital care. They were rarely homeless or 'reported to be dangerous' and they 'continued to show evidence of severe impairment' even during treatment under the CommTO.

From a retrospective study of these patients' records Cooper concluded:

- one third were readmitted to hospital during their first year on the CommTO
- one third had their order discharged during that year, instead of it being renewed
- 17% were treated by the same doctor during their first year on the CommTO
- many patients did not experience a consistent doctor-patient relationship
- CommTOs tended to increase compliance with medication and use of depot medication
- patients did not attend outpatient appointments more reliably than previously
- their levels of social contact remained limited
- incidents of known harm while patients were on the order were infrequent
- there was poor compliance by clinicians with the documentation required by law.

Forty-five of the treating clinicians (85%) responded to a survey concerning these 53 patients. Rating the usefulness of the CommTO on a 1-5 scale (1=very useful, 5=not useful at all), the mean response of clinicians was 2.4, a rather underwhelming result.

Cooper's general conclusion was that 'chronic patients' under CommTOs tended to show modest improvements when on CommTOs, mainly due to greater medication compliance. CommTOs may permit earlier discharge from in-patient care, especially in times of acute bed shortage. They also impose unwelcome administrative demands on clinicians. CommTOs should only be relied on, in his view, when there are 'clear clinical indications' for their use and they can be enforced through an adequate system of administration.

The published study of McDonnell and Bartholomew

These researchers from the Department of Criminology at the University of Melbourne collected data about 130 CommTO cases coming before the Victorian Review Board in the mid-1990s. These constituted approximately 10% of the cases coming before the Board in that period.

The CommTO had been extended beyond 12 months in 30% of these cases, and in 60% of those the order was extended once again.

Few patients had exercised their right of appeal to the Board (19%). Most only came before it when automatically entitled to a review.

In their conclusions, the authors express concern that (at 33-35):

- CommTOs in Victoria were being 'over-used to ensure compliance with medication'
- there was 'a predominant (and often exclusive) reliance on medication'
- too few other support services were available for patients
- treatment plans were not prepared for all patients
- the 12 month duration of the orders was excessive; 6 months was preferred
- mandatory annual reviews before the Board were too infrequent
- issues of 'intrusiveness and scrutiny' remained central for patients under CommTOs

- because these orders tended to be viewed as a less restrictive alternative to hospital, they may be used more frequently and for longer periods of time.

They recommended more research on the impact of CommTOs on patients' families, on patients who are discharged early from the order, and on inconsistencies found between clinicians in the extent of their reliance on these powers.

The studies by Power and Muirhead

Two Melbourne psychiatrists, Power (1998) and Muirhead (2000), have conducted more ambitious studies of the regime. Both use case control, 'mirror image' methods, in which the position of patients is compared before and after going on the CommTO.

There are well-known limitations to such studies, which both authors acknowledge. First, it is possible that any changes observed in the lives of patients in the period after they went on the CommTO were due to other factors: eg, a change in medication instituted during the intervening hospital admission.

Secondly, the results of such studies may be influenced by the phenomenon known as regression to the mean. That is, the period in the patient's life immediately before they went on the CommTO may have been exceptional. That may be why they were admitted to hospital and then placed on the CommTO. In the subsequent follow-up period, the patient's life may return to a more normal pattern: that is, they may 'regress to the mean'. That phenomenon would then explain why the patient appears to do better on the CommTO.

Nevertheless, 'mirror-image studies' of this kind are a common method of evaluating health interventions, especially because prospective, randomised controlled trials, which may avoid these difficulties, are problematic for ethical and legal reasons (Dawson, 2003).

Power's study

Power's MD thesis is an ambitious example of this 'mirror-image' methodology. It is a careful, retrospective study of the psychiatric records of all 125 patients residing in

the south central area of Melbourne who were placed under a CommTO during the 46 months from October 1987 to July 1991, as the Victorian CommTO regime was bedding in. The main results of this study have been briefly reported (Power, 2000), but it deserves greater exposure.

There were two principal aspects to Power's methods:

- a mirror-image study of the careers of the CommTO patients in equivalent time periods before and after they went on the CommTO
- a comparison of the characteristics and careers of the patients on CommTOs with a matched control group of patients who were admitted involuntarily to hospital in the same year, in the same area, but who were not placed on a CommTO.

The results on both counts show significant therapeutic benefits for patients on CommTOs.

Power found that the patients placed on CommTOs tended to be rated previously 'as quite poorly compliant with outpatient treatment, particularly in the year before the admission from which the CTO was issued' (286), and there was 'strong evidence' for a 'high prevalence of violence that pre-dated the CTOs among the sample', particularly for 'forms of violence towards others' (287).

The outcomes for patients were rated on six measures:

- change in number of hospital admissions
- change in total time spent in in-patient care
- change in median length of hospitalisation
- change in psychiatric symptoms
- change in violence score, based on a recognised violence assessment instrument
- change in outpatient medication compliance score.

The two central findings were that the patients placed on CommTOs showed significantly increased attendance at outpatient appointments and greater compliance with medication compared with the period before the order commenced.

The patients were then allocated to three broad outcome groups based on their combined scores on those outcome measures:

- a 'best' (or 'improved') group, who had improved on all six outcome measures
- a 'marginally better' group, for whom at least one measure was 'unchanged' and the others were 'improved'
- a 'worse' group, who had a worse outcome on at least one measure.

Forty eight per cent of the patients were rated as 'improved' on all outcome measures when under the CommTO, 24% were rated 'marginally better', and 28% were rated 'worse' on at least one measure.

A further analysis was then conducted of a sub-sample of 31 patients who had later been discharged from the CommTO for a sufficiently lengthy period to permit a second 'mirror-image' comparison to be made, between their life under the CommTO and their life after discharge from it. The mean outpatient medication compliance scores of these patients were found to have deteriorated significantly following their discharge from the order, and their mean violence ratings to have significantly increased. Forty-seven per cent were rated 'worse' during this final follow-up period, after their discharge from the order.

Power reached the following conclusions from this part of the study: 'improvements in the outcomes of these patients when placed on the CTO appeared to be quite dramatic on a wide range of variables that included outpatient medication compliance, global symptom rating, violence scores and readmission figures' (at 281). In his view, these findings 'confirm the general "therapeutic efficacy" of CTOs' (290).

Those patients who were identified as responding 'best' to CommTOs tended:

- to be older (over 28 years)
- to be in the middle phase of their history of illness and treatment
- to have a relatively low rate of admissions since the onset of their illness
- to have had spent a high percentage of their inpatient time as involuntary patients
- to have complied poorly with medication before the index admission.

The patients rated as ‘marginally improved’ tended:

- to have spent a lengthy total period in in-patient care
- to be in the later phase of the history of their illness and treatment.

The patients rated ‘worse’ on at least one outcome measure tended:

- to be younger (less than 28 years old)
- to have had a short duration of history and treatment for their illness
- to have had a low percentage of involuntary compared to voluntary hospital admissions
- to have had good compliance with outpatient medication in the previous year
- to have a dual diagnosis (usually concurrent drug abuse or dependence)
- to have had a history of violence towards others.

Of this last group Power commented: ‘Perhaps the complication of drug abuse/dependence in these younger patients is one of the major factors in aggravating their psychotic or mood disorder and a CTO or improved medication compliance will have little impact on their substance use’.

On this aspect of the study, Power concluded:

The ‘therapeutic efficacy’ of CTOs appears impressive, however not all patients respond favourably and a minority respond poorly on outcome measures such as outpatient treatment compliance and hospitalisation rates. CTOs may have their effect primarily through their impact on outpatient treatment compliance, though for a small proportion of patients other factors appear to be involved. What is interesting is that a CTO’s ‘therapeutic efficacy’ appears to be dependent on whether it is used in the early, middle or late stage of a patient’s illness history. The factors involved are no doubt complex and might have little direct association with the CTO itself: eg, characteristics associated with phase of illness, levels of family support, inherent relapse rates, levels of secondary morbidity, deteriorating therapeutic effect of medication with chronicity of illness and services’ resources.

In the second part of the study, Power compared 104 of the patients placed on CommTOs, who were randomly selected from the larger group of 125, with a random stratified sample of controls. The members of this control group were matched for age, sex, primary diagnosis and year of discharge from hospital. They had been involuntarily admitted to hospital in the same area, but not placed on a CommTO.

The aim was to ‘determine the patient characteristics that may differentiate CTO patients from other involuntary patients discharged into the community’ (298); and to compare outcomes for the two groups.

The patients placed on a CommTO were found to have a significantly greater rate of:

- concurrent drug abuse disorders
- violence to others and to property
- prior involuntary hospitalisations
- prior contacts with public community mental health clinics
- prior prescription of depot medication
- non-compliance with outpatient treatment in the prior year
- being ‘lost to follow-up’ in that year.

On the other hand, the CommTO group were not found to have spent more time under treatment, or to have had longer delays in commencing treatment after the original onset of their illness.

The single most powerful factor differentiating the patients placed on CommTOs after an involuntary admission was non-compliance with outpatient treatment in the preceding year (318).

Patients placed on CommTOs had a significantly higher rate, and longer duration, of hospital admission during the preceding period, and other indicators of greater psychiatric morbidity. Their mean number of readmissions was the same as the control group, however, when on the CommTO (321).

Power’s general conclusions here were:

Though the CTO sample's previous history has indicators of greater morbidity, the CTO sample improved relatively more when placed on CTOs than the control group in the corresponding period. On some indicators the CTO group actually ended up with less severe indicators of morbidity than their controls during the follow up periods: e.g., numbers of patients readmitted and levels of violence. In particular, the control group's poorer outcome was reinforced by the finding of 3 suicides during the follow-up period (at 333-334). ...

[T]hese findings suggest that, firstly, CTOs are reserved for those involuntary patients who are distinguished from other involuntary patients by indicators of more severe management problems (non compliance with outpatient medication) in combination with features of more severe morbidity (including more frequent hospitalisations, higher rates of violence, and co-morbidity). Secondly, when placed on CTOs these patients' distinguishing features (poor compliance with outpatient medication, violence, readmissions and lengths of hospitalisations) appear to 'normalise' to a level where they compare favourably with that of other involuntary patients (discharged from involuntary hospitalisations without CTOs). Indeed, it appears that despite their history of more severe morbidity, CTO patients when placed on CTOs demonstrate a relatively better outcome on follow-up than their counterparts who are discharged from involuntary hospitalisation without CTOs, possibly as a result of the improvement of outpatient treatment compliance brought about by the impact of [outpatient commitment].

Muirhead's Study

Muirhead (2000) used similar, retrospective, 'mirror-image' methods to assess patient outcomes in the year before and after their placement on a CommTO. The sample of 58 patients was drawn from a larger cohort of 132 patients placed on CommTOs in the north western area of Melbourne, during the 24 months from November 1996 to October 1998. By this time, the Victorian regime was used more widely and was more securely established than in the periods studied by Cooper and Power. Muirhead's study was limited to patients with a primary diagnosis of schizophrenia,

however, and the relevant data were again collected retrospectively from patients' files.

A particular aim was to determine whether use of CommTOs affected outcomes both for patients prescribed depot (or injectable) medication and for patients prescribed oral medication. For that purpose, the sample was divided into two experimental sub-groups:

- those treated primarily with oral medication on the CommTO (n=20); and
- those treated primarily with depot medication (n=38).

Muirhead was particularly interested to assess the outcome for patients who had been prescribed oral medication, because atypical antipsychotic drugs had become available just before the study period, but they were only available at that time in oral form. These new drugs had been found to be 'associated with significantly improved tolerability and acceptance of treatment' by patients, and their use might in turn lead to 'improved symptom control, decreased side effects and improved quality of life'(at 20). Muirhead's concern was that if all patients were prescribed depot medications when on the CommTO, some would be deprived unfairly of the benefits of the new drugs. That is, if the assumption became established that patients under CommTOs necessarily required depot medication, some would be 'denied the benefits of atypical versus typical antipsychotics', as only the latter were available in injectable form (20).

In Muirhead's view, psychiatrists in Melbourne were uncertain whether CommTOs could enhance patients' compliance with oral medication. 'Some hold the view', he stated, 'that if a patient will take oral medication then a CTO is not required'. Similarly some believe that 'a CTO will be of no benefit except when medication adherence is directly observed, which means depot medication in the majority of cases' (because depot medication is personally administered to the patient by a health professional). On the other hand, other psychiatrists took the view 'that a CTO can help to persuade a patient to take oral medication' (20). Muirhead therefore sought to measure whether CommTOs could produce positive outcomes for patients on oral medication as well as those receiving injections.

The results show that the patients *were* more likely to be prescribed depot medication when on the CommTO. Nevertheless, he reached the following general conclusions:

The findings were of significant increases in numbers of contacts with treating community services, significant decreases in number of admissions, length of inpatient stay and number of aggressive episodes following the commencement of the CTO. These differences were found for *the whole sample and for both experimental sub-groups*. There were no significant changes in measures of [referrals to crisis assessment teams], numbers of other episodes of relapse [not leading to hospitalisation], number of suicide or self-harm attempts, number of changes in accommodation, best level of employment or frequency of contact with family members. There was a significant improvement in the quality of the patients' relationships with their families *for the whole sample* and the sub-group treated with oral antipsychotics and a nonsignificant trend for improvement for patients on depot medication (at 4) (italics added).

This study is limited by the character of its methods, including reliance on data derived from patients' files, and by the small size of its sample. Nevertheless, Muirhead observed that its results 'challenge the notion that involuntary outpatient treatment needs necessarily to be combined with depot antipsychotic medication' (67). Instead, he argued, its findings 'support the notion that outcome can be positively influenced for selected patients even when compliance with prescribed medication cannot be directly influenced by mental health professionals'. This means that in appropriate cases 'clinicians may consider the full range of pharmacotherapy options when planning management for the patient' (67).

Discussion

This portrait reveals the Victorian CommTO regime bedding in during a period of transition to community mental health care. In the decade or so after its enactment, use of the regime significantly increased as teething problems were sorted out, as the number of hospital beds decreased, and as the community resources necessary to support its use became available.

This regime now appears to have the confidence of most experienced clinicians in Victoria who work within the public mental health system and few appear to doubt its efficacy when properly targeted and resourced. There also appears to be a widespread belief that the introduction of this regime facilitated a reasonably structured transition from a hospital-based system to one based on community care. CommTOs are certainly a well-established aspect of public psychiatric practice in the state (Brophy and Ring, 2004).

One senior psychiatrist said: ‘The good accounts of CommTOs come from areas where they have been embedded for a good while and have settled down and have the full backing of the community mental health services. Poor accounts come from areas where they are newly introduced and there is no consensus behind them’.

The frequency with which CommTOs are used in Victoria seems likely to be associated with the fact that they may be readily initiated by psychiatrists; the order lasts for a year; mandatory tribunal reviews are reasonably infrequent and not too lengthy or adversarial; and a workable process is provided for the swift recall of patients to hospital care. In addition, their use is almost certainly stimulated by the existence of relatively well-developed community mental health services, that are necessary to support the scheme, combined with a radical reduction in the availability of hospital beds.

In short, the CommTO regime appears to be a well-established feature of Victoria’s attempt to take a public health, or population-based approach to the provision of mental health care. Under that approach, it seems that a serious attempt is being made to provide an adequate, mobile community mental health service, via salaried public sector employees, that covers the entire population of the state. In an associated development, all transactions between patients and mental health services are recorded on a state-wide, electronic case register that clinicians can access to track their patients’ records.

The Victorian CommTO regime seems to be reasonably well-focused on the seriously mentally ill, especially on patients with a diagnosis of schizophrenia, several prior admissions to hospital, and a recent record of poor compliance with outpatient care.

There is increasing empirical evidence to support the scheme's use in these circumstances, derived from the 'mirror-image' studies, although this is not conclusive.

There is also considerable evidence of the link between CommTOs and the use of depot medication, even if the necessity for that connection is challenged by Muirhead's research.

Clearly the Victorian regime is not used for 'revolving door' patients alone. Significant numbers of patients are placed under it following their first admission to hospital. Power's study suggests this approach is likely to be taken with patients who have a concurrent history of substance abuse and violence to others. But his findings also suggest CommTOs are not likely to be very effective in such cases. This more controversial use of CommTOs may reflect a desire to prevent the unnecessary criminalisation of the members of this group, or to reduce the stress placed on their families. Or it may be one example of a defensive medical practice emerging as a result of the enhanced societal focus on the 'risk' posed by mentally disordered people, especially those who engage in substance abuse.

Many senior clinicians observed, on the other hand, that CommTOs in Victoria 'are resourced', and that community teams feel obliged to follow patients under them, who therefore get some priority for care. CommTOs are seen both to permit and to require patients to be tracked, to ensure they receive treatment, as they move about in a large urban zone, in which they might otherwise be 'lost to care'.

The principal remaining doubts about the Victorian regime appear to concern:

- the possibility that CommTOs are used too readily, and for too long, and with categories of patient for whom there is no evidence of their efficacy
- the tendency to use depot medication too readily with patients under them

- the infrequency of reviews by the Board
- the inadequacy of the information put before the Board
- gaps in accommodation for patients with complex needs
- the continuity and adequacy of the doctor-patient relationship for those under CommTOs, especially where cultural and language barriers exist between doctor and patient.

Chapter 5

New South Wales

Summary

The rate of use of CommTOs is lower in NSW than in Victoria, although it has increased rapidly in recent years, in parallel with reductions in hospital beds and the development of community mental health services in the state. The lower courts of the state and the review tribunal play a significant role in the NSW scheme. Diversion to a CommTO is possible from the criminal courts and there is a relatively frequent requirement of independent tribunal review. The regime is being implemented in a radically deinstitutionalised environment, but, compared with Victoria, there is a less well-developed infrastructure for community mental health care. In these circumstances, CommTOs seem to act as something of ‘safety valve’ for the criminal courts and inpatient facilities, which are under considerable pressure. Increasing the maximum term of a CommTO from 3 to 6 months in the mid-1990s encouraged their use. The legal regime in NSW is carefully crafted. It incorporates the major clinical indicators for use of involuntary outpatient care into the law, and it strikes a subtle balance between clinicians’ powers and patients’ rights regarding powers of entry and treatment without consent in community settings. The process for recall of a CommTO patient to hospital is inflexible, however, and is rarely used. Patients who relapse may be recertified and put back through the ‘front door’ of the involuntary treatment process instead. Particular concerns are the excessive burden of work imposed on the NSW review tribunal, the increasing use of CommTOs due to intense pressure on hospital beds, and the complicating effects for many involuntary patients of concurrent substance abuse.

The context in NSW

A well-established CommTO regime has been operating, since the early 1990s, in NSW. Like the Victorian scheme, its use has been steadily increasing since its introduction, in parallel with the deinstitutionalisation of mental health care. As a result, reviewing the use of CommTOs is now a major enterprise for the Mental Health Review Tribunal of NSW (the Tribunal). Unfortunately, the NSW regime has not been the subject of extensive research. Many of its consequences for patients

therefore remain unknown. It seems to have a distinct profile, in comparison with the Victorian scheme. It appears to confer less clinical discretion on psychiatrists, particularly regarding the recall of patients to hospital care, and its use is more frequently subject to tribunal review. The maximum duration of a CommTO in NSW is 6 months, as opposed to a year in Victoria. This means patients under CommTOs for long periods come before the NSW Tribunal twice as often for review. The NSW scheme is also more closely aligned with the criminal courts, with Magistrates having the power to place a person charged with an offence directly on a CommTO, in a classical form of a 'diversion' scheme. On the other hand, the rate of use of CommTOs is lower in NSW than in Victoria, but because the population of NSW is larger, roughly the same number of people seem to be on CommTOs in the two states.

Roughly 6.6 million people were living in NSW in 2003, more than half of them in the large metropolitan region of Sydney. But mental health services appear to be less well-funded in NSW than Victoria, and they appear to have developed in a more haphazard fashion (Abela, 2000; AIHW, 2003). The NSW services are still structured, in part, around older psychiatric hospitals, parts of which remain open, providing a significant proportion of the state's psychiatric beds. In addition, some private hospitals admit patients under the Mental Health Act, and many general hospitals contain 'co-located' psychiatric wards. Something of 'patchwork' of services seems to have developed, driven more by historical factors, perhaps, than a sustained vision for service development across the state.

Around 40% of psychiatric admissions still occur on an involuntary basis, although the proportion is much higher at some of the older psychiatric hospitals (Annual Report, NSW Department of Health, 1999/2000).

The deinstitutionalisation process is still well-advanced in NSW. The numbers of psychiatric beds available declined steeply during the 1980s and 1990s: by the year 2000 there were 2320 beds available for 6.5 million people in the state. That is a rate of roughly 3.5 beds per 10,000 persons, which is only slightly higher than the rate in Victoria at that time. On the other hand, community services are undoubtedly less

well-developed in NSW (AIHW, 2003), although their cover has been expanding in recent years: into the western suburbs of Sydney, for example.

In the past, the inadequacies of the community services in NSW have been the subject of serious criticism in a number of high profile inquiries and reports, particularly the well-known Burdekin Report (1993). As recently as 2002, a select committee of the NSW Parliament, having conducted an inquiry into mental health services in the state, declared there were major problems in funding, patient accommodation, forensic services, substance abuse treatment, and in services for indigenous people, the intellectually disabled, the elderly and young persons (Legislative Council of NSW, 2002). The committee expressed concern about suicides among discharged patients denied access to care, and recommended more resources should be directed to crisis teams, case management services and assertive community care.

Many people interviewed said there was acute pressure on psychiatric beds in NSW, that there were high rates of mental illness among prisoners awaiting trial, and that even the criminal courts had difficulty getting patients admitted to hospital for assessment. Perhaps as a consequence, the powers to permit Magistrates to place criminal defendants directly on CommTOs were enacted in 2003.

Nevertheless, the coordinated development of mental health services in NSW appears to have received greater priority in recent years, perhaps in response to the federal government's National Mental Health Strategy. A Mental Health Co-ordinating Council is active in the state, and the continuing expansion of community services seems to be one reason why the use of CommTOs in NSW continues to rise.

The CommTO legislation

This regime was established by the *Mental Health Act 1990* (NSW) and implemented the following year.

Criteria

To be placed on a CommTO, a person must meet the criteria for involuntary treatment in general, and then specific criteria applicable to involuntary outpatient care.

The criteria for involuntary treatment focus on:

- the presence of ‘mental illness’, illustrated by seriously impaired mental functioning and listed psychiatric symptoms
- the necessity for involuntary treatment to proceed, in order to protect that person or others from serious harm.

In deciding whether these criteria apply, the person’s ‘continuing condition’, and the likelihood of its deterioration without treatment, may both be taken into account (s 9(2); *Harvey v Mental Health Review Tribunal* (1994) 33 NSWLR 351).

Six further rules then apply to the use of CommTOs. These focus on (s 133):

- the role of the order as a less restrictive alternative to hospital care
- the existence of ‘an appropriate treatment plan’ that can be implemented
- evidence of previous refusal by the patient of appropriate treatment
- their subsequent ‘relapse into an active phase of mental illness’
- their deterioration leading to involuntary admission to hospital
- effective treatment of their illness on such prior admissions.

For a patient to be placed on a CommTO on a first admission to hospital, only the *first two* of these rules must be met. For patients on subsequent admissions, *all six* must be met.

In addition, the emphasis placed on the use of least restrictive alternatives, throughout the NSW Act, clearly indicates that CommTOs are to be used whenever possible, instead of involuntary hospital care (eg, ss 4(2), 20, 51(2)).

In effect, these rules incorporate the usual clinical criteria for the use of involuntary outpatient care into the law (see Geller, 1990).

Administration and process

Both Magistrates and the Tribunal may place patients on CommTOs in NSW. The order is to be made, in both cases, on the basis of a plan for the patient's treatment advanced by the responsible clinicians.

Prior to 1 October 1997, the maximum life of a CommTO was 3 months. It was then extended to 6 months. Most orders are made for this maximum term. A CommTO may be renewed any number of times, and most are renewed at least once (see the Annual Reports of the Tribunal).

Following a person's involuntary admission to hospital, their status is initially reviewed by a Magistrate, who may place them directly on a CommTO at that stage. A significant minority of CommTOs are made in this way. Thereafter, the task of reviewing a patient's involuntary status is picked up by the Tribunal. In performing that function, it may switch a person from involuntary hospital care to a CommTO, or it may renew any CommTO previously made.

The NSW Tribunal has a wide-ranging jurisdiction over the position of both forensic and civil patients. It has full-time leadership and about 100 part-time members. When reviewing individual cases, it sits in multi-disciplinary panels, chaired by a lawyer. The Act states that its proceedings are to be 'informal' and are not governed by strict rules of evidence: s 267. Very few CommTO patients appearing before the Tribunal are legally represented. Its workload is increasingly heavy and a cause of concern to its members. It conducted around 8600 hearings under the Mental Health Act in 2003. Roughly half of them concerned CommTOs.

The other administrative functions under the NSW scheme are spread between hospital-based clinicians and the staff of the community health care agencies that directly manage the patient's treatment.

Generally, the procedures rules governing the use of CommTOs emphasise:

- provision of information to the patient about their legal status and treatment
- consultation with those caring for the patient

- the assistance of interpreters, if required
- access to the tribunal at regular intervals, and more frequently on application
- the duty of clinicians to keep the patient's condition under regular review
- the duty to terminate the order if the criteria no longer apply, or if it is 'no longer likely to be of benefit to the patient': s 149.

Treatment plans

The treatment plan, which is attached to the CommTO, will usually be prepared by the patient's case manager. It is to be prepared after consultation with the patient, and after consultation with clinicians from the health care agency responsible for implementing the plan. It will state the obligations of that agency and of the patient concerning the treatment to be provided.

The plan will usually require the community agency's staff:

- to maintain weekly contact with the patient, through outpatient appointments or a visit to their residence
- to prescribe and supply medication to the patient
- to review the patient's condition on a regular basis
- to provide consultation and support for the patient's case manager.

The patient will usually be required:

- to take medication as prescribed
- to undergo associated medical tests
- to accept reasonable supervision of their treatment, including clear arrangements to ensure medication compliance
- to attend appointments for regular review by clinicians.

Whenever a CommTO is to be renewed, the Act requires a further, written report to be furnished to the Tribunal, by the case manager, on its 'efficacy': s 131(2B).

There has been some debate in NSW about the precise requirements that can be included in a community treatment plan. Some contentious requirements include: attempts to direct where the patient must live; treatment for non-psychiatric

conditions, such as diabetes; the inclusion of behavioural programmes; and drug and alcohol treatment programmes.

Determining the permissible contents of a treatment plan is especially important in NSW, because the provisions governing the patient's recall to hospital are linked to compliance with the treatment plan, and because the Tribunal must approve any major 'variations' made later to the plan.

The 'diversion' powers

These additional powers, conferred on Magistrates in 2003, to divert people appearing on criminal charges directly to a CommTO, may be exercised without the person's prior assessment in hospital, and without the need to convict them of an offence. All the usual requirements for the CommTO must be met, including the requirement that the responsible clinicians must propose a treatment plan. Most people dealt with under these powers are said to be 'well known' to the mental health services, which will accept their treatment without their further assessment in hospital. This diversion process has much in common with the role performed by 'mental health courts' in the United States.

The consequences for the patient

The powers to treat involuntary patients without their consent under the NSW Act apply to both patients in hospital and those under CommTOs. Involuntary patients retain their right to be informed about treatment, but they may be required to accept medication without consent for the duration of their involuntary status. As in Victoria and NZ, provided the patient continues to meet the criteria for a CommTO, ongoing assessment of their capacity to consent to psychiatric treatment is not required by law.

Further specific rules about involuntary *outpatient* treatment under the NSW Act state:

- the patient 'must comply with the order' (including the requirements of their treatment plan): s 145

- the staff of the responsible health care agency ‘may take all reasonable steps to have medication administered, and to provide services’ in accordance with the order’s terms: s146(1)
- medication may be administered to the patient in a community setting without their consent ‘if it is administered without the use of more force than would be required ... if the person had consented’: s 146(2)
- the staff may, without consent, ‘enter the land’ at the patient’s residence, ‘but not the dwelling’, in order to administer treatment: s 146(3).

On the other hand, no specific statutory power is provided to direct where the patient shall live, even though a ‘residence requirement’ is sometimes included in the patient’s treatment plan.

The recall process

Further detailed provisions govern the recall (or ‘breach’) process (ss 137-143A).

For a CommTO patient to be recalled to hospital, it must be determined that (s 137):

- they have either ‘refused’ to comply with the order, or have ‘failed to comply’
- the agency responsible has taken ‘all reasonable steps to implement’ the order
- there is a ‘significant risk of deterioration in the mental or physical condition’ of the patient.

The procedures to be followed specify:

- oral and written warnings to the patient of the consequences of their failure to comply, including the possibility that the Police may be involved
- offering the patient an explicit choice between accepting treatment and their return to a clinic or hospital for treatment to proceed
- powers to ‘take’ the patient to a clinic or hospital
- powers of entry and police assistance
- mandatory assessment on arrival at a hospital
- the right to apply for tribunal review of their inpatient status, if it continues.

Ultimately, if a patient under a CommTO continues to refuse treatment, despite those warnings, they may be returned to hospital, assessed, and treated with medication, without their consent.

On the other hand, the legislation also provides that a patient under a CommTO may be readmitted to hospital on an informal basis, without that revoking the order or affecting its term.

Obligations of service providers

The general obligations of the health care agency that is responsible for the patient's treatment of a patient should be stated in the approved community treatment plan.

In addition, further obligations concerning patients under CommTOs are specifically imposed on these health care agencies by the Act (s 147):

- to 'keep under review the prescription and use of drugs'
- to provide the patient with information about their medication at their request
- to provide that information to caregivers with the patient's consent.

No strong duty is imposed on those agencies by the statute, however, that specifically requires them to provide the services listed in the patient's treatment plan, or that seems likely to be enforced against them in civil litigation. But nor is any special immunity conferred on them by statute for failure to provide the treatment in the plan. No special immunity covers their liability to third parties, for instance, who might be harmed by a patient under a CommTO who has not received adequate care. These matters seem to be left to be handled under the general law of professional liability in NSW.

Community Care Orders

In addition to CommTOs, the NSW Act provides for Community Counselling Orders (CCOs). These are similar to CommTOs but are considered to be less enforceable and less easily renewed. They were described to me as 'toothless tigers' or 'a bluff'. They are used much less frequently than CommTOs, although they may be used by some clinicians for particular purposes. They might be employed after a patient has

already been on a CommTO for an extended period of time, for instance, to increase their sense of control over their treatment. Use of these orders is included in the figures presented below.

Numbers of patients under CommTOs in NSW

The number of *persons* being treated under CommTOs in NSW appears to have increased steadily since the regime was introduced in 1991 (see the Annual Reports of the Health Department of NSW and the Tribunal). The number of *orders made* certainly increased rapidly in the early years: 510 CommTOs were made in 1992, 1233 in 1994, and 2672 in 1996 (Annual Report of the Tribunal for 2001, Table 17). During this time the maximum life of a CommTO was 3 months, and many patients had their orders renewed many times.

The number of orders made reached a temporary peak of 3774 in 1997. The maximum term was then extended to 6 months, following an amendment to the law. The number of *orders made* then dropped the following year, as most orders would last for twice as long. It did not decline to anything like half like the prior level, however. It fell to only 2996, in 1998, and then again began to rise, to 3228 in 1999. Increasing the life of the CommTO therefore seems to have further encouraged their use. As a result, the *number of persons* being treated under CommTOs at any time would also have continued to rise.

By 2001, even the number of orders made, at 4175, had come to exceed the number made in 1997, despite the doubling of the order's maximum term. Further increases have occurred subsequently, as the number of hearings conducted by the Tribunal concerning CommTOs has increased steadily by more than 10% a year.

The number of CommTOs made by Magistrates has been consistently less than the number made by the Tribunal, although it has fluctuated over time. The number made by Magistrates leapt, for instance, from 673 in 2000, to 1289 in 2001 (MHRT, Annual Report, 2001).

Some data on the actual *number of patients under CommTOs* are provided in the Annual Reports of the NSW Department of Health. Based on returns filed by community health care agencies, it is said that 1434 patients were being treated under community orders in the state in June 2000, and 1571 in June 2001. These figures may somewhat underestimate the true numbers, however, as there are suggestions in these reports that the returns from the community agencies were incomplete.

Based on all these kinds of figures, concerning the numbers of CommTos made, and the numbers of hearings about CommTos before the Tribunal, and the figures provided by community agencies, it is possible to make a rough estimate of the number of patients on CommTos in NSW in 2003. Somewhere between 2000 and 3000 people would have been on a CommTO, for a total population of roughly 6.6 million. If we adopt the median figure of 2500, that would be 1 person in 2640 on a CommTO in NSW in 2003.

This is significantly lower than the equivalent rate of 1 person in 1850 estimated to be on a CommTO in Victoria that year, and lower than the estimated rate of 1 person in 2350 in NZ at the same time. Even so, there is a surprising degree of congruence between these rates, given the differences in the legislation, and in the structure of the psychiatric services, in these different parts of Australasia. In all these regions, there seems to be a relatively high rate of use of CommTos by most international standards.

The lower rate at which CommTos are used in NSW means that its community services appear to treat a smaller proportion of their patients under CommTos than their equivalents in Victoria or NZ. A figure of 40-50 clients on CommTos in 2003 was quoted to me for a community service in inner north Sydney, which served a population of about 200,000 people, and had 800 registered clients. A figure of at least 100 clients on CommTos would be more normal for an equivalent inner city service in Melbourne or NZ.

The reasons advanced to me for the rising rate of use of CommTOs in NSW in recent years include:

- the intense pressure on inpatient facilities in the state
- rising numbers of patients with a dual diagnosis of mental illness and drug abuse
- increasing use by Magistrates, to divert people from the criminal justice system
- increasing coverage of the state by community mental health teams
- greater societal focus on ‘risk’
- the emergence of more defensive medical practices
- very high rates of renewal of CommTOs by the Tribunal.

‘Breach’ practices

The recall (or ‘breach’) process, on the other hand, appears to be rarely used. The Annual Report of the Tribunal for 2001 states, for instance, that 12713 persons were ‘taken’ to psychiatric hospitals in NSW that year, but only 121 were taken there for ‘breach’ of a CommTO. Similar figures are provided for other years. Similarly, Ozgul and Brunero (1997) found that only 1% of the patients in their CommTO sample were ‘breached’ during the order.

Community clinicians in NSW were said to be reluctant to ‘breach’ patients in this way, due to the threat it posed to future relations with the patient. It was also said that when a patient’s readmission was considered essential other legal powers were often used instead, powers that are more readily activated than the series of warnings and notices required by the ‘breach’ provisions of the NSW Act. The patient may simply be ‘rescheduled’, as if freshly admitted under the Act, a practice referred to as ‘community scheduling’.

A further factor may be the legal requirement of refusal, or failure, on the part of the patient, to comply with the terms of their CommTO for the ‘breach’ provisions to apply. The patient’s non-compliance may not be clearly established, and some patients may relapse who have complied. It may then be necessary to put the patient back through ‘the front door’ of the civil commitment process, even though they are subject already to a CommTO.

The characteristics of CommTO patients

Little information has been published on the characteristics of patients under CommTOs in NSW, although some can be derived from the research conducted by Carne (1996), Ozgul and Brunero (1997), and Vaughan et al (2000). These studies suggest that over 60% of CommTO patients in NSW are men, a high proportion have a diagnosis of schizophrenia, and substantial numbers have a concurrent diagnosis of substance abuse. Few patients appear to be living in group homes or supported accommodation; most live alone in rented, publicly-owned flats, or with their families; and most are single and supported by a disability benefit. In Ozgul and Brunero's study, the patients had an average of 11 years' previous psychiatric illness; in Vaughan et al's study, they had an average of 6.4 previous psychiatric admissions. On the other hand, the average age of patients under CommTOs seems to be somewhat younger in NSW than in Victoria or NZ, being closer to 35 than 40 years.

Research on efficacy

Similarly, little research on the efficacy of CommTOs has been conducted in NSW. The only studies found were those of Carne (1996), Ozgul and Brunero (1997) and Vaughan et al (2000).

Carne conducted a retrospective study of 66 patients placed under community orders in various regions of the state, in 1991, during the first year of the regime, when it was still lightly used. Data were collected retrospectively from patients' records for the 6 months before and after they went on the order, and interviews were conducted with patients, case workers and family members. A 'mirror-image' analysis was then attempted of these patients' lives. Carne concluded that the results showed: 'The period of compulsory community psychiatric treatment was characterised by increased contact with community mental health staff, better medication compliance and improvements in social skills and wellbeing of the subjects. Families, where involved, felt less burdened by the care of the mentally-ill relative' (at 5). The most common complaint of patients interviewed was of 'unwanted effects they suffered from their medications' (at 84).

Ozgul and Brunero also attempted a ‘mirror-image’ study of the careers of 46 randomly selected patients from the Bankstown area, in south-western Sydney, in the year before and after they went on a CommTO, between 1993 and 1996. The analysis was based partly on retrospective analysis of patients’ records, and partly on questionnaires asking patients, case managers and family members to rate the patient’s progress on various outcome measures.

Some interesting findings were that:

- 90% of the orders were renewed for a further term
- there was ‘an overall trend for neuroleptic medication dosage to be *reduced* while the person remains on the community order’ (at 75)
- all three groups of respondents ‘rated community orders as being somewhat to moderately helpful in reducing family distress, having regular medication, contact with mental health worker and doctor, improving ability to work, thinking and concentration and participation in social activities’ (at 76)
- the proportion of patients from non-English-speaking backgrounds under community orders (35%) was no higher than the proportion of such persons with schizophrenic or bipolar disorders being treated by that service as a whole.

The authors conclude by discussing why more men than women are placed on community orders:

It may be related to the nature and course of the disorder experienced by males being different to that experienced by females. Males may experience more severe positive and/or negative symptoms, engage in high risk or dangerous behaviour, are resistant to and non-complaint with intervention and follow-up, and thus are more likely to relapse and have admissions to hospital.

Vaughan et al’s study is also a mirror-image analysis, of the lives of 123 patients placed on CommTOs in the northern suburbs of Sydney between 1994 and 1998. It is based on a retrospective study of their files. Only patients with a diagnosis of a

schizophrenic disorder and atypical psychosis were included. Rehospitalisation was the main outcome measure.

The data collected show that 969 patients with the above diagnoses were admitted to the Ku-Ring-Gai Hospital during the study. Of these:

- 533 (55%) were admitted involuntarily under the Mental Health Act
- 133 (14%) were then placed on a CommTO.

It was found that patients' compliance with depot medication was high while they were on the CommTO. The readmission rate for those on depot was also significantly less than those on oral medication.

The authors' discussion highlights the capacity of a CommTO to reduce the length and severity of a person's disturbed behaviour immediately before their subsequent readmission to hospital. In their view, CommTOs permit earlier identification of relapse, and cause more services to be directed to the relapsing patient. They found that the patients received 'a significantly increased mean number of services' in the 2 months before they were rehospitalised, when on the CommTO (at 806). They concluded:

Rehospitalisations ... during a CTO were shorter, with less Police involvement and involuntary admission than the index hospitalisations, suggesting the patients were admitted at an earlier stage of relapse when they were more amenable to treatment. This conclusion is supported by the most important finding of the study that duration of non-compliance and disturbed behaviour was reduced in the period prior to hospitalisations during CTOs After termination of CTOs admissions once again reverted to the pre-CTO pattern of a longer period of non-compliance and disturbed behaviour prior to hospitalisation It would seem likely that CTOs enable closer monitoring of patients and establishment of more clinical contact as symptoms of relapse become apparent (at 807-808).

As they point out, this means CommTOs may be:

associated with ... contrary effects: hospitalisations appear to have been reduced ... ensuring medication delivery particularly of depot medications, but may have been brought forward or even increased by earlier intervention during exacerbations in disturbed behaviour.

They concluded: 'A great advantage of CTOs is their ability to reduce the period of the patient's disturbed behaviour as it is not necessary to wait until the patient is sufficiently ill to justify involuntary admission' (at 808).

Concerns about the Review Tribunal

A particular concern among those interviewed was the over-burdened position of the Tribunal. It has faced rapidly increasing caseloads within a set budget and has difficulty recruiting sufficient psychiatrists to fill its panels. As a result, its reviews appear to be increasingly superficial, due to the speed at which they must be conducted. The Tribunal's members conduct up to 18 hearings a day, their average length is 20 minutes, and the use of video hearings (or 'tele-justice') is on the rise. The review process is given a low priority by clinicians. Patients already under CommTOs have no effective right to legal representation and very few are represented in practice. Only about 50% of the patients attend their own hearings. The independence of the Tribunal is also somewhat compromised by its being funded through the health sector that it is designed to review. Even so, the Tribunal appears to be increasingly cast into the role of a 'gatekeeper' to psychiatric services, as a result of its power to place patients on CommTOs, who may then receive priority for care.

These matters are of considerable concern to the Tribunal's leadership and its members. They illustrate the delicate balance between quantity and quality in mental health review procedures. The frequency and funding of those procedures needs to be regularly revisited in response to changing patterns in the use of the scheme.

Discussion

This account provides little more than a sketch of the role of CommTOs in NSW, due to the lack of sustained research on the subject. It reveals a mental health system, a Tribunal, and a criminal justice system under considerable pressure. Much of this pressure seems to have arisen from the rapid deinstitutionalisation of mental health services in the state, during the 1980s and 1990s, without sufficiently rapid developments in the infrastructure of community mental health care.

In these difficult circumstances, CommTOs appear to be used as something of a 'safety valve', both for the mental health services and for the criminal courts. Despite the existence of reasonably strict criteria for the use of CommTOs in NSW, the number of people treated under them has increased rapidly, as the number of hospital beds available has declined. Nevertheless, CommTOs still seem to be used more selectively in NSW than in Victoria or NZ, and they seem to be used with a somewhat younger group of patients.

As a result of these developments, the CommTO scheme in NSW now seems to fill a space somewhere between that occupied by the Victorian scheme and that occupied by the mental health courts in the United States that are engaged in diversion of mentally ill people from the criminal courts.

Reviewing the status of patients being treated under CommTOs for long periods, whose orders must be renewed every 6 months, imposes a major burden of work on the NSW Tribunal, and its resources appear barely adequate for the task. In addition, supervising the treatment of CommTO patients is said to impose significant administrative burdens on community mental health agencies in the state. Such consequences are to be expected, when use of CommTOs expands more rapidly than the resources available to administer the scheme. The stress on the system seems likely to continue unless the numbers of patients and the resources available come more closely into line.

Further rigorous research is urgently required into the NSW CommTO scheme: to provide a more detailed portrait of its operation, and to try to measure whether it

produces positive health outcomes for the various groups of patients for whom it is used.

Chapter 6

Switzerland

Summary

Involuntary outpatient treatment in Switzerland is governed by a complex structure of legal norms, drawn from European human rights law, Swiss federal law and the law of the Swiss cantons. These rules provide minimum standards, such as the requirement that all intervention be based on competent medical advice, but they still permit diverse procedures at the local level. Generally, within the Swiss cantons, there is a close relationship between the adult guardianship (or tutelary) system and the supervision of involuntary psychiatric care. Involuntary outpatient care may be authorised under that tutelary system, under the involuntary hospitalisation regime, or under the Swiss Penal Code. Involuntary hospitalisation may not authorise involuntary treatment, however. That is governed by the general law of consent to treatment, the basic proposition being that involuntary treatment may only proceed if the patient lacks the capacity to consent, or a serious emergency exists. A substitute decision-maker may be appointed to make treatment decisions for a patient, but family members are not necessarily appointed, due to the potential for conflicts of interest. A special feature of European human rights law, followed in Switzerland, is the principle of ‘proportionality’, which permits only a ‘proportionate’ response to the condition and risks presented by a mentally disordered person.

The general structure of Swiss law in this field

The particular purpose of studying Swiss law, in this context, was to consider the extent to which involuntary outpatient treatment is authorised in a European legal system operating within the civil law tradition. I studied Swiss law in French, particularly Swiss federal law and the law of the French-speaking cantons. I was fortunate to have the assistance of English-speaking Swiss lawyers, at the Institute of Health Law of the University of Neuchatel. They were familiar with Swiss mental health law and had produced a recent report on the laws governing outpatient care in the Swiss cantons.

Despite its modest population of 7.2 million people, Switzerland operates a federal system of government and has a relatively complex structure of legal norms. There are 23 cantons in the federation. Each operates a separate legal system within the framework of Swiss federal law. Three important features of federal law are the Swiss Constitution, the Swiss Civil Code and the Swiss Penal Code.

Generally speaking, within this framework, involuntary outpatient care may be authorised in Switzerland under three distinct legal regimes:

- under the tutelary (or adult guardianship) scheme, which operates according to the combined provisions of the Swiss Civil Code and the laws of the cantons
- under the mental health (or involuntary hospitalisation) regime, which is established by separate provisions of the Swiss Civil Code, again supplemented by cantonal law
- under the Swiss Penal Code, in the case of convicted persons and forensic patients.

European human rights law

Switzerland has been a party, since 1974, to the European Convention on Human Rights. No case appears to have been decided under that Convention, however, that specifically addresses the legitimacy of involuntary outpatient care.

A number of provisions of the Convention are directly relevant to mental health law (Jones, 2002), particularly those that guarantee:

- access for all detained persons to speedy and independent review
- the right to respect for personal privacy and family life
- the ‘right to liberty and security of person’.

This last right is provided by Article 5. However, Article 5(4) then declares that this right may be limited in the case of lawful detention of ‘persons of unsound mind’.

In its decisions on mental health matters, the European Court of Human Rights has granted nations governed by the Convention a significant ‘margin of appreciation’ in the design of their mental health legislation. It therefore seems unlikely that CommTOS would be declared inconsistent with the European Convention, on human rights grounds, provided:

- the regime covers only ‘persons of unsound mind’
- the person’s condition is assessed regularly by persons with appropriate medical expertise
- fair and speedy review procedures are provided, under which the patient may be discharged from involuntary treatment by a process independent of treating clinicians
- only a ‘proportionate’ response is permitted to the condition and risks presented by the person (Jones, 2002).

Mental health services in Switzerland

There appears to be great variation in the structure of mental health services provided in the Swiss cantons to support the operation of community mental health care. The canton of Geneva, for instance, appears to have a largely deinstitutionalised mental health system, with significant numbers of community nurses visiting both forensic and civil patients at their residences. It also has a strongly ‘patient-centred’ culture, influenced by the anti-psychiatry movement of the 1960s and 70s. There is an active consumer advocacy organisation, known as the Patients’ Council, and the use of ECT is banned by law in the canton. The practice of involuntary treatment is also regulated by another important Council, consisting largely of doctors and appointed by the government, called Le Conseil de Surveillance Psychiatrique. As in many other places, however, the great majority of admissions to the psychiatric hospital in Geneva still proceed on an involuntary basis (Weber P-C, 1996).

The public mental health service of the nearby canton of Fribourg, on the other hand, is largely based in one rural psychiatric hospital, which I visited. It had 180 beds, for a population of 280,000 people. That is about 2-3 times the number of psychiatric beds that would now be the norm for the equivalent population in Australasia. It was certainly a ‘Rolls-Royce’ hospital: thoroughly modernised, with impressive staffing levels, including 18 full-time psychiatrists. On the other hand, very limited public outpatient services were provided in the canton. The hospital’s outpatient service employed 2 psychiatrists and most after-care was provided by referral to private psychiatrists.

A related issue concerns the method of payment for outpatient care. It seems the costs of the outpatient services provided in most cantons would be charged directly to the patient, in the first instance. Those costs would then be reimbursed through insurance or social security schemes. That mechanism of payment may require revision if it was to support the regular visiting of patients on low incomes by community mental health teams, because those patients could probably not afford to pay the initial costs of their care.

Forensic care in Switzerland appears to fall under the jurisdiction of the criminal justice system, not the general medical system. The forensic hospital in Geneva is within the confines of the local prison, for example, not within the health service. Forensic patients are still separated from other inmates of the prison, and they may be transferred to the local hospital for acute care.

The treatment of forensic patients and prisoners is governed by the Swiss Penal Code. Involuntary treatment of such patients seems to be explicitly authorised, under certain conditions. This may include involuntary outpatient treatment, imposed as a condition of a prisoner's release on parole: Article 62(3). I was informed that these provisions are actively used in Geneva. Even those convicted of relatively minor crimes, like theft, may be placed under the forensic scheme. It was said there were about 30 people under forensic outpatient treatment at any time in the canton of Geneva, which has a population of about 500,000 people.

On the other hand, involuntary treatment is not generally permitted in Switzerland in the civil mental health system, even of lawfully detained patients, unless the patient lacks the capacity to give their consent. This is the reverse of the usual legal position in Australasia and Britain, where people within the custody of the criminal justice system may *not* usually be treated without their consent, unless they are transferred to the civil system and then treated under the authority of the Mental Health Act. Involuntary 'civil' patients, on the other hand, *may* generally be treated without their consent, whether they retain their capacity or not. The law in Switzerland may therefore provide a greater degree of authority over the treatment of persons within the

penal (and forensic) system than it does over the treatment of involuntary patients under civil mental health law.

Central aspects of civil mental health law

Tutelary (or guardianship) law

Under this system, tutelary authorities ('autorité de tutelle') are designated by law for each canton. The tutelary authority is often a local court, although some other appropriate body may be designated, under the laws of the canton, provided it is sufficiently independent of other branches of government and its procedures meet the minimum standards of fairness required by the Civil Code.

These tutelary authorities may exercise several kinds of jurisdiction relevant to involuntary psychiatric care. First, they may declare an incapacitated person to be under tutelage (or guardianship) and then appoint another person to be their substitute decision-maker (their 'tuteur' or 'curateur'). That SDM could then approve the psychiatric treatment of the person under their tutelage, on either an inpatient or outpatient basis, provided the scope of their appointment covered those decisions. This tutelage system appears to be widely used in many parts of Switzerland, for people whose incapacity arises from many different causes, including the effects of mental illness, aging, brain injury, and intellectual disability.

Family members, it seems, are not usually appointed SDMs, because they are considered to have too great a potential for conflict of interest with their incapacitated relative. Other decision-makers are employed. I was informed that in Geneva social workers employed by a public guardian's office frequently take this role, and that this was the principal mechanism through which involuntary outpatient psychiatric care was provided in that canton. Alternatively, lawyers active in the representation of psychiatric patients may take this role in Geneva.

Those appointed to be SDMs must discuss the patient's treatment with the responsible clinicians. I was informed by one senior psychiatrist in Geneva that the SDM then almost invariably endorse the course of treatment the clinicians propose. In his view, the clinicians were therefore the *effective* decision-makers about treatment, and the

system of appointing and employing social workers in the role of SDM was of questionable value.

A judge interviewed in Fribourg, on the other hand, said that he always appointed an independent psychiatrist to be the SDM for an incapacitated person, when exercising his tutelary authority to direct involuntary outpatient care. That psychiatrist would then supervise, but not provide, the patient's care. The judge said he most commonly used this power in cases of severe substance abuse, and he was always able to extract the consent of the person to undergo outpatient treatment, under threat of incarceration in hospital. If the person failed to comply with treatment, this would be reported to him, and his tutelary authority might be exercised in some other way.

The second set of powers exercised by the tutelary authorities of a canton is conferred by the mental health laws. These laws empower the tutelary authorities, and other designated officials, to order a person's detention in a psychiatric hospital. Fair procedures are prescribed, including an oral hearing. The tutelary authorities must keep the person's position under regular review and may subsequently order their release from the psychiatric institution.

Emergency psychiatric admission procedures are also provided, based on medical recommendations, as in other parts of the world. If those procedures are used, the tutelary authority is informed and a hearing conducted shortly afterwards.

Subsequently, a patient detained in a psychiatric hospital in this manner may be granted 'conditional leave' by the hospital authorities, or may be directed to undergo outpatient care ('traitement ambulatoire'), in accordance with the specific provisions of cantonal law.

Even so, the exercise of this form of tutelary authority, under the involuntary hospitalisation scheme, applies only to the patient's *detention* in hospital. It does not authorise their psychiatric *treatment* without consent. Separate rules concerning treatment are found in another part of the Civil Code, and in the law of the cantons. These separate provisions apply to medical treatment in general, including involuntary

psychiatric care. Generally speaking, except in serious emergencies, these rules only authorise the involuntary treatment of a patient who lacks the capacity to consent; and only treatment proportionate to their circumstances, and related to the cause of their mental disorder, is allowed. If the patient lacks the capacity to consent, a SDM may be appointed, under a distinct legal process, to make treatment decisions on their behalf. In that case, authority over their treatment would not necessarily lie in the hands of the responsible clinicians. It may be transferred to some other SDM lawfully appointed for that patient. In that process of appointing a SDM for the patient, the tutelary authority of the canton would again be involved.

The tutelary authorities therefore exercise three related forms of jurisdiction in Switzerland, covering adult guardianship in general, detention in psychiatric facilities, and treatment decision-making for incapacitated persons.

In total, these powers are very similar to those possessed by judges of the NZ Family Court. In other legal systems, these different forms of authority may be split between different bodies: notably, in Australia, between guardianship boards and mental health review tribunals.

The mental health legislation

The basic framework for the law governing detention in psychiatric hospitals is provided by Articles 397a to 397f of the Swiss Civil Code, which have been in force since 1981. This chapter of the Code is entitled ‘De la privation de liberté à les fins d’assistance’. This may be loosely translated as ‘Deprivation of liberty as a last resort’, a title that reflects core principles of the Code: that the least restrictive form of intervention should be used, and one that is proportionate to the seriousness of the person’s condition and the threat of harm posed. These principles may still be compatible with the use of involuntary outpatient care as an alternative to hospital.

These articles of the Civil Code establish a mandatory floor for Swiss mental health law. They are then supplemented by the mental health legislation of each canton. This permits a variety of approaches to the design of local civil commitment schemes. In general, the procedures established by recent legislation in the French-speaking

cantons closely resemble those found in mental health statutes in the common law world. The legal provisions are rather open-textured in Switzerland, and leave a good deal to the interpretation of the tutelary authorities, but all the main features of involuntary hospitalisation schemes, familiar to common lawyers, are to be found, either in the Civil Code or in recent cantonal laws.

Rules can be found concerning:

- medical certification of involuntary patients and other means to ensure their treatment proceeds on the basis of competent medical advice
- police assistance
- powers of entry on to private property
- provision of immediate treatment in emergencies
- fair, independent and regular review (these procedures are to be ‘simple and rapid’, according to the Civil Code)
- the powers (and duties) of hospital authorities to release involuntary patients.

The law of consent to treatment

Even so, the involuntary hospitalisation (or civil commitment) provisions of the Swiss Civil Code do not currently provide a clear legal foundation for the *treatment* of *psychiatric* patients. Specific authority of that kind must be found in the law of the cantons. Cantonal law in this regard is still limited by the Swiss Constitution, including Articles 7 and 10, which guarantee the fundamental right of all competent, adult persons to self-determination (‘un droit fondamental a l’autodétermination’). Cantonal law is also limited by the broad guarantees of the European Convention on Human Rights.

The laws of the cantons concerning non-consensual treatment are diverse, and not all cantons’ laws may be fully consistent with those constitutional and human rights norms. Cantons like Geneva and Fribourg, that have enacted recent consent to treatment legislation, adhere to the following general principles, even in the treatment of involuntary psychiatric patients (Bertrand et al, 1996; Manai, 1999):

- where a patient retains their capacity to consent, their freely and voluntarily expressed views on treatment must usually be respected; they may therefore refuse psychiatric treatment
- a patient may still be treated over their refusal in an emergency, when this is vital to avert an immediate threat to their safety or the safety of others
- where the patient lacks the capacity to consent and refuses treatment, a health care guardian ('curateur de soin', or 'curateur de santé') should be appointed to make treatment decisions on their behalf
- that guardian must take into account any competently-expressed prior views of the patient
- if the guardian refuses to approve the patient's treatment, the clinicians may appeal to the guardianship authorities; in the interim, emergency treatment may proceed
- all involuntary treatment must be recorded in detail in writing, and must be periodically reassessed and subjected to peer review
- the patient must be kept informed about their treatment as far as possible
- all involuntary treatment must respect the principle of 'proportionality'.

In addition, in a controversial decision in 1995, a Geneva court declared that a competent person may, through a valid advance directive, refuse all psychotropic medication in advance, even if they later lose their competence due to mental illness (K, 1995; Anonymous, 1995). Treatment without consent could then be administered, contrary to the terms of the advance directive, only to save the patient's life. This decision was not welcomed by psychiatrists. I was informed that it could lead to patients being held in full body restraints, or in seclusion, to prevent harm occurring, if they cannot be medicated during an acute psychotic episode.

Reforms currently proposed to the mental health provisions of the Swiss Civil Code would add the requirement to the law that a treatment plan be swiftly prepared for each involuntary patient. This would state the essential elements of the treatment proposed, including the reasons for it, its goals and risks, and why other alternatives were unsuitable.

These general principles are similar to those applied in many parts of North America.

Outpatient treatment schemes in the cantons

The finer details of a comprehensive CommTO scheme, such as the details of the process for recalling a patient to hospital care, are not usually covered in depth in the mental health laws of the cantons. A recent review by staff of the Institute of Health Law in Neuchatel found no canton's mental health legislation provided more than a few clauses on the subject of involuntary outpatient treatment, and many provided none at all (Guillod and Hänni, 2002; University of Fribourg, 2002).

Some relevant provisions were found, covering:

- the duty to try less restrictive approaches prior to involuntary hospitalisation
- the authority to employ less restrictive measures when the criteria for involuntary hospitalisation are met
- the authority of hospital staff to direct after-care or outpatient treatment on discharge from hospital (this may extend for up to 2 years in some places, but for a maximum of 15 days in Geneva)
- the specific powers of the tutelary authorities of a canton to direct outpatient care after a patient's discharge from hospital, and to review their compliance with care.

The procedures for enforcing outpatient care were rarely made explicit in the canton's statutes, and there was nothing like the detail to be found in the 'revocation' provisions of some Australian statutes, or in the 'take and convey' provisions of the English Mental Health Act. But the usual enforcement mechanisms were still established in general terms: the patient may be recalled to hospital; there may be further intervention by the tutelary authorities; or further treatment may be authorised by the patient's 'tuteur'.

Although not much detail about outpatient treatment can be found in cantonal law, the general legal position on these matters is still tolerably clear. All the general principles of Swiss mental health law continue to apply, along with broader legal principles concerning the right to consent to treatment of patients who retain their capacity.

To be lawful, involuntary outpatient treatment would have to proceed under fair procedures, on the basis of competent medical advice. It would have to be subject to regular independent review, usually by the local tutelary authorities. It might also be subject to the oversight of a specially-constituted Council in the canton, with substantial medical representation. The least restrictive mechanism would have to be employed and all intervention would be subject to the general principle of ‘proportionality’.

Involuntary outpatient treatment would not be specifically limited *by law* to any particular sub-categories of mental illness, but some limits of that kind are bound to be established in practice.

Outpatient psychiatric treatment would still be governed by general legal principles concerning consent to treatment. To stay within the law, a patient could only be treated involuntarily when they lacked the capacity to consent, and then usually with the concurrence of their appointed health care guardian (except in an emergency). Sometimes, following treatment, an involuntary patient would recover their capacity. In that case, outpatient treatment could continue only with their consent. The patient could still be treated in an emergency, but that exception would not usually apply to the provision of continuing outpatient care.

The application of these rules might present Swiss clinicians with the common conundrum that, having treated the patient involuntarily until they have recovered their capacity, the patient could then refuse continuing outpatient care, even if it could be reliably predicted that their illness would relapse, and even if that had happened on several occasions before. On the other hand, under these principles, the self-determination of psychiatric patients would be respected to a high degree, and to the same degree as that of patients receiving other forms of medical care. Consistent principles concerning consent to treatment would therefore be applied across the full field of medical law.

Discussion

The parameters within which involuntary outpatient care may proceed in Switzerland are therefore reasonably clear. The relevant principles can be drawn from the law concerning adult guardianship, involuntary hospitalisation, and consent to treatment in general.

Perhaps the most interesting aspect of Swiss law concerns the limits placed on the involuntary treatment of psychiatric patients who retain their capacity to consent. Those limits are said to pose some difficulties for Swiss psychiatrists, who cannot always provide the most effective treatment for patients, as a result. These difficulties still seem to be surmounted most of the time in practice. The great majority of psychiatric patients with psychotic disorders *will* be considered to lack the capacity to consent, when in an acute phase of their illness; and if their capacity returns there are many informal ways to obtain their consent. Their consent may be extracted under the threat that they will stay longer in hospital if not treated; pressure may be exerted by relatives or friends; their consent may be sought another day; another health professional may obtain their consent; and so on. As a last resort, the power of emergency treatment exists.

It might be thought that respecting the right to refuse treatment of detained patients who retain their capacity is not very practical, especially in under-resourced and radically deinstitutionalised mental health systems, where clinicians are under considerable pressure, and where patients cannot be detained for longer in hospitals, because no bed is usually available. In those circumstances, patients who refuse treatment may simply be discharged. That seems to be a particular concern of psychiatrists in Geneva, where the deinstitutionalisation is well-advanced. In some other parts of Switzerland, where greater reliance is placed on hospital care, this difficulty may be less acute, and in those regions there may be less urgency to develop a system of involuntary outpatient care.

The Swiss legal system still provides several legal engines that can be used to drive involuntary outpatient care. Active use can be made of forensic outpatient treatment, the well-developed adult guardianship (or tutelary) regime, conditional discharge from

hospital, and the threat of readmission to hospital care. The extent of the use of these mechanisms seems to vary across the country, as one would expect under Switzerland's decentralised system of government.

Using some combination of those measures, the Swiss appear to be pursuing rather similar objectives to those being pursued in other jurisdictions that have enacted more comprehensive CommTO schemes, but in a manner that gives a high priority to the autonomy of adult citizens who have not committed a criminal offence, and in a manner that fits within the established traditions of their civil law.

Chapter 7

Scotland, England and Wales

Summary

The introduction of comprehensive CommTO legislation has been proposed in Scotland, England and Wales, and a new Scottish regime is due to be implemented in late 2005. The schemes proposed would provide slightly greater powers to enforce community treatment compared with the current leave and supervised discharge schemes. Generally speaking, the new regimes would permit greater control over the patient's place of residence but would not permit 'forced treatment' in a community setting, and they may not provide a clear power of entry into private premises, in order to protect patients' privacy. The precise scope of the powers to be conferred remains contentious and the law reform process illustrates the renewed influence in the UK of European human rights law. The use of treatment plans, to be approved by a tribunal, is central to the new proposals. These plans will specify the precise elements of the outpatient regime in individual cases, permitting a 'proportionate' response to their particular circumstances. Listing the necessary treatment in such a statutory treatment plan may generate concerns, however, that civil liability will be imposed on health agencies for failure to provide the services listed, especially if a third party later suffers serious harm. Some consensus has been achieved behind the CommTO proposals in Scotland, following an extensive consultation process, but no consensus has emerged in England and Wales, where even the health professions are divided on the issue, and where there is considerable opposition to other aspects of the government's law reform proposals. It remains to be seen whether the new CommTO schemes proposed for the UK will be used more extensively than earlier, similar schemes. British clinicians may not consider the marginal increase in the authority the new schemes provide outweighs the administrative burdens associated with treating involuntary outpatients.

The constitutional context for mental health law reform

Two constitutional developments in the UK have influenced these law reform processes:

- the ‘devolution’ to Scotland of greater political authority over domestic affairs; and
- the incorporation into UK law of the European Convention on Human Rights.

The creation of a new Scottish Parliament, and the new Scottish Executive, in Edinburgh, as part of the devolution of greater political authority to the regions in the UK, has conferred on the Scots the power to enact their own mental health legislation. Previously, the Scottish legislation applied only to Scotland, but it was enacted for the Scots by the UK Parliament at Westminster. Under the devolution policies, that position has changed. Legislative authority has now passed to Scotland. The Scottish law reform process was thereby disentangled from the law reform process in England and Wales, leaving the Scots able to pass their legislation through a less unwieldy process and within a shorter time frame.

The other major constitutional influence on the law reform process has been the incorporation into UK law of the European Convention on Human Rights. This was achieved, firstly, by the passage of the Human Rights Act 1998 (UK); and, secondly, by imposing a prohibition, in the devolution arrangements, on the passage by the new regional parliaments of legislation inconsistent with the Convention’s terms.

These developments inevitably produced a spate of litigation in the UK challenging state practices on human rights grounds (Fennell, 1999; Gostin, 2000). Several of these challenges concerned mental health law. In particular, there has been litigation concerning the position of patients with a primary diagnosis of ‘psychopathic disorder’ detained within the Scottish forensic system (*Anderson v Scottish Ministers*, 2001; Fennell, 2002); and litigation concerning the position of patients who lack the capacity to consent or object to their mental health care (*Bournewood*, 1998; Dawson, 1999; *HL v UK*, 2004).

The reform of mental health legislation in the UK has therefore proceeded in a volatile constitutional environment, and both the Scottish and the UK Parliaments, when

considering CommTO legislation, must ensure its consistency with European human rights law.

The recent legal position concerning involuntary outpatient treatment

Introducing CommTOs in the UK would not be a radical departure from the current law. Many elements of such schemes have been provided previously, both in Scotland and in the combined jurisdictions of England and Wales. Measures for supervising the outpatient treatment of civil patients have been authorised, for instance, under the leave and guardianship provisions, and under the more recently enacted ‘supervised discharge’ schemes. Within the criminal jurisdiction, compliance with outpatient care may also be required of forensic patients under restriction orders, when they are granted ‘conditional discharge’ from hospital, and it may be required of convicted offenders on probation or parole.

The law in the UK has therefore provided some coercive measures for delivering outpatient care. But none of these measures expressly provides health professionals with a power to treat civilly committed patients with medication against their will outside hospital, when no medical emergency exists. In practice, the established legal position has been that psychiatric treatment over a civil patient’s objection can only take place in a ‘hospital’ (as defined by law). The main issues about outpatient care, in these law reform processes, have therefore been whether more extensive powers to enforce involuntary treatment outside hospital should be conferred on health professionals; and whether such powers would be consistent with European human rights law.

Previously, the mechanisms provided by the law have authorised:

- control over an outpatient’s place of residence
- access for health professionals to patients who are being cared for by other people
- the ‘taking’ and ‘conveying’ of a patient to a clinic, to be *offered* treatment there.

But the question is whether the law should go further:

- to impose an express obligation on involuntary outpatients to accept treatment, especially medication, even if they do not currently require hospital care

- to confer a correlative power on health professionals to enforce treatment of that kind.

A particular issue is whether the power to administer medication could be exercised at a clinic, as well as at a 'hospital' in which the patient is lawfully 'detained'.

In Scotland, those debates have now been resolved through the enactment of a carefully-crafted CommTO scheme. In England and Wales, on the other hand, no resolution of the debate is in sight. The British Government has consistently stated its intention to enact a CommTO regime, within a new Mental Health Act for England and Wales, and a draft Bill to that effect was put before the UK Parliament, by the Government, in 2004. But several other features of that draft Bill, including the categories of mental disorder to which it would apply, have been criticised by professional and consumer groups, including the Royal College of Psychiatrists, and the Bill could meet strong opposition in the House of Lords. With an election looming, it is possible that this Bill will not proceed, or that it will emerge from parliament in some other form.

If the Bill does not proceed, the involuntary outpatient treatment of psychiatric patients in England and Wales will continue to be governed by the Mental Health Act 1983 (UK), leaving only Scotland with a comprehensive CommTO scheme.

The law in Scotland

Some continuing oversight of involuntary outpatient care was authorised previously in Scotland under two related schemes. One scheme authorised involuntary patients to be granted 'leave of absence' from hospital, the other authorised Community Care Orders to be made.

Until 1996, a patient who had been involuntarily admitted to hospital in Scotland could be granted 'leave of absence' for up to 12 months, and their leave could be renewed any number of times. According to Atkinson et al (2002), these provisions were being increasingly employed by clinicians, prior to 1996, providing 'a de facto community treatment order' regime. Under an amendment to the Scottish legislation

that came into force in 1996, however, the maximum period of such leave was reduced to 6 months. At the same time, a Community Care Order (CCO) scheme was introduced, which closely resembled the 'supervised discharge' scheme introduced at the same time in England and Wales. A CCO permitted some additional control over an involuntary outpatient. It did *not* expressly permit medication to be administered without consent outside hospital, however, though it *did* impose additional administrative burdens on the clinicians concerned. In those circumstances, Scottish clinicians seemed to have little confidence in the scheme. Studies of its operation, conducted by Atkinson and colleagues in Glasgow, found the scheme was very lightly used (Atkinson et al, 1999; 2002a; 2002b).

Nevertheless, patients treated under the leave and CCO regimes in Scotland were found to have a very similar profile to patients treated under CommTos elsewhere (Atkinson et al, 1999; 2002b). More than 60% were men; 78% were on depot medication; more than 70% had a diagnosis of a schizophrenic disorder, and less than 10% a diagnosis of bipolar disorder or paranoia. In addition, the patients under the scheme exhibited high rates of concurrent substance abuse. Many had problems obtaining adequate supported accommodation and the support of their families remained vital to their care. Community psychiatric nurses formed 'the backbone of the service', but generally a low level of services was provided. In particular, adequate day hospital care was lacking. The patients' lack of insight, non-adherence to treatment, and self-neglect, were the most common reasons advanced for their involuntary outpatient status. The medical certificates also spoke of recent harm to others in a significant proportion of cases (28%). Overall, Atkinson reached the conclusion that many Scottish psychiatrists were using the extended leave provisions as a 'risk management strategy'.

Like the supervised discharge orders in England and Wales, a CCOs authorised an outpatient to be *taken* involuntarily to a clinic, and there to be *offered* treatment, and if they refused, they might then be admitted to hospital and treated without their consent. But the authority provided by a CCO did not expressly permit non-consensual treatment of patients who were not 'detained' at the time. Scottish psychiatrists therefore seem to have taken the view that this regime was 'toothless',

and that patients under CCOs were in largely the same position as other patients who could be ‘sectioned’ and put through the usual assessment process under the Act, if that was urgently required (Atkinson et al, 1997; 2000). The marginal utility of using a CCO, in other words, did not outweigh the administrative burdens involved. The supervised discharge orders met the same fate in England and Wales (Pinfold et al, 1999; Franklin et al, 2000).

Some conclusions reached by Atkinson and colleagues from their extensive research on these mechanisms in Scotland are that:

- the ability of Scottish clinicians to treat involuntary patients in the least restrictive environment was reduced by the changes introduced in 1996
- CCOs appeared to add little to patients’ care beyond that provided by existing systems of case management and supervision
- some clinicians still exploited the ambiguities in the law and made ‘pragmatic’ use of CCOs
- involuntary outpatient care was closely linked to the use of depot medication, which is disliked by many patients
- outpatient treatment orders presented new management issues for the mental health services, and imposed new administrative burdens on clinicians
- enforcing medication in community settings was problematic in practice
- the principle of reciprocity (or of adequate care being provided to compensate for the use of compulsion) was hard to satisfy when adequate services were not available
- many patients did not oppose the use of compulsion in their own case
- more use might be made of advance directives, in which patients specify their preferred forms of outpatient care.

This gives some idea of the background against which CommTOs were included in the Scottish legislation in 2003.

The new CommTO regime for Scotland

Scotland’s new CommTO scheme is provided by the Mental Health (Care and Treatment) (Scotland) Act 2003. This could be described as ‘state of the art’ CommTO legislation. No marked distinction is made between inpatient and

outpatient care, and no prior hospital admission is required for involuntary treatment to proceed.

Criteria

A Compulsory Treatment Order (CompTO) that authorises either inpatient or outpatient care, as required, may be made for up to 6 months. This can be extended for another 6 months, and can then be renewed from year to year.

The legal criteria for the order are (s 64(5)):

- the patient has a ‘mental disorder’
- medical treatment is available that would be likely to prevent that disorder worsening, or would be likely to alleviate its symptoms or effects
- the patient’s ability to make decisions about their treatment is ‘significantly impaired’
- there would be a ‘significant risk’ to the patient or others if treatment were not provided
- the making of the CompTO is ‘necessary’.

Two aspects of these criteria are particularly interesting. First, the term ‘mental disorder’ is defined in the Act to mean ‘any mental illness, personality disorder or learning disability, however caused or manifested’ (s 328). This means that the initial scope of the Act is defined more broadly than in most Australasian jurisdictions, where personality disorder alone would not usually be included within the scope of a mental health act, and where those with learning disabilities would usually be managed under an adult guardianship scheme.

Secondly, the inclusion of the requirement that the ‘ability’ of the patient to make treatment decisions must be ‘significantly impaired’ means a form of ‘incapacity’ test has been incorporated into the criteria for compulsory treatment in Scotland. This was recommended by the Millan Committee, which reviewed the prior Scottish law (Millan, 2001). This capacity test is stated in careful terms. It does not require the patient to ‘lack the capacity’ to make treatment decisions, as is usual with adult guardianship or incapacity schemes. It only requires the patient’s capacity to be

‘substantially impaired’. This is a subtle but important difference. The language used suggests that some patients with the well-known ‘negative’ symptoms of schizophrenia would meet this test, for instance, even if they were not acutely unwell (Jones, 1995). If so, they could be required to accept continuing medication as an outpatient. Such patients are often treated under CommTos elsewhere.

Further, inclusion of this capacity test suggests that the Scottish Act’s application to patients with a primary diagnosis of personality disorder may be limited in practice to those whose disorder is *severe*, or whose disorder is complicated by other disabling factors. This limit would probably apply because the decision-making ability of people with less severe personality disorders would probably not be *sufficiently impaired* to meet that test. This is one principled way to exclude *most* persons with a personality disorder from cover by an involuntary treatment regime, even if no other reference to ‘personality disorder’ is included in the legislation.

Administration

The central roles in the administration of the Scottish legislation will be played by:

- Mental Health Officers (MHOs)
- Responsible Medical Officers (RMOs)
- the Mental Health Tribunal for Scotland (the Tribunal).

MHOs are appointed by each local authority. Their functions range from the provision of advice to families about the position of mentally disordered persons, to crisis management, to personally initiating applications for involuntary assessment and treatment. Under the new legislation, they will carry heavy administrative responsibilities within the legal proceedings concerning involuntary patients. In each case, the MHO will make an application to the Tribunal, supported by medical evidence, for a CompTO to be made. That order can authorise *both* involuntary inpatient and outpatient care.

Care Plans

A plan for an involuntary patient’s treatment must also be formulated, following negotiations between the MHO, the responsible clinicians, the patient and their

family. Its final parameters are then fixed by the Tribunal. This plan may be wide-ranging in its requirements. When it has been endorsed by the Tribunal, and finalised by the MHO, it constitutes the heart of the compulsory treatment regime. The plan must specify the essential treatment measures to be authorised, and the measures of compulsion necessary to ensure that treatment is delivered.

The plan may specify the duty of the patient:

- to receive treatment outside hospital, including depot medication
- to reside in a specified place, or in a specified form of supported accommodation
- to afford access to health professionals, for the purposes of supervision or treatment
- to obtain permission to change their place of residence.

If major changes are proposed to the plan, an application to the Tribunal for its 'modification' must be made.

The MHO must also prepare a Social Circumstances Report on the patient at various points in the process.

The apparent intention of these arrangements is to provide some clarity in the course of treatment proposed, and to ensure there is independent supervision of the treatment's parameters. But the precise details of treatment appear to be left to the clinicians concerned.

The regime does *not* contain provisions for the appointment of family members, or other non-clinicians, to act as substitute decision-makers about the patient's treatment. As with the CommTO schemes in Australasia, consultation with the patient's family is required, but the primary authority to make decisions about treatment remains with the clinical team.

The duties imposed on health professionals and agencies

To enhance the element of reciprocity in these arrangements, a duty is imposed on the MHO to inform the Tribunal if any health services required by the plan are not being delivered. The Tribunal may then adjust the plan or discharge the patient from

involuntary treatment. The responsibilities of public agencies to facilitate the provision of some necessary services are also stated specifically in the Act: eg, in ss 25-27.

Concerning the precise duty to provide treatment these arrangements may visit on health providers, a recent guide to the Act states: 'While the Tribunal has no ultimate power to force any body, Health Board or Local Authority, to provide care or treatment, it has this authority to oversee the delivery of recorded matters and may call upon these bodies to account for their non-delivery' (Scottish Executive, 2004).

It might be going too far, therefore, to say that the Act provides an enforceable 'guarantee of services' for involuntary patients.

The 'breach' or recall process

Detailed provisions concerning 'breach' of the requirements of the outpatient treatment Plan are provided in the Act (Part 7, Chapter 5). If the patient does not attend for treatment, they may be taken to hospital, and detained there for up to 6 hours, and treated without consent if that is authorised by their plan. If non-consensual treatment is not authorised by their plan, the patient may still be taken to hospital and 'be detained there for so long as is necessary to determine whether the patient is capable of consenting': s 112(4)(b). Alternatively, if the patient does not comply with some *other* term of their order, such as a residence requirement, they may be taken to hospital and detained there for up to 72 hours. Beforehand, all reasonable efforts must be made to ensure the patient's compliance, and it must be 'reasonably likely that there would be a significant deterioration' in their mental health if they do not comply: s 113(2). The patient could then be detained in hospital for a further 28 days, if necessary, and so on.

It appears that neither of these 'breach' provisions could be activated if the patient's illness had relapsed *despite* their full compliance with the plan. This is a weakness of all 'breach' provisions that require non-compliance before they may be activated: if the patient relapses regardless, the conditions for lawful 'breach' of the order do not

apply. Then the patient may have to be recertified and put back through the ‘front door’ of the assessment process, although they are *already under a CommTO*.

The RMO, who has the principal responsibility for the patient’s treatment, is also explicitly authorised to ‘suspend’ any elements of the CompTO, and to reinstitute them, during its life. In effect, the usual flexibility found in the use of CommTOs is incorporated expressly into the legal scheme.

Discussion of the Scottish regime

This regime has been elegantly designed. It removes many legal distinctions previously made between involuntary inpatient and outpatient treatment, permitting either form of treatment to proceed, when authorised by an approved treatment plan. The criteria, the procedures and the power to make a CompTO are stated with reasonable clarity, but there is still some flexibility in the contents of the patient’s treatment plan. This leaves significant discretion and responsibility in the hands of the MHO, the RMO and the Tribunal.

There are some pitfalls with ‘approved treatment plans’. If the plan is stated in highly specific terms, it will be inflexible, and, if things change, it will have to be formally modified by the Tribunal. On the other hand, if the plan is stated in highly general terms, it loses much of its significance, and the elements of clarity and accountability may disappear. Coming on top of many other requirements to document treatment, this may not be a system that is very attractive to clinicians, and it may reduce their willingness to use the scheme.

A similar difficulty arises with the heavy administrative load imposed on MHOs. The Training Materials issued by the Scottish Executive on the new Act acknowledge that ‘the process of making an application [for a CompTO] is complicated and a great burden of work rests upon the MHO.... [T]he process should be multi-disciplinary and should involve in-depth consultation of all parties from early in the planning stage, throughout the entire process’ (at 8).

The need to channel all applications through MHOs could therefore create a serious ‘bottleneck’ in the process. One wonders about *their* rate of compliance with the law. The role of the MHO could be seen as a deliberate device built into the Scottish legislation to prevent its over-use. If that device is too effective, however, it has the capacity to subvert the utility of the scheme.

Another potential difficulty concerns the implications of the new regime for local authorities and public health agencies. The legal obligations to provide services, that are imposed on public sector agencies by the Act, may not be directly enforceable against them in proceedings before the tribunal or the courts. But the legal obligations imposed still seem likely to influence how health agencies allocate their resources between different categories of patient. That may be the intention of the Act. It may ensure that the most unwell patients get priority for care, and it gives greater meaning to the principle of reciprocity between involuntary patients and their carers. But if such an obligation was *too rigidly* imposed, the service providers may go to some lengths to avoid any entanglement with the CommTO scheme.

The implications of the duties imposed to deliver the services listed in the patient’s treatment plan will have to be very carefully worked out. If civil liability was imposed, to pay damages, to third parties harmed by a patient not been treated according to their plan, that could significantly undermine the confidence of clinicians, and of health authorities, in the CommTO scheme. It could be considered a weakness of the Scottish legislation that it will encourage the development of that kind of liability, which would not necessarily promote the effective use of CommTO schemes.

In the UK, the potential for that kind of liability does not seem to be clearly established. In the English case of *Clunis* (1998), it was held, for instance, that a rule in the 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 it was not fulfilled.

If the scope of civil liability imposed in such circumstances was to expand, it could be trimmed later by legislation. Some degree of immunity against unreasonable awards of damages could be conferred on those who operate the scheme, or a ceiling could be imposed on their liability. Ceilings of that kind have been imposed by legislation in some jurisdictions in the USA, concerning liability for ‘failure to warn’.

The final question is whether this new mechanism for involuntary outpatient treatment in Scotland will address the problems identified in the prior schemes by Atkinson and her colleagues. The heavy administrative burdens and the somewhat uncertain liabilities imposed may still mean the new scheme is very lightly used.

CommTos in England and Wales

The recent legal history of involuntary outpatient treatment for civil patients

The mental health legislation still in force for England and Wales is still the Mental Health Act 1983. This is an Act of the UK Parliament. It provides a complex network of provisions relevant to outpatient care. But it does not provide all the usual features of a comprehensive CommTO scheme.

The 1983 Act provides that:

- patients who are ‘liable to be detained’ may be granted ‘leave’ from hospital, on ‘conditions’: s 17
- they may be ‘recalled’ from leave to hospital: ss 17(4) and 18
- patients may be placed under a limited form of statutory guardianship, in the community: eg, ss 7-10
- patients may be placed under a form of ‘supervised discharge’ that continues even after their ‘liability to detention’ has ceased: ss 25A-I
- patients may be treated without consent in specified conditions, without their capacity being specifically assessed on each occasion

(Hoggett, 1996; Bean, 2001; Jones, 2002; Bartlett and Sandilands, 2003).

The institutional orientation of these provisions is clear, but this may reflect the fact that the deinstitutionalisation of psychiatric services is not as far-reaching in Britain as in many parts of Australasia and North America.

The main reason why the introduction of CommTOs in England and Wales is still under active consideration is that none of those provisions unequivocally *requires* involuntary outpatients to accept continuing medication outside hospital without their consent. Nor (putting the matter the other way around) is there a clear *power* provided to health professionals to administer treatment outside hospital without the patient's consent.

Under various provisions of the 1983 Act, powers can be obtained:

- to direct the patient's place of residence outside hospital
- to obtain access to a patient who is under the care of other people
- to 'take and convey' the patient to a clinic and offer them treatment
- to recall them to hospital from leave
- to 'resection' a patient and put them back in the 'front door' of the process.

But the Act does not appear to provide express powers:

- to enter an outpatient's own residence by force, or without their consent
- to detain a patient at a clinic to which they have been 'conveyed'
- to administer medication without consent at such a clinic.

The Act might appear to authorise some of these things. The powers of treatment provided by the Act appear to apply to *all* patients who are 'liable to be detained', for instance, and not only to those currently detained. That might be thought sufficient to authorise the medication without consent of a patient who is 'on leave', at a properly supervised clinic, not only at a hospital. But that is not how the legislation has been interpreted (Fennell, 1996). Nor is that the interpretation supported by the Code of Practice issued under the Act. The main point is that health professionals in England and Wales do not *claim* to exercise such powers.

The central questions in the law reform process have therefore been whether extra powers need to be conferred by law; and whether such powers would survive scrutiny under the Human Rights Act.

The litigation in England concerning the 'leave' regime

An important part of the background to the proposals for new community powers is the decision in the well-known case of *Hallstrom*, in 1986. In that case, the power of responsible clinicians to operate a de facto CommTO regime, under the 'leave' provisions of the 1983 Act, was successfully challenged in the English courts.

Under the 1983 Act, patients who are 'liable to be detained' may be granted 'leave' from hospital 'subject to such conditions (if any) as the [RMO] considers necessary in the interests of the patient or for the protection of other persons': s 17(1). That leave may be periodically renewed.

In the early 1980s, many clinicians apparently used extended periods of such leave as a kind of 'long leash' system (*Hallstrom*, 1986; Milton, 1988). They would keep patients on leave for long periods by renewing their leave on a regular basis. To ensure the patient's leave was lawfully renewed, they would recall them to hospital, for a brief assessment, shortly before their leave was due to expire. This meant the patient would be 'detained' in hospital when their leave was extended, as the law required. In addition, as a condition of their leave, the patient would be required to take medication. A similar system operated in NZ under the Mental Health Act 1969 (Dawson, 1991).

The legality of this approach was successfully challenged in *Hallstrom*. There it was declared by McCullough J, in the Court of Queen's Bench, that:

- an involuntary patient's 'liability to detention' under the Act, which was a precondition of their being granted leave, could *not* be extended if the patient was *on leave at the time*
- nor could the patient's leave be revoked unless there were good clinical reasons for their *treatment in hospital at the time*
- so the patient could not be lawfully recalled to hospital solely to create the conditions for their leave to be extended.

The judge also appeared to decide that a patient on leave could not be treated against their will outside hospital because they would not be ‘detained’ at the time. But that issue was not directly before the court.

The main effect of the *Hallstrom* decision was therefore to limit the use of leave to a maximum period of 6 months following the patient’s latest discharge from hospital. That decision had a substantial effect on the future of involuntary outpatient care in England and Wales.

Part of the decision was subsequently over-ruled by the English Court of Appeal, in *Barker*, in 1998. There Lord Woolf MR held that a patient, who had been placed on leave, but whose treatment specifically required their periodic return to inpatient care, could have their leave extended, even if *not* in hospital at the time. The case concerned the treatment of a patient who suffered periodic, drug-induced psychoses. Her treatment deliberately included periodic assessment and monitoring in hospital, including urine testing for drug use. The court held it would be lawful to extend such a patient’s leave for a further term, *provided a combination* of inpatient and outpatient care was ‘an essential part of the treatment’, even if she was on leave when it was renewed. That finding did not effect the core holding in *Hallstrom*, however: that the recall to hospital of a patient on leave must be for genuine treatment purposes if it is to act as the foundation for the extension of their leave.

The supervised discharge scheme

It was after the *Hallstrom* decision in 1986, therefore, that the debate about the introduction of a more structured CommTO system began in earnest in England and Wales. The Royal College of Psychiatrist immediately advanced proposals for a comprehensive CommTO regime (Royal College of Psychiatrist, 1987), but these proposals were not accepted by the Government in power at the time. Pressure for change continued, however, and this led to the passage of the Mental Health (Patients in the Community) Act 1995 (UK).

The effect of that legislation in England and Wales was twofold:

- it extended the period of leave that could be granted, from 6 months to one year, before renewal was required
- it introduced ‘supervised discharge orders’, which could continue even if the patient was no longer ‘liable to be detained’ under the 1983 Act.

This scheme provided new powers to ‘take and convey’ patients to clinics to *offer* them treatment. If the patient refused, the compulsory hospitalisation could follow. But no new power was provided to enforce medication outside a hospital. Nor was any explicit obligation imposed on the patient to accept outpatient treatment under the scheme.

Subsequent evaluations of the scheme suggest it could help ‘persuade the persuadable’ to accept treatment, and that it had improved outpatient medication compliance in some cases, but it was very lightly used (Pinfold et al, 1999; Franklin et al, 2000; Pinfold et al, 2001). Pinfold et al (1999) found, several years after its introduction, that the scheme was ‘used for only a small fraction of those patients who give rise to particular concerns among their professional carers’ (at 202). Many professionals thought supervised discharge orders were ‘powerless’, because the usual process of compulsory admission to hospital was the only mechanism for their enforcement. Placing a patient under the scheme therefore added little to professionals’ existing powers (at 200). A further theme was ‘the bureaucratic nature of procedures’, which were considered ‘cumbersome and involving excessive paperwork’ (at 201). As with the similar regime in Scotland, therefore, clinicians did not seem to consider the marginal advantages of using the scheme outweighed the costs of going through the procedures required.

The guardianship regime under the 1983 Act also contains limited enforcement mechanisms. It too has been very lightly used, throughout the life of the 1983 Act, and then mainly for people with intellectual disabilities, not mental illness (Hoggett, 1996).

The law reform process

The Blair Government then announced, in the late 1990s, that a thorough review of mental health legislation was required. So an Expert Committee was appointed to hear submissions and conduct a review of the law. The Committee was instructed that CommTOs would be included in the new legislation (Richardson, 1999), and their task was to recommend *how* this would be done. The Expert Committee therefore endorsed the introduction of CommTOs in its Report (Richardson, 1999). It recommended a framework similar to that adopted in Scotland. Involuntary outpatient treatment should be permitted under an approved treatment plan, and swift recall of the patient to hospital would be the main enforcement mechanism. The patient would have an immediate right to challenge their readmission, before a tribunal, to ensure compliance with human rights law.

In addition, the committee proposed several limits on the use of involuntary treatment that would apply to both inpatient and outpatient care. The first limit the committee suggested would apply to patients who did not threaten serious harm to others. In their cases, intervention would only be lawful if they lacked the capacity to consent to mental health care. In the view of the committee, this requirement would prevent discrimination against mentally disordered people, because it would ensure the same legal principles concerning consent to treatment were followed in psychiatric treatment as in other branches of medicine. In the view of the committee, a 'capacity' test should apply to all forms of medical care (Szmukler and Holloway, 1998; Richardson, 2002).

The second limitation on involuntary treatment suggested by the committee was that it must always be in the patient's 'best interests'.

Neither of those limits on involuntary psychiatric treatment was accepted by the Government when it subsequently published its own proposals for new mental health legislation for England and Wales. The Government's proposals initially took the form of a preliminary Draft Mental Health Bill circulated for discussion in 2002. Its revised proposals were then stated more definitively in the Draft Mental Health Bill,

which was placed before the UK Parliament and referred to a select committee, in September 2004. At the time of writing that Bill has not been passed.

The debate about the Government's proposals for CommTOs has been wide-ranging, but no consensus has been achieved. Consumer groups, and advocacy organizations, like MIND, and lawyers involved in the representation of involuntary patients, appear largely opposed to the introduction of CommTOs. In addition, Approved Social Workers and Psychiatric District Nurses, who would be deeply involved in the administration of the scheme, have apparently shown little enthusiasm for it. Medical practitioners seem to be largely supportive (BMA, 1997), and CommTOs of some kind have long been advocated by the Royal College of Psychiatrists.

There is a widespread fear that the introduction of CommTOs would lead to greater use of the Mental Health Act overall. This argument needs to be considered in light of the fact that the use of the 1983 Act has grown rapidly in recent years in any case, however, without a clearly enforceable CommTO regime (Hotopf et al, 2000; Hatfield and Antcliff, 2001; Salize and Dressing, 2004).

Overall, it cannot be said that the Government's current proposals are based on a clear consensus among the interest groups. On the contrary, the degree of opposition they have generated suggests that the levels of support necessary for the introduction of a comprehensive CommTO regime may not have been established in England and Wales.

The CommTO Proposals in the Draft Mental Health Bill 2004 (UK)

It is not surprising, therefore, that the precise proposals concerning involuntary outpatient care that have been placed before the UK Parliament do not go much further in conferring powers on clinicians than the supervised discharge scheme. Their main effect is to permit the kinds of powers now available under that scheme to be applied to all involuntary patients. No additional powers appear to be conferred to treat patients against their will outside hospitals, nor is an express power conferred on clinicians to enter a patient's private residence if they object.

Nevertheless, the new powers would provide *some* additional measures of control over involuntary outpatients' care. In place of the current line drawn between patients 'detained in hospital' and 'on leave', the Bill draws a distinction between patients 'resident' in hospital and 'non-resident'. Both would be subject to the 'formal powers' provided by the Act, and the same legal criteria would apply to the initial decision to place them under involuntary psychiatric care.

These initial criteria (called 'the relevant conditions' in the Bill: clause 9) require that:

- the patient suffers from a 'mental disorder'
- this is of such a nature or degree that its medical treatment is necessary
- appropriate treatment would be available
- the treatment is necessary to protect the patient from suicide or serious self-harm, or from serious neglect of their health or safety, or is necessary to protect others
- there is no other lawful way to provide the treatment.

Those who would be primarily responsible for the management and review of patients under the Act – their 'clinical supervisors' and a Mental Health Tribunal – are granted reasonably flexible powers to determine where such patients would reside and where their treatment would take place. The patient could be shifted swiftly between resident and non-resident care. Even their initial assessment could take place outside hospital, and outpatient treatment could continue indefinitely, provided the necessity for it was regularly reviewed in accordance with the procedures established by law.

The Bill requires a Care Plan to be prepared for each involuntary patient (cl 31-32). This would state in general terms the form of mental disorder for which treatment would be authorised, and the treatment to be provided. Consultation with the patient and others is required in formulating the Plan, but the ultimate authority over treatment decisions lies with the clinical supervisor. In relation to some special forms of treatment, like ECT and psychosurgery, there would be a further, independent element in the approval process, involving the Tribunal.

The extent of the new community powers

The Bill specifically states that a non-resident patient may be required to attend for treatment at a specified place that is *not* a hospital (eg, at a clinic). It also provides that the patient ‘may be taken into custody and conveyed to the relevant hospital or place’ by the responsible clinicians (cl 80). But the Bill is equally specific that treatment without consent *cannot* be provided at such a clinic or ‘place’. It can *only* occur in a ‘hospital’ (cl 198), as that term is defined by law (cl 2). These powers appear virtually indistinguishable from those exercisable over patients under the current supervised discharge scheme.

The Bill appears to go somewhat further, however, in the powers it provides to control where a non-resident patient shall live. Their precise place of residence may be specified. If they depart from it contrary to conditions imposed by their clinical supervisor, they are deemed to be ‘absent without leave’. They may then be taken into custody by health professionals or the Police, and may be returned to that residence, or be taken to a clinic or hospital (cl 81).

But the responsible clinicians are not given extensive powers of entry into the patient’s residence without consent. If the patient was living with other people (eg, in supported accommodation), then those people could admit the clinicians and permit them to see the patient, and the other powers available to ‘take and convey’ the patient to a clinic or hospital for treatment could then be exercised. But if lawful access could not be obtained to the patient without their consent (eg, entry is refused to the patient’s own home), then no direct power of entry is conferred on responsible clinicians by the Bill. In those circumstances, the clinicians may have to call an Authorised Mental Health Professional (AMHP), whose role succeeds that of Approved Social Workers under current law. An AMHP is entitled to ‘enter and inspect’ private premises under certain conditions (cl 226). They could therefore enter and assess the situation. But even they are not expressly empowered to detain a patient on private premises. If that was absolutely necessary, a warrant would have to be obtained from a Justice of the Peace, to authorise forcible entry (cl 225). Alternatively, the emergency powers conferred on the Police might be employed (cl 228).

The duties of service providers

No strong duties appear to be imposed by the Bill on local authorities or public health agencies to provide the services listed in the patient's care plan, although duties of that kind may be imposed by general health services legislation. In any case, a statutory immunity from civil liability or judicial review is conferred on those purporting to act under the authority of the Act, provided they have acted in good faith or with reasonable care: cl 298.

Diversion to involuntary outpatient care

The Bill would also permit mentally disordered persons to be diverted from the criminal courts to involuntary outpatient care. A criminal court could make a Mental Health Order for a person charged with an offence punishable by imprisonment, provided the court was satisfied the person had performed the actions with which they were charged. No criminal conviction would be required. The order would place the person under the authority of the Mental Health Act. The order could specify from the outset that the patient's treatment was to proceed on a 'non-resident' basis, or it could continue on that basis after an initial period of inpatient care. All the usual criteria for involuntary treatment have to be met before the order could be made, including the requirement that the clinicians propose a treatment plan.

Discussion of the proposals for England and Wales

The drafters of this Mental Health Bill have gone to great lengths to construct a regime that would permit greater control to be exercised over involuntary patients outside hospital, but would not permit their treatment to proceed in a unsafe manner, or in a fashion that contravenes European human rights law. The Bill would not authorise 'forced treatment' outside a hospital; nor would it permit unchecked intrusion by clinicians into private dwellings; and the requirement of a treatment plan would permit a proportionate response to be crafted to the circumstances of each patient. The regime therefore appears consistent with the requirements of the European Convention, which contains important guarantees about liberty and security of the person, fair review procedures, personal privacy, and respect for family life. Whether it is entirely successful in that regard could only be determined in litigation

following the Bill's passage into law, but it seems unlikely that the whole scheme would be declared inconsistent with human rights in a security-conscious world.

There is still the question whether this regime would be widely used by British mental health professionals, in light of their general lack of enthusiasm for the Government's reform package, and in light of their limited use of the supervised discharge scheme. Community psychiatric nurses, whose work is vital to the operation of such schemes, do not seem to have welcomed the Government's proposals for more rigorous 'enforcement' of outpatient medication, and British clinicians have generally been reluctant to employ the existing guardianship scheme.

The administrative burden that would be imposed on clinicians managing compulsory outpatients in England and Wales might be less than that imposed on Mental Health Officers in Scotland. But the marginal increase in the community treatment powers the Bill provides might still prove insufficient to encourage active use of the new scheme. The main supporter of the new scheme seems to be the government and, as in Ontario, there is a widespread perception that CommTOs are being advocated for the wrong reasons: to be seen to 'do something' about violence in the community, even if CommTOs will make little impact on rates of violence overall. The key recommendation of the Expert Committee, concerning the inclusion of capacity principles within mental health legislation, has been ignored, and there is widespread concern about the continued cover of patients with personality disorders by the Mental Health Act.

It therefore seems unlikely that this law reform process will lead swiftly to the successful introduction of CommTOs in England and Wales.

Chapter 8

Canada (especially Ontario)

Summary

Debate about CommTOs is strongly influenced by the constitutional environment in Canada, particularly the courts' interpretation of the Canadian Charter, with considerable emphasis being placed on individual rights to autonomy, privacy and equality. The Canadian courts have not directly ruled on the constitutionality of CommTO schemes, but it may be contrary to the Canadian constitution to treat *any* person on an involuntary basis who retains their capacity to consent to treatment, except in an emergency. If so, a person placed under a CommTO who regained their capacity to consent could withdraw from the treatment regime. The deinstitutionalisation process is well-advanced in Canada, but certain aspects of the service environment, such as the fee-for-service reimbursement system for psychiatrists, may pose barriers to the operation of CommTO schemes. The Canadian forensic system is highly developed, in contrast, and specialised mental health courts are emerging in the criminal jurisdiction, to divert people charged with crimes to mental health care. Among the Canadian provinces, only Ontario and Saskatchewan currently operate CommTO schemes, although very similar objectives may be achieved in other provinces under leave, adult guardianship or substitute decision-making schemes. Under the new Ontario CommTO regime, the person concerned must consent to treatment, or a substitute decision-maker must consent on their behalf. The review procedures are demanding and the recall process is tightly controlled. Introduction of the scheme was not widely supported by mental health professionals, and the scheme has been lightly used so far. In Toronto, it seems to be used mainly to link people to supported accommodation and outpatient services for the first time, with apparently positive results. Subject to certain conditions, the use of CommTOs has been endorsed by special task forces established by both the Canadian and the American Psychiatric Associations.

The Canadian context

In the year 2000, an unusual CommTO regime was enacted in Ontario, the most heavily-populated province of Canada. It permits a person who has been hospitalised involuntarily on a number of recent occasions to opt in to the CommTO scheme. Alternatively, if such a person lacks the capacity to give their consent, a substitute decision-maker (SDM), appointed on their behalf, may agree to their treatment under the scheme. This regime had been in force for nearly 3 years when I visited Ontario in late 2003 and some clinicians had significant experience of its use. As this was the most intriguing development concerning involuntary outpatient treatment in Canada, it became the focus of my research. Before turning to that scheme, however, something should be said about the wider context in Canada for the implementation of involuntary outpatient care.

Canada is a large federal country, with distinct regional differences between its provinces, including differences in the content of their mental health laws. To date, only Ontario and Saskatchewan have enacted comprehensive CommTO schemes, although similar objectives may be achieved in other provinces under ‘leave’ or adult guardianship schemes.

The constitutional environment

The debate in Canada about involuntary outpatient care is influenced by its federal system of government and the presence of a constitutional bill of rights (O’Reilly, 2004). Under Canada’s federal system, the criminal laws that apply to mentally disordered people charged with offences are enacted by the Canadian federal Parliament, for the whole of Canada. Civil mental health legislation, on the other hand, is enacted by the legislature of each province or territory, for its own region.

The permissible content of both federal and provincial mental health legislation is limited by the Canadian Charter of Rights and Freedoms, particularly Section 7 of the Charter, which states: ‘No one shall be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice’.

Involuntary outpatient treatment may obviously affect a person's liberty or personal security, by authorising their detention or involuntary treatment. Mental health legislation must therefore be carefully drafted to avoid infringing section 7's terms.

In addition, Canadian courts have found that section 7 protects a person's 'reasonable expectation of privacy', as one aspect of their personal security (eg, *O'Connor*, 1995). Legislation that threatens personal privacy is therefore constitutionally suspect on this ground as well.

The important guarantees concerning equality before the law (or non-discrimination) that are found in the Canadian Charter may also be relevant in this context. In particular, a CommTO regime may be considered inconsistent with those guarantees if it applies less favourable rules to the treatment of mentally disordered persons, in comparison with the rules applied to other forms of medical care, unless there is some compelling reason for the distinction made. In the current context, this may mean, for instance, that psychiatric treatment could not be lawfully imposed on a person who retains their capacity to consent, when other forms of medical treatment could not be imposed on that person. Unless there are compelling reason for that distinction, such as the existence of an immediate threat of harm to other people, applying less favourable rules to a person's psychiatric treatment could be considered a denial to the mentally disordered person of equality before the law.

The precise limits of these kinds the Charter imposes on the permissible contents of involuntary outpatient treatment schemes remains somewhat uncertain, however. The precise matter has not been litigated, and the Canadian courts would probably leave provincial parliaments with some room to design their own legislation in this field. But there is a widespread perception among lawyers in Canada that a clearly enforceable CommTO scheme, on Australasian lines, would be constitutionally suspect in Canada, and that it might not survive review in the courts on Charter grounds.

The structure of mental health services

The prospects for CommTOs in Canada must also be related to the structure and funding of the country's mental health services. The deinstitutionalisation process is the main feature of the service environment in Canada, as elsewhere. But in some provinces, like Ontario, that process has been proceeding under tight financial constraints. As a result, the progressive closure of hospital beds may not have been matched by sufficient developments in the infrastructure of community mental health care. Mental health budgets may have been increasing, but much of the increase may be spent on the growing costs of pharmaceuticals, not a co-ordinated system of community care.

In Toronto, a city of 3-4 million people, the community services appear to be highly decentralised in structure. Hospital and community services seem to operate in largely separate spheres, with care in the community provided under different administrative systems to that governing inpatient care. Care in the community is provided by many independent practitioners and not-for-profit organizations, and each may perform a separate function, providing nursing, supported accommodation, case management services, and so on, with no service offering an integrated programme of care. The package of services that would commonly be provided by one or two organizations in Australasia (and through the salaried employees of a public sector health mental health service) may be delivered through several contracted organizations in Toronto, each providing one or two aspects of a patient's care. In those circumstances, it may difficult to achieve a coherent policy direction for the service as a whole.

A distinct set of funding arrangements also exists, with psychiatrists, like other physicians, usually being paid on a fee-for-service basis (even when working in a hospital). This means they are paid principally on the basis of the time they spend with patients. That may be an excellent system in many respects, but it may have unforeseen consequences for the operation of a CommTO scheme. One consequence may be that insufficient funding is provided for the administrative tasks performed by psychiatrists managing patients under the scheme. They may not be well-remunerated, for instance, for their attendance at review board hearings, or for time

spent liaising with the numerous service providers involved in the care of a patient under the scheme. This may discourage psychiatrists from using CommTOs, even though their participation is vital to the operation of the scheme.

The forensic system

Canada's forensic system, on the other, has become increasingly developed in recent years. Following the passage of amendments to the Canadian Criminal Code, the process for the downstream review of forensic patients has become more flexible and less politicised. Each Canadian province now operates a Review Board to consider the status of forensic patients. These boards have full decision-making powers over the fate of forensic patients following their disposition from the courts. They are not limited to making recommendations. They now decide whether forensic patients should be granted conditional discharge or be released. So forensic patients charged with less serious offences can be moved reasonably swiftly through the forensic system, and be granted conditional discharge, subject to continuing outpatient care. This is an important mechanism through which involuntary outpatient treatment is now managed in Canada.

Perhaps the Canadian forensic system has even become over-developed, following these changes. Many people within the forensic system seem to have been arrested on relatively minor charges. It might be questioned whether their prosecution was required. Some might be better handled through more active use of civil mental health law.

This tendency to redistribute responsibilities between the forensic and the civil mental health systems seems to have been accelerated in some parts of Canada by a strong political emphasis on the reduction of crime. This emphasis has sometimes led to the imposition of 'zero tolerance' policies on the Police. This may require the Police to arrest people found committing certain kinds of crimes, even if they are clearly mentally ill.

In the United States, an important institutional response to such developments has been the rise of mental health courts operating within the criminal justice system

(Steadman, 2001; Griffin et al, 2002; Boothroyd et al, 2003; Petrila, 2003). There is no single model for the operation of these courts. They perform various functions. Their usual aim is to divert people from the criminal justice system, who appear to be mentally ill, into the care of the local mental health service. Under one approach, the charges brought against the person are *suspended* while their treatment is pursued. This occurs with the ostensible agreement of the person charged, who is advised by counsel. The person's subsequent treatment is then monitored by the mental health court. If they fail to comply with the treatment, the criminal case against them may be resumed and they may then be convicted and sentenced in the usual way.

Use of this mix of coercion and consent appears to be one of the main mechanisms through which outpatient treatment is now facilitated in the United States. *Civil* outpatient schemes, that might be used for similar purposes, may be on the statute books, but they may not be widely used, possibly due to the absence of a publicly-funded community mental health service to support them. To avoid that problem, some mental health courts are starting to run their own community mental health teams. There were said to be more than 100 mental health courts operating in the USA in 2003.

Similar kinds of developments are now appearing in Canada. A mental health court has been established in Toronto, and in New Brunswick, and perhaps elsewhere. I visited the well-known mental health court that operates daily in the Royal Courts of Justice in downtown Toronto. A parade of young men in handcuffs, from immigrant backgrounds, who did not speak English (but were assisted by interpreters), came before the court. They were charged with a variety of minor crimes, and their fitness to stand trial was under scrutiny. Many were being held in custody in the interim, or in the secure ward of a local hospital.

The judge who ran this court considered one reason for its existence was the limited use made of civil commitment law in Ontario, plus the absence of a clearly enforceable CommTO regime. In his view, many of those appearing before him might be handled better through the active use of civil mental health law. His court could not offer those appearing before it a mental health service outside the forensic

system, although it did employ social workers to liaise with the local civil service. To receive that liaison service, the person must be charged with a crime. The judge said his objective was to promote greater use of 'pre-arrest diversion' in Toronto, to prevent minor offenders coming before his court. He hoped in future his court would have no reason to exist, because large numbers of mentally ill people would not be appearing before the criminal courts.

The role of mental health courts is therefore an ambiguous one. In the circumstances faced by the criminal courts in North America, with large numbers of mentally ill people brought before them on minor charges, the development of such a specialised process may help prevent further 'criminalisation' of the mentally ill, by diverting them, with their apparent consent, into civil mental health care, and much of that care may be delivered on an outpatient basis. Nevertheless, the consensual character of this process may be questioned, as the threat of imprisonment, or disposition to the forensic system, hangs over the person, as the mechanism for enforcing their mental health care. In addition, the existence of mental health courts signifies a larger criminalisation process, one that has already occurred, under which persons who might be handled under civil mental health law are now arrested in large numbers on minor charges and processed through the criminal courts. The costs of these proceedings to the state seem very high, and it is doubtful whether this process really promotes the personal autonomy of the mentally ill.

The position of the Canadian Psychiatric Association

Those are some of the challenging features of the environment into which the Canadian Psychiatric Association (CPA) recently announced, in carefully measured terms, its support for 'Mandatory Outpatient Treatment' in Canada (O'Reilly et al, 2003). The CPA declared (at 1-2):

Providing consistent care and treatment for "revolving-door" patients has proved to be one of the major challenges of deinstitutionalization. The revolving-door patient typically responds to a course of treatment in hospital with remission of acute symptoms but does not recover insight into the pathological nature of his or her illness. As a consequence, the patient

repeatedly defaults from treatment when discharged from the structured environment of the hospital. Refusal of treatment in turn leads to a deterioration of his or her clinical condition, which ultimately results in involuntary hospitalisation....

[In those circumstances] ... it may be clinically and ethically appropriate to take a preemptive approach to reduce the risk of serious harm to the patient and, although less common, to others. Mental health legislation should be structured in a way that ensures that these clinical and ethical considerations are addressed.

The CPA considered the following conditions should still be met by a CommTO scheme:

- the principle of reciprocity should be satisfied, so involuntary outpatients should be guaranteed an adequate level of care
- a full range of community services should be available, including case management, appointments with psychiatrists, medication, counselling, supported accommodation, and day hospital care
- patients who retained their capacity to make decisions about their psychiatric treatment should *not* be compelled to accept medication or care
- clinicians should consult fully with the SDMs who were designated for patients
- patients should have access to regular, independent review of their status, and to adequate rights advice.

In those circumstances, said the CPA, clinicians should not have to wait until an involuntary patient was causing serious harm to themselves or others in order to recall them to hospital care, and *sustained* use of involuntary outpatient treatment would often be required.

South of the border, a similar position has been taken, a few years earlier, by a Task Force of the American Psychiatric Association (Gerbasi et al, 2000).

It would still be an exaggeration to say that there is a clear consensus in Canada or the United States in favour of CommTOs. On the contrary, the intensity of the continuing

debate shows there is no such consensus, even among the members of the mental health professions. Nevertheless, in the most interesting development concerning CommTOs in Canada so far, the principles being advocated by the CPA were adopted into the law of Ontario in 2000. After a controversial law reform process, which followed the killing in Ottawa of a media personality by a mentally disordered person, the Ontario legislation was amended to include a distinctive CommTO scheme.

This regime incorporates within its provisions the ethical principle of patient autonomy. A patient who retains their capacity to consent to psychiatric treatment cannot be treated involuntarily under the Ontario scheme. But such patients can *opt in* to the CommTO scheme. They may therefore use the scheme as a kind of advance directive for their future outpatient care. In addition, if the patient *lacks* the capacity to consent to treatment, their SDM may consent to their treatment under the scheme. Because it incorporates these capacity principles, this Ontario scheme is not likely to be struck down by the courts on constitutional grounds. The introduction of this scheme became the focus of my research, in Toronto, in late 2003.

The law concerning involuntary outpatient treatment in Canada

Standard legal works provide full accounts of provincial mental health legislation in Canada (Savage and McKague, 1988; Robertson, 1993; Gray, Shone and Liddle, 2000; Kaiser, 2002). Under these provincial statutes, a variety of mechanisms are provided for outpatient treatment to be administered without the patient's consent (Gray and O'Reilly, 2005). These operate in parallel with the forensic outpatient system operating under the aegis of the federal Criminal Code.

These provincial mental health statutes provide for:

- conditional or trial leave schemes for involuntarily hospitalised patients
- adult guardianship schemes, under which SDMs may be *appointed*, who may consent to outpatient treatment on an incapacitated person's behalf
- further substitute decision-making schemes, under which a SDM may be *automatically designated* for an incapacitated person, from a list of candidates stated in order of preference in the statute, whose appointment permits them to consent to outpatient treatment on the other's behalf

- advance directive schemes, under which a person with capacity may state in advance their preferences for their future health care, in a manner that will be binding, even if they later lose their capacity to make decisions about health care.

The well-known ‘leave’ schemes are still the most common mechanism in Canada under which post-hospital care is managed for involuntary patients (Gray, Shone and Little, 2000). Different periods of leave are authorised in the provinces: eg, 3 months in British Columbia and Ontario, but only 10 days in New Brunswick. Guardianship schemes seem to be used less frequently in cases of serious mental illness, although they are commonly used for people with intellectual disabilities, as in Australasia.

At present, two provinces have enacted more comprehensive CommTO schemes, within their mental health legislation: Saskatchewan (O’Reilly, 2000) and Ontario. In addition, a Bill to establish a CommTO scheme was recently introduced, but subsequently withdrawn, by the government in Nova Scotia (Bill No. 109, 2004; Law Reform Commission of Nova Scotia, 2002). These schemes all include incapacity principles in the criteria for their use. This prevents treatment proceeding when the person retains their capacity and does not give consent.

The constitutional position on consent to psychiatric treatment

It seems likely that a CommTO statute that did *not* incorporate those capacity principles would be considered inconsistent with the Canadian Charter by the courts. That precise issue has not been addressed directly in litigation in Canada. But many Canadian health lawyers believe the courts would take that view, and provincial legislation is being drafted in that light (Bay, 2004). This approach is consistent with generally-accepted principles of Canadian medical law that prohibit the involuntary treatment of patients who retain their capacity, except in some emergency situations (Downie, Caulfield and Flood, 2002).

Two cases frequently relied upon to support these principles in the mental health context are the decisions of the Court of Appeal of Ontario, in *Fleming and Reid* (1991), and the Supreme Court of Canada in *Starson v Swayze* (2003).

Fleming and Reid concerned the constitutionality of legislation that permitted a review board to authorise the involuntary treatment of a detained (and now incapacitated) psychiatric patient, contrary to the terms of an advance directive he had validly issued, at an earlier time, when he retained his capacity, which prohibited the use of the treatment proposed. The question was: when such a patient later loses his capacity to consent, as a result of mental illness, and is hospitalised, can a review board set aside his advance directive and authorise non-emergency treatment to proceed? The Court of Appeal of Ontario said a review board could not lawfully exercise that kind of power. The conferral of the power to set aside an advance directive issued by a competent patient, permitting psychiatric treatment to proceed without his consent, would be inconsistent with Section 7 of the Charter, and unconstitutional.

Mentally ill persons should not be stigmatised, said the Court, by having their competent advance instructions set aside, when equivalent instructions would not be set aside in the context of general medical care. Their autonomously expressed instructions should be honoured, especially in light of the unwanted effects and limited efficacy of psychotropic drugs. For the Ontario legislation to deprive psychiatric patients of such rights, even when they were lawfully detained, was contrary to the principles of 'fundamental justice' protected by the Charter, and could not be justified. This decision therefore supports the general principle that a competent patient's wishes cannot be lawfully set aside, when no emergency exists, even in relation to the mental health care of a patient who is lawfully detained at the time.

These capacity principles remain an important part of Ontario law. They limit the capacity of Ontario's parliament to enact a CommTO regime that would authorise the involuntary treatment of a patient who retained their capacity to consent.

Subsequently, the Health Care Consent Act of Ontario was enacted in 1996 to incorporate the capacity principles expounded in *Fleming and Reid*. It was the capacity provisions of that legislation that then came before the Supreme Court of Canada for interpretation in *Starson v Swayze*.

Starson v Swayze

The issue here was the precise interpretation and application of the legal test for capacity to consent that was included in the Ontario Health Care Consent Act. Starson, a forensic patient, was refusing psychotropic medication. Did he have the capacity to refuse such treatment, and what did ‘capacity’, in this context, *mean*?

The majority of the Court found that Starson should *not* have been considered to lack capacity in the circumstances, in a decision that was widely condemned by Canadian psychiatrists (Chaimowitz, 2004). The majority’s decision is based, at least in part, on a rather fine distinction between Starson’s ‘ability’ to understand the treatment proposed and his ‘actual understanding’ of it, a distinction that was considered too fine by the minority of the Court. The decision is therefore largely concerned with the finer points of capacity assessment, in a case in which delusions and denial on the part of the patient were important concerns.

Some of the more expansive statements made by the majority of the Supreme Court in their reasoning would still support the more general rule that a patient with capacity can never be treated without their consent, except in an emergency, not even a lawfully detained forensic patient. Major J wrote, for instance, that: ‘The enforced injection of mind-altering drugs against the respondent’s will is highly offensive to his dignity and autonomy, and is to be avoided unless it is demonstrated that he lacked the capacity to make his own decision’ (paragraph 91). Although the Court was not required to address the constitutional issues directly in *Starson*, the general principle expounded there may be entrenched in Section 7 of the Charter, and may therefore be constitutionally required.

The minority of the Court did not support a broad principle of this kind. The patient’s autonomy interests were highly relevant to involuntary treatment decisions, they said, but it was necessary to balance a number of competing interests against those concerns, including the need for effective treatment to proceed, and the need to protect others.

Ultimately, this decision turns on interpretation of the Ontario legislation, not the Charter of Rights. It does not directly establish general constitutional principles applicable throughout Canada. But the tenor of the majority judgments, coming on top of the lower court decision in *Fleming and Reid* (which is based on the Charter), certainly suggests that any mental health legislation in Canada that appeared to authorise the non-consensual treatment of a psychiatric outpatient who retained their capacity to consent would be constitutionally suspect. It is not surprising, therefore, that the CommTO legislation of Saskatchewan and Ontario does not authorise involuntary treatment in those circumstances.

The Ontario CommTO legislation

This regime was enacted via amendments to the Mental Health Act of Ontario in 2000 (inserting sections 33.1-33.9). The amendments are known collectively as Brian's Law (2000), after the media personality who was killed. The provisions begin with the statement that a 'physician' may issue a CommTO for the following purpose:

The purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility.... [A] purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and, as a result, the person must be readmitted to a psychiatric facility.

This 'revolving door' focus of these provisions is clear, and that is reflected in the criteria that govern the 'issue' of a CommTO.

Criteria

These are as follows (s 33.4):

- the person has been admitted to hospital at least twice, or for more than 30 days, in the last 3 years (in Saskatchewan it is 3 involuntary admissions or 60 days in the last 2 years); or the person has been previously placed under a CommTO
- they are suffering from a mental disorder ('any disease or disability of the mind') that needs continuing treatment or care and continuing supervision in the community
- they are otherwise likely to cause serious bodily harm to their self or others, or to suffer substantial mental or physical deterioration or serious physical impairment
- a community treatment plan has been developed, after consultation with all those involved, including the person and their SDM
- the person is 'able to comply' with the requirements of that plan
- the care and treatment specified in that plan 'are available'.

In addition:

- the person (if they are capable) or their SDM (if not) must consent to the order being made, and that consent has not been withdrawn
- the person must undertake to comply with the order, or their SDM must undertake to encourage their compliance with its terms
- the person and their SDM must have adequate access to rights advice
- the health care providers named in the community treatment plan have been consulted and agree.

Procedures and 'enforcement' mechanisms

The order is issued by a physician (who is usually a psychiatrist), not by a court or tribunal. That physician must have examined the person within the last 72 hours, to ensure the legal criteria are met. Once issued, the CommTO lasts for 6 months, but it may be renewed any number of times. The order is subject to review by the Consent and Capacity Board of Ontario (the Board), and it *must* be reviewed by that Board at least once a year.

The order requires the person to attend appointments with the physician and other carers named in the treatment plan, and to comply generally with the plan's terms: s

33.1(9). Requirements concerning medication, place of residence, and avoidance of substance misuse may be imposed. The obligations imposed on the ‘client’ (the term commonly used in Ontario) would still not prevail over their general right to withdraw their consent to treatment if they retain (or recover) their capacity. The client (or their SDM) can therefore give notice to the physician that they wish to withdraw their consent to the CommTO: s 33.4.

If notice of withdrawal is given, the physician concerned is *obliged*, however, to re-examine the client to decide whether they ‘can continue to live in the community without being subject to the order’. If not, the usual compulsory assessment process may be initiated. A similar process is used to enforce compliance with the order: the client may be required to submit themselves to re-examination by the physician, and the compulsory assessment process could then be initiated: s 33.3. In such cases, the Police may be used to assist. The possibility of compulsory reassessment and involuntary hospital care therefore hangs over a client who decides to withdraw from a CommTO.

Before the recall process can be set in motion, the physician must:

- believe the legal conditions for the CommTO still apply
- have ‘reasonable cause to believe that the person ... has failed to comply with his or her obligations’ under the treatment plan
- make reasonable efforts to inform the person (or their SDM) of their failure to comply
- ensure the person had been adequately assisted to comply.

That might be quite an onerous set of obligations to meet in the context of a psychiatric emergency.

The recall criteria are also tightly-drawn. If the client *has complied* with their treatment plan, for instance, but their health has *still deteriorated*, the recall power could not be used. The usual compulsory assessment process would have to be employed instead. That difficulty is likely to reduce the attraction of the CommTO from the physician’s point of view.

Health professionals are not granted specific powers of entry into the client's residence, though an agreement to permit their entry might still be included in the client's treatment plan. Nor are specific powers of entry conferred on the Police by Brian's Law, although, if the Police can lawfully obtain access to the person, they are empowered to 'take the person into custody' and 'promptly to the physician' for re-examination.

Obligations of service providers

The obligations to clients of the service providers named in the treatment plan are covered to some extent in the law: s 33.5. The physician who issued the order (or their delegate) is said to be 'responsible for the general supervision and management of the order'. The same kind of responsibility is imposed on other providers who agree to be named in the plan. That statement of 'accountability', as it is called, might impose a slightly higher set of obligations to the client than would be imposed by the principles of tort law. It might impose an additional obligation, for instance, to supervise the client's use of prescribed medication. It may therefore slightly enhance clinicians' liability concerns.

As to the precise responsibilities between the various providers named in the treatment plan: it is said that none of the named providers is liable for any 'default or neglect' by the others, provided they believed 'on reasonable grounds and in good faith' that the others were following their part of the plan: s 33.6.

The debate about this scheme in Ontario

As a general description, one might call this interesting Ontario regime a cross between a CommTO and an advance directive scheme. It might even be considered two schemes: one based on the consent of a capable person, the other based on the consent of their family, as family members are often designated as the SDM in such cases. In either case, the law requires that the client be 'able to comply' with the terms of their treatment plan. This would often include the ability to attend regular appointments with health professionals, as required. The requirements for use of the scheme are very specific. Even among persons with a serious mental disorder living

in the community, only a small proportion would seem to meet its tightly-drawn criteria.

I was informed that the introduction of this scheme was widely opposed during the law reform process. Opposition came from many community mental health providers, from lawyers who represent involuntary patients, from consumer advocacy groups, and even from the Board of a major teaching hospital. Many considered the scheme was being advanced by the government for the wrong reasons – to reduce violence – which it was unlikely to achieve. It was seen as a ‘top-down’ development, with no consensus in its favour among health professionals or consumers. The main impediment to adequate outpatient care in Ontario was seen to be lack of community resources, not the absence of powers to enforce outpatient treatment. In addition, the scheme was seen to subvert the contractual model of care to which most health professionals and their clients aspire. In that environment, ‘Brian’s Law’ came into force in late 2000.

Early experiences with the Ontario scheme

It is no surprise, therefore, that this scheme was very lightly used in its early years, even if that has also been the experience in many other jurisdictions when a CommTO scheme has been ‘bedding in’. The Ontario government made some effort to promote use of the scheme and some senior psychiatrists launched educational efforts among the health professions. In particular, some additional funding was provided, to help manage the scheme. These funds supported the work of a small network of ‘CTO Coordinators’, at least in Toronto. These Coordinators were based at the major hospitals. Their main role was to assist clinicians to administer the scheme. Some funding was also directed to Chief Psychiatrists at these hospitals, to be used at their discretion to promote the scheme. In some cases, these funds were directed to clinicians to reimburse the hours they spent in administering the scheme, that could not be billed as direct patient contact time.

Nevertheless, except at a few locations, the scheme did not catch on. Figures provided to me by the overall CTO Co-ordinator for Toronto, concerning this city of some 3-4 million people, show that something between 300 and 500 CommTOs were

issued, for a somewhat smaller number of clients, from late 2000 through to mid-2003: that is, during the first 2.7 years of the regime. Many orders had been renewed once, after 6 months, but most had been allowed to lapse before the annual review hearing was due before the Board.

Consent had been provided by SDMs in slightly more than 50% of cases, although in more than 40% the consent had come from the client. Use of the compulsory re-examination process, to 'enforce' a CommTO, had been rare, occurring in roughly 6% of cases. Roughly two thirds of those under CommTOs in Toronto during this time had a primary diagnosis of schizophrenia, 15-20% a diagnosis of bipolar affective disorder. Roughly half the clients were men and half women.

A major provider of supported accommodation in Toronto had also collated data on 116 people under CommTOs who were living in their facilities. These data showed: 58% of the clients were female; their average age was 42 years; 60% received weekly visits from mental health professionals; 29% received more frequent visits; 73% had a diagnosis of a schizophrenic disorder, and 25% bipolar affective disorder; 58% had personally consented to the CommTO.

By late 2003, some dozens of CommTO review hearings had been held before the Board. Some early hearings lasted up to 2 days and were described by some participants as 'highly adversarial'. This appears to have strongly discouraged use of the scheme. These kinds of hearings were considered a 'virtual discharge mechanism' by one clinician who used CommTOs quite frequently, because physicians could not possibly allocate to them such a lengthy period of time. The clinicians therefore routinely discharged clients from CommTOs before the hearing was due. Nevertheless, in the great majority of cases, the extension of the CommTO had eventually been confirmed by the Board.

How are we to assess the overall impact of this new regime on the delivery of mental health services in Toronto? Some hundreds of CommTOs, issued over 2.7 years, is not an insignificant level of use for the early life of a narrowly-focused regime. Referrals to the CTO Coordinators had been steadily increasing. By 2003, CommTOs

were being actively used by psychiatrists at 4 or 5 major hospitals in Toronto and considerable success was being claimed in individual cases. But it would still be hard to argue that use of CommTOs at that level could make a significant difference to the delivery of mental health services in a city the size of Toronto. The marginal character of the regime to service delivery was therefore accepted by those interviewed.

The reasons advanced by professionals for light use of the regime were:

- the very specific legal criteria for its use, which precluded its extension to many of the most severely mentally ill, who would not be not 'able to comply' with the terms of the treatment plan, especially attendance at outpatient appointments
- the orders were widely viewed as 'toothless' and impossible to extend beyond a year due to the length of the review board hearings
- there was a strong *perception* among clinicians that the use of CommTOs carried a 'high administrative load', despite the assistance available from the Coordinators
- multiple consultations might be required, with many independent service providers, to put together a treatment plan
- many community care providers would not participate or agree to be named in the plan
- the frequency of cross-cultural issues, and language barriers, in clinical practice in Toronto, discouraged complex negotiations with clients and their families
- the process for revoking community status was seen as particularly demanding
- lack of coordination between hospital and community providers could prevent rigorous enforcement of the scheme, as, when a client's recall to hospital was required, no bed could be found
- the consensual nature of the order meant 'the client can withdraw the next day', despite the efforts made.

I interviewed the CTO Coordinator and several clinicians at the hospital in Toronto where CommTOs were being used most frequently. In their view, they used CommTOs more frequently than at other hospitals because:

- the Chief Psychiatrist at their hospital had actively promoted CommTOs as a necessary clinical tool, and educated others about them

- the CTO Coordinator had been well-supported and provided with material assistance by the hospital
- the government funds provided to support the scheme had been distributed to clinicians who used CommTOs
- the hospital had a sufficient range of services available to offer a coherent treatment package to the client, including treatment for substance abuse
- the inpatient and outpatient services of the hospital were well-coordinated
- the clinicians were prepared to use the compulsory reassessment process, to facilitate a client's rapid readmission to hospital, if necessary, instead of the clumsy recall process
- they were prepared to use that reassessment process even if a psychiatrist had to visit the client personally at their residence to examine them there
- the hospital provided a lawyer to assist clinicians at review board hearings, if required.

Under the leadership of senior clinicians, the psychiatric staff of that hospital had made the scheme workable in their service environment. The principal services provided to clients were: case management, medical supervision, and medication administered through outpatient appointments. In addition, a minority of clients were visited at their residence by a community mental health team. Most clients were discharged from the CommTO prior to their annual review hearing before the Board.

These clinicians considered the scheme was particularly useful when used in combination with a range of other controls that could be exercised over the client's life, including control of their finances. They also considered CommTOs were particularly useful when used to place a client in supported accommodation for the first time. By using such a package of controls, a year-long CommTO could be used as a 'bridging device', to bring severely ill people into a structured form of care, who had not previously been in contact with community mental health care.

Research on efficacy

There have been two limited studies of which I am aware concerning the efficacy of the new Ontario scheme. Some research has been conducted by a major provider of

supported accommodation in Toronto, which initially opposed the scheme. This research compared the careers of 116 clients who were living in their facilities who had been on a CommTO with the careers of 52 other clients, who had a very similar diagnostic and demographic profile and had received the same case management services.

From this study, the very experienced director of this accommodation and support service, who had not previously favoured CommTOs, concluded that the clients placed on CommTOs had shown significantly reduced rates of admission to hospital while on the order, and had shown better engagement with mental health services even after the order had ended. Although CommTO clients had experienced a greater mean number of hospital admissions than the control group in the 6 months before going on the order, they had a lower mean rate of hospital admissions than the controls when on the order. In effect, as in Power's study in Melbourne, the ranking of the two groups in this regard was reversed by the CommTO.

Their research also found that 88% of the clients in their service who had been placed on a CommTO had never been successfully connected to a community mental health service before. In the view of the Director of this organisation, clinicians in Toronto were choosing clients for CommTOs 'very carefully due to the high opportunity costs'. They appeared to be selecting people who were not previously connected to community mental health services. Once connected, and receiving case management, such clients were likely to have good health outcomes. Nevertheless, his organisation would only cooperate with use of CommTOs if the clients 'were prepared to open the door'.

The first published research on the Ontario scheme comes from Ottawa (O'Brien and Farrell, 2004). A small 'mirror-image' study was conducted of the careers of 25 clients issued with CommTOs from the Royal Ottawa Hospital. Their mean age was 45 years; 60% were men; 72% were single and never married; virtually all lived on social assistance; 72% had a diagnosis of a schizophrenic disorder, and 8% bipolar disorder. They showed high rates of concurrent substance abuse. This is a similar profile to that of groups of patients under CommTOs in Australia. In this Ottawa

sample, consent had been given to the CommTO by the client in 44% of cases, and by SDMs in the remainder. No patient in the sample had chosen to contest the order before the Board.

A study of these clients' careers in the year before and after going on the CommTO showed:

- a 'significant decrease in the number of hospital admissions'
- a 'significant increase in the range of services used by patients'
- a 'marked increase' in 'the number of patients in supported housing arrangements' (at 172-173).

Discussion

Ontario's CommTO regime was still 'bedding in' when I visited Toronto in 2003. The pattern of its use may evolve, particularly as community mental health services become more widely available in the city. Its use may increase over time, as clinicians become more confident in its administration, especially if larger studies of client outcomes show positive results. Use of CommTOs has increased steadily in Australia, especially as hospital bed numbers have declined.

The small number of clients placed under the Ontario scheme appear to be a highly selected group. From the limited information available to me in 2003, it seems they have a somewhat different profile than the patient samples studied in Australia, where involuntary patients are placed under less consensual and more enforceable CommTO schemes. In Toronto, at least, there seems to be a higher proportion of women in the client group, a higher proportion with bipolar affective disorder, and a higher level of linkage of these clients to supported accommodation. The position may be somewhat different in Ottawa. It was suggested to me that the lower proportion of men under CommTOs in Toronto may be a reflection of the number of men being processed through the forensic system in that city.

CommTOs may therefore be used in a distinctive way in Toronto. This pattern may be linked to the quasi-consensual nature of the regime, to the order's de facto maximum term of 1 year, to the developing character of community mental health

services in the city, and to the absence of a prior mechanism to link discharged patients in a sustained fashion to outpatient services. CommTOs seem to be used in Toronto particularly to link people to a community service who have had several recent admissions to hospital, but who have not been linked to a community service before. They are also used to place such clients in supported accommodation. The clinicians seem to believe that linkage could not be successfully achieved by other means.

It is perfectly plausible, in those circumstances, that the outcome for the client will be positive. For the members of this group at least, the clinicians seem to believe that the likely benefits of CommTOs outweigh the administrative ‘hassles’ involved. Once the client has been successfully connected to the service, the order can be allowed to lapse at the end of the year. This use of the regime seems entirely consistent with the stated aims of Brian’s Law.

On the other hand, CommTOs seem to be used less frequently for long periods in Toronto, compared with the position in Australasia. They may also be used less for younger men with serious mental illness and concurrent substance abuse, the group upon whom they seem to be particularly focused in Sydney, a city not unlike Toronto. The members of this group may be less willing to go on a CommTO voluntarily, or their relatives be less willing to consent on their behalf, or they may not be considered suitable clients for a supported accommodation service. They may therefore not be selected very often as candidates for CommTOs by clinicians in Toronto, even though they may pose a greater threat than other mentally disordered persons to ‘community safety’. They may not then receive sustained treatment for their mental illness, except within the forensic system, or under threat of imprisonment.

It is questionable whether the cycles of under-treatment and over-confinement that is typical of that approach really promote the personal autonomy of people with serious, recurring mental disorders that are considered to require continuing medication. On the other hand, it must be conceded that the use of CommTOs with this group is not well-established by the research. Power’s study in Melbourne suggests, in fact, that CommTOs are *least* likely to be effective with this group (Power, 1998).

In the large cities of eastern Australia, it seems that more effort may be made to manage such difficult clients under civil mental health legislation, using mobile community mental health teams. These teams usually operate out of suburban community mental health centres rather than hospitals, and their members are usually the salaried employees of a public sector mental health service. They can rely, perhaps, on more enforceable CommTO schemes than would survive constitutional scrutiny in Canada. They also encounter less demanding review board hearings and financial reimbursement issues do not pose a major barrier to their work. Long-term use of a CommTO is therefore viable. Even so, relatively high rates of mental illness are encountered in the criminal courts in Sydney.

The quasi-consensual CommTO regime that has been enacted in Ontario, within the constitutional limits prescribed by Canadian law, may work well with some clients, but it may not be reaching the most treatment-resistant clients of all.

Chapter 9

Conclusions

So, what conclusions can be drawn from this comparative study, bearing in mind the limitations of its methods and the significance of the context in each jurisdiction for the design and implementation of a CommTO scheme?

The common issues confronted

What this study has shown above all is the similarity of the issues being facing in the different jurisdictions as they grapple with the concept or the operation of an involuntary outpatient treatment scheme.

First, there is the *constitutional issue* whether a CommTO regime *can be lawfully enacted*, in a particular jurisdiction, in light of any limits imposed on the legislative powers of its parliament by an entrenched bill of rights, or by directly enforceable international human rights norms. Entrenched constitutional arrangements of that kind may affect the content of any CommTO legislation that is enacted, and the content of the legislation will then affect the manner in which it is used. Major dilemmas can be posed for legislators in these constitutional circumstances. On the one hand, they may wish to enact a clearly enforceable CommTO scheme, but that scheme might then be declared unconstitutional by the courts, which might place greater emphasis than the legislature on the autonomy or privacy interests of the patients concerned. On the other hand, if a less enforceable CommTO scheme was enacted instead, that scheme might not be declared unconstitutional, but nor may it confer sufficient powers of treatment on health professionals to give them the confidence to use the scheme. This dilemma has been faced by many governments in Europe and North America in recent years. It is not faced so acutely in Australia or NZ, where the powers of parliaments to enact legislation are not controlled directly by entrenched human rights norms. This is a major difference between the legal situations in Europe and North America, and Australasia. It is may be the key factor explaining why CommTOs are used so actively in Australia and NZ.

Closely related *ethical issues* then arise concerning whether CommTO legislation *ought to be enacted* at all. The central dilemma here concerns the degree of emphasis that should be placed on the right to refuse treatment of people with serious mental disorders and a history of non-compliance with outpatient care, who are the most likely candidates for treatment under the scheme. How is the right of those persons to be left alone by the mental health services to be assessed against the advantages, for them and others, of their involuntary treatment under the scheme?

A third issue is whether a CommTO scheme *will be enacted* in any jurisdiction in which it is proposed. This is pre-eminently a *political issue*, concerning the factors that influence the legislature's will to enact the scheme. The critical factors here seem to be: the reigning political culture, and the degree of emphasis it accords to the 'negative' and 'positive' rights of the mentally ill; the balance of power in the political process between the relevant interest groups, particularly professional groups and organisations representing consumers and families; the extent of the change proposed from the existing mental health legislation; and the perceptions of the government concerning the wider society's demands. There seems to be more trust in government, and in the mental health system, in some jurisdictions than others, and in some places the political climate has been affected by particular tragedies, involving the death of patients discharged to the community, or the death of others at their hands. Above all, it seems to be the interaction between these factors and the constitutional arrangements in a particular jurisdiction that establishes the specific climate for law reform. The complexities and uncertainties that interaction can generate are well-illustrated by the current law reform process in England and Wales.

A fourth set of issues concerns *the detailed design of any CommTO legislation that is proposed*. These are the *legal issues* that have been the principal focus of this report.

Finally, a series of *empirical issues* arises concerning *the operation of any established CommTO regime*. To understand how that regime operates in practice we need to know: the categories of patient for whom it is used; the services they receive; the consequences of their treatment; the frequency of its use; and how that regime interacts with other social systems, like the criminal justice system. Unless

information is collected regularly on these matters, it will be very difficult to reach an informed assessment of the value of any particular CommTO scheme. Unfortunately, because much of this information is not regularly collected, many judgements about CommTO regimes are being made in the dark.

What this study has revealed, above all, is the relevance of these issues across the jurisdictions studied, despite the different environments in which those issues must be resolved.

In the remainder of this chapter, an attempt is made to draw more specific comparative conclusions on the issues most central to this study: the design of CommTO schemes, patterns in their operation, and potential explanations for the varying rates at which they are used.

The major fault-lines in the design of CommTO legislation

Study of the legislation has revealed the complex choices faced by a legislature in the design of a CommTO scheme, from its central concepts and powers, to the detailed criteria for decision-making at specific points in the process. The two issues of principle that seem most troubling are the role of competency (or capacity) principles in the criteria governing use of involuntary outpatient care, and the precise powers of health professionals to enforce outpatient treatment.

The role of competency (or capacity) principles

Here the main question is whether the involuntary psychiatric treatment of a person who retains their competence to consent to treatment (or their capacity; the terms are interchangeable) should ever be permitted under a CommTO regime. The trend in the North American jurisdictions, and in some parts of Europe, is to apply to psychiatric treatment the same rule that is applied to other forms of medical care: that only an incompetent patient may be treated without their consent. In Switzerland, Ontario and many states of America, this rule is applied even to the psychiatric treatment of patients lawfully placed under mental health legislation, including patients under CommTOs. Adherence to this principle may even be considered a constitutional

requirement in some jurisdictions, one that is necessary to protect the entrenched liberty or privacy interests of the patient.

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 being treated for mental disorder under the Mental Health Act; and it removes the suggestion that the law discriminates against mentally disordered people when it applies less favourable rules to psychiatric treatment than are applied to other forms of medical care.

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

These issues are particularly relevant to the provision of involuntary outpatient care. Involuntary outpatients are considered well enough to live outside hospital, and they often remain under CommTOs for long periods of time. Some may lack the competence to consent to psychiatric treatment throughout their time under the order, but not all will. Some will no doubt regain their competence to consent while still under the CommTO regime, or their competence will fluctuate during their involuntary care. The right of these latter groups of patients to refuse further psychiatric treatment, when they regain their competence, is the principal fault-line dividing the CommTO statutes in North America from those in force in Australasia and proposed in the UK.

In North America, the general position is that psychiatric treatment cannot be provided without consent to a competent patient, even a patient who is already under a civil commitment scheme. This is not the legal position in Australasia, nor will it be

the position in Scotland, England or Wales if their CommTO schemes are implemented in the form in which they are currently proposed.

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

That position has its own 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 such patients may be viewed in a longitudinal manner, taking into account their full psychiatric history and their likely prognosis if treatment were withdrawn. An explicitly 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. In the long run, that approach may be thought to promote a person's liberty and privacy interests more effectively than allowing them to pass repeatedly through the 'revolving door'.

The pre-eminent question of 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 approach, which draws more heavily on legal and bioethical reasoning, should be adopted instead, to recognise more firmly a competent person’s autonomy over their mental health care.

If the North American approach was adopted, it might significantly reduce both the *rate* of use, and the typical *length* of use, of the Australasian CommTO schemes. Those changes would in turn put pressure on other social systems, and greater use might be made of the criminal justice system as an alternative means of social control.

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 in English mental health law, perhaps under the influence of developments in European human rights law, that change 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 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 clearly recognised as an overriding requirement of European human rights law.

It is understandable that the incorporation of capacity principles within mental health legislation has been resisted by the British government, in light of the difficulties those principles may pose to the sustained treatment of people with severe but fluctuating mental conditions. Permitting an involuntary patient to refuse medication immediately, if they temporarily regain their capacity, may, in some cases, prevent

that person receiving a sustained course of treatment at all, even if their condition poses a serious threat of harm to their safety, or that of others, and even if their condition might improve substantially if they could be treated effectively for a reasonable period of time. It may simply 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 ongoing dilemma posed by the application of capacity principles to people with severe but fluctuating mental conditions.

This problem must be taken seriously, but it does not necessarily follow that there is no room for capacity principles in mental health legislation. They could still be included within the legislation in modified form: that is, in a form that would recognise their importance to the law of consent to treatment as a whole, but would also acknowledge the difficulties likely to arise from their inflexible application in the mental health field. An intermediate position may still be found that is widely acceptable. One such position is the 'substantially impaired capacity' test that was included in the new Scottish legislation after a comprehensive consultation process.

The 'substantially impaired capacity' test

On the recommendation of the Millan Committee, the new Scottish mental health legislation has added the criterion of substantially impaired capacity to consent to treatment for mental disorder to the fundamental criteria governing all involuntary interventions under the Act. This approach has much to commend it, in my view. Adoption of this new standard would incorporate capacity principles within the legislation, as a general standard governing both detention and treatment, but capacity principles would be included within the legislation in a modified form: that is, the person's capacity would only have to be 'substantially impaired'. This is a more flexible approach than incorporating a 'pure' capacity test. It may therefore surmount many of the difficulties associated with the application of capacity principles to patients with severe but fluctuating mental conditions.

The 'substantially 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 lacks the capacity to consent to treatment much of the time can be considered to have substantially impaired capacity overall. Their sustained treatment could therefore be authorised.

But the inclusion of this test within mental health legislation still affirms the central role of capacity (and autonomy) principles within the law of consent to treatment as a whole. It would also respond, to some extent, to the suggestion that mental health legislation discriminates against people with mental disorders if it fails to include capacity principles within the law governing *psychiatric* treatment, when these principles are included in the law governing consent to all other forms of medical care.

Under the new Scottish legislation, this ‘substantially impaired capacity’ test would be *an additional legal standard* governing all interventions under the Mental Health Act. It would not replace the usual criteria, concerning mental disorder and serious threats of harm. It adds an additional criterion, based on modified capacity principles, the effect of which is to harmonise, to a significant degree, the rules governing consent to treatment under the mental health legislation and the rules governing consent to other forms of medical care.

Requiring the capacity of a person treated under the mental health legislation only to be ‘substantially impaired’ involves some departure from the principles applied to other forms of medical care. *But the additional criteria of mental disorder and the presence of a serious threat of harm would still have to be met as well*, for involuntary psychiatric treatment to proceed. As a whole, this is still a demanding set of tests to meet. The criteria for intervention under mental health legislation would be slightly different, but they would be no less demanding than the tests for treatment without consent applied in other fields of medical law, where ‘pure’ capacity principles may be applied, but *additional evidence* of serious mental disorder and potential harm is *not* required for involuntary treatment to proceed.

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

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

Relying on these criteria as a whole would acknowledge the central role now played by capacity principles in medical law, but it would also acknowledge that the treatment of people with severe but fluctuating mental conditions, who pose significant threats of harm, is a special field of social concern.

Adding a substantially impaired capacity test appears perfectly consistent with the ethics of psychiatrists, and it should not discourage the appropriate use of civil commitment schemes. It is a standard that might attract a considerable consensus, as appears to have occurred in Scotland. It can be applied to both detention and treatment decisions, and to hospital and community care. It can be incorporated into mental health legislation as a whole, or into specific statutes that authorise involuntary outpatient treatment. In short, it appears to provide a balanced approach to the rules governing involuntary treatment, one that seems capable of reconciling many potential conflicts in the field.

The precise powers to ‘enforce’ treatment in community settings

The second major question of principle troubling the various jurisdictions is the precise scope of the powers to treat patients in the community that should be conferred on the members of community mental health teams. Can a regime be devised that is sufficiently enforceable and yet still consistent with patients’ human rights?

Two general approaches have been adopted to the specification of community treatment powers, as legislatures try to balance these concerns. The first approach 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 the CommTO regime. 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 all of these powers would be applicable to any patient under the scheme. This is the general approach taken in the ‘first generation’ CommTO statutes, like those found in Victoria and NSW. It has the advantage of being both transparent and simple.

The second approach is taken in more recent statutes that require the formulation for each patient of a statutory treatment plan. Under this approach, the precise powers of health professionals to enforce treatment under a CommTO are specified *indirectly*. Instead of providing a list of powers in the legislation, that may then be applied to any involuntary outpatient, at the discretion of the treating clinician, a court (or tribunal) is empowered to specify the particular means that may be used to enforce treatment in an individual case, when it approves the contents of the patient’s treatment plan.

This approach may be less transparent, particularly if the kinds of enforcement mechanisms that the courts are authorised to include in the plan are expressed in the legislation in vague or general terms. In that case, only subsequent research 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 mechanisms of enforcement that are considered ‘proportionate’ to the circumstances of the individual case, as may be required in jurisdictions governed by European human rights law.

As to the specific powers to enforce community treatment that are being conferred on health professionals: great care is taken in some CommTO statutes to specify enforcement mechanisms that will provide some ‘teeth’, but 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 the commentators and the statutes agree: that forced medication of involuntary outpatients in community settings is unacceptable if we are to guarantee *all* citizens the levels of privacy, dignity and

personal security required by contemporary human rights norms. Virtually every other practical means to enforce outpatient treatment is expressly authorised in the law of one or other jurisdiction, but not that one. Even the NZ statute, which may contain the most explicit treatment powers, 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.

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 CommTO regime.

What the experience of the Australasian jurisdictions demonstrates, nevertheless, is that conferring precisely that kind of power on health professionals is not necessary to encourage the use of CommTO schemes. 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 on 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.

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

- to direct the kind (or ‘level’) of residence at which the patient must reside
- to place a duty on the patient to accept psychiatric treatment (subject to the same limits as are placed on treatment in hospital)
- to direct the patient to accept visits from health professionals and to attend outpatient appointments
- to recall the patient swiftly to hospital, and to transport them there
- 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.

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. Limited powers of entry of this kind are provided in the Australasian statutes. They are not so clearly provided by the Draft Mental Health Bill for England and Wales, nor by the Ontario CommTO scheme.

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’.

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

Arguably, an adequate compromise can be found, therefore, that confers sufficient powers on health professionals to ensure they use the scheme, as the legislature intends, while still not authorising the unjustifiable infringement of patients’ human rights.

The single most important power in practice seems to be the power to recall the patient swiftly to inpatient care, by-passing the complexities of the usual certification process. These recall powers are not frequently activated fully in practice, but there

appears to be widespread agreement among the community clinicians who operate these schemes that the credible threat of their use, and their ready availability in a crisis, are central to the successful operation of a CommTO scheme. A recall power that is burdened by procedural requirements that cannot be followed in a mental health emergency is not seen to contribute positively to the scheme. If the recall power cannot be readily activated in an emergency, the likely outcome is that the patient will be recertified, and will be put back through the ‘front door’ of the civil commitment regime, to become again an involuntary inpatient. There is no obvious advantage in that for the patient, but it substantially reduces the value, for clinicians, of the CommTO regime.

This illustrates a more general point about CommTO schemes: that the likely effect of imposing extensive procedural requirements, or rigidly-defined criteria, on the exercise of clinicians’ powers, is the *disuse*, rather than the *appropriate use*, of the scheme.

Treatment plans

The most important development seen in the ‘second generation’ statutes is the requirement to prepare for each patient a statutory treatment plan. This is a contentious development, because it usually comes on top of existing policies, of an administrative or professional kind, that already require clinicians to prepare individualised treatment plans. How much value is then added by the requirement to prepare a further statutory treatment plan? There are advantages and disadvantages to this approach. The preparation of a statutory plan, under the supervision of a court or tribunal, may provide a focus for negotiations between interested parties, under neutral leadership, about the patient’s treatment; it may prevent unnecessarily broad treatment powers being conveyed; it may enhance the service providers’ sense of obligation to provide the listed treatment; and it may provide clearer standards for later review. It may help ensure the least restrictive form of intervention occurs and that proper accountability mechanisms exist.

On the other hand, the preparation of statutory treatment plans may produce confusion concerning the precise location of responsibility for the patient’s treatment. Are the

treating clinicians responsible, even if their treatment options are limited by the court's decisions concerning the contents of the treatment plan? What of their ethical position in those circumstances, if their treatment options are limited by the treatment planning decisions of a tribunal? Further, listing the treatment to be provided in a statutory plan may give involuntary patients even greater priority for resources, at the expense of voluntary patients; it may enhance clinicians' liability concerns, if the treatment is not provided; and a cumbersome 'variation' process may have to be activated, if the patient's condition (and their treatment needs) were to change substantially. Generally speaking, preparing an additional plan will increase the administrative burdens imposed on community clinicians, by multiplying the planning and risk assessment exercises in which they must engage. Ultimately, the requirement of a statutory plan may promote a situation in which some patients receive a high quality service, while others get much less. All those undesirable consequences may then discourage use of the CommTO regime.

In these circumstances, the advantages of requiring a court to approve a special CommTO plan are not clearly established, in my view, in comparison with the alternative approach, of simply requiring the clinicians to put *evidence* before the court or tribunal, concerning the treatment proposed. The court or tribunal should insist that such evidence is presented, in my view, but should not itself 'approve' the contents of the treatment plan.

Legal pitfalls to avoid

Several other pitfalls in CommTO legislation, that have emerged from study of the various jurisdictions' schemes, include:

- inflexible criteria for the use of CommTOs that cannot accommodate well-established developments in psychiatric opinion as to the appropriate uses of this form of care
- requiring non-compliance with treatment before a patient can be recalled to hospital, when they may relapse and require urgent rehospitalisation despite their compliance
- requiring frequent review hearings before under-resourced tribunals
- permitting review hearings to be so lengthy and adversarial that they constitute a 'virtual discharge' mechanism

- imposing strong statutory duties on health agencies to provide treatment to involuntary patients, in a manner that would encourage the courts to award civil remedies against the agencies (or against individual clinicians) for failure to comply
- permitting the CommTO to be cancelled, or the patient's review entitlements to be diminished, by a brief readmission to hospital
- confusion of responsibilities between the various administrators of the scheme.

Other fault-lines

Other controversies concerning the design of CommTO legislation include:

- whether the use of CommTOs should be limited by law to patients with a history of prior hospital admissions, or whether patients on their first admission to hospital may be placed under the scheme, in light of increasing research evidence about the benefits of early intervention in schizophrenia (RANZCP, 2005)
- whether family members, who may have a conflict of interest, should have veto powers over the patient's treatment, in addition to consultation and information entitlements
- whether criminal courts should be empowered to place people directly on CommTOs, without their prior assessment in hospital.

Trends in the use of CommTO schemes

The review conducted of the empirical studies of the various jurisdictions' CommTO schemes also reveals some fairly clear trends. In the early years of such schemes, 'teething problems' are frequently encountered, especially problems in familiarising clinicians with their administration and with the possibilities for their use. Once the regime becomes more firmly embedded, its use often increases steadily, particularly if there is a parallel reduction in the number of hospital beds and an associated build-up of community mental health teams. The Australian figures even suggest that when the average length of involuntary hospital stays falls below some critical length (perhaps 2-3 weeks), the use of CommTOs tends to jump significantly, due to the early stage in treatment at which patients are then being discharged.

The scale of the changes that often occur during the 'bedding in' period suggest that CommTO schemes cannot be properly evaluated until several years after their

introduction, by which time clinicians, courts and tribunals have become familiar with their use. The extent to which changes in their rate of use continue to occur, even a decade after their introduction, also suggests their use must be regularly re-evaluated as the context evolves.

The upward trends in their rate of use also suggest that increasing the community resources available tends to increase the use of CommTOs. No evidence was found to support the contrary views, that are sometimes expressed, that the coercion imposed by a CommTO may act as a substitute for an adequate community service, or that CommTOs would be unnecessary if only adequate community services were available. On the contrary, there is widespread agreement among those in the field that CommTOs cannot work effectively without the backing of a comprehensive community service, and that there are some people who cannot effectively be engaged in voluntary outpatient care, often due to the impact of their condition. In their case, the choice may not be between voluntary and involuntary treatment, but between involuntary treatment (at least for a period) and no treatment at all.

Well-embedded schemes are usually found to focus on certain categories of patient. The trend, in most jurisdictions, is for male patients to outnumber females, often by a ratio of about 60:40; and for most patients to be aged in their 30s and 40s, to be in the middle phase of their illness, and to have a diagnosis of schizophrenia, several prior hospital admissions, and a recent history of non-compliance with outpatient care. A considerable proportion are usually found to have concurrent problems with substance misuse, and a significant minority to have previously experienced imprisonment or forensic care. In most jurisdictions, only a minority of CommTO patients live in group homes or supported accommodation; most live alone in rented accommodation, or with their families.

Nevertheless, not all patients under CommTOs fit this profile. When clinicians have some discretion, they will tend to use the regime somewhat more widely. The regime will be extended to some patients with delusional, affective and schizoaffective disorders, and to some experiencing their first major episode of psychosis, who may be placed on a CommTO on discharge from hospital, if the clinicians consider they

are still very unwell, they continue to present one of the necessary threats of harm, and they cannot be relied upon to accept continuing medication as an outpatient.

Patients with this kind of profile would also seem to be the primary candidates for involuntary hospital care. There is therefore little in this data to suggest that substantial 'net-widening' occurs on the introduction of a CommTO scheme. Power's research in Melbourne, in particular, suggests that CommTOs can be successfully targeted in practice on those patients who are identified in the literature as the primary candidates for involuntary outpatient care. His research also suggests that CommTOs have the best outcomes for patients who are in the middle phase of their illness, have spent a high percentage of their inpatient time as involuntary patients and have complied poorly with medication before their last admission.

Although there are limitations in the 'mirror image' evaluation studies typically conducted of CommTO regimes, the results of those reviewed here almost always revealed: significant therapeutic benefits for patients; greater compliance with outpatient treatment, especially medication; and reduced rates of hospital admissions. Some also revealed: better relations between patients and their families, or enhanced social contacts; reduced levels of violence and self-harm; and a shorter period of disturbed behaviour prior to subsequent readmissions (or earlier identification of relapse). These findings are consistent with the results of the empirical studies conducted in the United States, reviewed by Gerbasi et al (2000), Hiday (2003), O'Reilly et al (2003), and Swartz and Swanson (2004).

Nevertheless, the empirical research also suggests that the use of CommTOs is strongly linked to the use of depot (or injectable) medication, which many patients dislike, due to the unpleasant side-effects. It is also a common complaint of patients that their treatment is dominated by the use of medication, with little access available to alternative forms of care. CommTOs also tend to be issued for the maximum period permitted by law. Discharge from the order is likely to come shortly before an independent review hearing would be held, and, in jurisdictions where those hearings are not overly demanding of clinicians' time, many orders will be renewed for a further term. These practices suggest clinicians have a strong belief in the value of

continuous medication for this patient group, and tend to have a strong preference for the status quo – or do not want to ‘rock the boat’ – when the patient’s treatment is proceeding satisfactorily under the CommTO. On the other hand, the studies also reveal that clinicians show considerable resistance to the legal regime’s administrative demands, and that there is considerable variation between clinicians in their willingness to use the regime, and their willingness to take pragmatic steps to ‘make it work’.

It is also widely believed that patients under CommTOs get some priority for care, and receive more intensive treatment, as has been found in the USA (Wagner et al, 2003). The order may help direct resources to patients at an earlier stage in their relapse, and it may facilitate their readmission, when necessary, to hospital care (Romans et al, 2004; Brophy and Ring, 2004). In addition, there is some evidence that the amount of medication administered to patients under CommTOs decreases during the course of their care. Incidents of serious violence by patients under CommTOs also seem to be rare.

Many of the mechanisms through which CommTOs may work seem to be structural and indirect in their operation, and act to enhance the commitment of service providers to the care of patients who are difficult to engage in treatment, as much as they act on the patient. Even regimes that do not permit ‘forced medication’ in community settings are considered to be able to ‘persuade the persuadable’ patient. They appear to work largely through the therapeutic relationships they help maintain, meaning that the quality and continuity of those relationships, and of the communication possible in cross-cultural settings, is probably critical to their success. The problem of concurrent substance abuse among patients on CommTOs, on the other hand, and the lack of good supported accommodation, especially in major urban areas where the cost of housing is very high, seem to be two major barriers to their success.

Within these parameters, it is possible to distinguish specific uses of CommTO schemes. They are used for post-forensic care and for diversion from the criminal justice system; they are used to link some people to supported accommodation; they

are used to monitor patients closely in the community who are being introduced to atypical anti-psychotic medication; and they even seem to be used by some people with affective disorders as an advance directive for their own involuntary outpatient care.

The use of CommTOs seems most likely to produce positive outcomes when:

- the regime is well-embedded and has the full support of clinicians
- a reasonably intensive community service is provided, by clinicians who visit the patient at their residence and are committed to enforcement of the scheme
- a good range of supported accommodation is available, plus a range of additional mental health services, beyond the provision of medication, including ready access to treatment for substance misuse
- the local inpatient and outpatient services are managed under the same administrative umbrella, or their operation is at least well-coordinated, permitting rapid access for involuntary outpatients to hospital care
- there are no financial barriers, or problems in reimbursement systems, discouraging use of the scheme, meaning that clinicians engaged in the liaison, consultation and accountability processes typical of such schemes must be paid at the same rate when performing those functions as they are paid for direct patient care
- there is considerable continuity of staff in therapeutic relationships, and the staff are experienced and assertive, have sound relations with well-trained Police, and have a high degree of cross-cultural capability
- the independent review procedures are not so frequent or intensive that they act as a virtual discharge mechanism or overly discourage, in appropriate cases, long-term use of the scheme.

On the other hand, some pitfalls clinicians should try to avoid include:

- assuming that all patients on CommTOs must be administered medication by injection, rather than in oral form
- the de facto confinement of CommTO patients in sub-standard accommodation
- over-use of CommTOs for patients with affective disorders, for whom their efficacy is particularly uncertain, and who may swiftly resume their capacity to consent after initial treatment

- over-use of CommTOs with younger, male patients, with concurrent substance abuse disorders, as an alternative to the criminal justice system, as there is also less evidence for positive outcomes in this group
- over-use of CommTOs when there is extreme pressure on hospital beds
- failure to review actively the need for the CommTO with patients who have been on them for long periods of time.

Nevertheless, even if all these indicators and practices were to fall simultaneously in line, it should never be expected that implementing a CommTO scheme will be straight-forward. The entire focus of such schemes should be on patients who are difficult to engage voluntarily in their care. Their treatment is likely to be difficult, especially in the under-resourced circumstances typical of mental health care. Conflicts are bound to occur between short-term objectives in their treatment and the methods needed to establish a long-term therapeutic alliance. Many of the levers provided by a CommTO to control the patient's treatment are structural and indirect, and act upon the services, rather than being immediately enforceable against the patient, and considerable time will have to be allocated to the accountability processes required by law. It is even possible that increased monitoring of the patient's condition will increase the time they spend in hospital. Ultimately, many different and potentially conflicting criteria can be used to measure the 'success' of treatment under a CommTO, and the clinicians concerned will sometimes be none-the-wiser as to whether their patients have benefited overall. In these circumstances, ambivalence is bound to continue about CommTO regimes.

The varying rates at which CommTOs are used

What explanations can be offered, then, concerning the varying rates at which these regimes are used in the jurisdictions studied? Why are CommTOs used much more frequently in Victoria and NZ, for instance, than in Ontario or most other parts of North America? In my view, the critical factor in determining their rate of use is *the perception of clinicians concerning their advantages*. CommTO schemes will only be used actively when they are viewed positively by the clinicians who must drive the process forward. The clinicians must decide to initiate the CommTO process, rather than discharging the patient outright from hospital; and they must complete the

documents, put the necessary evidence before courts or tribunals, propose the order's renewal, and so on. In making those decisions, the clinicians must assess the effort required to continue the process in light of other calls on their time. In those circumstances, they must believe that use of the CommTO in a particular case would confer significant advantages. The central point is that use of a CommTO scheme contains significant elements of discretion 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 CommTOs 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
- 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 on such relationships of the *stigma and coercion* that may be experienced by the patient.

Based on those factors, the following kind of formula can be constructed to describe the calculation that is likely to be undertaken by a clinician to assess the advantages of using the scheme.

The balance of advantage

Marginal authority x community mental health service x community expectations

Divided by

Administrative burdens x liability concerns x negative impact on therapeutic relationships

Equals:

Clinicians' willingness to use the scheme.

This calculation can be used to assess both the chance that a CommTO will be used in an individual case, and the overall rate of use of the scheme in a particular jurisdiction. To give an example of such a calculation in an individual case: if the clinician believed that the local CommTO regime conferred significant marginal authority, to provide a helpful and available community service to a particular patient, and 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 CommTOs, would tend to *decrease* clinicians' use of the scheme.

Similarly, if any of these factors went awry, that could totally subvert 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.

On this approach, reducing the number of hospital beds available for involuntary *inpatient* treatment may be best understood not as a single factor increasing the rate of use of CommTOs, but as a general influence on several of the factors listed above.

If this view is correct – that clinicians’ perceptions of the balance of advantage are the key to the rate at which CommTOs are used – this would impose important constraints on the capacity of legislatures to design useful CommTO schemes. A scheme that seems impeccably fair to the legislature, and fully consistent with human rights norms, may still be largely inoperative in practice, if it is viewed in a negative light by the clinicians expected to drive its procedures forward. In practice, there is little point, therefore, in a legislature enacting a CommTO regime that does not have the confidence of the relevant health professions, because that scheme is likely to wither on the vine.

The rate of use in particular jurisdictions

Following this line of reasoning, it should be possible to explain the differing rates at which particular schemes are used. If we consider the situation in Ontario: it seems likely that CommTOs are used infrequently there because the new scheme is still bedding in, and because, at present, it is not viewed positively by most clinicians who would be responsible for its implementation. They may not view it positively because it confers little additional authority to treat outpatients; a limited range of community services is available; expectations do not seem to be high in Ontario concerning the use of involuntary outpatient treatment; there is a strong perception among clinicians that the scheme is ‘administratively top-heavy’; and there is a high degree of sensitivity to the negative impact on patients of involuntary treatment. These factors would all discourage use of the Ontario scheme.

In addition, there is the reimbursement issue for psychiatrists in Canada, whose role is invariably central to CommTO schemes. They may not be properly remunerated for the administrative work required. So, although the Ontario statute had sufficient political backing to be enacted, in the wake of a highly-publicised tragedy, and it seems consistent with the rigorous demands of the Canadian constitution, this scheme currently withers on the vine, except at a few hospitals, where local attitudes have been positively influenced by particular psychiatrists. This situation seems likely to continue unless there is a general change in attitude towards the scheme among the leaders of the mental health professions in Ontario.

Similar points can be made about the low rate of use of the ‘supervised discharge’ schemes in the UK. A combination of limited treatment powers, limited community services, the perception of high administrative burden, the general preference among community clinicians for the voluntary approach to treatment (or for treatment in hospital), plus enhanced concerns about the capacity for involuntary treatment to infringe patients’ human rights, seems to have contributed to the general perception among clinicians that there is little advantage in using the scheme. As not much more authority to treat outpatients would be provided by the ‘non-resident’ treatment scheme proposed in the Draft Bill for England and Wales, and most of the other discouraging influences would remain unchanged, not much greater use could be expected of that scheme.

The position in Australasia

How, in contrast, can we explain the fact that CommTOs are used so extensively in Victoria, NSW and NZ, the most populous regions of Australasia?

First, the Australasian legislatures, unconstrained by entrenched constitutional bills of rights, have enacted CommTO schemes that provide the most extensive powers to facilitate the treatment of involuntary outpatients; clinicians retain significant discretion in the use of those powers; and the powers remain available even on the temporary resumption of the patient’s competence, so long as they remain lawfully under the scheme. The marginal authority to treat patients these schemes provide is therefore significant, even if they do not authorise ‘forced medication’ in community settings.

Secondly, a reasonable network of publicly-funded community mental health services is available in the region, at least in urban areas, where the great majority of the population lives. The quality and extent of these services could undoubtedly be improved, but thorough-going deinstitutionalisation has occurred. Most large hospitals are closed. They have usually been replaced by purpose-built psychiatric wards, attached to general hospitals, and an extensive network of community teams. These teams include many experienced nurses, who are prepared to visit patients in their homes; and, in NZ, they often include Maori health professionals. In addition,

the relatively strong social welfare and public housing traditions in the region provide support for patients' community tenure, even if lack of adequate supported accommodation is still considered the greatest weakness in the operation of these schemes.

Thirdly, there appear to be strong community expectations in Australasia, especially among patients' families, that CommTOs will be used actively by health professionals, following patients' discharge from hospital, as were the prior 'leave' schemes. These expectations may have been enhanced during the 1990s by a number of highly-publicised tragedies involving discharged patients.

The administrative burdens involved in treating patients under CommTOs are still important concerns for clinicians in Australasia. Nevertheless, clinicians in the region have not yet been exposed to unreasonable liability in the courts for the conduct of patients under CommTOs; and, in NZ, the potential for liability is greatly reduced by the general ban on civil actions for damages for causing 'personal injuries' that is found in the country's unique, no-fault accident compensation scheme. Nevertheless, exposure to other forms of liability – in health commissioner's inquiries, disciplinary proceedings, coroner's inquests, and the media – are still serious concerns for clinicians and health authorities.

Many clinicians in Australasia say they are troubled by the sense of coercion and stigma that is experienced by some patients under CommTOs, and by the effect this may have on therapeutic relationships. But most clinicians seem to believe *the advantage of maintaining some kind of relationship* with the patient still outweighs that problem in most cases. The predominant view, drawn from the recent survey of clinicians in NZ, was that, 'while compulsion can harm relations with patients in the short term, the advantages of continuing treatment usually outweigh this problem, and that where greater insight follows treatment, therapeutic relations will often improve in the end' (Romans et al, 2004, at 840).

There also seems to be considerable consensus in Australasia that the local CommTO statutes have been correctly focused on serious mental illness and its consequences,

not on personality disorder or learning disabilities. There is agreement that family members should be consulted about involuntary patients' treatment, but should not be granted full decision-making (or veto) powers. Inpatient and outpatient services are usually provided under the same administrative umbrella, facilitating their coordination. And there are no major reimbursement barriers at the individual level to the operation of CommTO schemes, as these are run by the salaried employees of public sector mental health services, with staff being paid uniformly for administrative functions and direct patient care.

In these circumstances, clinicians in Australasia generally seem to believe that the balance of advantage favours the use of CommTO schemes. One might even go further and say that because these schemes are used so widely, they are clearly *the preferred* mechanism in Australasia for the delivery of involuntary outpatient care. In other jurisdictions, like the United States, several different forms of 'leverage' may be used, in combination, to facilitate such care. That cluster of leverage mechanisms may then have similar effects (Monahan et al 2005). But, in Australasia, the whole of the field may be covered by CommTO schemes.

This does not mean, of course, that the Australasian approach to involuntary outpatient care should be followed in other jurisdictions. That would depend on their constitutional circumstances and their social and professional conditions. What the Australasian situation does suggest, however, is that certain theories advanced about CommTOs can be disproved: the theory, for instance, that CommTOs cannot attract the confidence of clinicians unless 'forced medication' in community settings is expressly authorised by law. That theory is shown to be incorrect by the experience in NZ, Victoria and NSW.

Policy-makers in Australasia should note that the particular features of the local legal and service context that have just been discussed make a strong contribution to the active use of CommTOs in this region. If those features were eroded, this form of care might be used much less actively by local clinicians. It is therefore those features of the local context that should be supported by governments if the extensive use of

involuntary outpatient care is to remain the preferred response in this region to the deinstitutionalisation of mental health care.

Chapter 10

Implications for New Zealand Law

From those general conclusions, I suggest the following implications can be drawn for NZ.

The structure of the NZ CommTO regime

The general structure of the NZ's regime is satisfactory, but two significant additions to the law should be contemplated in the next general reform of NZ's mental health legislation:

- to add a test of 'substantially diminished capacity to consent to treatment for mental disorder' to the general criteria governing all interventions under the mental health legislation, including the use of CommTOs
- to require mandatory, periodic review by the tribunal of *all patients*' involuntary status, even those patients who are on CommTOs for long periods and do not apply for a review.

Subject to those conditions, NZ's mental health laws and policies should continue to encourage the use of CommTOs under civil mental health legislation, particularly to try to avoid the unnecessary criminalisation of mentally ill people, and the over-use of the forensic mental health system. We should try to forestall the need to develop specialised mental health courts within the criminal jurisdiction.

The major functions of the law in this area should continue to be to specify clearly:

- the criteria for the appropriate use of involuntary outpatient care
- the administrative infrastructure for managing patients under CommTOs
- the powers in the community of clinicians and the Police
- the frequency and nature of independent review procedures.

The focus of NZ's CommTO regime should remain on the position of people with serious and continuing mental illnesses, and not on people with a primary diagnosis of

learning (or intellectual) disability or personality disorder. The administrative structure of the regime should remain ‘deinstitutionalised’, being based on a regional system of administration, not the institution of the psychiatric hospital. The law should not inflict excessive administrative burden on clinicians using CommTOs, unless the intention is to reduce significantly their willingness to use the scheme; and there should be room for significant elements of clinical discretion within the framework of the law.

Community treatment powers

The principal power to determine the treatment of an involuntary patient, including a patient under a CommTO, should remain with their responsible clinician. Family and whanau members should not be appointed under the mental health legislation to be substitute decision-makers about patients’ treatment, due to the potential for conflicts of interest. Instead, the strong obligations currently imposed on clinicians by NZ law, to consult with the patient’s family and whanau about their treatment, should be affirmed.

The same general limits should continue to be imposed on the treatment of involuntary outpatients as apply to involuntary treatment in hospital. But NZ law should *not* authorise the ‘forced medication’ of involuntary patients in community settings, nor should the current legislation be interpreted in a manner that would permit that to occur. The absence of an express power in the Act to restrain and medicate involuntary outpatients should be noted, along with the concession made by the Ministry of Health in the statutory Guidelines to the Act (2000) that ‘no power to detain the patient for the purposes of treatment’ in a residential setting is provided by NZ law. That important position should be maintained, and no additional power to medicate patients by force in a community setting should be conferred, to prevent the violation of patients’ human rights.

Further, the law should not confer on community clinicians an overly-broad power of entry into the private residence of a patient under a CommTO, to avoid excessive intrusions on privacy. Entry without consent should only be permitted at reasonable times, and for specific purposes, directly related to the community treatment regime.

Nor is it necessary to confer an additional power on the courts in NZ to order an outpatient to reside at a specified address. It is sufficient to permit the responsible clinicians to direct an involuntary outpatient to reside at a certain type or 'level' of accommodation, as a condition of their community care. The patient should usually be free to move to another residence that provides the same level of care.

The NZ regime should still place *a duty* on the patient to accept psychiatric treatment in the community, as directed by their responsible clinician; and NZ law should continue to provide all involuntary patients with a general right to receive appropriate treatment, and to be informed about their treatment, under the general code of involuntary patients' rights.

In addition, NZ law should continue to authorise clinicians:

- to direct the patient to accept visits from health professionals, and to attend outpatient appointments
- to recall the patient swiftly to hospital, and to transport them there
- 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.

To clarify the precise scope of the authority to treat patients in the community, the following rule from NSW could be adopted: that medication may be administered without consent to a patient under a CommTO 'if it is administered without the use of more force than would be required ... if the person had consented'.

The criteria upon which clinicians may shift involuntary patients between hospital and the community should not be inflexibly defined, nor should the power to recall outpatients to hospital be constrained by unrealistic procedures, in light of the urgency with which those powers may have to be used.

The law should not promote confusion between the role of clinicians and that of courts and tribunals, concerning the details of involuntary patients' treatment. Courts

and tribunals should review the need for the patient's involuntary status to continue, not specifically approve the contents of the patient's treatment plan. Nor should the preparation of a special statutory treatment plan be required. It should still be expected, as a matter of policy and professional practice, that a clear treatment plan *will be* swiftly prepared for each patient, and courts and tribunals should *demand evidence* from the treating clinicians, concerning their precise treatment plans, before treatment orders are made. But insisting on evidence is not the same thing as approving the contents of a treatment plan.

Independent review procedures

The current system in NZ for reviewing involuntary patients' status, that involves both District Court Judges and review tribunals, at different stages of the process, is desirable and should be continued. It has the advantage of sharing the burden of the review process between two institutions, and it ensures an independent judicial body is always available to review cases at short notice in most parts of the country. It also prevents review tribunals being overwhelmed with work, a problem being experienced in Victoria and NSW. Over-burdened tribunals may have to adopt excessively rapid procedures. To be credible, the 'gaze' of a court or tribunal must be reasonably intense.

The inquisitorial and relatively informal character of the current review process should nevertheless be maintained if the review of CommTOs is not to become a 'virtual discharge' mechanism.

Six months is a suitable length for the initial CommTO. That is the preferred length in many jurisdictions. Requiring the order to be renewed through a formal process after only 3 months imposes too great a burden of administration on clinicians, and on reviewing courts or tribunals. On the other hand, 12 months may be too long a time before the first mandatory review hearing is held.

Three other desirable principles of the NZ review system are that:

- more frequent reviews occur during the early life of a CommTO

- there is a mix of mandatory reviews, triggered by the passage of time, and optional reviews, held at the election of the patient or their representatives
- the tribunal may review, of its own motion, the status of an involuntary patient.

On the other hand, the current NZ system, whereby a CommTO becomes ‘indefinite’ in duration when it is renewed for a second time by a court, is not fully satisfactory. The effect of that approach is that some patients, who are treated under CommTOs for long periods of time, and do not apply for reviews, may not appear before a court or tribunal for years at a time, despite their involuntary status. That approach does not meet the minimum requirements of procedural fairness required in such circumstances, in my view, when persons with severe mental disorders cannot be expected to initiate the review process. It is not an approach that encourages responsible clinicians to assess rigorously the need for the CommTO.

The best approach is for all involuntary treatment orders to last for a limited period of time. The system of indefinite orders under the NZ regime should therefore be replaced by orders that have a maximum term of 12 months, after two consecutive 6 month orders have been made. For that 12 month order to be renewed, a mandatory review should be held before a court or tribunal. That would require, however, that significant additional resources be directed to the review process, especially if the extra reviews were to be conducted by the tribunal, to prevent its proceedings becoming too expedited under the additional caseload.

In general, NZ should be careful *not* to adopt a system of frequent, mandatory reviews before an under-resourced tribunal. Nor should review proceedings be so onerous as to overly discourage clinicians from using the CommTO regime.

A further positive aspect of the NZ regime that should be retained is the ability to readmit a CommTO patient to hospital for a short period without that affecting the duration of their order, or their usual review entitlements.

Civil liability

The law concerning the civil liability of the health services and of responsible clinicians for the conduct of patients under CommTOs does not require legislative attention at present. Those matters are being handled satisfactorily under the general law of civil liability in NZ, and under the provisions of the accident compensation regime.

The service environment

The continued development of mobile community mental health teams should be given a high priority by health providers, to ensure patients under CommTOs receive a reasonably intensive level of service, as the evidence suggests is required. Particular attention should also be directed to the development of ancillary mental health services for such patients, such as counselling and rehabilitation services, that go beyond the provision of medication in community settings. Such services should not be provided at the expense of adequate inpatient facilities, however, as any further reduction in hospital bed numbers is likely to increase significantly the use of CommTOs.

In addition, a high priority should be given to the development of good supported accommodation services for people with serious mental disorders. Inadequacies in accommodation services have been widely identified as the major barrier to the successful use of CommTOs, along with increasing levels of substance abuse among involuntary patients.

NZ policy-makers should be aware that adopting any new financial system for the payment of mental health professionals could have implications for involuntary outpatient care. Considerable time must be spent on administration, and on liaison with other service providers, in the administration of CommTO schemes. If the scheme is to operate successfully, the staff must be paid at the same rate for performing those functions as they are paid for direct patient care.

Other factors in the service environment that seem to contribute to the successful use of CommTOs include: close liaison between inpatient and outpatient services; close

liaison between community teams and well-trained Police; continuity in therapeutic relationships; and a high degree of cross-cultural capability among mental health staff.

Finally, the law should not impose strong statutory duties on health providers to deliver services to patients under CommTOs. Imposing such duties may appear to create a desirable contract for care between health providers and involuntary patients, but the outcome is likely to be that health providers will hesitate to accept responsibility for the care of involuntary patients, for fear of exposing themselves to additional forms of liability in the courts.

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