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Compulsory community treatment in the context of mental health reform in Victoria, Australia

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Abstract

Background

The use of Community Treatment Orders (CTOs) in the treatment and care of those with severe mental illness continues to attract debate and remains controversial despite increasing use in many countries. Mental health legislation is driven by the policy directions of the government of the day, and also reflects community attitudes and expectations. In recent years there has been an increasing focus on individual rights as reflected in the expectation that use of restrictive interventions and compulsion will be kept to a minimum. These changes in policy and law have occurred in parallel with a reduction in bed-based services, and in Victoria, a reduction in service availability overall on a per capita basis. The objective of this thesis was to examine the processes involved in civil commitment under mental health legislation and factors that influence this, and to seek the views of those who provide the most direct care and support in the community. The thesis sought to determine whether subsequent care is influenced by the manner of discharge from a compulsory order, and the impact of new legislation with a greater emphasis on human rights. The thesis considers the changes in rates of compulsory care following reform of mental health legislation in the context of ratification of the United Nations Convention on the Rights of Persons with Disabilities. The thesis also considers the influence of substance use on whether compulsory care is instituted, and the experience of those who care for people with severe mental illness.

Methods

This thesis incorporates four studies. Studies one to three use the Victorian state-wide data system of mental health service utilisation. Two separate cohorts of people who had been on a CTO for at least three months were followed for two years. The first covered service utilisation for two years following the end of a CTO during 2008 – 2010, and the second from 2014 – 2016. This enabled consideration of the role of external review such as by the Mental Health Review Board in discharge and continuity of care planning, a comparison between two different legislative regimes, and the impact of clinical factors such as having substance use disorder in addition to severe mental illness. Study four incorporated a mixed qualitative/quantitative survey posted to carers who were members of two carer support and advocacy groups. This study sought to understand the views and experience of people who cared for those with severe mental illness such as schizophrenia. Through these studies the candidate sought to determine: whether the mode of termination of a CTO was related to subsequent service utilisation; whether the intention of legislative reform to reduce the use of compulsory treatment was supported by comparison between service utilisation after a CTO under the *Mental Health Act (1986)* and *Mental Health Act (2014)*; and whether co-morbid substance use resulted in greater likelihood of being made a compulsory patient.

Main Findings

Study 1 found that the way a CTO ended influenced subsequent treatment as a compulsory patient. If the CTO ended suddenly the person was more likely to require use of the mental health act in the future.

Study 2 showed that there had been a reduction in the use and duration of orders under the *Mental Health Act (2014)* compared to the *Mental Health Act (1986).* There was also an increase in the number of CTOs varied to an inpatient order by the authorised psychiatrist.

Study 3 found that having a substance use disorder increased the use and duration of compulsory orders. This related to those with schizophrenia and mood disorders, with the latter more likely to return to inpatient care. The study raised the question of how effectively or otherwise mental health services and drug and alcohol treatment services work together.

Study 4 showed that most of the carers who responded supported the use of CTOs. They reported considerable negative experience of care-giving.

Conclusions

The Victorian mental health service system has changed greatly over the past decades. Legislation has been reformed to meet contemporary expectations of oversight and regulation, including the introduction of CTOs. However, the intent of legislative reform may have been limited by the system failing to keep pace with population growth. The research raises questions about how we care for those with severe mental illness in the community and the impact the current service system has on carers and other support services. Reforming mental health legislation does not, of itself, result in improved patient outcomes or experience of care. Under the current system of care, the thesis supports continuing use of CTOs, but with greater emphasis on clinical engagement and care planning with other relevant care providers, including family or carers. This research occurred in the context of growing disquiet regarding the mental health service system and the subsequent commissioning of a Royal Commission.

Declaration

This is to certify that:

i. the thesis comprises only my original work towards the PhD except where indicated in the Preface
ii. due acknowledgement has been made in the text to all other material used
iii. the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies, and appendices.

Ruth Geraldine Vine

Preface

This thesis owes much to those who contributed data and support with analysis and drafting. The candidate developed the initial conception of the studies and led the design and ethics application. The candidate provided the additional explanation and reassurance required by the Ethics Committee before approval.

The data for studies 1 – 3 was obtained with the kind assistance of Mr Lachlan Rimes from the Department of Health and Human Services. While the candidate was the primary author of the papers which form the basis of this thesis, the supervisors (co-authors) provided comment and suggestion on each study and a co-author provided support with the statistical analyses. The candidate drafted each of the papers and responded to the requests by reviewers for changes or amendments.

The candidate developed the questionnaire for carers and carried out the negotiations with the carer advocacy and support organisations to gain their consent and support to mail out the questionnaire. The candidate collated the surveys and carried out the initial analysis of the responses. The co-author of the paper which informs Study 4 assisted with statistical analysis.

The papers referred to in this thesis have all been published in peer reviewed journals.

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During the course of my candidature, I was incredibly fortunate to have the guidance and support of my supervisors, Professor Jane Pirkis, Professor Fiona Judd and Associate Professor Matthew Spittal. Each gave generously of their time and wisdom. A special thanks to Angela Komiti, Suzy Turner and Holly Tibble who showed great tolerance and patience when helping me with statistical analyses. I am also grateful for the support of those who contributed to my Advisory Committee, especially Professor Carol Harvey and Professor Lisa Brophy who both provided valuable input and suggestions for improvement through the development of this work.

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Chapter 1. Introduction

1.1. Introduction

The treatment and care of those who have severe mental illness often differs from that of people with physical illness because of the different impact of these illnesses on self and society. This is particularly the case in illnesses such as schizophrenia which is characterised by a change in attribution, and alterations in thought, perception, and behaviour. The person experiences the illness as if the cause is external as evidenced by symptoms including delusional beliefs, auditory hallucinations, and ideas of reference. Not recognising the symptoms as manifestation of an illness is referred to as lack of insight. This has a direct impact on judgement and therefore capacity to weigh up information and determine the risks and benefits of proposed interventions. These changes often significantly affect the way a person behaves in relation to others whom he/she believes are acting against them, and may be associated with risk of harm to self through reacting to the false beliefs and associated emotions. These risks are mitigated by treatment. While capacity and judgement may be impaired in association with physical illness, this is most often because of other disability such as intellectual disability, or because the illness itself is associated with cognitive decline such as delirium, dementia, or organ failure.

The complex issues which arise in relation to severe mental illness are recognised in most countries by having separate mental health legislation to regulate when and how detention and treatment for mental illness can be imposed. In particular, the need for separate mental health legislation is recognised as a response to mental illness which most often responds to treatment, but may be associated with risk of harm to self and others and lack of insight, which means that biological (medication) treatment is often refused.

In Victoria, Australia, those with psychiatric illness are able to receive treatment and care from primary health providers and in the private sector, but the state funded public sector is the only service system mandated to provide treatment under mental health legislation. That is, involuntary or compulsory care can currently only be provided by public mental health services in both inpatient and community settings.

Those providing clinical care in this system, especially consultant psychiatrists, make decisions that are not just about clinical treatment, but which also involve issues such as determination of capacity and level of risk of harm to self and others. Determination of these issues influence whether a patient should be treated under mental health legislation as a compulsory patient. This, in turn, will be influenced by the availability of services and other factors such as social support and accommodation. These decisions are not simple and are subject to external review. The context of service delivery – whether it relates to the component parts of the service system or the relevant legislative framework – often dictates what can be provided clinically. The public health sector is also more likely to be called upon to provide treatment and care to those who present with multiple and complex needs such as the added burden of intellectual disability, substance misuse, homelessness, or involvement with the criminal justice system.

Over the past three decades there have been significant changes in how mental illness is viewed by the general community. There have changes in the intentions of policy on how and where people with severe mental illness receive treatment and care, and the legislative regimes which provide for compulsory care. Although severe mental illness is still poorly understood, there is greater awareness of its impact and greater visibility within our community. A major policy change was the closing of large segregated institutions in the 1980s, with the delivery of care transferred to community settings whenever possible. The presentation and management of mental illness has also been influenced by other changes, including the improvement of medications to treat psychosis which has allowed many of those disabled by mental illness to live in the community. Alongside this, has been the increased use of illicit substances such as amphetamines and methamphetamines. Violence and aggression towards frontline staff have increased. Stronger law and order policies have seen expansion in the numbers of people incarcerated, including those with mental illness. In real terms, per capita State funding for mental health has declined with reduction in the range and accessibility of services [1-3].

From a legislative perspective there have been two highly influential shifts. The first of these was to extend involuntary or compulsory care to the community separate from an inpatient admission, resulting in Community Treatment Orders (CTOs; also referred to as Compulsory Community Treatment or Assisted Outpatient Treatment). The second, and more recent change, was a greater emphasis on human rights culminating in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) which explicitly included those with psychosocial disability [4]. This shift from parens patriae to increased focus on the rights of the individual has brought greater emphasis on areas such as respect for personal integrity, right to freedom of movement and right to be free of cruel and unusual punishment. These have been incorporated in reformed legislation. The threshold for compulsory care has risen and greater external review and oversight have been introduced. These changes have occurred across developed countries.

The push towards greater individual freedom and care in the community has also come under critical scrutiny, often hastened by a political need to respond to different pressures or events. For example, changes in legislation in the United States of America have been in response to particular tragedies, such as Kendra's law[1] in New York State. This followed a series of incidents including one where a person with untreated schizophrenia pushed a person into the path of an oncoming train [5]. There has been an increased focus on law and order with various 'tough on crime' changes in sentencing duration, resulting in increases in prisoner numbers [2]. These changes have happened at different times in different jurisdictions. CTOs came relatively early to Australia. Victoria was among the first jurisdictions to introduce compulsory community care with the passage of the *Mental Health Act (1986),* with other States following soon after [6, 7]. CTOs were not introduced in the UK until 2008 in the face of considerable debate and opposition [8].

This thesis was conceptualised and written in this context. The candidate has worked as a consultant psychiatrist and mental health service administrator in forensic, community and acute mental health settings in Victoria for almost thirty years. During that time the Victorian population has grown from 4 million to 6.6 million people – with growth most marked in outer metropolitan areas [9]. The profile of services has also changed with fewer beds and fewer community staff per capita [10]. Mental Health services have been 'mainstreamed' with general health services, with a greater proportion of patients being admitted via the Emergency Department [10]. The number

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[1] 'Kendra's Law' along with a number of others was a response to a specific incident involving a person with mental illness. Kendra's Law, effective since November 1999, is a New York State law concerning involuntary outpatient commitment. It grants judges the authority to issue orders that require people who meet certain criteria to regularly undergo psychiatric treatment. Failure to comply could result in commitment for up to 72 hours.

and proportion of people being treated under a CTO has increased [11]. These changes have not come about without debate.

There has been considerable research regarding CTOs, but their utility and ethical basis is still hotly disputed. In particular there is an apparent divide between third parties who impose or who are indirectly impacted by a CTO (psychiatrists and care givers), and those who research CTOs or who may be subject to CTOs (academics and consumers). While much has been written on whether or not CTOs are effective and whether they should or should not be supported, there is still limited understanding of how CTOs are used as part of treatment planning in a complex service system. Much of the complexity lies in the different regimes in different jurisdictions, but there is also a paucity of understanding about what happens to a person after they have been on a CTO, and whether their trajectory is influenced by the process of discharge planning, and by service availability and intensity.

How legislative policy and intent in the context of service system issues impact on discharge decisions and service utilisation after discharge from a CTO has also not been well addressed in the literature. There has been limited consideration of the effect of external review as mandated by mental health legislation on subsequent service utilisation. Although there has been considerable research and debate regarding the utilisation and effectiveness of compulsory care under mental health legislation, our understanding of sequential episodes of care is still limited. While the literature has considered outcomes such as readmission, there has been little consideration of whether that readmission is as a compulsory patient, with all the distress and disturbance that is associated with forced detention and treatment. The literature has considered factors that influence whether compulsory treatment is imposed, but to date this has mainly been in relation to hospital admission rather than community treatment, and has considered broad categories such as ethnicity, diagnosis and past treatment episodes. There has been little exploration of factors such as substance use on the use and duration of compulsory orders.

As noted above, service delivery happens in a context. This thesis was written in a time when Victorian mental health services were under considerable pressure in the face of greater than anticipated population growth without proportional increased funding in line with this growth. There has been concern expressed in the media about increased presentations to Emergency Departments and worrying occupational violence involving those with mental illness in the health system. There has also been increasing concern about the level and type of substance use with considerable investment to tackle the impact of methamphetamine abuse on Emergency Departments and mental health services. The increased pressure on inpatient and Emergency Department services was also the subject of a very critical report from the Victorian Auditor-General [10]. In November 2018 the government announced that they would set up a Royal Commission into mental health services in Victoria. The Commission was established in early 2019 and released their interim report in November 2019 [12].

This thesis considers the particular characteristics of mental illnesses most likely to be associated with a need for treatment to be provided under compulsion within the rights and protections of mental health legislation. The thesis examines the social and ideological context in which mental health legislation is developed and enacted, and some of the mechanics of operationalising the law in the clinical setting. The thesis considers the subsequent service delivery and utilisation of compulsory treatment following discharge from a CTO under two different legislative regimes. It examines service delivery across two time periods (2008 – 2012 and 2014 – 2018) which cover times when there was substantial change in the availability and intensity of services, and in the prevalence of use of illicit substances, especially psychostimulants. The candidate also considers the views of an important group of stakeholders – those who are involved in the care of people with severe mental illness. By focussing on a particular subset of those with mental illness who received treatment as compulsory patients in the community, this thesis aims to better elucidate aspects of mental health service delivery to those with the most severe and complex presentations. The tension between policy, practice and legislation that support an individual’s autonomy, and that which endeavours to curtail risk to self and others, remains unresolved. These sometimes-competing public policy aims are directly played out in mental health services and have an impact on service delivery and treatment outcomes.

1.2. Roadmap of the thesis

Chapter 2 sets the context for the studies undertaken, including a review of the literature.

Sections 2.2 to 2.4 expand on the nature of severe mental illness that falls under the rubric of ‘psychosis’, with a focus on schizophrenia. The candidate describes the impact of the illness on the person, their family, and the broader community, and why this illness or group of illnesses is associated with treatment and detention under mental health legislation. The sections consider areas such as lack of insight into the impact of the illness and the resultant necessity for treatment to reduce the associated risk of deterioration or harm to the individual or others. Importantly, despite changes in the social and legal paradigms regarding mental illness, there has been little change in the prevalence or manifestation of illnesses such as schizophrenia. While treatments have improved and are largely effective, they are only effective while being used, and the likelihood of relapse and further functional deterioration is high if treatment is stopped. The risk of relapse is heightened if the person also uses psychoactive stimulants such as amphetamines or methamphetamines. Substance use is also associated with increased likelihood of aggressive behaviour and criminal offending.

Section 2.5 considers the role of carers and the experience of providing care for a person with severe mental illness. This considers their experience of interacting with the mental health service system, and of treatment provided, including that under a CTO. The section includes comment on studies that have sought to understand the burden experienced by carers and how they view more recent developments, including recovery-oriented care.

Sections 2.6 to 2.7 consider the policies and associated legislation relating to the management of those with severe mental illness. These sections trace the development of mental health law, especially in Victoria over the past thirty years. The sections describe the shift in emphasis from clinically based paternalism to a greater emphasis on individual rights and prediction of risk of harm, and the shift from medical dominance to review and determination by an external board or tribunal underpinned by procedural fairness and based on administrative law. The heightened prominence of prediction and management of risk over provision of care has greatly changed the purpose and use of inpatient care. Increasingly care has shifted to be provided in the ‘less restrictive’ environment of community rather than hospital. These shifts were partly driven by social movements that resulted in closure of large stand-alone psychiatric hospitals in many high-income countries. These changes have been accompanied by the emergence of a new form of compulsory care. CTOs provide for compulsory status in community settings, regardless of whether this follows or occurs before inpatient care. The candidate has considered how CTOs evolved and the continuing debate regarding their utilisation.

Section 2.8 discusses the shift to a greater focus on individual human rights. This has been greatly influenced by the United Nations Convention on Rights of Persons with Disabilities (CRPD). How this has been interpreted and the implications for clinical practice are discussed. The ratification by the Australian government of the CRPD hastened the imperative to enact further reform to law and practice in this area so that legislation complied with the convention. Nonetheless the extent to which current mental health law is compatible with the CRPD is still a matter for dispute. This especially relates to two issues commonly present in mental health legislation. Compulsory treatment could be seen to be in conflict with Article 17 (protecting the integrity of the person) regarding the right to respect for physical and mental integrity, and substituted decision making which may conflict with Article 12 (equal recognition before the law) in relation to legal capacity and the right to make decisions for oneself – even if with considerable support. In Victoria the changes introduced to mental health legislation improved compatibility with the CRPD. The *Mental Health Act (2014)* raised the threshold for compulsory treatment, and determined that compulsory treatment should be used only when treatment as a voluntary patient is not possible and only for the shortest period. In addition to strengthening the focus on individual rights, mental health policy as outlined in Victorian and national mental health plans also emphasised improved access to treatment, and early intervention both at the onset of illness and in any recurrence [13, 14]. They supported the Recovery movement which champions greater consumer involvement in treatment and care, especially in choice of treatment and setting the parameters for clinical involvement.

Section 2.9 brings elements of the above sections together to consider the development, enactment and implementation of mental health legislation in Victoria, the *mental health act (1986)* and *mental health act (2014)*.

Section 2.10 considers aspects of the economic and social context which impacted mental health services in Victoria during the period examined in the thesis. A paper on the current context of service delivery and how this may affect CTO utilisation was published in a peer reviewed journal in 2019 and is drawn on in this section.

<u>Chapter 3</u> provides a conceptual and methodological overview of the thesis. It articulates the aims and associated hypotheses, and provides an overview of the methods used in the four studies. Each component study of the thesis is outlined, including the process for ethics approval.

The interaction of legislation that mandates shorter periods of compulsory treatment, and mental illness that is often relapsing and recurring, and which may lead to the person being subject to this legislation, is complex. When the person experiencing the symptoms of an illness such as schizophrenia ascribes them to an external process such as persecution by others, he/she is unlikely to seek help from health services and more likely to present late because of pressure from family or police. Additionally, presentation is likely to be delayed and the need for compulsory treatment more likely if the person is lacking social support or using illicit substances. These issues are compounded if the service system is under pressure because of increased demand against a constant or even reducing capacity. To meet the need for increased throughput, inevitably the threshold for admission goes up, and the improvement required for discharge goes down. In Victoria, there has continued to be a comparatively high utilisation of CTOs alongside reduced length of stay and high occupancy in inpatient units [7].

Three of the four studies are based on two cohorts of patients selected on the basis of being on a CTO for at least three months. This criterion was chosen on the basis that only those with severe mental illness and associated disability and complexity would warrant compulsory treatment over that duration. The data sets were then interrogated to determine factors that influenced subsequent service utilisation.

Although the views of carers on the use of compulsory orders have been explored in a number of jurisdictions, there has been limited examination of their experience over time, or their experience of care-giving, especially in the context of recovery-oriented care. The fourth study considered the experience of a group of carers selected for having increased likelihood of being the care-giver for a person with a severe mental illness.

Chapters 4 to 7 provide the publications of the four studies mentioned above. This thesis has taken the novel approach of exploring what happens after a period of compulsory care in the community. The candidate examines whether aspects of legislation and policy such as external review have influenced service utilisation and return to compulsory care after cessation of a CTO. The candidate was able to compare aspects of service utilisation under two different legislative regimes, the more recent having a stronger focus on human rights and recovery-oriented care. The period covered by the studies is 2008 – 2018. The fourth study considers how compulsory community care is perceived by an important stakeholder group – a subset of very engaged and informed carers who are often the main support and care providers of those under compulsory care in the community.

In addition to the four publications in peer reviewed journals, the studies were also presented at a number of conferences including the International Academy of Mental Health and Law (IAMHL) congresses in 2017 and 2019, and at the Royal Australian and New Zealand College of Psychiatrist (RANZCP) congresses in 2016 and 2019, in addition to a number of presentations at local events in Melbourne such as to the Mental Health Tribunal.

Chapter 8 provides a discussion and conclusion. The intention of this thesis was to examine mental health service utilisation – in particular compulsory care in the community - under mental health law and policy over the period from 2008 to 2016 through four related studies. But legislation and policy do not occur in isolation. The operationalisation of both is influenced by a number of factors including policy in other areas such as justice and human services, community expectations and population growth, and the level of funding provided. The final chapter discusses the service context in which this thesis was undertaken, the progress of the Royal Commission into Victoria's mental health services, and directions for future research and service development.

Chapter 2. Setting the context

2.1. Introduction

This chapter discusses the epidemiology and clinical features of severe mental illness characterised by psychosis, with a focus on schizophrenia. Associated illnesses include schizo-affective disorder and bipolar affective disorder. These are the illnesses most commonly treated within the public mental health system, and most commonly the reason for management as a compulsory patient under mental health legislation. The chapter considers the impact on carers of those who have a severe mental illness and who are likely to receive treatment as compulsory patients. The chapter then considers the policies and plans which have influenced when and how people receive treatment for mental illness and the legislation that governs compulsory treatment. As the empirical studies in this thesis were carried out in relation to Victorian mental health services, there is a separate section on mental health legislation in Victoria.

2.2. Mental illness and its treatment

While there have been major advances in many areas of health care over past decades, the main changes in the management of severe mental illness have been in where and how we provide care, rather than prevention or treatment. There have been advances in the range and side effect profile of medications, which continue to be the mainstay of treatment [15]. Despite improvements in medications and other forms of treatment, a significant proportion of people who develop mental illnesses such as schizophrenia will experience considerable disability and struggle to maintain independence [16].

Increasingly care is provided in the community rather than in bed-based settings, and for time limited episodes rather than over years. But the characteristics and diagnostic profile of those who are most likely to receive treatment under the provisions of mental health legislation has remained remarkably constant. People who receive treatment over longer periods (months or years) as involuntary or compulsory patients are likely to have a diagnosis of a psychotic illness. In Victoria, as reported by the Mental Health Tribunal in their annual report, over 80% of people who appear before the Tribunal have a diagnosis of schizophrenia, schizo-affective disorder or bipolar affective disorder [17]. Schizophrenia related illnesses are the primary diagnosis in over

70% of patients in community mental health services [18]. A study by the candidate found that schizophrenia and mood disorders accounted for 82% of those who had been on a CTO for at least three months under the *Mental Health Act (1986)* [19]. To understand why these illnesses are so highly represented in those treated in public mental health services under mental health legislation, this chapter considers the nature and impact of psychosis.

In spite of considerable research and advances in understanding the biological and social determinants, the aetiology of non-organic psychosis remains unclear, and there has been little shift in ultimate prognosis over recent decades [20]. These are also the diagnostic groups which seem to carry the most damaging images of mental illness. In recent years there have been many attempts to 'normalise' and de-stigmatise mental illness, but while these may have increased awareness and acceptance of some illnesses such as depression, they appear to have done little to shift opinion in relation to low prevalence mental health disorders such as psychotic illness [21-23]. It is also possible that some people with severe mental illness avoid treatment because of the associated stigma [24]. The chapter also discusses the complications and associated co-morbidities related to schizophrenia such as poor physical health, increased prevalence of substance use and homelessness. There is also increased likelihood of contact with the criminal justice system. Untreated mental illness is associated with increased risk of violent offending [25].

2.3. Schizophrenia

Schizophrenia has long been recognised as a severe mental illness. As noted by Fleischhacker et al, the term schizophrenia describes a mental disorder characterized by abnormal thinking, perceptual disturbances, and diminished or exaggerated emotional expression [26]. It is estimated that schizophrenia directly affects at least 26 million people worldwide, and that at least twice as many are indirectly affected (for example, as carers).

2.3.1. Epidemiology

There have been several large multi-centre studies with agreed diagnostic criteria which have endeavoured to determine the incidence and prevalence of schizophrenia [27]. These have demonstrated that the clinical syndrome of schizophrenia can be diagnosed reliably and that although there are differences in the incidence and prevalence between geographic areas, schizophrenia is present in all societies. The lifetime prevalence ranges between 4 – 7.2 per 1000 population while the incidence ranges between 7 - 14 per 100,000. A recent review concluded that the overall point prevalence was 0.28% [28].

Schizophrenia affects men more often than women and there may be an earlier age of onset in men with the illness most likely to be diagnosed between 20 to 24 years. However, schizophrenia can have its onset from childhood into older adulthood [29]. Schizophrenia is associated with a number of comorbid conditions. In particular there is a strong association with other psychiatric conditions including anxiety, depression and substance use [30]. Schizophrenia is associated with an increased burden of disease and has a greater standardised mortality rate compared to the general population [31]. While this predominantly relates to premature death from physical illness, there is also an increased risk of suicide [32]. The aetiology of schizophrenia remains unclear. While the vulnerability to develop schizophrenia has a genetic basis as evidenced by twin studies, there is likely to be an interplay between biological, genetic and environmental factors [26, 33]. The original concept of schizophrenia as a progressive brain disease or dementia is no longer supported by the evidence, despite cognitive and structural brain abnormalities being found before and subsequent to episodes of psychosis [34].

2.3.2. Presentation

Schizophrenia is manifest by profound disruption in thought, mood, and behaviour. It is associated with changes in perception, speech, and sense of self. There is a fractured relationship with reality. The term schizophrenia is generally applied to a heterogenous syndrome characterised in most instances by onset in young adulthood, long duration with a tendency to recurrence, and symptoms that encompass bizarre delusions and hallucinations, alteration in drive and volition, alteration in neuro-cognition and affective dysregulation [33]. Historically a number of different subtypes were described, but more recent evidence and studies have not supported this distinction [35, 36]. The initial presentation is often preceded by months of social withdrawal and change in behaviour at work and at home. The symptoms of schizophrenia are often referred to as positive (for example perceptual disorder, delusions, disorganised speech, and behaviour), and negative (for example anhedonia, decreased motivation and limited attention). These symptoms respond differently to current treatments [26, 35].

The practical effect of these symptoms is that the person is likely to struggle to maintain self-care, appear distracted and disturbed to others, and to misinterpret the intentions and actions of others. Depending on the type of delusional belief they may be fearful of others, or believe that they possess special powers and are owed special treatment, or that their bodily functions have altered. Most often, those with acute illness present in an extremely distressed state, often confused, perplexed, and agitated. They may be at imminent risk of self-harm, or harm to those around them. In the longer term, those with psychotic illness have an increased risk of suicide compared with the general population [37], and are over-represented among violent offenders [38]. While both suicide and perpetration of violent offences have a low base rate, lesser forms of harm including self-neglect are common.

A common feature of schizophrenia is a lack of insight or a refusal to accept the diagnosis, and consequent need for treatment. Insight is a difficult construct to investigate and understand, but lack of insight could be considered one of the defining features of psychotic illness. With lack of insight, the person does not accept that the phenomena experienced are caused by the illness, and that the associated behaviours or other impacts are directly related to the illness [39] [40]. Lack of insight has been considered both as a defensive mechanism and as a consequence of neurological damage especially to the frontal lobes [41]. However, there is a general consensus that poor insight is a manifestation of the illness rather than a coping mechanism [42]. Amador and David describe insight as a multidimensional concept that includes (1) awareness of mental disorder; (2) understanding of the social consequences of disorder; (3) awareness of the need for treatment; (4) awareness of specific signs and symptoms of disorder; and (5) the attribution of symptoms to the disorder [40]. Gilleen et al conclude that self-awareness has multiple aspects, and contend that this requires a sophisticated approach when trying to address or minimise its impact as part of clinical management [43]. Lack of insight has also been associated with poor treatment compliance and this in turn with increased likelihood of being made an involuntary patient under mental health legislation [26, 44].

2.3.3. Prognosis

Prior to the 1950s, schizophrenia was viewed as a debilitating illness with poor long-term outcome and which required long term institutional care. With the advent of effective antipsychotic medication this view has been modified to recognise that most people with schizophrenia are able to live outside hospital, and only receive treatment as inpatients for limited periods. Notwithstanding that living in the community may be preferable to living in institutional care, many people with schizophrenia will require ongoing support financially and in managing activities of daily life [45]. People with schizophrenia are at increased risk of homelessness, unemployment and poor physical health, all of which contribute to poor treatment outcomes [16, 26]. In addition, the life expectancy of those with schizophrenia is significantly lower than that of the general population and this gap has not lessened in the past decade, despite efforts to improve access to treatment and treatment services [46, 47].

Jääskeläinen et al carried out a systematic review of recovery in schizophrenia, setting a threshold for definition of 'recovery' as improvement in both clinical and social domains that had persisted for at least 2 years [48]. Clinical recovery referred to symptom remission and no periods of hospitalisation; social domains included areas such as living independently, full psychosocial functioning and employment status. They found that only one in seven people with schizophrenia met their criteria for recovery. They found there had been little improvement in this over time, and concluded '*We found no evidence to suggest that we are 'getting better' at getting our patients better'* (p1305). This somewhat pessimistic conclusion is at odds with the findings of recovery outcomes using more consumer oriented definitions which start with an assumption that all people with schizophrenia have capacity to improve and develop a life beyond the diagnosis of schizophrenia [49]. It has also been suggested that personal recovery outcomes may be improved where there is limited insight or awareness of aspects of the illness. A study by Guisti et al considered the relationship between personal recovery, and variables such as psychopathology, insight, and social functioning. They found that a stronger self-perception of recovery was correlated with a lower awareness of the impacts of illness, lower social functioning and more severe symptomatology [50].

Fleischhacker et al concluded that '*owing to the chronic nature of the condition, it affects a person's wellbeing, shortens life and is among the top 10 causes of disability* *globally'* [26] (pS165). Nonetheless, they commented that studies found that up to 50% of individuals potentially had a good outcome in terms of having a fulfilled life and being able to live independently (pS166). Van Os and Kapur concluded that the course and outcome of schizophrenia is characterised by heterogeneity which remains largely unexplained; with less than 50% having a good outcome and less than 50% having a poor outcome [33]. Regardless of the actual rates, it does not appear that there is evidence to support the notion that recovery rates have improved over time [48]. However, it is clear that those with schizophrenia are at increased risk of causing harm, both to themselves and to those around them, and at risk of deterioration in the absence of treatment. It is this nexus between treatment and mitigation of distress, disability and risk that is relevant for those who provide mental health services to people with schizophrenia. If the patient refuses treatment because of a lack of insight with risk of consequent deterioration, then consideration is given to the provisions of mental health legislation that allow compulsory treatment.

2.3.4. Treatment

Although schizophrenia is still poorly understood, and prevention and curative treatment still elude us, there has been progress over recent decades. Antipsychotic medications have been the mainstay of treatment for schizophrenia since their discovery and introduction into clinical treatment regimens. For some patients with very acute psychotic illness, electro-convulsive therapy (ECT) can be faster acting and safer than medication, especially where there is an affective component to the presentation [51, 52].

There is general consensus that pharmacological treatment using either first or second generation antipsychotic medications is the recommended treatment in schizophrenia [26]. The actual medication used, the route of administration and the dose are determined by previous treatment and side effect experience, patient preference, relevant psychiatric and medical history and longer term treatment planning [53]. However, some argue that it is difficult to be confident that oral treatment is complied with by many patients, and that longer acting depot medication should be encouraged [54]. Treatment with anti-psychotic medication has also been associated with reduction in aggression and in suicidal behaviour [26]. Although effective for many people with schizophrenia, the response to medication is often partial. Treatment resistance is least likely early on in the course of illness. The response to treatment lessens with subsequent relapses. Clozapine remains the gold standard for management of treatment resistant schizophrenia, but also has the risk of significant side effects and can only be taken orally [15]. Tiihonen et al concluded that although there may be different risks with first compared with second generation anti-psychotics, any antipsychotic is better than none [46]. Maximising the treatment response of the mental illness is also important for physical health and to lessen the risk of suicide [26].

The tension that remains is how long treatment should be continued after symptom reduction, with many researchers supporting ongoing pharmacological management, but some dissenting and suggesting that longer term outcome is as good or better if treatment is discontinued [53, 55, 56]. Long term follow up studies have shown that some patients who discontinue treatment remain well [57]. These patients were found to have better internal resources, less anxiety, and more positive prognostic features. However, identifying patients who do not need longer term treatment is difficult and most likely to be successful in the context of a trusting therapeutic relationship. In most patients the illness is characterised by relapses when treatment is discontinued, and there is limited evidence to support intermittent treatment [26]. A longer initial period of treatment does not appear to reduce the risk of relapse, which suggests that discontinuation of treatment in clinical practice should be weighed up carefully against the likely consequences of relapse [58]. Ongoing use of anti-psychotic medication is also likely to be associated with longer term health care engagement, and reduction of the risk of relapse. Studies suggest that when the diagnosis is clear and medication side effects can be minimised, a trial of ceasing antipsychotic medications is not recommended [59-61].

Anti-psychotic drugs will have maximum benefit if provided alongside psychological and social supports to provide a combination of health and social care with engagement of the person and their family/carers [26, 62]. Social and psychological treatments have been found to be beneficial [15]. These include family therapy, assertive community treatment, and cognitive behavioural therapy. Improved functional outcomes are more likely with vocational and occupational rehabilitation, and these in turn are more likely to be sustained and effective with ongoing medication adherence [63]. The goal of treatment should be recovery with a focus on optimal outcomes and access to a range of disciplines working to provide an integrated bundle of interventions [26]. The combination of medications and community case management can lead to remission in up to 80% of patients, but this is sustained only if medication is continued [64, 65].

Despite the strong evidence that long term medication reduces the risk of relapse [66], adherence to medication is often low with the average nonadherence rate estimated at about 50%. Non adherent patients are more likely to require hospitalisation, to have poorer long term function, to be violent and to attempt suicide [26]. Van Os and Kapur note that as well as the usual reasons for stopping prescribed medication, people with schizophrenia may be more at risk of non-adherence because of social factors such as the stigma associated with psychotic illness, and biological factors such as the negative impact on motivational drives by the dopamine blocking medications commonly used [33]. Other reasons for low adherence include a lack of information or understanding of the illness, a lack of improvement in symptoms but troublesome side effects, financial difficulty, chaotic lifestyle, or a poor relationship with clinical staff. For those at greater risk of disengagement from services, such as people experiencing homelessness or with substance abuse problems, assertive community treatment (ACT) has been found to be beneficial in supporting adherence to treatment [67-69]. Negative symptoms, cognitive impairment, and use of drugs and alcohol also impede compliance with treatment recommendations. Adherence can be improved by simplifying the treatment regime, use of longer acting injectable medication, and ensuring the consumer is involved to the greatest extent possible in treatment decisions.

2.3.5. Capacity to give informed consent to treatment

As noted above, a common reason for a person rejecting the need for treatment is a lack of insight or acceptance that the thoughts, emotions, and perceptual disturbance experienced are a manifestation of illness and could be ameliorated by treatment.

The relationship between a lack of insight and capacity to give informed consent to treatment is also complex. Capacity is a broad concept linked to the ability to make autonomous decisions about treatment and other issues of personal relevance. Determination of capacity has become increasingly important as mental health legislation and policy move from a paternalistic and harm reduction frame to a greater emphasis on individual rights, personal autonomy, and management of risk [70, 71]. This is especially relevant to implementing recovery-oriented services where personal choice and supported decision making mean that there should be tolerance of a degree of risk associated with decisions that would seem poor to treating clinicians. Okai et al contend that capacity can be reliably assessed and determined for specific decisions, but concede that psychosis, illness severity and treatment refusal are likely to be associated with a lack of capacity [69].

The relationship between insight and capacity in relation to mental health treatment was recently considered in cases before the Victorian Supreme Court and Victorian Civil and Administrative Tribunal (VCAT) with different outcomes – one supporting the view of clinicians that the patient lacked capacity to give informed consent to electroconvulsive therapy (ECT) (HKN v Mental Health Tribunal (Human Rights) [2019] VCAT 825), and the other finding that the patient's understanding of their illness and decision to refuse ECT did not displace the presumption of capacity (PBU & NJE v Mental Health Tribunal VSC 2018 (564). Both cases considered in detail the impact of symptoms of schizophrenia, especially delusions, on the ability to use or weigh information relevant to the decision to accept or refuse treatment. It was noted that the shift from a best interest paternalism to least restrictive care reflected contemporary human rights concepts [72]. There needed to be shown to be a clear nexus between the symptoms of the illness and the decision or choice made by the patient. This is an important area for further study since such legal deliberations will determine where the bar is set for decision making in relation to medication and other treatments such as ECT for severe mental illnesses such as schizophrenia. The debate is a challenging one – with some arguing that article 12 (equal recognition before the law) of the United Nations Convention on the Rights of Persons with Disabilities prohibits all substitute decision making, and others contending that such rigid prohibition would undermine critical rights of those with mental illness such as the right to the highest attainable standard of health [73].

2.3.6. Impact on physical health and social well-being

Schizophrenia, in common with other severe mental illnesses, has a strong association with difficulty in social functioning and problems across a range of physical and psychosocial areas. The Survey of High Impact Psychosis (SHIP) collected data on 1825 Australians with psychotic illness in several states in Australia in 2010 and found that important issues for people with severe mental illness included physical health, occupation, accommodation and relationships with others [16]. Chronic schizophrenia is associated with a cascade of worsening socioeconomic and lifestyle factors such as homelessness, substance use and poor diet, all of which increase the risk of physical illness and consequent morbidity and mortality. People with schizophrenia are less likely to be compliant with treatment for physical illness, or to seek health care. Recognition that people with schizophrenia and other severe mental illness have a worse outcome in morbidity and mortality than those without mental illness is not new [74]. In fact the gap in reduced life expectancy has widened in recent years, despite improvements in overall population health [75]. Recent studies have given little hope that the ultimate outcome, risk of premature mortality, has changed. There remains a substantial gap between the health of people with schizophrenia and the general community, and it appears that the differential mortality gap has increased in recent decades [76]. The lack of progress in this area was confirmed by a large prospective study from Finland which found that the improvements in health outcomes experienced by the general population have not extended to those with severe mental illness [46].

While part of the increased risk of premature death is related to the mental illness, such as increased risk of suicide, more than 60% is related to poor physical health [77]. This in turn is linked to the direct and indirect impact of mental illness and its treatment, such as reduced income, limited exercise, and side effects of medication, including for example weight gain and constipation [78]. But much is also linked to inequitable access and utilisation of health services and of limited health care provision [75]. In an area such as dental health, both the impact of medications and limited access to dental services are associated with poor outcomes [79, 80]. There is some evidence to suggest that engagement in treatment improves access to treatment for physical illness [81] but this is only so if clinicians proactively follow up physical health issues. There is also concern that assertive assessment and management of physical health risk factors and emerging illness is less likely in community settings than in inpatient settings [45].

The SHIP study illustrated starkly the social impact of psychotic illness such as schizophrenia. The survey found that 85% of those surveyed relied on a government benefit for their main source of income. Sixty-three per cent were found to have poor social functioning and 13% were homeless for long periods with a greater number having housing instability [16].

Schizophrenia and other psychotic illness also have a strong association with substance use. A large Danish study found a lifetime prevalence of substance use of 37% in patients with schizophrenia [82]. A recent systematic review found that almost

42% of patients with schizophrenia or related disorders had substance use disorder. The additional diagnosis of substance use was made more often in males and was associated with an earlier onset of schizophrenia. While the prevalence overall had not changed over two decades, the use of illicit substances had increased [83]. There is also a strong association between comorbid substance use and criminal offending in those with schizophrenia. In a large Australian data linkage study Mullen et al found that people with schizophrenia were significantly more likely to be convicted of criminal offending than controls, but those with substance abuse had a disproportionate increased likelihood of criminal convictions for a range of offences, including violent offences [84]. An earlier Australian study found that men with schizophrenia who also had a history of substance misuse were 8 times more likely to be convicted of a violent offence than those without comorbid substance misuse [25].

2.4. Other severe mental illness

Section 2.3 focused on schizophrenia. Other illnesses which are likely to occur in those who receive treatment as compulsory patients under the mental health act include schizo-affective disorder and bipolar affective disorder [85]. These illnesses share features with schizophrenia but have a stronger affective or mood component. Like people with schizophrenia, those with schizo-affective disorder or bipolar affective disorder tend to experience recurrent episodes of illness, and a significant proportion develop chronic symptoms or disability. These illnesses may have an onset from the mid-teens to middle age, but most have their onset in early adulthood – just when the person is undertaking vocational training or tertiary education and developing independence.

A diagnosis of schizo-affective disorder has become more common in recent decades as discussed in a recent review [86]. In this illness the presence of mood disturbance is associated with significant change in thought and perception. A diagnosis of bipolar disorder requires a definite episode of elevated mood as well as a clear episode of depressed mood. The lifetime prevalence is between 1 – 5% [87]. It is often the manic or hypomanic episode that causes the most disruption and is more likely to lead to the person being made compulsory under mental health legislation. In both schizoaffective disorder and bipolar affective disorder, medication is the mainstay of treatment. Most often, patients will require a combination of mood stabiliser and antipsychotic medication. Strategies to improve adherence to treatment are multifactorial but similar to those discussed in relation to schizophrenia. They include having a positive therapeutic relationship, providing evidence-based information to the patient and family, and considering the medication used and route of administration to minimise side effects and promote adherence. It should be noted that often people who present with symptoms of psychosis are given a diagnosis of schizophrenia, schizo-affective disorder or bipolar affective disorder depending on their cross-sectional presentation. It is often only with a longitudinal perspective that a definitive diagnosis is made.

2.5. Carers

This section considers the impact of schizophrenia and other severe mental illnesses on those most involved in the care of people with these conditions. It explores the views of carers on the mental health system and the benefits or otherwise of compulsory treatment under mental health legislation, especially in the community.

The progressive closure of bed-based services, especially longer stay inpatient care, means that most people with severe mental illness receive most of their treatment in the community. But it has also meant that ‘care’ is more often provided by family or other community supports. A number of authors have commented on the tolerance shown by carers of difficult behaviour in the context of their increased exposure related to the move to greater care in the community [88-90]. The impact of the illness is profound for the person but also very significant for family and other close associates.

Bland and Forster emphasise the importance of families in understanding the experience and impact of mental illness [90]. They note that clinical research has considered families as part of the problem in consideration of the aetiology and presentation of mental illness; as part of the solution of where and how care is provided; and as a distinct movement in terms of advocacy and the impact of policy and service delivery models on family and carers. The impact of schizophrenia on families has also been movingly described by authors such as Anne Deveson who wrote about her experience of caring for her son who developed schizophrenia [91]. While ‘carer’ is not synonymous with ‘family’, most studies have found that carers are most often female family members, often older mothers [92]. Consideration of who is impacted by having a relative with a severe mental illness such as schizophrenia, requires appreciation of the family unit (not just parents but also spouses and dependent children) to which the person with an illness belongs [90].

Carers also often report their sense that the treating mental health service failed to recognise the impact of the illness on the family, or include the family in care planning [93, 94]. This is despite successive mental health plans and policies giving greater attention to the role of carers, and their needs for inclusion in both service development and treatment provision. Carers have been instrumental in lobbying for improvement in services through large self-help groups such as the National Alliance for the Mentally Ill (NAMI) in the United States, and Schizophrenia Awareness National Enterprise (SANE) in the United Kingdom and Australia. NAMI was established in 1979 with 300 family members and has rapidly grown since then. SANE was established in the United Kingdom and Australia in 1986 and has continued to campaign for better services for those with mental illness. More locally, the organisation now known as Wellways, began in 1978 as the Schizophrenia Fellowship of Victoria, and later changed its name to the Mental Illness Fellowship. It was created by families and other community members to support the welfare of those with schizophrenia and their families.

2.5.1. The impact of mental illness on family and carers

The impact of severe mental illness on those who provide care, especially when policy and service delivery favour care in the community, has been the subject of considerable research. A number of researchers have sought to develop greater understanding of the impact of caring for a person with a severe mental illness. Fadden et al reviewed the literature on the burden of care and areas of impact on families and concluded that there were real advantages in giving more attention to the needs of carers – both for their own well-being and in order to reduce the risk of relapse of illness [88]. They discussed the impact in terms of carer ‘burden’ and considered the additional tasks that carers undertook, as well as the restrictions on their own lives as a consequence of caring. They noted a number of areas which were impacted such as social relationships, the attitudes of extended family members, and the impact on family finances. The symptoms experienced by the family member also had an impact. The more florid symptoms such as aggression, delusions, and hallucinations, and problematic negative symptoms of apathy and poor self-care were associated with a rating of severe burden.

As discussed by Szmukler et al the concept of ‘burden’ comprised both objective and subjective elements but the relationship between the burden experienced and patient characteristics was unclear [95]. More severe behavioural disturbance was generally associated with greater burden, but negative symptoms were also noted to cause significant distress to carers. Szmukler et al endeavoured to establish a clearer understanding of the dimensions of caregiving through the development of a self-report measure which considered caregiving in a stress-appraisal-coping framework, the Experience of Caregiving Inventory (ECI) [96].

The ECI has been used in a variety of countries and settings. The questions seek the view of the carer regarding the impact of the illness on the person cared for (patient), and on the carer’s life and wellbeing. The ECI has now been validated in a number of studies [97]. Harvey et al used the ECI in a study of 154 relatives as part of a larger UK study. Family members who had a negative appraisal experienced more psychological distress, but there was little correlation between social or clinical characteristics on the level of psychological distress [98]. In general, better social functioning, such as having employment or other occupation is seen as important, with both positive and negative symptoms difficult for family members to tolerate.

2.5.2. The impact of mental health policy and service changes on families and carers

One of the perhaps unanticipated consequences of deinstitutionalisation was the increased expectations on families to provide ongoing care [89]. Those exiting long stay psychiatric facilities often had few options for accommodation, beyond moving back to the family home. Providing care for those with severe illness in community settings has increased the demands and expectations on carers, especially parents of adult children. This is not a recent phenomenon. Even going back to the 1960s in the very early stages of deinstitutionalisation, there was concern regarding increased expectation that care would be provided in the community, and would result in increased burden for the family [99]. Lauber et al noted that a reduction in longer stay admissions would have an impact on the families of those with severe mental illness, and concluded that families should be supported to better cope with disturbing behaviour, including aggression and threats. They noted that family members should be consulted in decisions about whether or not to hospitalise a person who had become or was becoming unwell [100].

The impact on carers of more recent changes in service delivery, especially reduction in bed numbers, has been noted by clinicians and researchers [101, 102]. In many jurisdictions there has been an overall reduction in the availability of mental health services, especially longer stay bed-based services, for those with severe mental illness. This relates to changes in policy such as a move towards care in the least restrictive setting, and greater emphasis on personal autonomy. As previously noted, there has also been a mismatch between population growth, and investment in capital and operational funding for mental health services in many jurisdictions. As hospital admission becomes harder to obtain with the reduction of bed availability, pressure on family members has increased [89].

The progressive reduction in service availability has also placed increased burden on families and other carers to provide not just emotional support but also accommodation and financial support [101]. Some carers complain that as services become more stretched, and admission harder to obtain, they are forced to seek the assistance of police, or to exclude their ill family member from their home [93]. As noted by Benson, the very obvious presence of mental illness among the homeless may reflect the level of family stress and distress that they are unable to support and accommodate their relative with mental illness [89].

Benson notes the importance of having appropriate accommodation options, and that families cannot provide the support needed without having extra support. Yesufu-Udechuku et al found that interventions such as psychoeducation and support groups had a positive impact on the experience of care-giving by carers of people with schizophrenia. They found that carers provide on average 5 to 6 hours per day in providing support. They noted that this is a considerable cost saving (or cost shifting) for governments which previously provided total care to a large proportion of those with severe mental illness [102].

Not surprisingly perhaps, research shows that caregivers are generally supportive of involuntary or compulsory hospital treatment, even if only as a necessary safety net [103]. Getting a loved one into treatment and seeing improvement in their symptoms and level of distress is understandably a desirable outcome. A multi-centre trial found that the strongest association with care-givers appraisal of involuntary hospital admission was symptom improvement [104]. This level of support is less likely when the inpatient admission is of short duration because of the pressure for throughput in a service system under pressure.

The Victorian government established a Royal Commission to consider the current mental health system in March 2019. The Commission received over 3250 submissions and heard from many others at their community forums and through formal hearings. The Interim Report noted that more than 430 family members and carers participated in the community consultations and more than a third of the submissions related to the experience and needs of families and carers [12]. Among the many submissions to the Royal Commission was one from Tandem, the peak mental health carers organisation [105]. The submission notes the distress and frustration experienced by carers who cannot get the access to inpatient services for their loved ones that they believe are needed, and who have to watch while their loved ones deteriorate before they are able to access much needed inpatient care and treatment. A number of other individual submissions also reflected the distress and frustration experienced by family members in trying to get the care they felt their loved one needed.

2.5.3. Carer perspectives on compulsory treatment in the community

The ability to provide compulsory care in the community under a CTO has meant that people who do not accept that they need treatment, and who seek to disengage from treatment, can be compelled to attend appointments and accept treatment, or risk being admitted to an inpatient facility. But increased use of CTOs also places increased pressure and expectation on family and other carers. If the person with a mental illness is likely to have shorter admissions and to be more unwell when admitted, it follows that the family and/or carers will need to provide support and care to a person who is unwell and more disturbed and distressed both before and after admission to an inpatient service.

Research on how family members view CTOs has yielded mixed views. An early study from Oregon found that family members had often been struggling for many years. The typical patient had experienced a number of involuntary admissions, was more likely to be male and to have schizophrenia. The carers were supportive of mandated community care, but only if hospitalisation was available if care in the community was too challenging [106]. More recent studies confirm this view; in general, family members are supportive of CTOs, but only if they are included in decision making and if hospitalisation is available when they believe it is indicated [8, 107-109]. A number of reasons are given for this support. CTOs provide a legal recognition of the need for care, and provide a level of structure and containment, but the care provided is often limited to medical care [110]. Families also expressed concern about the level of help and support available, and that CTOs were used by the treating service as punitive intervention rather than as a carefully considered therapeutic endeavour as part of a more extensive treatment plan [111].

Corring et al undertook a systematic review of qualitative studies that considered the views of families of people on CTOs [109]. They concluded that from the perspective of family members the benefits outweighed the disadvantages. These included the support provided to the person who had an illness as well as support to family members, and the availability of more rapid response when the situation deteriorated. The benefit of treatment adherence with longer periods of remission was noted to have benefits for the family as well as the patient. Families also felt that they were better consulted and more engaged in care when their ill relative was on a CTO. The negative comments were largely directed to the often cumbersome process of getting onto a CTO, and that the support provided was too focused on medication and did not provide sufficient support for housing and occupation that would promote recovery [109].

External review bodies such as the Mental Health Review Board (*Mental Health Act (1986)*) and Mental Health Tribunal (*Mental Health Act (2014)*) are very supportive of family members appearing before them. However, family members may be placed in a difficult situation in relation to hearings by the external review body. They often play an important role in providing ongoing care but may not wish to be seen as supporting involuntary care. An opportunity to contribute is important, but family members also need to know what information will be disclosed at the hearing and the expectations of procedural fairness [93, 112]. They need acknowledgement of their role and the impact of the behaviours associated with severe mental illness, and reassurance that they do not hold full responsibility.

There is no doubt that service availability and the quality of the services play an important part in how carers perceive the mental health service system. The papers considered in this section show remarkable consistency in how carers view compulsory treatment. They want their loved one to have access to good services, with continuity of care and provision of more than narrow medication management. They support the use of compulsory care in the community if it results in longer periods of well-being, but also want hospitalisation to be available when required. They want to be informed and consulted. They do not want to see their loved one incarcerated or homeless because treatment and appropriate supports for those with mental illness were not available. The extent of the shift of responsibility from State to community/family with the massive reduction in bed numbers during previous decades, and the impact this has had on families has not been sufficiently acknowledged and recognised by service providers.

The views of people who are made subject to a CTO are more generally more negative than those of carers or clinicians, but are still mixed. Studies have generally taken a qualitative and/or semi-structured approach through interviews and focus groups. Gibbs et al interviewed 42 patients who had been subject to a CTO in New Zealand and found the majority supported the CTO and found it beneficial. Benefits cited included being able to stay out of hospital for longer, better access to treatment, improved general health and even that the CTO was lifesaving when they were contemplating suicide [113]. Often a degree of ambivalence is reported. Patients may accept that the structure and consistency was beneficial and that there were overall improvements in aspects of their life, but still dislike the experience of coercion and being labelled mentally ill [114, 115]. Stability, and acting as a ‘safety net’ were also themes in the research by Stroud et al in a NHS trust [110].

2.6. Mental health policy and plans

This section provides an overview of mental health law and policy over the past fifty years, particularly the shifting emphasis from medical to legal oversight and influence, and the move from institutional to community care. Government policy to move from institutional care to care in the community resulted in many improvements but has also been the subject of considerable criticism, including that there has been a lack of funding to provide adequate resources to those living with severe mental illness in the community. As discussed by Jones, it was not necessarily that the place of care was bad or that the motives of those who provide the care was suspect, but too often that funding and capacity were manifestly inadequate [116].

How the shift from bed based to community based services played out in different countries has been the subject of much debate, with concern that in some cases the major change was a loss of funding, with subsequent decline in care, while in others substantial new services were created [117]. These changes and related criticisms apply to the United Kingdom, United States of America, and Australia.

The shift to community care was particularly rapid in Victoria Australia, and was accompanied by legislative provision for compulsory care in the community. These changes have occurred contemporaneously with an increased focus on human rights. There has been progressive refinement of how human rights should be considered and included in civil legislation and policy relating to those with mental illness. The Victorian *Charter of Human Rights and Responsibilities (2006),* and the ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2008 significantly impacted mental health law and practice in Victoria, Australia and elsewhere [4, 118, 119].

Alongside these changes in public policy in Victoria, there has been significant change in Ministerial responsibility and levels of investment in clinical mental health services. There have also been a number of inquiries critical of mental health services, and associated government planning and policy documents. The increased focus on person centred care and patient choice has shifted the balance of decision making from the primary or treating practitioner to the person, their family and external review bodies. The growing influence of the recovery movement championed by consumer groups has also played an important role in how services are delivered. These issues are discussed in the following sections.

2.6.1. Shift from institutional care to community

In the United Kingdom, United States of America, and Australia there was a rapid reduction in the numbers of people housed in the stand-alone institutions and the funding allocated to these services from the 1960's onwards. The policy (or movement) to reduce the size and number of stand-alone psychiatric institutions and to shift care to community settings, was influenced by the pragmatic problems of overcrowding in the institutions, population growth, and a failure of investment to maintain the facilities with resultant reduction in standards of care [117]. The period was also marked by socio-political activism which challenged authoritarian institutions and the management of those with mental illness, as well as the introduction of more effective treatments which allowed for treatment in less institutional environments [116, 120-124]. The medical paradigm was challenged, reinforced by exposure of mis-treatment and over-use of intrusive and damaging treatments and restrictive interventions [125].

The changes in policy were accompanied by criticism and allegations of abuse while under institutional care, such that reformers were in general supportive of the move to increased care in the community. In 1961 the then Minster for Health in Britain, the Hon Enoch Powell made dramatic assertions that over 15 years the number of places in hospitals for those with mental illness would be reduced by half [126]. A further United Kingdom Government paper in 1971 proposed abolition of the stand-alone mental hospitals and a shift to smaller district hospitals alongside community based social services. The move to provide health services in different locations would be accompanied by growth in day services, community workers and other supports to provide 'community care' [127]. In the United States of America a Joint Commission was established to provide recommendations on the future of the institutional asylums [128]. This led to the development of a federal mental health program championed by J.F. Kennedy which resulted in a shift from state run institutions to federally funded community health centres. Similar changes occurred across Australia, further supported by the National Mental Health Strategy agreed to by all health ministers in 1992. This incorporated the National Mental Health Policy, Statement of Rights and Responsibilities, and First National Mental Health Plan [129, 130].

However, the implementation of community care was uneven, and the promises held out of decreased need for more intensive services not always realised. The shift from bed based to community care drew attention to just how many supports had been provided in the institutions, and the need to find substitutes or replacement in community settings. As described by Fuller Torrey, the changes came with great optimism but little real understanding of all of the functions which hospital based care had provided [128]. Many people with severe mental illness discharged into the community had high support needs beyond medication which were difficult to obtain and which both directly and indirectly hampered recovery from illness [131] (p145). In particular stable accommodation, adequate occupational opportunities, and financial and personal capacity to maintain physical health often still eluded those with severe mental illness [127].

Overall, the intended move to community care, was accompanied by an increased appreciation that community services cannot completely replace inpatient care, and cannot achieve the desired outcomes of access to treatment and social stability without investment in a range of clinical and support services [132-134]. As summarised by Petrila and Swanson regarding the impact in the United States of America:

The new medicines proved less than magical; life in the community failed to cure schizophrenia; and President Reagan effectively defunded the community mental health centres that had been initiated by President Kennedy's administration. People with serious, disabling psychiatric conditions emerged as an increasingly visible element in every urban community in the United States of America. They revolved in and out of acute psychiatric hospitals, were chronically unemployed, sometimes homeless, and not infrequently came to the attention of the police and the criminal justice system. Some of them failed to recognize their need for treatment. Others sought treatment that was increasingly difficult to access [135] (p13).

Australia followed the direction of international reforms in reducing the size and number of bed based services for those with mental illness, drug and alcohol dependence and intellectual disability [117]. These three areas of health and community services became increasingly separate from each other in terms of workforce, ideology, and relevant legislation. Victoria was (and remains) the only state in Australia that closed all the stand-alone institutions other than the forensic service. Victoria made the shift to community services more completely than other states as shown in the Mental Health Services report by the Australian Institute of Health and Welfare (AIHW) [3].

While previously legislation had sought to segregate people with mental illness to provide more humane treatment and care, concerns about wrongful detention led to more stringent criteria and processes, and a greater emphasis on protecting the rights of those who were detained. Nonetheless, there has been continued community support for specialised mental health legislation that provided for the care and treatment of people with mental disorder in circumstances where the person was unable or unwilling to give consent [136]. As described by Glover-Thomas, the policy imperatives that have accompanied the changes described above have been polarised between the '*two viewpoints of legalism (or liberalism) and medicalism (or welfarism)'* [131] (p2). Those supporting greater legal controls argue that the medical profession cannot be trusted to act in the best interest of the patient, and question whether 'best interests' should have primacy over rights; supporters of greater medical oversight point to the importance of medical discretion and judgement, and their concern that legal rules limit therapeutic interventions based on evidence and experience [116]. Community support for different models of treatment has also wavered with support for the medical model when it appeared to hold out hope for cure or prevention, and a withdrawal of support when the emphasis reverted to social control and custodial care, even if not in institutional settings [131]. Medical training has also changed with increased emphasis on consideration of ethical practice, beneficence and personal autonomy and agency.

Justification of treatment and detention has generally hinged on a need for protection of the patient or others that would be achieved if indicated treatment was provided [137]. Concern has been raised that the increasing emphasis on risk of harm to self and others perpetuates and worsens discrimination against people with severe mental illness [137, 138]. As will be discussed later, increasingly decisions regarding whether people meet criteria for involuntary or compulsory treatment are shifting from clinical staff to 'independent' external Boards or Tribunals [138, 139].

Jones, who studied the legal and policy approach towards those with mental illness over the centuries, said in 1980: 'Law cannot cure the mentally ill. Law cannot fully protect the mentally ill. It can only provide the enabling framework…. within which good policies can develop. Beyond that, it is counterproductive, creating fear, secrecy and deception' [116]. She also noted comments made a century earlier by Dr Mortimer Granville that the lack of personal touch and lack of money were the real evils rather than insufficient safeguards for personal liberty. She contends that while there have been cycles of more or less legal restraint on clinical discretion, what has not been tried because of lack of investment is good community care (p14). Weller contends that "However pragmatic or necessary compulsory health care may appear in the short term, the analysis of such schemes should proceed from the assumption that a resort to coercion represents a failure of care" [140] (p30).

The shift from bed-based care to community care was supported by changed emphasis in mental health legislation. Compulsory care was only to be used as a last resort and care should be provided in the 'least restrictive' way which was interpreted as meaning that care in the community is less restrictive than that in inpatient settings. The two sectors (inpatient and community care) do not operate in isolation. A reduction in inpatient capacity has important ramifications for both the effectiveness of inpatient care and the effectiveness of community care. Both impact on the use of legislation to impose treatment [141]. If the threshold for acceptance into care rises because of comparative reduction in capacity, or if less intensive care is favoured over more assertive resource intense interventions, people will tend to present later in the course of an illness and be more likely to require treatment under mental health legislation. More recently, Canadian and Australian researchers have re-considered the importance of having sufficient numbers of inpatient beds and the impact on a number of key service and patient outcomes [142].

2.6.2. National and state policy and plans

As noted above, in 1992 Australia developed a national mental health strategy with bipartisan agreement and collaboration from all states and territories. The National Mental Health Policy, Statement of Rights and Responsibilities, and First National Mental Health Plan made up the strategy [130]. These set the scene for more locally developed policies and service system structures. Victoria was among the first of the states to develop a cohesive policy and service framework which resulted in massive changes in where and how those with mental illness received treatment and care [143]. A key element of both the national strategy and the Victorian framework was that care should be provided in the community whenever possible. To support this, there was rapid growth in community mental health services with development of specialist teams. These included teams to deliver urgent out-reach services in the home (Crisis Assessment and Treatment Teams; CATT); clinic based continuing care (CCT); and intensive longer-term home-based treatment (Mobile Support and Treatment Teams; MSTT). All were linked to area based inpatient services. In the decades since the First Plan and Victorian Framework, there have been a number of revised plans and policy documents (Table 2.1; Figure 2.1).

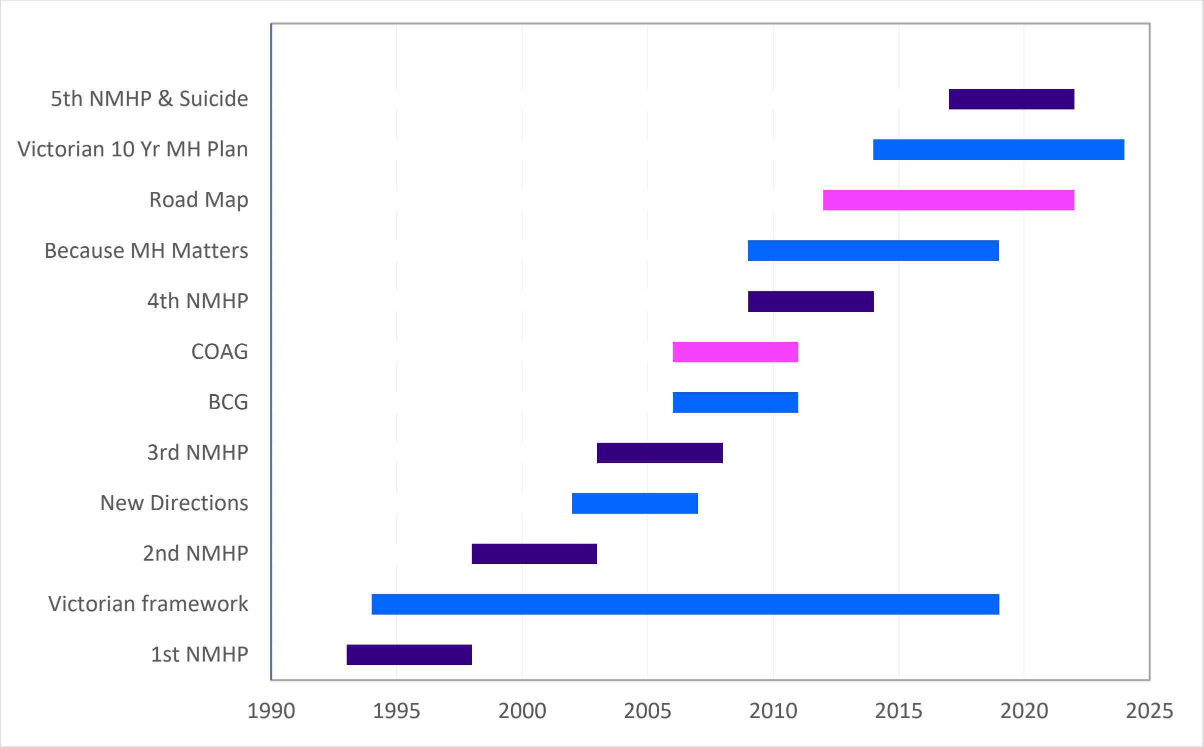
Table 2.1. National and state plans and policy documents

Year	State (Victoria)	National	Priorities
1992		1st National Mental Health Plan (1993–1998), National Mental Health Policy, Statement of Rights and Responsibilities 1993-1998	Consumer rights Relationship between mental health and general services sectors Linking mental health with other sectors Primary care services Carers and non-government organisations Mental health workforce Research and evaluation Monitoring and accountability.
1994	Framework for Service Delivery		Age based, area based, mental health services Mental health services integrated with acute health services Care in the community – CATT, MSTT, CCT Case management
1998		2nd National Mental Health Plan 1998–2003	(in addition to 1st National Mental Health Plan) Promotion and prevention Partnerships in service reform and delivery Quality and effectiveness
2002	New Directions for Victoria's mental health services: the next five years		Priority to those greatest in need Care in the community Consumer and carer participation Service quality and responsiveness Continuity of care Expanding service capacity Creating new service options Extending prevention and early intervention Building a strong and skilled workforce Long term planning for mental health services

Year	State (Victoria)	National	Priorities
2003		3rd National Mental Health Plan 2003–2008	(in addition to 2nd National Mental Health Plan) Dual diagnosis Underserved populations
2003	Demand Management Strategy for mental health services in Victoria		Strategy to support the New Directions priorities
2006	Improving mental health outcomes in Victoria: the next wave of reform. Boston Consulting Group report		Access to consumer-focused clinical services for all those in need Connectedness between component parts Prevention and early intervention Local partnerships and accountability
2006		Council of Australian Governments (COAG) – National Action Plan for Mental Health	Promotion, prevention and early intervention Integrating and improving the care system Participation in the community and employment, including accommodation Increasing workforce capacity Coordinating care
2009		4th National Mental Health Plan 2009–2014	Social inclusion and recovery Prevention and early intervention Service access, coordination and continuity of care Quality improvement and innovation Accountability – measuring and reporting progress

Year	State (Victoria)	National	Priorities
2009	Because Mental Health Matters 2009–2019		Promoting mental health and wellbeing Early in life Pathways to care Specialist care Support in the community Reducing inequalities Workforce and innovation Partnership and accountability
2012		Roadmap for National Mental Health Reform 2012–2022	Promote person-centred approaches Improve the mental health and social and emotional well-being of all Australians Prevent mental illness Focus on early detection and intervention Improve access to high quality services and supports
2013	Victoria’s Priorities for Mental Health Reform		Reform of MH legislation Strengthening of clinical mental health services Improving community mental health support services Increasing connections between MH services and other services Widening prevention and promotion Building a stronger more sustainable mental health workforce

Year	State (Victoria)	National	Priorities
2015	10 year Mental Health Plan 2014–2024		Mental health and wellbeing Equality in emotional and social wellbeing Close the gap Reduce the suicide rate Early in life Best mental health at all ages Families and carers Services that emphasise respect, safety, choice and recovery Inclusion and participation Self-management Universal access to public services Access to specialist mental health services
2017		5th National Mental Health and Suicide Prevention Plan 2017–2022	Achieving integrated regional planning and service delivery Effective suicide prevention Coordinated treatment and support for people with severe and complex mental illness Improving Aboriginal and Torres Strait Islander mental health and suicide prevention Improving the physical health of people living with mental illness and reducing early mortality Reducing stigma and discrimination Making safety and quality central to mental health service delivery Ensuring that enablers of effective service performance and system improvement are in place



* Victorian state plans. **Australian Health Ministers. ***Council of Australian Governments (COAG)

(BCG = Boston Consulting Group; NMHP = National Mental Health Plan)

Figure 2.1. Successive plans at state*, national health ministers and first minister (Prime Minister and state and territory premier)*** levels**

Australia now has its Fifth National Mental Health and Suicide Prevention Plan [144], and Victoria has had a series of policy and service planning documents, largely driven by change of political leadership [13, 145]. Common to these policy documents has been the continuation of a drive to provide care in the community and an emphasis on early intervention, and on the active participation of consumers and carers in their care. There has also been an expansion of interest from mental illness to mental health and wellbeing. As stated by the Department of Health in the National Mental Health Report 2013:

> *In terms of mental illnesses, the remit of the* Second Plan *was broader than that of the* First Plan*; it moved beyond the severe and disabling disorders that are typically treated in state and territory funded services, and also considered more prevalent conditions like depression and anxiety. It also fostered important partnerships – between the public and private sectors, between specialist services and primary care*

providers, and, more broadly, between the health sector and sectors outside health that have an influence on people's lives.

The Third Plan *set out to consolidate the achievements of the previous two plans by taking an explicit population health approach and reaffirming an emphasis on the full spectrum of services that are required to assure the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation' [146].*

The *Fourth* and *Fifth Plans* have continued this broad approach but have also focussed on particular areas of current or emerging service gaps as noted in Table 2.1. There has been concern that by widening the areas of focus in each Plan the actual reform and improvement of services is diluted [147]. Australia now invests a considerable portion of mental health spending in psychological therapy for those with mild to moderate illness, but this has come under criticism in academic journals and the broader media [148, 149].

Another change at both federal and state levels has been the development of a ministerial portfolio for mental health, often combined with other ministerial responsibilities such as disability and child protection. The separation of ministerial responsibility for mental health from Minister for Health to Minister for Mental Health has further focussed attention on community rather than hospital care [150]. In Victoria, a major policy and planning report – 'Because Mental Health Matters' – was released in 2009 after extensive consultation under the oversight of the first Minister for Mental Health [13]. It was wide ranging and ambitious in its coverage and was intended to set out government policy for the next ten years, but was largely abandoned with a change in government in 2010. In 2015 another plan was released which included very little mention of severe mental illness or the clinical mental health sector [145]. While both documents made reference to the importance of an integrated system and access to the care in the most appropriate place, there was little mention of inpatient care, or the need for treatment under the protections of mental health legislation.

2.7. Compulsory care in the community

The move to community-based care has been accompanied by new forms of coercion – both direct through the development of legal frameworks such as CTOs, and indirect through assertive community treatment. In some jurisdictions, welfare payments, parole conditions, housing etc can be linked to compliance with recommended treatment [151] [152]. Sometimes voluntary treatment is negotiated, but with an understanding that an order will be made if the person does not comply.

As noted in a previous section, most people who are made subject to compulsory treatment have a psychotic illness such as schizophrenia and related conditions [153]. In many cases these are recurrent and relapsing illnesses. The most effective management is a combination of medication and psychosocial support. Both need to be ongoing to minimise the risk of relapse and associated loss of functioning. Regrettably, the most effective interventions and support are not always available or accessed by people who need such services [154]. While every effort should be made to support people to voluntarily adhere to prescribed treatment such as through provision of education and information, minimising side effects, or simplifying the treatment regime, there are a number of people who repeatedly cease taking treatment and experience a serious relapse of the illness. There are many reasons why people stop treatment, but in severe mental illness, an additional reason is lack of insight resulting in false attribution and failure to recognise that the symptoms experienced are manifestations of an illness [42]. Untreated psychosis may be associated with self-neglect or disturbed behaviour with risk of aggression to others. These are most often the reasons compulsory treatment is instituted.

The treatment and oversight of people with severe mental illness in the community has attracted debate and discussions for many years. Before CTOs were established, mental health legislation provided for conditional leave, but that was for people who had been an inpatient, and even if the leave was for an extended period, it was still linked to an inpatient admission. As described by Churchill et al, CTOs are qualitatively different from conditional leave because they 'enforce compulsory treatment *outside (and independently) of the hospital,* contain specific mechanisms for *enforcement and/or revocation* and are authorised by *statute'* [8] (p20. Italics in original). Churchill et al describe the different types of legislative frameworks which include CTOs, dividing them into those which include a 'least restrictive' criterion (where the criteria for hospital and community orders are the same, but the CTO is a less restrictive alternative); and 'preventive' (where the criteria for hospital and CTOs are different and the CTO is to prevent deterioration which results in dangerousness). McCafferty and Dooley provide a definition of CTO as: '*A legal mechanism by which people with mental health problems who need treatment are compelled to submit to treatment on an outpatient basis'* [152]. But there has been considerable debate regarding whether they are a legal mechanism to reduce risk to the community , or a medical intervention with health benefits for the individual [8]. In general those who are responsible for making CTO, generally psychiatrists, are positive about their usefulness and effectiveness for those patients with severe mental illness who are at risk of non-compliance with treatment, or who have previously effused treatment with negative consequences [155]. This has been found across jurisdictions including Canada, [114] New Zealand, [156] Norway, [157] England and Wales, [158] and Victoria, Australia [159].

2.7.1. The ethics of compulsory treatment in the community

There has long been debate about whether the shift from institution to community care has translated into more or better quality care. This debate has occurred in parallel with a shift in emphasis from an expectation that the treating clinician should provide care to meet the person's clinical needs, to one of greater consideration of patient's rights. Mulvey et al, writing in 1987, contended that the shift to community care re-framed but did not resolve the basic problems connected with providing care to alienated patients with chronic mental illness [107]. At that time statutory provisions to enforce treatment existed in a number of states in the USA but were rarely used. But homelessness amongst people with mental illness and readmission rates were rising. Mulvey et al put the issue and problem very neatly: '*Involuntary outpatient commitment represents the most recent effort to address a long-standing problem – balancing individual rights and the state's duty to provide treatment to those individuals too disturbed to request it'* (p572). They note the underlying rationales of parens patriae under which the state is obligated to act in the best interests of those who lack capacity, and police power under which the state has the obligation to protect citizens by restraining the freedom of identifiably dangerous individuals.

The early concerns about compulsory community treatment included that this would be nothing more than benevolent coercion – a form of social monitoring without the necessary resourcing to make this actually beneficial. The social monitoring might extend to more intrusive actions invading the privacy of those under supervision such as monitoring the use of drugs and alcohol, welfare status, or family and other associations [151, 160, 161]. There was also concern that community care is less visible and less expensive than inpatient care which is overseen or observed by a number of professional, legal, and social advocacy bodies. Another early concern was that involuntary treatment in the community would take away the main therapeutic tool of those who work with alienated people in the community – trust [156]. The therapeutic relationship is based on trust, and an understanding that the intervention is meant to be helpful – not a monitoring or police function.

Mulvey et al conclude that for those opposed to compulsory community treatment, the potential costs in civil liberties and professional identity are too high [107]. Those who argue against CTOs point to the lack of a solid evidence base, the risk that CTOs bring greater overall compulsion and a concern that CTOs will lessen a focus on funding and finding solutions for voluntary support and treatment. Arguments have also been made that CTOs may focus resources on the few rather than the many, or that having a CTO in place may lessen the intensity of effort by community services to engage with their patients who have more complex presentations and needs [162, 163]. In addition, there is the over-riding concern that CTOs violate the right to determine and control one's own treatment decisions.

Those who support compulsory treatment in the community argue that treatment can and will be provided to those who most need it, and that sufficient oversight can be put in place to ensure there is not abuse of civil liberties [164, 165]. They also argue that treatment in the community can be linked to a wide range of other interventions of benefit to the person, and bring a more holistic approach with improved longer term outcomes [81, 166, 167].

Fennell contends that the prime driver of social policy and the raison d'etre of mental health legislation is the management of risk [71]. He goes on to suggest that *'risk management justifies legislative mechanisms in overriding a person's refusal to accept admission to hospital or treatment for a mental disorder'* (p15). The type of risk considered includes deterioration in self-care, increased risk of self-harm and risk of harm to others, often in a domestic context. It should be noted that although many people are deemed to meet criteria for involuntary treatment, only a small number of those with severe mental illness commit serious crimes [25]. The opposing argument is that CTOs are not about reduction of risk but should be seen as an option in the provision of humane community-based care. The middle ground is to place limits on what treatments can be enforced and to have good external oversight of the process.

These are real concerns, especially the fear that CTOs have meant that hospitalisation has become an undesired outcome – even though better assessment and stabilisation may only be possible in the structured and better staffed environment of an inpatient unit. CTOs may have also enabled reduced funding for mental health services, especially assertive community engagement, while imposing greater responsibility on clinicians to minimise risk and enhance the physical health of those with severe mental illness through coercion. In the face of CTOs being continued or included in mental health legislation, the question has shifted from whether CTOs are ethical to whether they are effective [168]. There is also growing debate about what form of research is best suited to determine effectiveness and whether a more nuanced research agenda should be pursued [169].

2.7.2. Evidence for effectiveness

The literature regarding CTOs effectiveness is varied and often polarised. An enduring problem has been the limitations of the methodology used to research the effectiveness of CTOs [168, 170]. It is difficult to get around methodological issues such as an inability to conduct a randomised control trial of a legally mandated coercive intervention [171]. There are also other factors which weigh heavily on whether CTOs are seen as effective or not, such as whether re-hospitalisation is seen as a positive event or a failure of treatment, the impact and role of family members, and the stability of housing options [172]. Research attempting to compare jurisdictions which do allow CTOs with those that don't also struggles to determine whether having provision for CTOs makes a difference, or whether other factors such as intensity of intervention and ability for earlier intervention are more relevant [151, 173].

A limited number of randomised controlled trials regarding CTOs have been carried out, each with slightly different methodologies and in different legal and social contexts. These did not find that CTOs were effective in terms of reducing subsequent hospitalisation, although they suggested that if the CTO is of longer duration then hospitalisation may be reduced [174-176]. The most recent randomised controlled trial (the Oxford Community Treatment Order Evaluation Trial; OCTET) claims to support the lack of evidence for effectiveness on a range of outcomes, but compared two variants of involuntary treatment in the community, with movement allowed between streams [177].

Segal et al considered the use of CTOs after the first episode of hospitalisation using the CMI/ODS Victorian data set[2] and concluded that for those treated under a CTO there was a reduction in subsequent inpatient care, but noted that they were unable to include a number of factors that may have influenced this such as availability of family care and other service options [166]. There have been a number of smaller studies considering different aspects of treatment provided under a CTO, such as those by Muirhead et al [178] and Owens and Brophy [179] which considered use of depot medication and the impact of revocation respectively. Swartz et al suggested that CTOs of longer duration resulted in reduced admission, especially if linked to assertive community treatment [176, 180]. A study using the Victorian CMI/ODS data set and another from Toronto, Ontario which has a very different CTO regime, also suggested that a longer duration of CTOs resulted in decreased risk of readmission [181, 182]. While acknowledging that medication adherence is difficult to monitor, it also appears that being on a CTO and especially being on a CTO of longer duration is associated with improved medication adherence [175, 180].

Recent research has provided more concrete support for a difficult proposition, namely that CTOs are effective in that they increase engagement in the community and do delay readmission, but only while in force [183]. Harris et al noted that while on a CTO, patients had more community contacts. In a debate article which followed, Ryan argued that under most current legislation, if the person has capacity then they should be able to exercise that capacity to refuse treatment [184]. This seems to represent the crux of the issue. Clinicians agree that CTOs are effective and they use them frequently [165]. Mental health legislation tries to put a balance on the threshold for imposing compulsory treatment and uses words like ‘immediate’ and ‘serious harm’. But from a practical operational perspective, a person cannot be moved from compulsory to

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[2] The Department of Health Victoria administers the Client Management Interface/Operational Data Store (CMI/ODS) data system that records all registrations and contacts with state-funded mental health services. The CMI/ODS records basic demographic information about patients as well as detailed information about the use of mental health services.

voluntary status from day to day; there needs to be a reasonable time frame in which treatment is provided and engagement encouraged. As a CTO may be made for up to twelve months, ‘immediate’ is generally linked to the risk of relapse rather than to actual relapse. Consideration of capacity includes that a person can retain information and reach a decision that is sustained over time.

The general conclusion from the research on CTOs seems to be that more studies should be done to understand the service processes that may impact on how a CTO is used rather than their effectiveness or outcomes. Swanson and Swartz opine that the current evidence of effectiveness is sufficient to justify implementation of CTO and that the gold standard of randomised controlled trial will never be fulfilled [185]. In a similar vein, Mustafa notes that there is a difference between the experience of randomised trials and real-world situations where patients are at greater risk of non-compliance [186]. Barnett et al suggest there should be greater attention to treatment adherence, and greater investment in providing more accessible and effective community care. They also recognise that it is possible that some groups who are typically excluded from randomised controlled trials because they have more severe illness may benefit more [187]. Consideration of the challenges in researching CTOs led O’Reilly and Vingilis to propose that a range of research designs are relevant and we should not rely solely on randomised controlled trials [174].

2.7.3. Literature reviews of Community Treatment Orders

The literature on CTOs has been extensively reviewed over the past decade [8, 174, 187-192]. Probably one of the most influential of these reviews was the paper considering international experiences of CTOs by Churchill et al [8]. This work was carried out in the context of a proposal for reform of mental health law in England and Wales that would introduce a framework for compulsory care in the community. The authors considered 72 studies from between 1966 to 2005. Their paper found little evidence to support CTOs but noted the many confounding factors that made trying to compare a variety of regimes difficult, the limitations of the empirical work done to date and the scarcity of any truly comparative studies. Churchill et al noted that while the legislative regimes may differ there was a remarkable consistency in the type of patient who was placed under a CTO. The paper noted that some regimes focussed on the CTO being a less restrictive alternative to hospitalisation, while others emphasised that the

CTO was being used to prevent further relapse and deterioration. In a practical sense there is likely to be overlap between these rationales.

Dawson described the different regimes in place across the USA, Australia, New Zealand and the UK and the variation in utilisation [193]. CTOs have also been considered using the Cochrane methodology by Kisely et al in 2005 and again in 2011. The number of studies that met criteria for inclusion was very small, and most had small sample sizes [188, 189]. The authors noted the limited number of studies and concluded that there was little evidence for effectiveness on outcome indices such as health service use, cost, social functioning, mental state, or satisfaction with care. A literature review in 2009 again highlighted the equivocal results of research and methodological problems. The different views held by clinical staff compared with service users was noted, as was the shifting focus on risk to the community rather than access to treatment and the rights of the service user [194]. The authors comment that a CTO is of itself not an intervention, and any impact is likely to be highly dependent on the service system and supports available. They note the ethical overlay associated with CTOs and the impact this may have on how they are perceived and used by clinicians.

A review was published in 2014 by Maughan et al who are also involved in the OCTET study in the UK in 2014. They sought to update the review carried out by Churchill et al but found little change in the outcomes described [190]. Again, the findings were conflicted, with some studies showing increased rates of readmission and others reduced rates. Maughan et al concluded that there was no consensus of evidence that CTOs are associated with any particular outcome other than improved medication adherence [190]. They did not comment on what a desirable outcome might be (e.g. whether it is preferable that people experiencing a relapse are admitted earlier rather than later in the course of the relapse; or whether re-hospitalisation might be a positive if it involves reducing the impact and lasting effect of the relapse). They did note the apparent association between duration of CTOs and outcome as indicated in the studies referenced above. The authors also pointed to the difference between a ‘recall’ or brief admission during a CTO, and ‘revocation’ or discharge from the CTO, and suggested that further studies should focus more on the process separately from the outcome of the CTO. They noted that the literature does not distinguish between types of readmission or the reasons for admission and cited similar problems with community contacts as a proxy for engagement. One study in their review did suggest that CTOs were associated with reductions in crisis and routine community contacts [195] but others did not make such a distinction. Maughan et al concluded that there is a lack of differentiation between CTO process (community engagement, recall) and outcome (revocation, subsequent hospitalisation) in the studies to date [190].

The review literature was taken a step further by the systematic review and meta-analysis by Barnett et al [187]. They considered readmission and engagement with community care, and while no significant difference was found in contemporaneous controlled comparison studies (both randomised and non-randomised), they found large effects in pre and post studies on readmission, use of community services and compliance with treatment. The authors noted the heterogeneity between studies but appeared to conclude that there was less validity in the pre and post studies because of risk of confounders such as regression to the mean. Their final conclusion was to support the position that the evidence does not support compulsory community treatment.

Alongside these extensive literature reviews, are the hard facts that CTOs are used, used in greater numbers than anticipated, and that there is no sign that their use is decreasing [11]. There is also a growing literature expressing the concerns of clinicians who use CTOs and who are discombobulated by the repeated research that rejects the efficacy and utility of CTOs, in contrast to their clinical experience [165, 196, 197].

In summary, although there are a number of qualifying issues, it appears from the literature that CTOs, especially if of longer duration, are associated with reduced hospitalisation, and improve medication compliance while in force. The strengths of the research to date is that it has included a number of different methodologies including longitudinal, case based, and randomised controlled trials. The weaknesses include the potential biases introduced in some studies and the varied nature of CTOs under different legislative regimes and in different mental health systems. Despite many research attempts to establish whether or not CTOs are effective and when or how they should be utilised, the literature remains conflicted and polarised.

2.8. Rights and recovery

The changes to mental health law and policy described in the previous sections have occurred contemporaneously with an increased focus on human rights generally, and specifically for those with a disability, including disability secondary to mental illness. There has been progressive refinement of how human rights should be considered and included in civil legislation and policy relating to those with mental illness. The National Mental Health Strategy incorporated the Mental Health Statement of Rights and Responsibilities [130]. The enactment of the Victorian *Charter of Human Rights and Responsibilities Act (2006)* and ratification of the United Nations Convention on the Rights of Persons with Disabilities significantly impacted mental health law and practice in Victoria, Australia and elsewhere [4, 118, 119]. The Convention included a number of articles relevant to those with mental illness and associated psychosocial disability. The increased emphasis on rights has also meant that there is a shift from 'best interests' which is seen as being paternalistic, to a stronger focus on perceived or predicted risk as the justification of imposing restrictions on autonomy and compulsory treatment [198].

2.8.1. The rise of rights

As noted above, in 2006 the Victorian parliament passed the *Charter of Human Rights and Responsibilities Act (2006)* which established the expectation that all other Acts of parliament should be consistent with the values and rights espoused. The Charter contains twenty basic rights that Government and other public authorities (such as health services) should consider in the development of laws, policies, and service delivery. Those relevant to mental health services include the right to freedom of movement; right to recognition and equality before the law; right to protection from torture and cruel, inhuman or degrading treatment; right to liberty and security of person; right to humane treatment when deprived of liberty; and right to a fair hearing. The charter provides that in certain circumstances, some rights may be limited. But any limitation must be lawful, necessary, reasonable, proportionate, logical and demonstrably justified [118].

Australia also supported the values espoused in the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, although this was criticised for being overly paternalistic and failing to uphold autonomy [199, 200]. A more significant shift and one that has ongoing potential to change much in mental health law and policy is the United Nations Convention on the Rights of Persons with Disabilities [4] which Australia ratified on the 17th July 2008. The ratification was associated with a declaration that:

Australia recognises that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards;

Australia recognises that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards;

Australia recognises the rights of persons with disability to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others. Australia further declares its understanding that the Convention does not create a right for a person to enter or remain in a country of which he or she is not a national, nor impact on Australia's health requirements for non-nationals seeking to enter or remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria [201].

The significance of the Convention on the Rights of Persons with Disabilities (the convention) is that it is a formal convention rather than a set of guiding principles, and thus informs international law. The convention brings the rights of people with disabilities within the scope of human rights more generally. The convention endeavours to re-articulate rights found in many other treaties in a way that has practical meaning for people with a disability, and explicitly includes those with psychosocial disabilities caused by mental illness [202, 203].

As noted by McSherry, the convention merges civil and political rights with economic, cultural and social rights, and rests on a social rather than medical model of disability [204]. An important shift in perspective is that the convention provides that it is <u>up to society to change</u> to minimise discrimination, rather than expect the person with the disability to modify their behaviours or expectations to fit in with society. Non-discrimination is a core value such that disability is seen as a consequence of inadequate social responses to the needs of an inclusive community [202, 205]. The drafting of the convention was significantly influenced by the involvement of non-government organisations.

The convention has influenced how care and treatment are provided to those with a disability and has supported a transition from welfare and care, to reconceptualise disability as a matter of human rights. The convention shifts the discourse regarding capacity in that it creates an assumption that all adults, including those with a disability, have legal capacity. There is an expectation that support will be provided to enable people with a disability to exercise their legal capacity. In the context of provision of treatment for severe mental illness, this 'right' and expectation sits uneasily with coercive care initiated in order to provide ongoing treatment. There is a danger that mental health services will become more focussed on harm reduction rather than provision of treatment and care. The convention assumes that disability alone cannot be cited as a factor in determining whether compulsion can be imposed. This is a significant shift from the assumption that under certain circumstances compulsion in relation to treatment and detention is justified because of the impact of mental illness on areas including social functioning [202].

The expectations of the Convention on the Rights of Persons with Disabilities were not consistent with the *Mental Health Act (1986)*. The convention holds that any limitation to exercising legal capacity should be applied for the shortest time possible. The intention is to regulate different frameworks for a person with a disability only where necessary and only to the extent that is required [205]. Weller contended that the different systems in place for determination of capacity to consent or refuse treatment in medical patients, compared with those for treatment of severe mental illness, demonstrate discrimination on the basis of disability [206]. Weller outlined the two poles of the debate on whether compulsory treatment should be viewed as a necessary life-saving and humane intervention, or uncritical and unwarranted infringement of physical and mental integrity (p90).

A number of the articles in the convention are of direct relevance to those who receive compulsory treatment for a mental illness, such as the requirement for support in exercising legal capacity (article 12) and right to respect for physical and mental integrity (article 17). Article 12 relates to equal recognition before the law. As discussed by Szmukler, interpretations which have been issued by the committee which monitors the implementation of the convention lead to a conclusion that substitute decision making and involuntary detention of people with mental health disabilities are prohibited [73, 207]. Szmukler has proposed an interpretation that would allow the long-standing 'will and preference' of a person to be taken into account when determining legal capacity, thus still enabling substitute decision making for treatment in circumstances where the impact of mental illness resulted in obvious difference from the person's usual mode of behaviour and determination. Article 17 of the convention states that: 'Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others' [4]. This short provision was the end result of much debate, particularly influenced by the involvement of non-government organisations in the drafting process. As discussed by Bartlett and Sandland, quite how this will end up influencing mental health legislation and practice is probably still unfolding [208] (p431). The provisions enabling compulsory treatment were considered in the context of Article 17 by McSherry [209]. McSherry discussed the drafting process of Article 17 and drew on a number of regional interpretations to conclude that the right to respect for physical and mental integrity limits some non-consensual medical interventions. Article 17 also places constraints on when interventions such as restraint and seclusion are used, but allows deprivation of liberty and freedom of movement when justified for the purpose of necessary treatment (p121). The Committee overseeing the convention continues to express disagreement with the stance Australia has taken in relation to compulsory care in the community.

The Committee recommends that the State party repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders [207].

Perhaps more challenging is the extent to which the CRPD will result in greater attention to the realisation of positive rights. Article 25 requires states/territories to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and sets out a number of obligations regarding types of services and access to services [204]. As noted by Hale, mental health law struggles to reconcile the competing goals of protecting the public, ensuring access to services that people with mental illness need, and safeguarding their civil rights [210]. Hale pointed out that in general we have been much better at protecting people against unnecessary treatment than providing them with what they want or need. This has particular salience for those with severe mental illness. The high number of people with mental illness in prison and homeless populations, and the higher rates of premature mortality from avoidable causes, provide evidence of how far we have fallen behind in ensuring the basic needs of vulnerable people are met [47, 147]. As this thesis will demonstrate, the use of compulsory orders under the MHA is not unrelated to a lack of appropriate supports and availability of assertive therapeutic engagement.

2.8.2. Recovery oriented care

Complementing the increased emphasis on human rights as the conceptual framework within which treatment and care is provided to those with severe mental illness is the recovery movement. As discussed by Davidson et al, recovery as a movement focusses on the needs and goals of the consumer, with treatment being a shared endeavour, but shifted from the professional's perspective to the consumer's perspective [211]. This has been described as personal recovery rather than clinical recovery, with a focus on achieving a fulfilled and valued life rather than on symptom reduction [212, 213]. Providing treatment and care in a recovery-oriented environment inevitably leads to tension and debate on how choice and collaboration can be maximised alongside due regard to duty of care and promotion of safety [214].

The recovery movement was begun and championed by people who had experienced mental illness and treatment in mental health services, and who wished to challenge the pervading professional and community expectations that illnesses such as schizophrenia were chronic disorders with little hope of a positive outcome. By reframing recovery as one of personal growth or the realisation of an individual's potential rather than symptom reduction or return to full functioning, the emphasis shifted to one of hope and empowerment [213]. Recovery has been defined in a number of ways. Anthony described recovery as… *'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness…*' [215].

Recovery-oriented care has gained momentum in many developed countries with the development of policy and practice frameworks [212, 216, 217]. In recovery-oriented care services, the perspective of the consumer is given greater attention and interventions focus on resilience and strengths. People may refer to themselves as 'in recovery', a process of adaptation to the illness rather than recovery from the illness [218]. As Bellack pointed out, the emergence of more positive findings from long term clinical studies, and the reconceptualisation of recovery from a consumer perspective have contributed to changed political discourse and principles of service delivery, as discussed in the section on mental health legislation. However, the different meanings of the term – as an outcome or as a process - have resulted in some confusion [49]. There is general agreement that recovery-oriented services include characteristics such as empowerment, agency and hope, and that they are assumed to be non-linear and linked to self-direction. It is also expected that there should be greater utilisation of peer support and respect for the decisions made by consumers who are seen as having personal responsibility for their own self-care [219]. Difficulties remain in how recovery-oriented services are operationalised alongside compulsory treatment regimens and how change should be measured and assessed given the importance of subjective experiences and attitudes [220, 221].

In regard to compulsory care in the community, there is recognition that imposition of a CTO does not sit easily with elements of recovery-oriented care [222]. Slade et al set out a number of areas where they felt the concept of personal recovery was mis-understood or mis-used. Among these was their contention that compulsory treatment '*works against the recovery goal of reclaiming a meaningful life – a process that is based on self-determination and respect for the individual as a citizen of society'* [223] (abuse 4, p 13). This view is difficult to align with the degree of disturbance and deviation from a person's normal outlook on life when they are experiencing symptoms of psychosis. In a recent Victorian study involving six consumer participants who had been on a CTO, Eden et al observed that the consumers felt there was benefit in staying supported, but that there was limited choice in treatment, an emphasis on medication and the threat of hospitalisation. Those who participated did not feel that their treatment and interactions with clinical staff had been recovery focussed, but did report differences in the approach by staff over time. Staff who were interviewed acknowledged the challenge in providing recovery oriented practice to people on a CTO, but also reported signs of a shift and increased willingness by senior staff and management to support greater patient autonomy [222].

Recovery-oriented care (for now at least) is the defining direction of mental health service delivery and sits alongside the use of approved guidelines and evidence-based practice as the expectation of high-quality services. Consumers' personal experience of mental illness, and of mental health services and the professionals who provide treatment, are as important as the clinical and scientific understanding of the manifestations of illness and interventions to minimise the impact of the illness. The two conceptualisations of recovery can be seen as complementary. Many evidence-based treatments are entirely consistent with a recovery approach, but not all are likely to be acceptable to those with severe functional disability because of mental illness and impaired capacity. As noted by Bellack, there remains a challenge in how to balance the tenets of recovery with the expectations of family and community where people are severely impacted by their illness. Consumer choice and evidence based practice are not always compatible [49]. This is particularly so where the consequence of not taking prescribed treatment is likely to be associated with behaviours that cause harm to the person or others, or lead to deterioration in physical and/or mental health.

A group of practitioners from the South London and Maudsley NHS and South-West London and St George’s NHS Trusts developed a paper demonstrating that clinical services could shift their focus, outlining how recovery principles could be introduced across a range of mental health settings [224]. Others have discussed how risk and the ‘dignity of risk’ can be incorporated into recovery based practice [225]. But accepting a degree of responsibility for one’s own mistakes and failures is different from exposing others to risk because of a poorly treated or untreated mental illness. The shift to personal responsibility and choice by people who have psychosis may also mean an added burden of care for family and carers. It is in this complex interface between autonomy and risk that mental health legislation must be interpreted.

2.9. Mental health legislation in Victoria

Legislation to govern the management of people with mental illness dates back to the mid-19th century. Increasing confidence in psychiatric practice with the introduction of new and more effective treatments was evident in mental health legislation enacted in the mid-20th century which vested the medical profession with absolute power and discretion to determine admission and discharge from involuntary status as exemplified in the Victorian *Mental Health Act (1959)* [226, 227]. There was no external review short of seeking habeas corpus proceedings in the Supreme Court and the medical superintendent of the institution was empowered to consent to any medical or surgical procedures on behalf of both voluntary and involuntary patients. Although the 1959 Act remained in force for over 25 years, pressure to change this absolute power began much sooner. A review of mental health legislation and proposals for reform in the 1970s resulted in the Myers Report [226, 228].

A major shift in oversight and in the justification for compulsory care came with the passage of the *Mental Health Act (1986)* [6].

2.9.1. Mental Health Act (1986)

After considerable debate, and numerous amendments the mental health bill (1986) was passed, and the Act commenced in 1987. The objects and principles of the 1986 Act illustrate that mental health legislation in Victoria moved from a clinically informed paternalism based on best interests to a rights-based approach closely linked to prediction of risk of harm – a paradigm shift. The criteria for involuntary treatment were:

(a) the person appears to be mentally ill; and
(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action [6] (s8).

An important change introduced in the *Mental Health Act (1986)* was the establishment of the Mental Health Review Board to provide independent review of those detained under the Act. Initially the Act stipulated that the Mental Health Review Board was to carry out a review within four to six weeks of a person being detained as an involuntary patient, but this was shifted out to eight weeks by a subsequent amendment [6, 226, 229]. In the second reading speech the then Minster for Health, the Hon. David White stated:

At all stages, every attempt has been made to strike a realistic balance between the rights of individuals and those of the community. I am aware that some professionals *have expressed a number of concerns about the proposed legislation. Some psychiatrists believe, for example, that the proposed appeal and review procedures relating to involuntary admissions are unnecessary. They feel that, as people with a great deal of expertise, they are in the best position to determine the necessity or otherwise for admission.*

Understandably, they do not wish to spend their time preparing and presenting material to a review tribunal. The function of the Mental Health Review Board is not to interfere with the clinical practice of professionals. It is there to ensure that the responsibility for making decisions that affect the liberty of individuals rests with a broadly-based and accountable group. The Bill indicates very clearly that the board is expected to act in an informal, non-adversarial manner and hearings will be held at the hospital where the patient has been admitted. The board will base its decisions on discussions with treating staff, consideration of case notes and meetings with the patient concerned' [230].

The *Mental Health Act (1986)* provided that if a person met the criteria under section 8, they could be made subject to an inpatient or community treatment order (CTO). The introduction of a separate form of involuntary treatment (CTO) was to be very significant. As described by the Hon. David White:

Honourable members will note the introduction of an innovative treatment option to be known as community treatment orders. These will allow involuntary patients to be treated in a community setting when it is apparent that hospital admission is neither necessary nor appropriate. Community treatment orders are to be reviewed by the Mental Health Review Board [230].

Under the legislation the CTO could be revoked which meant that the person could be apprehended and taken to an inpatient facility. If the order expired because the date of the order was passed, then the person was no longer subject to the order.

As discussed by Rees, a number of the changes introduced in the 1986 Act ratified and formalised existing practice [226]. The process of closure of large institutions and movement of focus of care to the community had already commenced. Many patients of those institutions were already residing in the community on trial leave. However, the introduction of CTOs as offering a less restrictive option of involuntary treatment than inpatient treatment brought substantial change. When the Department of Human Services undertook a review of the operation of CTOs in 2003, CTOs had overtaken inpatient involuntary care. The report noted that by 2003 there were over 2,700 people on a CTO with approximately 1,000 commencements each quarter [231]. Experience in other jurisdictions in Australia and the United Kingdom has also shown enthusiastic uptake of CTOs by treating clinicians, although per capita use in Victoria remains among the highest [7]. While the legislative rationale of CTOs was to enable treatment in a less restrictive environment, consumers, clinicians and advocates have raised concerns that whether intentional or not, the reality has been that the promise of community based care has not been realised because insufficient resources have followed the intended changes to accompany the closure of the stand-alone institutions [232, 233]. The merits or otherwise of CTOs were considered in section 2.7.

The very significant changes of the *Mental Health Act (1986)* were accompanied by similarly major changes in disability and guardianship laws [230].[3] These each provided for an independent review panel or board and aimed to promote the rights of people with disabilities to live as normal a life as possible, although they still provided for substitute decision making and promoted a best interests framework.

In the context of the changing social and political dialogue regarding human rights, and the changing realities of service provision, including the increasing numbers of patients under CTOs, a number of amendments were made to the *Mental Health Act (1986)* in the 1990s [234, 235]. The debate in parliament regarding amendments to clarify aspects of CTOs included comment that:

> *First of all, Community Treatment Orders are a much better way of treating people with mental illness. We are talking about some of the most vulnerable people in our society. We need to be finding the best sort of treatment models that we can. It is a real bonus for the client. It is less distressing for them; it is certainly less distressing for their families; and it ends up with better outcomes (than inpatient care) [235] (p870).*

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[3] Most of the *Guardianship and Administration Board Act 1986* (Vic) came into operation on 14 July 1987, while most of the *Mental Health Act 1986* (Vic) commenced operation on 1 October 1987. The *Intellectually Disabled Persons Services Act 1986* (Vic) (now replaced by the *Disability Act 2006* (Vic)) was part of the same package of legislation for the benefit of people with a disability.

2.9.2. Mental health law reform

With the *Mental Health Act (1986)* becoming increasingly complex and 'band-aided', there was growing support for reform and renewal [236]. In addition to support for a stronger focus on rights, the push for development of a new act was influenced by the recovery movement and drew heavily on the *Mental Health (Care and Treatment) (Scotland) 2003* Act which included provision for advance statements and nominated persons to bolster the opportunity for supported rather than substituted decision making [237]. The *Mental Health Act (1986)* was not compliant with the requirements of the *Charter of Rights and Responsibilities Act (2006)* which gave greater support to the values of autonomy and respect for human dignity. The Charter provided for rights to be limited, but only under strict conditions that could be demonstrably justified [118]. The *Mental Health Act (1986)* was also found to be outdated when the United Nations Convention on the Rights of Persons with Disabilities was ratified in 2008 [4]. As noted previously, the convention encompassed those with psychosocial disability, and included the principle of personal autonomy and freedom to make choices. The principles of recovery-oriented care are intended to reflect greater awareness of the consumer's hopes and aims, and to shift the focus of decision-making from one directed by the care provider, to a more collaborative consensus. In legislation this shift is reflected by provisions for more supported decision making and greater restrictions on when, how and by whom compulsory treatment can be imposed. The consultation and drafting of the new mental health bill considered a number of these areas [238].

Against the backdrop of the Convention on the Rights of Persons with Disabilities, major reviews of mental health legislation occurred in a number of states and territories in Australia. In Victoria, reform began with the release of a consultation paper by the then Minister for Mental Health, the Hon Lisa Neville in December 2008 [239]. A community consultation panel chaired by a former Public Advocate was established which produced a report in 2009 following extensive round table consultation and receipt of numerous written submissions [240]. The report discussed broad areas where the legislation was outdated and in need of reform. These included the criteria for a person to be detained; human rights issues; principles of treatment and care and the objects of the law; and codes of practice. The report concluded that although there were mixed views, the '*majority of submissions identify the need for involuntary treatment, accompanied by robust safeguards to protect human rights'*

[240]. The panel noted that the *Mental Health Act (1986)* was based on a substitute decision-making model where treatment decisions were made by psychiatrists. They suggested that reformed legislation should shift this to ensure that as much as possible people could make their own decisions and exercise their autonomy. This would be promoted by reformed legislation including a presumption of capacity, although the report concluded that where the person was unable to make an informed decision, substitute consent should still apply. The consultations found broad support for mechanisms to promote supported decision making such as provisions for advance statements and inclusion of enhanced information sharing with a person nominated by the patient.

The consultations also sought views on whether the person '*appears to have a mental illness*' was sufficient justification to impose involuntary treatment. It was proposed that having staged orders with a brief assessment period before a longer period of enforced treatment could commence would result in a higher threshold for compulsory detention and treatment. The panel also considered the timeliness and authority of external review, and access to complaints mechanisms that had power to investigate and compel services to provide a response. The *Mental Health Act (1986)* had established a Chief Psychiatrist employed by the Department to provide oversight, respond to complaints and queries, and to monitor restrictive interventions. It was felt by those who made submissions that this role was not sufficiently independent, and that other external complaints oversight was required. The panel also proposed stronger safeguards for electroconvulsive therapy (ECT).

The Labor government released an Exposure Draft of a proposed new Mental Health Bill in October 2010 [241]. Labor was unsuccessful in the election in November 2010. The Minister for Mental Health under the new Coalition government, the Hon Mary Wooldridge, extended the time for comment on the Exposure Draft and held a further series of roundtable discussions. These covered the areas of independent review and oversight of compulsory treatment; independent oversight of electroconvulsive therapy for compulsory patients; patient information privacy and the provision, disclosure and collection of personal information; treatment of children and young people; and consent and capacity. The Coalition Government released *Victoria's Priorities for Mental Health Reform 2013 – 2015* in 2013 [242]. This included as the first priority reform of mental health legislation.

2.9.3. Mental Health Act (2014)

The Minister for Mental Health introduced the Mental Health Bill into the Legislative Assembly on 18 February 2014. The background and intentions of the Bill were debated in parliament 12th and 13th March 2014 [243]. Ms Elizabeth Miller, a member of parliament who had previously worked in the nursing profession commented that:

This piece of legislation takes a holistic approach to the outcomes for an individual… The goal is to establish a recovery-oriented framework for treatment and embed supported decision making. The outcome of that would be that patients are informed and treatment preferences are respected, patients are supported to make or participate in all treatment decisions, patients understand and are supported to exercise their rights and there is improved patient, family and carer involvement in treatment decisions. The bottom line is to give the person input into and control of their own treatment and care. I think that is very important [243] (12 March 2014, p677).

There was extensive debate on the use and regulation of electro-convulsive treatment (ECT) and of the oversight mechanisms proposed, but very little commentary on what lies at the heart of mental health legislation – the imposition of compulsory detention and/or treatment on people with severe mental illness in order to reduce the risk of harm to self or others, or deterioration in physical or mental health. There was almost no mention of the impact of severe mental illness on the person and his or her ability to function, and very little comment on access to services. The diagnoses and treatments most likely to be influenced by the provisions of the Act, other than ECT, were not covered in the debate. There was also very little debate on whether introducing a presumption of capacity would improve or impact determination of whether a person met criteria under the Act.

The reformed legislation passed through parliament with very minor amendments in March 2014 and commenced from 1st July 2014 – a very short lead time. Supported decision making was not included in the *Mental Health Act (1986)*, but was included in the objectives and principles of the M*ental Health Act (2014*) [14]. The 2014 Act shifted the debate in the direction of individual human rights in a number of ways. The Act sets out as one of its objectives: *'to enable and support persons who have mental illness or appear to have mental illness – to make, or participate in, decisions about their assessment, treatment and recovery'* (s10 (d)). It provided that '*persons* *receive assessment and treatment in the least restrictive way possible and with the least possible restrictions on human rights and human dignity'* (s10 (b)). The principles in the Act include '*persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk'* (s11 (d)). Degree of risk is not defined in the Act.

Supported, rather than substituted, decision making is promoted through the presumption of capacity and introduction of advance statements (s20), nominated persons (s23) and second psychiatric opinion (s78). The Act established an Independent Mental Health Advocacy service and a Mental Health Complaints Commissioner. The option of substituted decision making remains for those situations where treatment is needed urgently or where the person lacks capacity.

Two of the stated aims of the reformed mental health legislation were to minimise the use and duration of compulsory orders by making the criteria for a compulsory order more stringent, and to increase the safeguards by giving the external review body greater powers and responsibility [244].

The treatment criteria for a person to be made subject to a Temporary Treatment Order or Treatment Order are:

(a) the person has mental illness; and

(b) because the person has mental illness, the person needs immediate treatment to prevent

  (i) serious deterioration in the person's mental or physical health; or

  (ii) serious harm to the person or to another person; and

(c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and

(d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment [14] (s5).

Although the criteria for compulsion include similar requirements to those in the 1986 Act in that they require that the person has a mental illness and needs immediate treatment, the threshold in relation to risk was shifted to 'prevent **serious** deterioration to the persons mental or physical health; or **serious** harm to the person or another person' [14] (s5(b)). The Act provides for staged orders, each of a finite duration as described in detail below. The Act shifts the power and responsibility for making orders of longer duration from the authorised psychiatrist to the newly established Mental Health Tribunal. The clear intention is that the duration of compulsory treatment must only be for the period that the person is likely to meet the criteria. If at any stage the person no longer meets criteria, the authorised psychiatrist must discharge the person from the order.

Mental illness is defined in the Act as ‘a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’. A person with a mental illness who meets the criteria under the Act for a period greater than a few days or weeks is highly likely to have a psychotic illness, although there are exceptions. Whether the person has capacity to provide informed consent to treatment is not included in the criteria for a Treatment Order. The Act includes a presumption of capacity, but allows treatment without informed consent in prescribed circumstances (s70, s71). The Act provides that a person has capacity to give informed consent if the person (a) understands the information he or she is given that is relevant to the decision; and (b) is able to remember the information that is relevant to the decision; and (c) is able to use or weigh information that is relevant to the decision; and (d) is able to communicate the decision he or she makes by speech, gestures or any other means (s68).

The process of recommendation under the *Mental Health Act (2014)* is staged. *If* a person is deemed to meet the criteria for compulsory treatment an Assessment Order can be made by a mental health practitioner or medical practitioner. The Assessment Order is for a maximum of 24 hours but can be extended. A consultant psychiatrist can then make a Temporary Treatment Order which is effective for up to 28 days. Any longer order – Inpatient Treatment Order (ITO) or Community Treatment Order – can only be made by the Tribunal. The authorised psychiatrist can vary the Order from an inpatient to a community order or vice versa. The Order expires if not revoked before the end date. If the authorised psychiatrist varies the Order from a CTO to an ITO another hearing of the Tribunal is convened. An ITO can be made for a maximum of 26 weeks and a CTO for a maximum of 52 weeks. This means that there is little change in the possible duration of a CTO, but the process of application means that the Tribunal gives greater consideration to duration, with the expectation that this will be for the shortest time congruent with the expected treatment aims and outcomes.

2.9.4. Implementation of the Mental Health Act 2014

The *Mental Health Act (2014)* came into force a few months after it had been debated and enacted in parliament. There was a flurry of activity including training and education, the establishment of a new Mental Health Complaints Commission, creation and expansion of the Mental Health Tribunal (formally the Mental Health Review Board), the Independent Mental Health Advocacy service and the Second Psychiatric Opinion Scheme. Increased funding was made available to support legal representation at hearings. Additional resources were provided to clinical services to support the increased administrative burden of more frequent Tribunal hearings although the impost on clinical staff was still considerable.

The implementation of the 2014 Act was also influenced by other factors. Victoria's population, especially that of Melbourne, was increasing at unprecedented rates – 2.4% per annum [245]. This rapid growth in population in the outer suburbs and increased density in inner suburbs was not accompanied by increased capital investment in expansion of mental health facilities. There was also concern at rising rates of substance misuse, especially methamphetamine, in people who were treated as compulsory patients [246]. Victoria experienced a rapid growth in the numbers of people in prison, both sentenced and on remand, many of whom had a mental illness [2]. Whatever the rhetoric in the materials supporting the Act of improved access to mental health services, earlier intervention, better coordination, recovery orientation and less emphasis on crisis, without investment to meet the clinical needs of a growing and complex population, it was hard to see how service improvement would follow [242].

2.9.5. External review of treatment orders

An important change in mental health legislation since the introduction of the *Mental Health Act (1986)* was the establishment of an external review body – the Mental Health Review Board under the 1986 Act and the Mental Health Tribunal under the *Mental Health Act (2014)*. This reflected the greater emphasis on rights through the provision of independent external review. There is generally a set time between when a person is admitted under the relevant mental health legislation, and when a review is required so that not all persons subject to the legislation will be reviewed. The establishment of an external review process reflected concern that compulsory treatment was used excessively, and that decisions made by psychiatrists could be arbitrary. The Board/Tribunal is not empowered to direct admission to mental health services.

Under the *Mental Health Act (1986)* the Mental Health Review Board was obliged to review all persons detained under the Act within eight weeks of admission and thereafter at least annually or on appeal. The timeframes changed under the *Mental Health Act (2014)* as detailed above. Although the timing and powers of review or decision differ between the two Acts, in both the hearing involves a tribunal comprising a legal member, psychiatrist and community member. In common with legislation in other countries and across Australia, the external Board or Tribunal functions to make or review decisions about compulsory admission and treatment, including CTOs. In some jurisdictions, the Mental Health Tribunal (or equivalent) has additional responsibilities regarding the approval of electroconvulsive therapy. The Tribunal must make its decision in accordance with the criteria laid down in the relevant legislation, but inevitably this requires a balance to be set between the consumer's welfare and their 'rights', community expectations and an understanding of current and future risks and treatment needs. As discussed by Carney et al, mental health tribunals are called on to consider various classes of rights of those who are hospitalised and subject to compulsory treatment. These include: the right to freedom and self-determination such as the right to refuse treatment; the right to treatment and protection; the rights of society to protection against harm; and the right to fair legal process including representation and procedural fairness [247] (page11). The person who is subject to compulsory treatment has a right to procedural fairness and is encouraged to be present at the hearing. They have the right to legal representation.

Mental illness is not a homogenous entity. How it impacts a person and their family is influenced by many other factors such as social support, use of illicit drugs or other substances, response to treatment, and history of violence - to give but a few examples. Given this, it is not surprising that the process and outcome of Tribunal hearings can be variable, and also influenced by the ideals and experiences of the sitting members. What is remarkably similar across mental health tribunals working within different jurisdictions is the very low rate of discharge from inpatient or community orders initially made by the treating psychiatrist – generally in the order of 5% [247] (p 126 – 129). This reflects that many people initially placed under an order will have been discharged from the order prior to the scheduled Tribunal hearing because they have improved and no longer meet the criteria, and also that the Tribunal is generally in agreement that those deemed by treating clinicians to need the protection of mental health legislation do indeed meet all criteria.

Carney et al followed people who had been placed under inpatient or community treatment orders and had contact with mental health boards or tribunals in Victoria, New South Wales and the Australian Capital Territory over a two year period after the initial hearing. They found that over half the patients had multiple orders during the two year period. In a comparison between New South Wales, Victoria and the Australian Capital Territory, Victoria had the lowest number of subsequent hearings, perhaps reflecting the longer duration of order possible under the *Mental Health Act (1986)*. In the Australian Capital Territory which allowed the shortest duration, 75% of the people considered by the Tribunal had two or more orders over 2 years [247] (p132). This is a cogent reminder of the propensity of severe mental illness to be enduring and/or relapsing. Somewhat surprisingly, the authors concluded that tribunals should be better resourced with better access to legal support and improved facilities, rather than there should be better access to treatment and clinical services.

As would be expected from the greater reliance on community based services compared with bed based services, people in Victoria are more likely to be on a CTO and remain on a CTO compared with people in other Australian States [3]. The duration of the order was not a relevant consideration for the Mental Health Review Board, but setting the duration of the order is a requirement of Mental Health Tribunal hearings under the *Mental Health Act (2014)*. The first annual report from the Mental Health Tribunal indicated that 46% of CTO were made for the maximum possible of 52 weeks, with a further 36% made for between 14 – 26 weeks, and 16% for between one to 13 weeks [248]. This seems to be a stable pattern with the most recent annual report finding that 58% of 3835 CTO were made for less than or equal to 26 weeks [249]. This represents a significant change in practice in Victoria between the *Mental Health Act (1986)* and *Mental Health Act (2014)*. The Mental Health Tribunal annual report noted that the majority (79%) of those appearing had a diagnosis of schizophrenia or other psychotic illness and were prescribed psychotropic medication [249]. This is consistent with the diagnoses listed by the Mental Health Review Board in earlier annual reports. The annual reports of the Mental Health Review Board included the primary diagnosis of those seen. The 2012/2013 and 2013/2014 annual reports show a consistent pattern whereby approximately 80% have a primary diagnosis of schizophrenia, schizoaffective disorder, or paranoid schizophrenia. A further 8 – 9% have bipolar affective disorder

[250, 251]. The two most recent annual reports of the Tribunal showed that 79% had one of the above three diagnoses [17, 249].

2.10. Contextual issues in the implementation of mental health legislation

This thesis considers practice under two legislative regimes, looking at data from 2008 – 2010 and from 2014 – 2016 and the service utilisation for the subsequent two years for each cohort. The analysis and discussion of the data is considered in subsequent chapters. As shown in Table 2.2, this covers a period during which funding and associated clinical services declined in Victoria in comparison with the national average. These changes are important since the implementation of mental health legislation and effectiveness of provisions such as CTOs are influenced by how available and accessible the service system is to those who may be reluctant to seek assistance, but who are in great need of treatment [169, 252, 253]. Limited availability of inpatient services is also likely to mean that people are discharged earlier in their recovery or admitted later in relapse, both of which may increase the likelihood that they will meet the criteria for treatment as compulsory patients.

It is not just the mental health system that is relevant in considering the care and treatment of people with severe mental illness. Issues such as increased rates of imprisonment, homelessness and other social determinants, and the prevailing pattern of illicit substance use are also important factors [254, 255]. These factors influence who may present to Emergency Departments, brought by police or family. Having a high proportion of remandees in prisons means that people with mental illness may be released by the courts or placed on bail with little or no time to plan for ongoing treatment and care.

On a per capita basis, Victoria currently spends less, has fewer beds and fewer staff across community and bed based services than comparable states in Australia [3] (Table 2.2). Victoria also has a lower bed day cost. In a recent review of quality and safety assurance in Victoria, Duckett et al singled out mental health services as requiring adequate funding to deliver safe and timely care [256]. It should be noted that the Victorian Government substantially increased funding to community mental health services in the 2017/18 and the 2018/19 budgets, but it will take several years of such increases and further investment in bed-based services to bring Victoria back to the national average.

These proportional changes in population in the absence of increased capacity in community and bed-based services have resulted in increased pressure on state funded health services. The results include increased throughput with a higher threshold for acceptance and shorter length of stay in inpatient units. An example from NorthWestern Mental Health in Melbourne where the candidate worked is that there were 621 admissions to a 25-bed unit in 2011/12, while the same unit had 704 admissions in 2016/17. There were 1092 admissions in 2011/12 to a 50-bed unit, but this increased to 1394 in 2016/17. The increased rate of throughput is reflected in overall increases in acuity, and higher proportion of new, previously unknown patients. While there is not data to indicate whether services have improved, the sense from services is that the increased pressure on throughput has not supported the aims of person-centred care.

Table 2.2. Comparative mental health services, Australian Institute of Health and Welfare (AIHW)

Per capita number/ funding/EFT	1994/95 Victoria	1994/95 National average	2008/09 Victoria	2008/09 National average	2015/16 Victoria	2015/16 National average
Recurrent expenditure per capita*	128.25	113.9	192.98	203.78	197.30	226.52
Acute public beds in general hospitals per capita**	7.9	12.9	18.1	17.7	17.2	18.0
Total beds per capita**	34.2	39.6	22.9	30.5	21.9	29.4
FTE equivalent staff per capita***	114.3	102.9	117.7	128.5	118.2	133.3
Proportion of community accessing clinical services****			1.13%	1.6%	1.08%	1.8%
Population (million)*****	3.32	18.07	5.44	21.69	6.24	24.13

*AIHW Mental Health Services in Australia. Table EXP.4 (expenditure); ** AIHW Mental Health Services in Australia. Table FAC 13 (facilities); *** AIHW Mental Health Services in Australia. Table FAC 37 (facilities);

**** AIHW Mental Health Services on Australia Table KPI 8.1; Victoria's mental health services Annual Report 2016/17 (Key Performance Indicators); *****Australian Bureau of Statistics

These population changes mean that a comparatively lower proportion of the population accesses public mental health care. Victoria's mental health services annual report shows that the proportion of the population accessing state funded mental health services has fallen from 1.13% in 2008-2009 to 1.07% in 2016 -17 [257]. This had increased to 1.16% in the most recent annual report [258]. However, this is still far lower than conservative estimates of the prevalence of severe mental illness in our community and considerably lower than the national average [259]. As a consequence of a number of changes in sentencing practices, there has been a concomitant and substantial increase in the prison population. Between June 2006 and June 2016, Victoria's prison population increased by 67% [2]. There are also anecdotal concerns at the rising number of mentally ill persons in prison and using homeless crisis services, increased rates of readmission, sexual and physical aggression on inpatient units, and blockages in Emergency Departments [260-263].

2.11. Summary

This chapter has provided an overview of the impact of severe mental illness, with a focus on schizophrenia. While there have been major changes in the delivery of mental health services, and the policy and legislation that provide the framework for those services, there have been comparatively minor changes in the treatment and prognosis of schizophrenia over the past 50 years.

The reforms in policy and legislation have been consistent with the intent to have greater oversight and to minimise the intrusion on a person's human rights. The chapter includes discussion of mental health law reform in Victoria with the passage of the *Mental Health Act (1986)* and subsequent reforms introduced in the *Mental Health Act (2014).* The 2014 Act introduced more robust external review, an emphasis on supported decision making and expectation of shorter duration of compulsory treatment. But there are tensions in how completely the aims of policy and subsequent legislation can be realised. In Victoria, population growth without congruent growth in infrastructure has resulted in pressure on parts of the service system. Although compulsory treatment, and in particular compulsory treatment in the community continues to be debated, there is no doubt that mental illness is common among the homeless and those incarcerated. This brings into focus the interplay between service availability and utilisation and mental health legislation. It is arguable whether the high use of CTOs in Victoria reflects difficulty in accessing more intensive services in the community, or relates to limited bed-based capacity that results in early discharge into the community.

While there are conflicting views as to the effectiveness or otherwise of CTOs, it is clear that they are used extensively, and their use seems to be increasing. The literature suggests that the accepted gold standard of randomised clinical trials may not be entirely applicable to CTOs given the multiplicity of factors which impact on their use and effectiveness. It is also apparent that there are strongly held ethical views as to the appropriateness of compulsory treatment and care – be it in bed based or community settings. Among the responses to such ethical debates has been the increased external oversight of compulsory care, and greater reliance on supported rather than substituted decision making. This has been driven by the United Nations Convention on the Rights of Persons with Disabilities and also the consumer movement which has supported greater patient involvement and supported decision making. But despite considerable research into the area of compulsory treatment, much is still unclear. In Victoria, there has been a worrying reduction in funding and service availability per capita, alongside reforming legislation. There has been increased concern over the use of illicit substances, especially methamphetamines and the impact this has on the presentation of underlying mental illness and need for restrictive interventions. The extent of community concern about mental health services has resulted in a Royal Commission being established to inquire into the service system and make recommendations for improvement.

The studies which comprise this thesis originated in an environment of contrast between increased emphasis on rights and legislative protection, and real reduction in service quality and availability. The studies were designed to address some of the resultant questions and gaps in our understanding.

The current literature does not provide answers to questions on the interaction between legislation and service delivery, or on aspects of the process of instituting compulsory treatment and external review. There has not been clarification of what happens after a person is taken off a CTO, or whether the means by which the CTO is ended has an impact on subsequent care. The literature has not considered particular aspects of care such as whether the determinations made by external review bodies influence subsequent care. Planning and engagement to negotiate different phases of care warrants greater exploration. Although there has been consideration of the risk factors for being made a compulsory patient, the specific impact of risk factors such as substance use has not been explored. While there has been much discussion regarding the need for a ‘no wrong door’ policy and attention to better recognition of those with dual diagnosis, the effect of having a comorbid substance use disorder on service utilisation has not been explored. There has also been considerable research on the views of carers, but limited exploration of their experience of care or understanding of the service system, especially when access to services has become more difficult and acceptance for admission often delayed such that it most often occurs in the context of an urgent need for containment and care.

The studies which comprise this thesis examine whether changes in policy and legislation, and a particularly common co-morbid presentation of substance use influence subsequent service utilisation and institution of compulsory care.

Chapter 3. Methodological overview

This chapter provides a methodological overview of the studies that make up the original work of this thesis. It describes the aims, hypotheses and methods of the studies and describes how they inter-relate. The central questions addressed by the thesis relate to the treatment and care provided to those with severe mental illness who meet criteria under mental health legislation for compulsory treatment.

3.1. Overall aim and specific research questions

This thesis aimed to elucidate aspects of mental health service delivery. In particular, the aim was to better understand the utilisation of public mental health services in Victoria by those who had a severe mental illness. For the purposes of the thesis, the candidate considered people who had been treated under a Community Treatment Order (CTO) for at least three months duration as having a severe mental illness. Mental health legislation sets out the circumstances under which involuntary or compulsory care can be provided. Importantly, while a person who meets criteria **may** be made involuntary, once they are deemed to no longer meet criteria they **must** be discharged from the Order. Thus, needing to be under a CTO for a lengthy period is a reasonable proxy as a measure of severity. The questions and resulting hypotheses informing this thesis are:

- Research Question 1. Under legislation where external review is mandated, are subsequent treatment episodes influenced by who or how a determination is made that the treatment order should cease? How does a determination that the person no longer meets criteria impact on subsequent care, including a return to compulsory treatment?
- Hypothesis 1. If a CTO is terminated abruptly there will be a greater likelihood of treatment discontinuation and subsequent relapse.
- Research Question 2. When legislation is reformed to bring a greater focus on individual rights, does this impact on the use and duration of compulsory treatment?
- Hypothesis 2. A change to more rights based legislative settings will result in fewer and shorter compulsory orders.

- Research Question 3. Does comorbid use of illicit substances influence the use and duration of compulsory orders?
- Hypothesis 3. Use of stimulant drugs of abuse will be associated with a need to return to compulsory treatment sooner and for a longer duration than required by those patients who do not have an additional diagnosis of substance use.
- Research Question 4. How are compulsory care regimes viewed by carers who are often the main providers of support in the community? How do carers view their experience of providing care?
- Hypothesis 4. Carers will support the use of compulsory treatment in the community, and will describe a significantly negative experience of care-giving.

3.2. Methodological overview

The thesis incorporates four studies. The studies sought to utilise existing data where possible. Studies 1, 2, and 3 considered subsequent service utilisation after being on a CTO and used the state-wide CMI/ODS data source which is used by all public mental health services. Study 4 sought the views of carers and used data obtained through a postal survey.

3.2.1. State-wide data

Victoria has maintained a state-wide data collection of service utilisation for many decades. The system in operation currently comprises the Client Management Interface (CMI) which is accessed and entered into at the service level, and the Operational Data Store (ODS) which is maintained centrally by the Department of Health and Human Services (DHHS). The DHHS collates and generates reports using the ODS which are then provided back to services to allow reports to be developed and benchmarking between services. Each mental health service can run its own reports from the CMI of their own data. The CMI/ODS contains demographic details, primary and additional diagnoses made according to ICD- 10 [264], legal status and service utilisation including inpatient and community episodes of care. The date and outcome of external review by the Mental Health Review Board (under the *Mental Health Act (1986)*) and Mental Health Tribunal (under the *Mental Health Act (2014)*) are included in the

CMI/ODS. Services are also required to enter any use of restrictive interventions such as seclusion and restraint, and particular treatments such as electro-convulsive therapy (ECT). The CMI/ODS has previously been used to consider epidemiological associations of treatment under a CTO [81, 265]. Previous work has not considered the different impact of particular legislative regimes.

The CMI/ODS provides information on service utilisation. It does not include qualitative consideration of the perceived value or otherwise of treatment under a CTO or how the mental health service is viewed by the service provider or the service user.

In order to consider service utilisation and the factors associated with this over time, two datasets from the CMI/ODS were obtained. The first included all those who had been on a CTO for at least three months and had been discharged from the CTO between 1 January 2008 and 31 December 2008 and their subsequent service utilisation over 24 months. This data set considered services provided under the *Mental Health Act (1986)* and included records for 1,478 patients. A similar dataset was obtained of patients who had been discharged from a CTO of at least three months duration at December 2014 and their service utilisation over 24 months under the *Mental Health Act (2014)*. Both data sets were analysed to establish basic demographics and clinical features. Further analysis considered the association between mode of discharge and subsequent service utilisation, and the impact of other factors including service location, age of the patient, diagnosis, and co-morbidity such as substance use. The two data sets were then compared to determine whether there had been change in service utilisation under the two different mental health legislative regimes. All analyses were undertaken using Stata.

3.2.2. Survey of carers

Study 4 was based on a posted survey which included a questionnaire about demographic details, experience of CTOs and service contact. The questionnaire was made available to two well-established carer support and advocacy organisations, the Mental Illness Fellowship (formally the Schizophrenia Fellowship) and the Association for Relatives and Friends of the Mentally Ill (ARAFMI). The survey was mailed to all those on the ARAFMI mailing list and included in the newsletter of the Mental Illness Fellowship, with a subsequent mail out to those who agreed to participate. Both organisations have a long history of advocacy for better services for those with severe mental illness, especially schizophrenia. Statistical analysis was performed using SPSS and was able to consider correlations within the current study and comparison with other studies which had used the same instruments in related populations.

3.2.3. Ethics approval

Ethics approval for the studies based on CMI data and for the study using the survey of carers was obtained through the Melbourne Health Research and Ethics Committee. The committee noted that consent was not being sought from people whose details were on the CMI/ODS and that no individual would be identified. The committee also noted the supports available to carers who received the questionnaire.

3.3. The four studies

The four studies that make up the original work for this thesis are described in brief below in terms of the research questions they address and the datasets they use to do so. Each resulted in a publication in a peer reviewed journal. A fifth paper was written to provide overall service context and the changes that had occurred over the past decade.

3.3.1. Study 1. Mental health service utilisation after a Community Treatment Order: a comparison between three modes of termination

This study addressed Research question 1 and Hypothesis 1. The study used the data set from CMI/ODS of patients under the *Mental Health Act (1986)* in the years 2008 – 2010. The aim was to examine service utilisation after discharge or discontinuation of a CTO and to determine whether the mode of discharge or termination of the CTO impacted subsequent service use.

In the candidate's experience, if a person under a CTO evades the treating service or actively seeks to be taken off the CTO by the external body, the person is highly likely to discontinue prescribed medication.

The hypothesis was that if a CTO was terminated abruptly there would be a greater likelihood of treatment discontinuation and subsequent relapse.

The dataset was analysed to determine socio-demographic details and key descriptors including diagnosis, as well as consideration of age, gender and whether the service was in a rural or metropolitan area. The association between the three modes by which the CTO was terminated (decision by the treating psychiatrist, expiry of the Order, or determination by the independent external Mental Health Review Board) and likelihood of further episodes of compulsory care were then compared [19].

3.3.2. Study 2. The relationship between legislative change and the use and duration of compulsory treatment orders

This study addressed Research question 2 and hypothesis 2. The study compared the 2008-2010 CMI/ODS data set (*Mental Health Act (1986)*) with that relating to service delivery under reformed legislation in 2014-2016 (*Mental Health Act (2014)*). In addition to the data set utilised in study 1, the candidate obtained a second distinct data set of persons who had been on a CTO for at least three months and their subsequent treatment episodes over two years from 2014-2016. While the CTO of some of those included in the data set may have commenced while the *Mental Health Act (1986)* was in operation, their service utilisation over the two years after the CTO ended occurred under the *Mental Health Act (2014)*, and the original CTO would have been reviewed by the Mental Health Tribunal.

The two data sets were compared to assess the difference in the use and duration of compulsory orders. The study considered the duration of the index CTO, and the odds of having a further admission over two years. This allowed comparison between the data sets of time spent as a compulsory patient. This study also considered the mode of discharge – whether by the treating psychiatrist, expiry of the Order or independent external body. Under the *Mental Health Act (2014)* the external body is the Mental Health Tribunal which serves a similar function to the Mental Health Review Board although has greater powers and responsibility for making orders and their duration. The Tribunal has authority to make an order or to revoke an order, and to set the duration of the order within time limits provided by the legislation.

A notable difference between the two data sets was the increase in CTOs revoked to inpatient treatment orders by the treating psychiatrist under the *Mental Health Act (2014)*. However, the high rate of revocation by the treating psychiatrist also suggested that patients were being put on a CTO in preference to an Inpatient order, and that this was not able to be sustained. The candidate considered that this may be related to decreasing resource availability resulting in less assertive treatment in the community and reduced community supports [266].

3.3.3. Study 3. The impact of substance use on treatment as a compulsory patient

Study 3 considered Research question 3: Does comorbid use of illicit substances influence the use and duration of compulsory orders? This study used the CMI/ODS data set of 2014 – 2016. The aim was to consider the impact of having a diagnosis of substance use on the use of compulsory orders to address the question of whether comorbid use of illicit substances influences this. The methodology used was to determine the frequency of an ICD code related to substance use to determine the association between this and subsequent service utilisation, including treatment under the MHA. The study incorporated three separate time to event analyses looking at factors associated with the time to first: (a)Treatment Order; (b) Community Treatment Order; and (c) Inpatient admission following the conclusion of the patient's index order. A negative binomial regression was conducted in order to assess factors associated with the duration of subsequent orders after the conclusion of the index order [267].

There has been growing concern regarding the level of substance use in those presenting with mental illness, especially amphetamines and methamphetamines which are associated with increased severity of psychosis and increased rates of aggression towards staff and other patients. Use or dependence on drugs and/or alcohol on their own is not considered to be a mental illness for the purpose of mental health legislation, and does not meet the criteria for being made a compulsory patient unless the person has developed a drug induced psychosis or significant mood disorder [14] (s4(2)(l), s4(3)). The separation of use of drugs and alcohol from other forms of mental illness can be difficult in practical terms. A person who has a mental illness, but who is also dependent on drugs or alcohol may be excluded from drug and alcohol treatment services, and also deemed not to meet criteria for treatment under the mental health act, even though their behaviour appears disordered and to be associated with risk of harm.

3.3.4. Study 4. Carer experience of Community Treatment Orders: implications for rights based/recovery oriented mental health legislation

Study 4 addressed the research question: how are compulsory care regimes viewed by carers who are often the main providers of support in the community?

The questionnaire (see appendix 1) included a section designed to obtain general information about the carer and the person cared for, including their exposure to CTOs and the Mental Health Review Board. In addition to the survey, the study included two validated instruments that had been developed for use in studies of those who provided care and/or treatment to people with severe mental illness. The intention was to keep the questionnaire reasonably short, and to obtain information on the experience of care giving and the carer's knowledge regarding recovery through these tools. The Experience of Caregiving Inventory (ECI) was developed to explore the impact of the mental illness on the caregiver, their life and wellbeing. It includes 66 items covering a number of negative and positive areas [96]. The Recovery Knowledge Inventory (RKI) was developed by Bedregal et al [268]. It was primarily developed to assess the knowledge of recovery-oriented practices among providers, and to assist in training. It is a self-report instrument and covers four domains of understanding: roles and responsibilities in recovery; non-linearity of the recovery process; roles of self-definition and peers in recovery; and expectations regarding recovery.

The survey gave information on how CTOs and other aspects of the mental health system were viewed by this selected group. The study also gave an indication of how often the mentally ill person relapsed and required a return to compulsory status when discharged from a CTO.

Chapter 4. Study 1 – Mental health service utilisation after a Community Treatment Order: a comparison between three modes of termination

This chapter describes study 1 which examined mental health service utilisation after a CTO and compared three modes of termination. The chapter incorporates the accepted version of a paper prepared by the candidate and accepted for publication by the *Australian and New Zealand Journal of Psychiatry* and published in 2016 (Vol 50(4) 363 – 370). The candidate was the first author and lead the research component as well as undertaking the drafting and reviews. The co-authors assisted with drafting and with the statistical analysis.

4.1. Background

Chapter 2 discussed the impact of severe mental illness – especially schizophrenia. Clinical, social, and epidemiological research has emphasised that many of those who have schizophrenia will be at risk of long-term disability, and that the risk of relapse is increased if the person ceases medication treatment or reduces without close monitoring. The problem of lack of insight or acceptance that the symptoms experienced by the mentally ill person are manifestations of an illness that requires treatment is also considered. It is noted that good engagement between the mentally ill person and their family, and the treating clinicians is an important part of improving adherence to treatment recommendations. Chapter 2 also described the legislative frameworks put in place to try to ensure treatment is provided when a person who is showing disturbed thought, mood, and behaviour because of mental illness. Mental health law endeavours to balance the intrusion on a person's autonomy in regard to treatment and freedom of movement, with the benefit and reduction in harm that results from treatment. With the reduction in bed-based services, increasingly compulsory treatment is being provided in the community under a CTO. The *Mental Health Act (1986)* provides that a person must be reviewed by the Mental Health Review Board within eight weeks of an order being made, and that the maximum duration of a CTO is fifty-two weeks, although it may be renewed. The patient may appeal the order at any time, and has a right to legal representation if requested. Although the effect of the CTO will lapse after twelve months if not renewed, discharge is generally determined by the treating team at clinical review.

Study 1 considered a cohort of 1478 patients who had been on a CTO for at least three months in 2008 under the Victorian *Mental Health Act (1986)*. The data obtained provided their service utilisation, including legal status for two years following the termination or expiry of the CTO. The data did not distinguish between a mandatory review or application for review. The hypothesis was that if the CTO came to an abrupt end through expiry or because the Mental Health Review Board ended the CTO, this would impact discharge planning and result in a more severe relapse with increased likelihood of a return to involuntary treatment. The study sought to address a gap in our understanding of CTOs – that is whether the mode of discharge or termination has an impact on subsequent course of illness and therefore service utilisation. There has been limited work in this area although a study by Munetz et al reported on twenty patients who had been maintained on outpatient commitment in summit County, Ohio in 1996 [269]. This study is of interest as it compared outcomes at twelve months of those who had been taken off the order by their psychiatrist, the courts or because the order lapsed for administrative reasons. While the numbers were small, the authors found that in all three cases where the order lapsed, the patient relapsed, while this was only true for three of ten cases where the order was terminated by the psychiatrist, and two of five patients whose orders were terminated by the court.

It is important to note that the treatment provided under a CTO should be more than just medication. Psychosocial support and interventions to assist in daily functioning and community interactions are also relevant, but often neglected because of time and resource constraints [270]. As noted in the paper, the data did not allow consideration of the duration or quality of clinical contacts, and did not include commentary on the reasons for the decision by the Mental Health Review Board to terminate or continue the CTO. The CTO could only be continued if the person was found to meet all criteria under section 8 of the *Mental Health Act (1986)*. The data set did not allow consideration of outcomes other than readmission or reinstatement of involuntary care. It did not allow consideration of whether there was any change in outcomes such as self-harm or contact with the criminal justice system.

4.2. Mental health service utilisation after a Community Treatment Order (CTO): A comparison between three modes of termination

4.2.1. Abstract

Objective: Little work has examined Community Treatment Order processes, including mode of termination. This paper aimed to examine service utilisation and legal status following CTO termination by a review board, treating psychiatrist or expiry of order.

Method: Data-linkage study following the service utilisation of those discharged from a CTO of at least three months duration for the subsequent two years. We used the state-wide database of all contacts with state funded mental health services in Victoria, Australia.

Results: Of 1,478 patients who were discharged, 5% were discharged by the review board, 88% were discharged by the treating psychiatrist and in 7% the order expired. Logistic regression indicated that those discharged by the treating service were less likely to be subsequently be placed under an involuntary order than those discharged by the Mental Health Review Board, or those whose order had expired (OR = 0.61).

Conclusions: Poorly planned discharge as a result of expiry of the CTO or abrupt discharge by the review board may be associated with a more severe relapse and subsequent need for compulsory treatment. The likelihood of being readmitted as an involuntary patient is greater for younger adults and those living in urban settings. In order to minimise the risk of major relapse strong community engagement with treating services should be supported.

4.2.2. Introduction

Community Treatment Orders (CTOs), in which a person receives involuntary care in the community, have been the subject of considerable controversy, with conflicting evidence as to their effectiveness and utility[168, 189, 190] (Kisely et al, 2011; Kisely and O’Reilly, 2015; Maughan et al., 2014). CTOs were introduced in Victoria through the Mental Health Act (1986). Their introduction occurred concurrently with the closure of stand-alone long stay mental health beds. Victoria has been recognised as having one the highest rates of CTO utilisation compared with other jurisdictions with provision for involuntary treatment in the community [7, 193](Dawson, 2005; Light et al, 2012). Arguments for CTOs include a reduction in the need for inpatient admission by better adherence to medication in the community and thus reduced risk of relapse and possibly better morbidity and mortality outcomes [271](Pinfold and Bindman, 2001). Recent work in the UK has contributed to the debate on the effectiveness or otherwise of CTOs [177, 272, 273](Burns et al., Burns and Molodynski, 2014); Curtis, 2014) with a systematic review of the effect of CTOs on service use concluding that other than medication adherence there was little evidence that CTOs influenced hospitalisation and service outcomes [190](Swartz et al, 2010). CTOs of longer duration appeared to confer added benefit in terms of relapse (Swartz et al, 2010). The review concluded that studies of CTO effectiveness should consider the different aspects of process and outcome.

Until the commencement of a reformed Mental Health Act in 2014 external review of the decision to make a person subject to an involuntary order in Victoria, Australia was made by the Mental Health Review Board (MHRB). The rate of discharge by the MHRB remained relatively static with less than 7% of reviews resulting in a ruling to discharge the patient from the CTO and terminate the involuntary order (Mental Health Review Board, 2013). It is assumed that discharge ordered by the MHRB will be counter to the views of the treating team since the person must be discharged from the CTO if the treating psychiatrist believes the person no longer meets the criteria. (MHA 1986, s14). Discharge from a CTO is mostly determined by the treating service in the context of discharge planning and provision of ongoing treatment. Some people actively evade mental health services such that the CTO expires, rather than finishing as part of treatment planning.

There has been limited research on whether the mode of discharge results in different outcomes for the person being treated. A study of 124 persons (inpatients) discharged by the Mental Health Review Tribunal under the English 1983 Mental Health Act found no difference in subsequent survival period in the community or readmission rate when compared to those not discharged by the Tribunal [274](Myers, 1997). CTOs were not available in England at the time of that study. The purpose of our study was to examine service use following discharge from a CTO, making comparisons between those discharged by the MHRB, by the treating psychiatrist, or by the expiration of their CTO.

4.2.3. Methods

Study design

In this retrospective cohort study, we identified all individuals in Victoria, Australia who had been on a CTO for at least three months and were then discharged between 1 January 2008 and 31 December 2008 (n = 1,520). We followed these individuals for 24 months to identify their service use. This period was chosen to facilitate a later comparison between two legislative frameworks. We excluded the records of 24 individuals whose reason for discharge was death, and 18 individuals where no information on the reason for discharge was available, giving a sample of 1,478 participants.

We used a three-month period on a CTO as the inclusion criteria because in our clinical experience, this corresponded to those with severe mental illness with associated disability and need for treatment. We considered service utilisation a proxy measure of whether the person had experienced a relapse (need for inpatient admission), the severity of the relapse (return to involuntary status), and whether the person remained engaged with services following discharge from a CTO (ongoing community contacts). Ethical approval was obtained from the Melbourne Health Human Research Ethics Committee (No. 2013.109).

Data sources

The Department of Health Victoria administers the Client Management Interface/ Operational Data Store (CMI/ODS) data system that records all registrations and contacts with state funded mental health services. The CMI/ODS records basic demographic information about patients as well as detailed information about the use of mental health services. The Department provided us with baseline data on the 1,478 individuals who met the inclusion criteria along with follow-up data on any inpatient admissions (n = 2,407 records), any community mental health contacts (n = 7,078 records) and information on changes in their mental health legal status (n = 8,652 records). The data set included mental health diagnosis. As this sometimes changed between episodes, we used the primary diagnosis prior to discharge, or if this was unavailable, we used the primary diagnosis immediately following discharge. Using a unique identifier, we converted these administrative records to a person-level dataset, constructing outcome variables that represented whether the individual went back onto an involuntary order of any type in the subsequent 24 months (yes or no), went onto a CTO (yes or no) or had an inpatient admission (yes or no). We also constructed predictor variables based on the patient's status at discharge. These were: method of discharge (discharge by the Mental Health Review Board, discharge by the treating psychiatrist, or expiration of order), sex, age (16-24 years, 25-65 years, >65 years), location (urban, rural) and days on order prior to discharge (≤180 days, 181--364 days, >364 days).

Statistical analysis

We report descriptive statistics of the sample. In order to assess whether there were systematic differences between patient's method of discharge and the other predictors, we calculated two-way cross-tabulations between method of discharge and sex, age location and days on order prior to discharge. Using logistic regression, we examined the association between method of discharge and each of the outcome variables (involuntary order of any type, CTO, inpatient admission). As we were interested in the outcomes of those whose CTO was terminated by the MHRB compared to the other modes, we made this our reference category. Our models adjusted for sex, age, location, days on order prior to discharge and diagnosis. All analyses were undertaken in Stata 13.1.

4.2.4. Results

Sample characteristics

The characteristics of the sample are shown in Table 4.1. The majority were male (60%), aged between 25 and 65 years (85%), living in urban location (77%) and had been on a CTO for more than a year at discharge (80%). The most common diagnosis was schizophrenia and related disorders (72%). We were unable to provide a diagnosis in 12% of cases.

Table 4.1. 2008 Sample characteristics

Variable	Number	Percentage
Discharge Reason		
MHRB recommendation	80	5
Expiration of Order	95	7

Variable	**Number**	**Percentage**
Discharge from MHA involuntary status	1303	88
Participants		
Male	882	60
Female	596	40
Age at CTO discharge		
Youth 16-24	138	9
Adult 25-65	1255	85
≥Aged 65	85	6
MH Service location		
Rural	337	23
Urban	1141	77
Days on order prior to discharge		
90-180 days	294	20
>181 days	1184	80
< 1 year	1016	67
> 1 year	462	31
IPU General admission within 2 years	560	38
IPU Special admission within 2 years	20	1
Community episode within 2 years	816	55
Extended care rehab episode within 2 years	72	5
Residential care episode within 2 years	63	4
Back on Order of any type within 2 years	590	40
Back on CTO within 2 years	509	34
Diagnosis		
Schizophrenia, paranoia and acute psychotic disorders	1066	72
Mood disorders	149	10
Substance abuse disorders	44	3
Personality disorders	13	1
Other disorders	35	2
Unknown	171	12

*(Note; The initial client sample N = 1520 however we removed those consumers whose reason for discharge from their CTO was either ‘death’ (n = 24) or ‘not applicable’ (n = 18)). Special admission refers to units such as Eating Disorder, Mother and Baby. Diagnosis refers to the primary diagnoses prior to discharge, and if unavailable, following discharge.

A total of 80 individuals (5%) were discharged from the CTO by the MHRB, 1,303 individuals (88%) were taken off the CTO by the treating service and orders expired for 96 individuals (7%). Of the sample, 590 (39%) went back on an involuntary order (Inpatient or CTO) within the following 2 years and 509 (34%) went back onto a CTO at least once. For those who went back on an order of any type, the mean time between coming off the CTO and going back onto any type of order was 262 days. The mean time for going back onto a CTO was 304 days. There was no significant difference between discharge by the service and discharge by the MHRB in days to next contact, or days to next admission. Of those discharged by the MHRB, 34 (43%) experienced another inpatient admission within the subsequent two years while 495 (33%) of those discharged by the service were admitted. Of the total number, 560 (38%) were admitted during the following two years. There was no significant difference in age or gender in those who were discharged by the service or MHRB or whose order expired. There appeared to be a greater likelihood that those in a rural setting would be lost to follow up resulting in expiry of their CTO (Table 4.2). The diagnosis did not differ significantly between the modes of CTO termination.

The logistic regression analysis showed that the odds of going back onto an order of any type within two years of release differed by the mode of discharge (Table 4.3). In comparison to those released by the MHRB (the reference category), and independent of the other covariates in the model, those released because their order had expired had approximately the same odds of returning to a new order of any kind (inpatient or CTO) (OR = 1.02) and those discharged from the order by the treating psychiatrist had lower odds of returning to a new order (OR = 0.61). Similarly, those discharged from the CTO by the MHRB had about the same odds of returning to a CTO as those whose order had expired (OR = 1.2) while those who were discharged from the MHA involuntary status by the treating psychiatrist had lower odds (OR = 0.63).

Table 4.2. Mode of discharge

	Mental Health Review Board No. (%)	Discharge from MHA Involuntary status No. (%)	Expiration of Order No. (%)	Total No.	p-value
Sex					0.157
Male	52 (65)	766 (59)	64 (67)	882	

Female	28 (35)	537 (41)	31 (33)	596	
Age at CTO discharge					0.604
16-24	4 (5)	125 (9)	9 (10)	138	
25-65	73 (91)	1102 (85)	80 (84)	1255	
≥65	3 (4)	76 (6)	6 (6)	85	
Location					0.008
Rural	18 (23)	285 (22)	34 (36)	337	
Urban	62 (77)	1018 (78)	61 (64)	1141	
Days on Order prior to discharge					<0.000
≤180 days	15 (19)	268 (21)	5 (5)	288	
>181 days <364 days	21 (26)	636 (49)	29 (31)	686	
≥365	44 (55)	399 (30)	61 (64)	504	
Diagnosis					0.921
Schizophrenia, paranoia, and acute psychotic disorders	59 (74)	935 (72)	72 (76)	1066	
Mood disorders	8 (10)	134 (10)	7 (7)	149	
Substance abuse disorders	3 (4)	37 (3)	4 (4)	44	
Personality disorders	0 (0)	12 (1)	1 (1)	13	
Other disorders	3 (4)	31 (2)	1 (1)	35	
Unknown	7 (9)	154 (12)	10 (10)	171	

Table 4.3. Unadjusted and adjusted logistic regression results predicting going back on an involuntary order of any type, a CTO, and general inpatient admission

(a) Unadjusted

		Order of any type		CTO		Inpatient admission	
Variable	**No. (%)**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**
Discharge reason			0.0035		0.007		0.4
MHRB	80 (5)	1		1		1	
Discharge from MHA invol status	1303(88)	0.63 (0.40-0.99)		0.63 (0.40-1.00)		0.83 (0.52-1.31)	
Expiration of order	95 (7)	0.94 (0.52-1.70)		1.11 (0.61-2.02)		0.66 (0.35-1.21)	
Sex			0.391		0.56		0.33
Male	882 (60)	1		1		1	
Female	596 (40)	0.91 (0.74-1.13)		0.94 (0.75-1.17)		0.90 (0.73-1.12)	
Age at CTO discharge			0.0001		0.0001		<0.0001
16-24	138 (9)	1		1		1	
25-65	1255(85)	0.69 (0.49-0.98)		0.69 (0.48-0.98)		0.52 (0.36-0.74)	
≥65	85 (6)	0.28 (0.15-0.51)		0.26 (0.13-0.50)		0.20 (0.11-0.38)	
Location			0.006		0.012		0.39
Rural	337 (23)	1		1		1	
Urban	1141(77)	1.42 (1.10-1.84)		1.40 (1.07-1.82)		1.12 (0.87-1.44)	

		Order of any type		CTO		Inpatient admission	
Variable	**No. (%)**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**
Days on order prior to discharge			0.15		0.54		0.0027
≤180 days	288 20)	1		1		1	
>181 days <364 days	686 (46)	0.85 (0.65-1.13)		0.88 (0.66-1.17)		0.80 (0.61-1.06)	
≥365	504 (34)	0.75 (0.56-1.00)		0.85 (0.63-1.14)		0.60 (0.45-0.81)	
Diagnosis			<0.0001		<0.0001		<0.0001
Schizophrenia, paranoia, and acute psychotic disorders	1066 (72)	1		1		1	
Mood disorders	149 (10)	0.96 (0.68-1.36)		0.87 (0.61-1.24)		1.07 (0.76-1.51)	
Substance abuse disorders	44 (3)	1.36 (0.74-2.48)		1.44 (0.79-2.63)		1.51 (0.83-2.76)	
Personality disorders	13 (1)	0.77 (0.25-2.38)		0.70 (0.21-2.29)		1.18 (0.39 – 3.54)	
Other disorders	35 (2)	0.73 (0.37-1.47)		0.63 (0.30-1.33)		0.72 (0.35-1.46)	
Unknown	171 (12)	0.06 (0.03-0.12)		0.07 (0.03-0.14)		0.05 (0.02 -0.11)	

(b) Adjusted

		Order of any type		CTO		Inpatient admission	
Variable	**No. (%)**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**
Discharge reason			0.0172		0.0049		0.44
MHRB	80 (5)	1		1		1	
Discharge from MHA invol status	1303(88)	0.61 (0.38-0.99)		0.63 (0.39-1.01)		0.80 (0.49-1.29)	
Expiration of order	95 (7)	1.02 (0.54-1.91)		1.20 (0.64-2.24)		0.66 (0.34-1.25)	
Sex			0.70		0.97		0.58
Male	882 (60)	1		1		1	
Female	596 (40)	0.96 (0.76-1.20)		1.00 (0.80-1.27)		0.94 (0.75-1.18)	
Age at CTO discharge			0.0080		0.0053		0.0002
16-24	138 (9)	1		1		1	
25-65	1255(85)	0.72 (0.50-1.04)		0.71 (0.49-1.03)		0.54 (0.37-0.79)	
≥65	85 (6)	0.36 (0.18-0.68)		0.32 (0.16-0.64)		0.27 (0.14-0.52)	
Location					0.126		0.59
Rural	337 (23)	1	0.10	1		1	
Urban	1141(77)	1.25 (0.96-1.64)		1.24 (0.94-1.65)		0.93 (0.71-1.22)	

		Order of any type		CTO		Inpatient admission	
Variable	**No. (%)**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**	**OR (95% CI)**	**p value**
Days on order prior to discharge			0.36		0.79		0.011
≤180 days	288 20)	1		1		1	
>181 days <364 days	686 (46)	0.96 (0.72-1.28)		0.97 (0.72-1.30)		0.91 (0.68-1.22)	
≥365	504 (34)	0.82 (0.60-1.12)		0.90 (0.65-1.24)		0.73 (0.53-1.00)	
Diagnosis			<0.0001		<0.0001		<0.0001
Schizophrenia, paranoia, and acute psychotic disorders	1066 (72)	1		1		1	
Mood disorders	149 (10)	0.99 (0.69-1.41)		0.91 (0.63-1.31)		1.06 (0.74-1.51)	
Substance abuse disorders	44 (3)	1.27 (0.69-2.33)		1.33 (0.72-2.44)		1.42 (0.77-2.62)	
Personality disorders	13 (1)	0.74 (0.24-2.29)		0.68 (0.21-2.23)		1.12 (0.37-3.40)	
Other disorders	35 (2)	0.74 (0.36-1.49)		0.64 (0.30-1.35)		0.67 (0.32-1.38)	
Unknown	171 (12)	0.07 (0.03-0.14)		0.07 (0.03-0.16)		0.05 (0.02-0.12)	

In addition, the odds of returning to an order of any type, a CTO or having an inpatient admission, were related to age. Youth had the highest odds of returning to a new order, and this declined with age. Similarly, those living in urban locations had higher odds of returning to an order of any type or a CTO than those living in rural locations, although this finding did not hold for inpatient admissions. Finally, sex and the number of days on order prior to discharge were unrelated to returning to an order.

4.2.5. Discussion

There are a number of tensions in where and how we provide services to those with severe mental illness. There is general support for policy and practice that encourages consumer choice, provision of care in the least restrictive way and respect for the rights of individuals. But there is also increasing recognition and concern regarding poor physical health and disability outcomes of those who suffer severe mental illness, and concerns regarding violence in mental health clinical settings and community safety [34, 138](Szmuckler, 2004; Zipursky et al., 2013). There is also concern that for some people disengagement with services and non-adherence with treatment leads to increased risk of relapse and progressive deterioration related to the mental illness [275](Weiden, 2006). Maintaining engagement and treatment adherence in illnesses such as schizophrenia is challenging where there is episodic treatment by mental health services, fragmented funding and a dearth of strong community health and support services [154](Fleischhacker et al., 2014).

Mental health legislation reflects the tension between individual autonomy and clinical care in that it provides for treatment and detention as an involuntary patient where the person is deemed by clinical staff to meet strict criteria, but also places limits on this by empowering an external non-clinical body to reverse those decisions. In general, involuntary treatment can only be provided where the person has a diagnosed mental illness that is believed to be associated with increased risk of harm, and they have refused or are unable to comply with recommended treatment.

Under the 1986 Victorian Act the decision to place a person on a CTO was made by the Authorised Psychiatrist (AP) and subject to review by the Mental Health Review Board (MHRB). With the introduction of a new MHA in 2014 there has been a significant shift in that the decision to place a person on a CTO, and the duration, is now made by the Mental Health Tribunal (MHT)[14].

In most cases, CTOs are made in regard to persons who suffer severe and often relapsing mental illness such as schizophrenia and schizoaffective disorder. In our sample and more generally in Victoria these two diagnoses account for three-quarters of people who appear before the MHRB (MHRB Annual report, 2014). Although there is now agreement that the outlook for people with schizophrenia is better than was believed in the past, long term studies show that a significant number of people will experience clinical and social deficits[33](Van Os and Kapur, 2009). The best outcomes are associated with ongoing medication and psychosocial support. It is also likely that with each relapse there is further deterioration in social and occupational functioning [60, 276](Zipursky et al., 2014; Zygmunt et al., 2002). Relapse is strongly associated with non-adherence to treatment [277](Gitlin et al., 2001). Non-adherence has also been associated with poorer functional outcomes including increased likelihood of readmission, violence, substance abuse and victimisation [278](Ascher-Svanum et al., 2006). CTOs are primarily aimed at improving treatment adherence and facilitating engagement along with improved understanding and acceptance of treatment.

In this study we were interested in whether there was any difference in subsequent service contact where the MHRB made a decision counter to the treating team. While there were few differences in subsequent contact, we found that there was a greater likelihood of going back onto an involuntary order if the discharge was made by the MHRB, or if the CTO expired – most likely because the person had disengaged with services. It is plausible that discharge planning was less advanced in these cases. We were not able to consider whether there was a different pattern of diagnosis associated with termination of the CTO by the service, the MHRB or because of expiry.

An additional finding of this study is that the risk of needing further treatment as an involuntary patient was greater for young people and for those living in urban settings. It seems likely that younger people have less understanding of their illness and are thus more likely to drop out of treatment. Urban services carry a greater proportion of those who are homeless and who have co-morbid substance use, which may contribute to the increased risk of relapse and readmission as an involuntary patient.

There is good evidence that the best outcome for those who suffer severe mental illness is to minimise the number and severity of relapses, and that the best way to achieve this is through medication alongside good psychosocial support [34, 154](Fleischhacker et al., 2014; Zipursky et al., 2013). Adherence to prescribed treatment is more likely when patients are well informed, when their choice regarding treatment can be supported and where there is good clinical engagement. CTOs have a primary function of endeavouring to improve treatment adherence. Ideally this adherence means that a person remains well while he or she learns more about the illness such that they will continue with treatment in the absence of compulsion. While recognizing that more than 50% of those who were discharged by the MHRB did not have an admission over the next two years, our findings suggest that those discharged by the MHRB, or those who dropped out of treatment because they were lost to follow up and the CTO expired, were at increased risk of having a relapse of a severity that required readmission under the MHA. While perhaps little can be done to address those who actively seek to avoid services, our findings suggest that we should be working with the external review body and those who develop mental health policy to allow a period of discharge planning rather than abrupt cessation of the CTO. This study does not purport to provide evidence of support for CTOs per se, but does suggest that engagement and discharge planning associated with appropriate use of a CTO may lessen the severity and therefore the negative impact of future illness episodes. Where discharge occurs as a result of the decision of the MHRB, the service and patient should be given time and encouragement to put in place supports for ongoing treatment and engagement.

This study has a number of limitations. We have only included service utilisation in the two years after termination of the CTO, and so cannot comment on admissions over a longer period. We were not able to include comorbidity as a variable of interest as this is not reliably entered into the database. We were not able to determine whether the persons discharged by the MHRB were more or less likely to have legal representation. It is also acknowledged that the data only covers contact with mental health services funded by the State and thus excludes those services provided through private specialist and primary care services. In Victoria all involuntary or compulsory care is provide only in State funded services. In addition, a number of psychosocial factors that may impact on decisions made by the MHRB, or the service, such as family support, vocational or educational achievements were not able to be included. Despite this, this study has a number of advantages over previous studies in this area, including the use of a state-wide data collection and a long follow-up time. Our finding of less likelihood of returning to involuntary care if discharge was planned and implemented by the treating service supports the aims and intention of better engagement by treating services with people who experience severe mental illness.

4.2.6. Acknowledgements

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Chapter 5. Study 2 – The impact of legislative change on the use and duration of compulsory treatment orders

This chapter describes study 2 which considered the impact of the move from the *Mental Health Act (1986)* to the *Mental Health Act (2014)* which placed greater emphasis on recovery principles and supported decision making. The chapter incorporates the accepted version of a paper published in the *Australian and New Zealand Journal of Psychiatry* 2019 Vol 53(5) 433-440. The candidate was the first author and lead the research component as well as undertaking the drafting and reviews. The co-authors assisted with drafting and with the statistical analysis.

5.1. Background

Chapter 2 considered the changes in mental health policy that resulted in reformed legislation. In particular there was greater emphasis on making periods of compulsory care as short as possible. The threshold for meeting the criteria for compulsory care was raised and the extent of external oversight and scrutiny enhanced. Study 2 built on the previous study by comparing service utilisation over the two years following termination of a CTO of at least three months duration between a patient cohort under the *Mental Health Act (1986)* with that under the *Mental Health Act (2014)*. As discussed in chapter 2, the *Mental Health Act (2014)* brought an explicit focus on rights of the individual and was informed by the United Nations Convention on the Rights of Persons with Disabilities and recovery principles.

The time covered by the *Mental Health Act (2014)* CMI/ODS data set was between December 2014 (six months after the Act commenced) to December 2016. The cohort comprised 1297 patients. The hypothesis was that under a mental health act which explicitly brought a recovery orientation and sought to reduce compulsory treatment, and which brought in external oversight with greater powers and responsibilities, there would be a reduction in the use and duration of compulsory treatment.

Consistent with the previous study, study 2 raised the question of the adequacy of community treatment and support. While the study found there had been a reduction in the use and duration of compulsory care, it could not definitively conclude that this was because of the reforms in mental health legislation. Legislation can afford protection of some rights, but how it is used and its effectiveness is influenced by other service delivery factors. Since this was a retrospective study based on data routinely collected, it could not include consideration of the quality of service provided. Further work is needed to resolve whether having excellent community services in place would have been associated with more or less use and duration of compulsory treatment. The conundrum of whether it is better to access treatment – even if under compulsory orders – or not, is still debated. As with Study 1, the data did not allow consideration of other outcomes such as self-harm, criminal offending, or homelessness. In addition, the study did not allow interrogation of whether people who were unlikely to benefit from the CTO were being placed under a CTO.

5.2. Does legislative change affect the use and duration of Compulsory Treatment Orders?

5.2.1. Abstract

Objective: Victoria, Australia introduced reformed mental health legislation in 2014. The Act was based on a policy platform of recovery-oriented services, supported decision making and minimisation of the use and duration of compulsory orders. This paper compares service utilisation and legal status after being on a community treatment order under the *Mental Health Act 1986* (Vic) with that under the *Mental Health Act 2014* (Vic).

Methods: We obtained two distinct data sets of persons who had been on a community treatment order for at least three months and their subsequent treatment episodes over two years under the MHA and/or as an inpatient for the periods 2008 – 2010 (MHA 1986) and 2014 – 2016 (MHA 2014). The two sets were compared to assess the difference in use, duration, and odds of having a further admission over two years. We also considered the mode of discharge – whether by the treating psychiatrist, external body or through expiry.

Results: Compared with the MHA 1986, under the MHA 2014 index community treatment orders were shorter (mean 227days compared with 335 days); there was a reduction in the mean number of community treatment orders in the two years following the index discharge - 1.1 compared with 1.5 (IRR=0.71, 95% CI = 0.63-0.80); and a 51% reduction in days on an order over two years. There was a reduction in the number of subsequent orders for those whose order expired or was revoked by the psychiatrist under the MHA 2014 compared to those under the MHA 1986. The number of orders which were varied to an inpatient order by the authorised psychiatrist was notably greater under the MHA 2014.

Conclusion: The reformed MHA has been successful in its intent to reduce the use and duration of compulsory orders in the community. The apparent increase in return to inpatient orders raises questions regarding the intensity and effectiveness of community treatment and context of service delivery.

5.2.2. Introduction

Mental health legislation sets out the requirements which must be met to permit compulsory treatment of those with severe mental illness, including those interventions which must be reported and the requirement for external review or oversight. Current mental health legislation includes provision for compulsory treatment to be provided in community settings (Community Treatment Order; CTO). These are widely used, especially in Victoria [7](Light et al., 2012). However, the perceived utility of CTO by clinicians is at odds with the findings of much of the research in the area [165, 192, 279](Hastings and Gray, 2016; Little, 2018; Rugkasa et al., 2014).

Studies have suggested that CTOs of longer duration are associated with reduced risk of relapse [180](Swartz et al., 2010) and that CTOs do support medication adherence. These benefits are particularly apparent while the CTO is in effect [183](Harris et al., 2018). Debate on the effectiveness of CTOs is ongoing [192, 280](Burns and Molodynski, 2014; Rugkasa et al., 2014). Maughan et al (2014) proposed that future research should aim to distinguish between CTO recall and revocation and different patterns of community contact, as this would assist in differentiation between CTO process and outcome [190].

Controversy about the use of CTOs relates not only to concerns about their effectiveness, but also to concerns about an individual’s rights of autonomy and freedom of choice, and access to treatment [180, 281](Burns, 1999; Swartz et al., 2010). Recent developments in mental health legislation have placed greater emphasis on compatibility with human rights consistent with the provisions of the Convention on the Rights of Persons with Disability [4, 160](Kallert et al., 2011; United Nations, 2006).

Victoria, Australia implemented forward thinking mental health legislation in 1986 (*Mental Health Act 1986* (Vic)). The MHA 1986 introduced external review by the Mental Health Review Board (MHRB) and provision for involuntary treatment in the community - CTO. Although the MHA 1986 was amended on many occasions it was deemed not compatible with the Victorian Charter of Human Rights and Responsibilities, and reformed legislation was enacted in July 2014 [14, 118](Victorian Government 2006, 2014). This was outlined by the then Minister for Mental Health, the Honourable Mary Wooldridge to the parliament in February 2014 [282](Wooldridge, 2014b). The *Mental Health Act 2014* (Vic) was based on a policy platform of recovery-oriented care. It was explicit in its intention to minimise the use and duration of compulsory orders, treatment in the least restrictive way, and to promote supported decision making through mechanisms including the introduction of independent advocacy, nominated persons, independent second opinion and advance statements [243, 244, 283](Department of Health, 2012; Legislative Assembly, 2014; Wooldridge, 2014a).

The MHA 2014 commenced in July 2014 and introduced a staged process for compulsory status with restrictions on what treatment could be instituted in the first 24 hours (Table 5.1). It increased the threshold for compulsory care by requiring an immediate need for treatment to prevent ‘serious’ deterioration or ‘serious’ harm, and that the order must be ‘immediately’ revoked if the criteria no longer apply. The MHRB was replaced by the Mental Health Tribunal (MHT) which had the power to make both Community and Inpatient Treatment Orders (ITO). The discretion of the Authorised Psychiatrist (AP) to determine treatment and detention as a Compulsory Patient was reduced to 28 days. Any order for a longer time could only be made by the MHT. The duration an order could be made (by the MHT) was reduced to a maximum of six months (compared to 12 months by the AP under the MHA 1986) for a current inpatient and 12 months for a community patient with requirement to justify the length of the order made. The MHA 2014 also increased external oversight with the creation of a Mental Health Complaints Commissioner. The Act emphasised supported decision making over substituted decision making. The principles included that persons should be allowed to make decisions about their treatment that involve a “degree of risk” (MHA (2014), s11 (d). Commencement of the MHA 2014 was accompanied by a comprehensive information and education package supported by funding for additional MHA support staff in every area mental health service.

Table 5.1. Comparison between MHA 1986 and MHA 2014

	MHA 1986	MHA 2014
Definition of Mental Illness	Mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception, or memory (s8(1A))	Definition unchanged (s4(1))
Overarching legislative intent	Includes Objects (s4) and Principles of treatment and care (s6A) to emphasise least restrictive environment and treatment in the community.	Includes Objectives (s10) and mental health principles (s11) to promote rights, recovery, participation, with voluntary treatment preferred.
Naming	Involuntary patient	Compulsory Patient
Order Stages	Recommendation, Treatment order made within 24 hours. Duration max 12 months unless discharged by AP or MHRB	Assessment Order – 24 hours Temporary Treatment Order (TTO) – 28 days Treatment Order – Inpatient Order (ITO) max 6 months unless discharged by AP Community Treatment Order (CTO) max 12 months
Criteria	The person appears to be mentally ill (s8(1)(a)); and requires immediate treatment (s8(1)(b)); and necessary for health and safety (whether to prevent deterioration) or for the protection of members of the public (s8(1)(c)); and has refused or unable to consent to treatment (s8(1)(d)); and cannot receive treatment in a manner less restrictive (s8(1)(e)).	The person has a mental illness (s5(a)); and needs immediate treatment to prevent serious deterioration in the person's mental or physical health; or serious harm to self/others (s5(b)); and immediate treatment will be provided if the person is subject to a TTO or TO (s5(c)); and no less restrictive means reasonably available (s5(d))
External Review	MHRB* – Within 8 weeks and annually. Reviews decision by Authorised Psychiatrist (AP)	MHT* - Within 28 days and when order due to expire Makes Order and sets duration
Discharge/ Revocation	If AP considers criteria in s8(1) do not apply, must discharge the person from the order (s37)	An AP who determines that the treatment criteria do not apply, must immediately revoke the order (s61)
Capacity	Not explicitly included	Presumption that person has capacity to give informed consent included (s70)
Decision making	Substituted decision making	Supported decision making strongly encouraged
Mechanisms to assist patient	Right to a second opinion, but could be from within service	Independent Mental Health Advocacy Second Psychiatric Opinion Scheme (Division 4) Mental Health Complaints Commission (Part 10) Nominated persons (Division 4) Advance Statements (Division 3)

*MHRB – Mental Health Review Board; MHT – Mental Health Tribunal

There were also substantial changes to the service system from 1986 to 2014, with progressive closure of large stand-alone services, increased funding to non-clinical community support services, and a preference for community-based care over inpatient care. In a previous publication examining service utilisation and legal status following CTO termination under the MHA 1986, we reported that there was a significantly greater likelihood of subsequently requiring treatment as an involuntary patient if discharge from a CTO had been unplanned such as through expiry of the Order or by determination of the MHRB, rather than as part of discharge planning by the treating service [19](Vine et al., 2016).

In this paper we explore whether there are any differences in the duration and frequency of use of CTOs under two mental health acts which differ in their emphasis on the rights of the individual, external determination and justification of the imposition of compulsory treatment. We hypothesised that the duration of the CTO would be shorter under the MHA 2014 compared with the MHA 1986, both because of a shift in the threshold for compulsory treatment, and a more assertive MHT. Related to this, we questioned whether there would be more episodes of compulsory care under the MHA 2014 because people may be more at risk of relapse if taken off an order earlier on in the course of the illness or relapse.

5.2.3. Methods

Study design

Two distinct data sets were obtained from the Department of Health and Human Services (DHHS). The first identified all individuals who had been on a CTO (under MHA 1986) for at least three months in 2008 and subsequent service utilisation over the 24 months post discharge or expiry of the CTO. This data set comprised 1478 individuals. The second data set identified all those who had been on a CTO of at least 3 months duration at December 2014 (under MHA 2014) and their subsequent service utilisation over two years. We considered the mode of termination of the CTO (whether by the AP, MHT or expiry) and whether the person was subsequently admitted or placed under an Order. The two data sets are from the same source such that we were able to compare the 2008 – 2010 outcomes with those under reformed legislation in 2014 – 2016.

Ethical approval was obtained from the Melbourne Health Human Research Ethics Committee (No. 2013.109).

Data sources

The DHHS Victoria administers the Client Management Interface/Operational Data Store (CMI/ODS) data system that records all registrations and contacts with state funded mental health services. Compulsory treatment can only be provided in the state funded and operated health services. The CMI/ODS records basic demographic information about patients as well as detailed information about the use of mental health services. The Department provided baseline data on individuals who met the inclusion criteria and follow-up data on any inpatient admissions and changes in mental health legal status. The data set included diagnosis.

Statistical analysis

We report descriptive statistics of the samples, and associations between mode of discharge and key variables. We also undertook a direct comparison between the two data sets to assess the difference in the odds of having at least one admission within the 2 years following expiry or discharge. We carried out a comparison of the number of admissions and duration under a compulsory order under the two Acts. These were adjusted for discharge reason, sex, age, service location and duration of order. Logistic regression was used to determine predictors of subsequent orders within 2 years of index discharge. All analyses were undertaken in Stata version 15.1.

5.2.4. Results

The data sets included 1478 patients who had been on a CTO for > 3 months under the MHA 1986 (2008 -2010) and 1297 patients on a CTO for >3 months under the MHA 2014. Index community treatment orders were shorter under the MHA 2014. Median duration under the MHA 1986 was 335 days compared with 227 under the MHA 2014. Thirty-four per cent were less than 6 months under the MHA (2014) compared to only 20% being less than 6 months under the MHA 1986 ($p< 0.001$) (

Table 5.2).

Table 5.2. Demographics of individuals at index CTO

	MHA (1986 (n=1,478)	MHA (2014) (n=1,297)	Absolute decrease in percentage (95% CI)	Chi-squared p-value for independence
Index CTO Discharge Type				0.007
MHT revoke	80 (5.4%)	55 (4.2%)	1.2 (-0.4, 5.3)	
Expiration of order	95 (6.4%)	122 (9.4%)	-2.9 (-5.0, -0.9)	
Authorised Psychiatrist Revoke	1,303 (88.2%)	1,120 (86.4%)	1.8 (-0.7, 4.3)	
Sex				0.006
Female	596 (40.3%)	457 (35.2%)	5.1 (1.5, 8.7)	
Male	882 (59.7%)	840 (64.8%)		
Age at Index CTO End				<0.001
16-24 (Youth)	138 (9.3%)	79 (6.1%)	3.2 (1.3, 5.2)	
25-34	415 (28.1%)	287 (22.1%)	6.0 (2.7, 9.2)	
35-49	570 (38.6%)	567 (43.7%)	-5.2 (-8.8, -1.5)	
50-65	270 (18.3%)	288 (22.2%)	-3.9 (-6.9, -0.9)	
66-95 (Aged)	85 (5.8%)	76 (5.9%)	-0.1 (-1.9, 1.6)	
Location				<0.001
Rural	310 (21.0%)	182 (14.0%)	6.9 (4.1, 9.7)	
Urban	1,168 (79.0%)	1,115 (86.0%)		
Time on Order				<0.001
3 to 6 months	294 (19.9%)	441 (34.0%)	-14.1 (-17.4, -10.8)	
6 months to 1 year	772 (48.8%)	518 (39.9%)	8.9 (5.2, 12.6)	
> 1 year	462 (31.3%)	338 (26.1%)	5.2 (1.8, 8.6)	

Mode of termination

Under the MHA 1986 88% of patients were discharged from the CTO by the AP. A similar proportion (86%) had the CTO ended by the AP under the MHA 2014, but a noticeable difference was that 410 of the 1297 patients had their CTO varied to an Inpatient order by the treating psychiatrist, rather than being discharged to voluntary status. We included these in the analysis on the basis that to exclude them would misrepresent the outcome of those on the CTO. These patients were included in the category revoked by the Authorised Psychiatrist. In a sensitivity analyses, it was found that the 410 patients on a ‘vary order’ had been on longer CTOs (31% over a year vs. 24%), were more likely to be male (71% vs. 62%) and have a substance use disorder (13% vs. 7%) but less likely to have a mood disorder (3% vs. 9%), compared to the remainder (887). Compared to the participants in the study period under the MHA 1986 (n=1,478), those under the MHA 2014 (n=1,297) had a higher proportion of index orders ending by expiry (9% vs 6%) (

Table 5.2).

Frequency of episodes

On average, participants had 1.5 further community treatment orders in the two years after index discharge under the MHA 1986, compared to 1.1 under the MHA 2014- a 29% reduction (Table 5.3). If the discharge mode is disaggregated, the main difference is the reduction in number of episodes for those whose index CTO discharge was authorised by a psychiatrist (31% reduction) compared to only 14% for those revoked by a mental health tribunal (non-significant reduction). For inpatient treatment orders, there was a 22% reduction between the MHA 1986 and MHA 2014. Index CTOs discharged by a MHT revocation had the least difference (17%; non-significant reduction) while expired and psychiatrist discharged orders both had a significant reduction. For inpatient admissions, there was no meaningful change in incidence between the MHA 1986 and MHA 2014.

Those on a varied order had significantly more CTOs (IRR = 1.43, 95% CI = 1.20- 1.70) and inpatient admissions (IRR = 1.23, 95% CI = 1.09 – 1.37) than those who were discharged to voluntary status, while there were fewer ITOs (IRR = 2.75, 95% CI = 0.60 – 0.79).

Table 5.3. Incidence Rates in the two years following index CTO discharge by discharge reason

Event	Discharge reason	Mean events MHA (1986)	Mean events MHA (2014)	IRR (95% CI)
Community Treatment Orders	MHT Revoked	1.53	1.32	0.86 (0.48–1.56)
	Expired	2.11	1.57	0.74 (0.51–1.09)
	Authorised by psychiatrist	1.44	1.00	0.69 (0.61–0.79)
	Overall	1.50	1.06	0.71 (0.63–0.80)
Inpatient Treatment Orders	MHT Revoked	2.80	2.32	0.83 (0.56–1.23)
	Expired	3.46	2.34	0.68 (0.48–0.96)
	Authorised by psychiatrist	2.97	2.34	0.79 (0.72–0.86)
	Overall	3.00	2.34	0.78 (0.72–0.85)
Inpatient Admissions	MHT Revoked	2.56	2.68	1.05 (0.72–1.53)
	Expired	3.32	3.24	0.98 (0.70–1.36)
	Authorised by psychiatrist	2.70	2.97	1.10 (1.01–1.20)
	Overall	2.74	2.98	1.09 (1.00–1.18)

Duration of subsequent orders

There was a 25% reduction in the number of days on orders (inpatient or community) over the following 2 years under the MHA 2014 compared with the MHA 1986 (

Table 5.4). This represents a change from an average of 479 days (over two years) on an order, to 357 days under the MHA 2014. While this reduction is not significant for index CTOs discharged by MHT, those that expired lead to a 55% reduction in days on order for the MHA 2014 compared to the MHA 1986 (95% CI: 35 – 68%), and a 21% reduction for those discharges authorised by psychiatrist (95% CI: 11 – 30%). Time on order was higher for those whose orders were varied – 454 vs 267 days (IRR = 1.70, 95% CI = 1.46 – 1.98).

Table 5.4. Days spent on order (community and inpatient treatment orders) in the two years following index CTO discharge by discharge reason

Discharge Reason	Mean under MHA (1986)	Mean under MHA (2014)	IRR (95% CI)
MHT Revoked	459.00	327.74	0.71 (0.40–1.27)
Expired	757.74	344.05	0.45 (0.32–0.65)
Authorized by psychiatrist	455.17	455.17	0.79 (0.70–0.89)
Overall	479.22	357.15	0.75 (0.66–0.84)

Order recurrence – adjusted analysis

Further analysis was carried out to assess the difference in the odds of having at least one inpatient admission, community treatment order, or inpatient treatment order in the 2 years following discharge. Both analyses were adjusted for discharge reason, sex and age of the consumer, mental health service location and the number of days on order prior to discharge (Table 5.5). The admission odds ratios show that individuals were more likely to have an inpatient admission in the 2 years from discharge under the 2014 MHA, but there was no significant interaction between the two data periods for the treatment orders.

Those on a varied order had significantly higher odds of at least one subsequent admission (IRR = 16.22, 95% CI = 11.28 – 23.31), CTO (IRR = 7.13, 95% CI = 5.40 – 9.43) and ITO (IRR = 2.23, 95% CI = 1.74 – 2.87) compared with those discharged to voluntary status.

Table 5.5. Adjusted logistic regression of having an admission or Treatment Order

Event	Adjusted odds MHA (1986)	Adjusted odds MHA (2014)	AOR (95% CI)
Community Treatment Orders	0.309	0.291	0.92 (0.77–1.08)
Inpatient Treatment Orders	0.368	0.379	1.05 (0.89–1.23)
Inpatient Admissions	0.408	0.541	1.74 (1.49–2.03)

Note: adjusted for Age at Index CTO End, sex, location and time on Index CTO

5.2.5. Discussion

We found that there was considerable change in the pattern of compulsory treatment in 2008 -2010 under the MHA 1986, and 2014 – 2016 under the MHA 2014. As we had hypothesised, the duration of the index CTO was significantly reduced under the MHA 2014 compared to the MHA 1986, as was the time spent on subsequent Orders. Unexpectedly, almost a third of patients had the order varied to an inpatient order by the AP under the MHA 2014. There was no comparable group under the MHA 1986, but the sensitivity analysis suggests that this group was more likely to be male and have comorbid substance use. It is possible that the high rate of return reflects the greater challenge that these patients experienced in the community, and also the greater intention to support patients to have a trial of care under a CTO. It is also possible that this apparent change over time reflects the growing pressure to discharge people from inpatient care on a CTO in order to free up inpatient beds to meet demand.

From a practitioner's perspective the changes between the MHA 1986 and the MHA 2014 include a requirement for more detailed information from the treating service, including stronger justification of why an order is required, and why there is a preference for an inpatient over a community treatment order. This reflects the enhanced role of the external review body (MHT). The increase in the number of orders varied from community to inpatient may reflect people being put on a CTO at an earlier stage of treatment as intended by the shift in policy to a more recovery oriented focus of care and the direction that treatment be provided in the least restrictive environment, or may reflect limited engagement with community services with subsequent deterioration in mental state. There were also a greater proportion of orders which expired rather than being revoked after consideration by either the MHT or the AP.

We had expected that shorter orders would be associated with more episodes of care under the MHA over the subsequent two years. Instead, we found that patients had fewer episodes of being treated as a compulsory patient under a CTO under the MHA 2014 compared with the MHA 1986. This is consistent with the aims of the MHA 2014 to support voluntary treatment. If the CTO was varied or revoked by the AP, patients were least likely to have a further CTO under both legislative regimes, while those who became disengaged from treatment services such that their CTO expired were less likely to have a further CTO under the MHA 2014 than under the MHA 1986.

These changes to fewer and shorter periods of compulsory care suggest that the expressed aims of the government in reforming mental health legislation have been realised. Does this mean that users of the mental health system have been more empowered to seek treatment without needing the rights and protections of compulsory status, and that we have implemented recovery-oriented care? Unfortunately, our data does not help us to know whether outcomes or patient experience have improved. Also, we only considered changes in legal status and inpatient admissions, not all contacts with mental health services. This is relevant since it is expected that more accessible and assertive treatment might result in better engagement, and earlier intervention. Without knowing the frequency and duration of community contacts we are not able to comment whether there was greater engagement with community treatment under the MHA 2014, or whether there has been a change in access or outcome.

It is also worthwhile to consider what other contextual issues may have impacted on these service changes. Victoria was a leader in closing the large stand-alone bed based services and developing innovative community mental health services in the 1990s [117](Gerrand, 2005). Much has changed since then with some commentators noting an increasing distance between what was promised and what was delivered through supposed reforms [284](Singh and Castle, 2007). On a per capita basis, Victoria had the highest per capita expenditure on mental health in 1992 – 93, but by 2015/16 Victoria had the lowest per capita spend on mental health across Australia (AIHW 2017, Table EXP 4) [285](Australian Institute of Health and Welfare). The acute bed base dropped from 18.1 per 100,000 in 2008/09 to 17.2 in 2015/16 (AIHW 2017, Table FAC 13) compared to the national average of 29.4. In 2015/16 Victoria had the lowest number of full-time equivalent staff with 118.2 per 100,000 population compared with the national average of 133.3 (AIHW, Table FAC 37) which suggests that there may be less ability to provide assertive care in the community. In summary, on a per capita basis, we are spending less, have fewer beds and fewer staff than comparable States in Australia despite a significant increase in population.

Increased population in the absence of proportional increases in capacity has resulted in increased pressure on state funded health services and mean that a comparatively lower proportion of the population accesses public mental health care. Victoria's mental health services annual report shows that the proportion of the population accessing state funded mental health services has fallen to 1.08% [286](Victorian Government, 2017). This compares to a national average of 1.8%

(AIHW KPI 8.1). This relative reduction in service availability is likely to impact on the effectiveness of treatment, whether services can be accessed early in the course of illness or relapse and therefore on the utilisation of compulsory orders. However, it is unclear what impact these changes have had on how mental health legislation is utilised in the clinical setting.

Swanson and Swartz suggest that factors such as differing legislative regimes, funding levels, and service systems mean that the gold standard evidence of CTO effectiveness will always be elusive [185](Swanson, 2014). O'Reilly and Vingilis (2017) point to the complexity of factors impacting the use and effectiveness of CTO [174]. Our study found that a substantial number of those placed on a CTO under the MHA 2014 were unable to be managed in the community and had their order varied to an inpatient order. We also found that the duration of a CTO has an impact on future need for compulsory treatment. Harris et al (2018) found that while on a CTO there was a delay in readmission and increased community care. Our study found that the reformed MHA has been successful in its intent to reduce the use and duration of compulsory orders. This conclusion needs to be considered in the service context. Further research should consider inclusion of patient outcome such as Health of the Nation Outcome Scales (HoNOS), duration of community contact, and patient experience to better understand whether the policy objectives have been achieved while retaining or improving experience of care and health outcomes. It should be noted that our data relates to the first two and a half years after the commencement of reformed legislation and so may not reflect the full impact of intended reforms.

5.2.6. Acknowledgements

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Chapter 6. Study 3 – The impact of substance use on treatment as a compulsory patient

This chapter reports on study 3, undertaken to examine the impact of substance use on the use and duration of compulsory orders. This chapter incorporates the accepted version of a paper published in *Australasian Psychiatry* 2019 Vol 27 (4) 378-342. The candidate was the first author and lead the research component as well as undertaking the drafting and reviews. The co-authors assisted with drafting and with the statistical analysis.

6.1. Background

As discussed in chapter 2, mental illness such as schizophrenia has a strong association with a number of adverse physical and psychosocial factors. Although the criteria for needing treatment as a compulsory patient require that the person has a mental illness, the other criteria, especially whether the person is a risk to him/herself or others, and cannot receive treatment in a less restrictive manner, are also influenced by other factors. There has been considerable research on factors beyond mental illness that have an impact on the use of compulsory treatment. A recent review has considered a number of social as well as clinical factors that are associated with compulsory hospitalisation [287]. In addition to finding that non-adherence to treatment, previous compulsory treatment and a diagnosis of psychotic disorder presented the greatest risks for compulsory treatment, the review found that social factors such as unemployment and being in receipt of benefits were associated with compulsory rather than voluntary admission. The authors noted that a better understanding of factors associated with increased risk of compulsory hospitalisation would help develop targeted interventions to prevent or reduce the use of compulsory treatment.

Substance misuse is commonly cited as one of the factors that influences the prognosis of psychotic illness, and has strong associations with other social disadvantage [288]. A study of young people with first episode psychosis found that those with substance misuse were more likely to have involuntary hospitalisation and poor treatment outcome [289]. Involuntary hospitalisation was also found to be associated with substance use in a large Norwegian study [290]. The impact of substance misuse has been particularly associated with increased risk of harm to others, which may explain in part why there is an association with use of compulsory orders and hospitalisation [291]. In particular, in people admitted as compulsory patients who presented with increased aggression and required restrictive interventions were found to have a high incidence of recent methamphetamine use [246]. It should be noted that substance use of itself is not considered a mental illness and a person cannot be detained under the Act only because of intoxication or substance dependence. CTOs can only stipulate the treatment required for the mental illness and cannot mandate treatment for drug and alcohol dependence. A person under a CTO cannot be made to submit to a urine drug screen, unless they are required to do so as part of a correctional order. In Victoria, services for drug and alcohol use are provided separately to mental health services. There are relatively few dual trained clinicians, and limited integration although this is improving.

Substance misuse has also been considered in community samples. A survey of clinicians in the UK on their views and use of CTOs found that substance misuse and lack of accommodation were the factors most likely to undermine the effectiveness of a CTO [158]. An audit of fifty patients on CTOs in Wales found that 40% had a diagnosis of substance misuse, but this was only included in the discretionary conditions attached to the CTO in 20% [197]. This may well reflect the difficulty of providing integrated care, especially when drug and alcohol services are separated from mental health services.

Using the CMI/ODS data from the 2014 – 2016 patient cohort, the candidate determined the frequency of a comorbid diagnosis of substance use. The hypothesis was that u*se* of stimulant drugs of abuse will be associated with a need to return to compulsory treatment sooner and for a longer duration than required by those patients who do not have an additional diagnosis of substance use. The findings of the study provide further evidence of the frequency of substance use in those subject to compulsory treatment and the relevance of providing better training in how to address these issues to promote better outcomes and reduced need for subsequent periods of compulsory care. The findings also support consideration of development of services which respond to both mental illness and drug and alcohol dependence, with staff experienced in managing both sets of presentations.

6.2. The impact of substance use on treatment as a compulsory patient

6.2.1. Abstract

Objective: This paper considers the impact of having a diagnosis of Substance Use Disorder on the utilisation of compulsory orders under the Victorian Mental Health Act (2014).

Methods: We analysed the subsequent treatment episodes over two years of people who had been on a Community Treatment Order for at least three months and determined the odds of a further treatment order if there was a diagnosis of substance use at or about the time the index CTO ended.

Results: An additional diagnosis of a substance use disorder was coded in 47.7% and was associated with significantly increased odds of a subsequent treatment order in the following two years for those with a main diagnosis of schizophrenia (AOR = 3.03, p<0.001) and 'other' disorders (AOR = 11.60, p=0.002). Those with a main diagnosis of mood disorder had a significant increase in odds for an inpatient treatment order if there was an additional substance use disorder diagnosis (AOR = 3.81, p=0.006).

Conclusion: Having an additional diagnosis of substance use disorder was associated with increased likelihood of being placed on an order. This study supports greater emphasis being given to treatment of substance use concurrently with that of mental illness.

Keywords: Compulsory Treatment; Mental Health legislation; substance use.

6.2.2. Introduction

Community Treatment Orders (CTO) are widely used, especially in Victoria[1] [7]. However, there has been limited research on the impact of variables such as comorbid substance use on the effectiveness or otherwise of compulsory care in the community. A recent systematic review and meta-analysis highlighted the complexity of assessing effectiveness of interventions. The authors commented that further work continues to be needed to understand why people do not engage with services, and to promote better community care[2] [187]. A significant number of persons who present with mental illness have comorbid problems of substance misuse, often with a negative impact on the mental illness in terms of relapse and severity[3,4] [197, 292]. In this paper we consider the effect of having an additional diagnosis of Substance Use Disorder (SUD) on the subsequent use of state funded mental health services. We used the term SUD to cover the Mental and Behavioural Disorders due to Psychoactive Substance Use (F10 – F19) in ICD-10[5] [264].

6.2.3. Methods

Study design

A data set was obtained from the Victorian Department of Health and Human Services (DHHS). This identified all those who had been on a Community Treatment Order (CTO) of at least 3 months duration at December 2014 and their subsequent service utilisation over two years. We selected the primary diagnosis code in the ICD-10 Mental and Behavioural Disorders due to Psychoactive Substance Misuse closest to the time when the index CTO ended.

Data sources

The DHHS Victoria administers the Client Management Interface/Operational Data Store (CMI/ODS) system that records all contacts with state funded mental health services. The data set included demographic details, treatment episodes, and the main psychiatric diagnosis as well as additional diagnoses including SUD (and the substance(s) used). The main diagnosis was defined as the diagnosis given at the time of discharge from the index CTO.

Sample

The data set reviewed included 1297 patients who had been on a CTO for > 3 months under the Victorian Mental Health Act (2014)(MHA)[6] [14]. Diagnoses of these patients were recorded against ICD-10 codes. Drug induced psychosis was included with other psychoses.

Statistical analysis

We conducted three separate time to event analyses looking at factors associated with the time to first: (a)Treatment Order; (b)Community Treatment Order; and (c)Inpatient admission following the conclusion of the patient's index order. A negative binomial regression was conducted in order to assess factors associated with the duration of subsequent orders after the conclusion of the index order. All analyses were undertaken in Stata version 15.1[7] [293].

Ethical approval was obtained from the Melbourne Health Human Research Ethics Committee (No. 2013.109).

6.2.4. Results

An additional diagnosis in the F10-F19 codes (Mental and behavioural disorders due to psychoactive substance use) was recorded in 507 (39.1%) of patients during the period of the study, with a further 112 (8.6%) having SUD as the most recent diagnosis after the end of the index CTO. That is, significant substance use was recorded in 47.7%. The F1 ICD codes and impact of use are shown in Table 6.1 and Table 6.2. Alcohol, cannabinoids, stimulants and tobacco were most commonly used - singly or in combination. In the majority, the ICD codes indicated that the use reached threshold for harmful use or dependence (93%).

Table 6.3 shows the distribution of those with and without a SUD and subsequent Treatment Orders.

Table 6.1. Distribution of F1 ICD-10 diagnosis codes 2nd (substance type) (619 of total 1297 sample).

ICD Code	Substance	Frequency	%
F10	Alcohol	104	16.8
F11	Opioids	36	5.8
F12	Cannabinoids	150	24.2
F13	Hypnotics	4	0.1
F14	Cocaine		
F15	Stimulants (amphetamines)	79	12.7
F16	Hallucinogens	1	
F17	Tobacco	141	22.8
F18	Volatile Solvents	1	
F19	Multiple and Other	103	16.6
TOTAL		619	100.00

Table 6.2. 4th (Impact) character at end of index CTO

ICD 4th Character	Frequency	%
.0 Acute Intoxication	21	3.4
.1 Harmful Use	323	52.2
.2 Dependence Syndrome	250	40.4
.3 Withdrawal state	16	2.6
.4 Withdrawal with Delirium		
.5 Psychotic Disorder		
.6 Amnestic Syndrome		
.7 Residual/late onset Psychotic		
.8 Other disorder	2	
.9 Unspecified Disorder	7	1.1
	619	100

Table 6.3. Association of substance use with subsequent Treatment Orders

Cell key: n (%)	Index CTO Discharge Type: n (%)			p-value
	Primary: SUD (n=112)	Primary without Secondary SUD [a,b] (n=678)	Primary with Secondary SUD [a,b] (n=507)	
Subsequent Orders within 2 years				<0.001
None	45 (40.2)	431 (63.6)	188 (37.1)	
At least one	67 (59.8)	247 (36.4)	319 (62.9)	
Subsequent Community Treatment Orders within 2 years				<0.001
None	68 (60.7)	528 (77.9)	320 (63.1)	
At least one	44 (39.3)	150 (22.1)	187 (36.9)	
Time to next Community Treatment Order [c]				0.707
Up to 180 days	26 (59.1)	90 (60.0)	104 (55.6)	
More than 180 days	18 (40.9)	60 (40.0)	83 (44.4)	
Subsequent Inpatient Treatment Orders within 2 years				<0.001
None	64 (57.1)	490 (72.3)	242 (47.7)	
At least one	48 (42.9)	188 (27.7)	265 (52.3)	
Time to next Inpatient Treatment Order [c]				0.606
Up to 180 days	20 (41.7)	82 (43.6)	126 (47.5)	
More than 180 days	28 (58.3)	106 (56.4)	139 (52.5)	

SUD = Substance use disorder; a, includes paranoia and acute psychotic disorders including drug induced psychosis; b, Includes those with unknown diagnosis; c, Percentages only for those with subsequent CTO or IPO within 2 years

Table 6.4. AOR for a secondary diagnosis of a substance use disorder, for each primary diagnosis category

	Order of any type	Community treatment order	Inpatient admission [a]
Primary diagnosis	Adjusted odds ratio [b] (95% CI)	Adjusted odds ratio [a] (95% CI)	Adjusted odds ratio [a] (95% CI)
Schizophrenia [c]	3.03 (2.30–3.99)	2.31 (1.71–3.13)	3.69 (2.78–4.90)
Mood Disorders	1.95 (0.79–4.81)	0.94 (0.29–3.07)	3.81 (1.48–9.77)
Other Disorders [d]	11.60 (2.48–54.23)	5.39 (0.91–32.03)	15.58 (3.63–66.85)

Note: a, with or without an inpatient treatment order; b, controlling for index CTO discharge method, age at index CTO end, sex, location of mental health service for index CTO (rural/urban), and time spent on index CTO; c, includes paranoia and acute psychotic disorders including drug induced psychosis; d, includes those with unknown diagnosis.

An additional diagnosis of a SUD significantly increased the odds of a subsequent treatment order in the following two years for those with a diagnosis of schizophrenia (AOR = 3.03, $p<0.001$) and ‘other’ disorders (AOR = 11.60, $p=0.002$) but not for mood disorders (AOR = 1.95, $p=.178$) (Table 6.4). This finding related especially to community treatment orders. There was also a significant increase in odds of inpatient admission for those with a diagnosis of a mood disorder with an additional SUD diagnosis compared to those without (AOR = 3.81, $p=0.006$).

The adjusted Cox regression showed that those with comorbid SUD were likely to be placed under an order sooner than those without. This was especially noticeable for CTOs made for patients with schizophrenia and substance use (

Table 6.5).

Those with an additional diagnosis of SUD were not found to have a longer duration of treatment order when controlling for age, sex, index order discharge mode, practice location, primary diagnosis, and time spent on index order.

Table 6.5. Adjusted Cox regression predictors for time to first event in the year following index order end

	Order of any type		Community treatment order		Inpatient admission [a]	
	HR (95% CI)	p-value	HR (95% CI)	p-value	HR (95% CI)	p-value
Primary Diagnosis		<0.001		<0.001		<0.001
Other disorders [c] without secondary SUD	1.00		1.00		1.00	
Other disorders [c] with secondary SUD	5.11 (1.57–16.70)		2.56 (0.57–11.53)		8.17 (2.90–23.04)	
Schizophrenia [b] without secondary SUD	2.89 (1.07–7.79)		2.39 (0.76–7.53)		2.64 (1.09–6.43)	
Schizophrenia [b] with secondary SUD	5.51 (2.04–14.84)		4.09 (1.30–12.89)		5.85 (2.41–14.21)	
Mood disorders without secondary SUD	2.48 (0.83–7.38)		1.59 (0.43–5.89)		2.42 (0.90–6.51)	
Mood disorders with secondary SUD	4.21 (1.38–12.81)		1.34 (0.30–6.02)		5.16 (1.92–13.85)	
SUD	5.44 (1.96–15.06)		4.54 (1.40–14.76)		5.84 (2.34–14.53)	

Note: a, with or without an inpatient order; b, includes paranoia and acute psychotic disorders; c, includes those with unknown diagnosis.

6.2.5. Discussion

Substance misuse in psychotic illnesses is common[8-10] [30, 83, 288], and is associated with greater risk of relapse and of violence[11] [291]. There is a greater likelihood of aggressive behaviour in those with schizophrenia who have recently used amphetamines[12] [294], and a recent study found that methamphetamine use was associated with a greater likelihood of restrictive interventions such as seclusion and restraint[13] [246]. In our study, approximately 40% of those who had been on a CTO for at least 3 months had an additional diagnosis of at least one SUD coded, and needed the provisions of the MHA more often and sooner than those who did not. This is likely to reflect the greater risk of relapse and of behaviour leading to increased risk of harm to others.

There was a difference in the use of CTO and Inpatient Treatment Orders between those who suffered mood disorder, and those with schizophrenia. We found that those with a diagnosis of mood disorder were more likely to require inpatient care; possibly because they are more imminently at risk of harm to self or others and require more urgent and intensive intervention, as opposed to re-stabilisation on treatment, which could occur in the community.

An important consideration with respect to our findings is the current disjunction between Drug and Alcohol services, and clinical mental health services. The lack of clinically led alcohol and drug (AOD) services and the means to compel those who use drugs at harmful levels to accept treatment or remain abstinent has resulted in many AOD services being reluctant to provide services to those with mental illness. This means that for people who have a dual diagnosis and who are reluctant to engage in treatment, it is more likely that they will present to mental health services – often requiring treatment under the MHA, even though the exacerbation of symptoms may be directly related to substance misuse.

One criticism of CTOs has been that they reflect a more medical or biological model of care, rather than addressing some of the other associations of both substance misuse and severe mental illness; such as social isolation, contact with the criminal justice system, poverty and inadequate accommodation[14,15] [26, 270]. This less than holistic approach is especially likely to occur in the context of constrained mental health services[16,17] [295, 296].

Our findings support the conclusions reached by Barnett et al[2] that we should focus more on enhancing the quality of community care to strengthen engagement [187], in order to reduce the risk of return to harmful substance use and associated relapse of mental illness. In particular, there should be greater integration between mental health and drug and alcohol services with capacity to provide treatment for both types of disorders during the period under the MHA. Such integration would also support more holistic care.

6.2.6. Acknowledgements

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6.2.7. References

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Chapter 7. Study 4 – Carer experiences of Community Treatment Orders: implications for rights based/recovery-oriented mental health legislation

This chapter reports on study 4 which sought to examine how compulsory care regimes are viewed by carers and to explore their experience of providing care. The chapter incorporates the accepted version of a paper published by *Australasian Psychiatry* 2015 Vol 23(2) 154 – 157. The candidate was the first author and lead the research component as well as undertaking the drafting and reviews. The co-author assisted with drafting and with the statistical analysis.

7.1. Background

Chapter 2 considered the impact of schizophrenia and other severe mental illnesses on carers and how this had changed over the decades in association with changed service delivery and related policy.

Moving people with severe illness such as schizophrenia from large bed-based services to live in the community has a significant impact on mental health services and carers in the community. There is also an impact on other services and systems such as courts and prisons, and homelessness services. Many people with schizophrenia will only be able to function in the community with provision of additional supports, and often this falls to family members – most often parents. To further explore the understanding and attitudes of carers, the candidate undertook a mixed quantitative/qualitative study. The carers were selected on the basis of their engagement with carer support organisations, and were therefore more likely to have had experience of caring for a person with severe mental illness. They were also more likely to be informed about mental health policy and practice, and to have been informed of changes in legislation.

Study 4 was based on a survey which incorporated a questionnaire and two validated instruments (see attached questionnaire). The survey was posted to members of a well-established advocacy and support organisation, and highlighted in the newsletter of another. The hypothesis was that carers will support the use of compulsory treatment in the community, and will describe a significantly negative experience of care-giving. It should be noted that the survey was distributed in 2013/14 and the paper written in 2014, and so considers the views of carers under the *Mental Health Act (1986)*. The discussion in the paper makes comment that the impact of the *Mental Health Act (2014)* is still unknown. That was true at the time of publication. Theses issues were considered in the paper presented in Chapter 5.

7.2. Instruments used and comparative studies

The study found that the burden of care was considerable and was consistent with previous studies. The tools used were the Experience of Care Inventory (ECI) which was developed by Szmukler et al and the Recovery Knowledge Inventory (RKI) developed by Bedregal et al [96, 268].

The ECI is a 66 item questionnaire that includes eight negative and two positive scales. It has been used in a number of studies which have involved carers of persons who have psychosis [97, 297, 298]. The eight negative subscales are: difficult behaviours (e.g. being moody, unpredictable), negative symptoms (e. g. being withdrawn, uncommunicative), stigma (e.g. feeling the stigma of having a mentally ill relative; how to explain the illness to others), problems with services (e. g. how health professionals do not take you seriously; finding out how hospitals and mental health services work), effects on the family (e.g. how they get on with other family members; how family members do not understand the illness), loss (e.g. what sort of life the person might have had; whether they will ever get well), dependency (e.g. being able to do the things you want to do; their dependence on you), need for back up (e.g. difficulty looking after money; setting up accommodation). The two positive scales are: positive personal outcomes (e.g. whether they have learnt more about themselves, whether they have contributed to others understanding of the illness) and good aspects of the relationship with the patient (e.g. that they have grown in strengths in coping with the illness, that they makes a valuable contribution in the household). The items are rated on a Likert scale (0=never, 1=rarely, 2=sometimes, 3=often, 4=nearly always). A score is calculated by adding up the responses to achieve an overall score.

The RKI has mainly been used to assess the knowledge of recovery among service providers and as part of training. It includes 20 items over four scales [299]. The four subscales are: roles and responsibility in recovery; non-linearity of the recovery process; the roles of self-definition and peers in recovery, and; expectations regarding recovery. The overarching findings are included in the published paper provided below, but it is relevant to provide the breakdown to note the similarities with other studies (see tables 7.1 and 7.2).

Table 7.1. Experience of caregiving inventory scores: current vs. comparison study

		Comparison Study [298]
Experience of Caregiving Inventory (ECI) scores	**Current study (N=58)**	**Campos et al., (2006) (N=50)**
Negative subscales: mean (SD)		
Difficult behaviours	15.9 (9.4)	16.5 (7.5)
Negative symptoms	15.1 (7.2)	13.0 (6.0)
Stigma	8.1 (5.5)	4.9 (4.2)
Problems with services	14.2 (7.6)	13.9 (8.9)
Effect on family	13.9 (6.9)	10.4 (6.2)
Need to back-up	13.3 (5.9)	13.4 (4.8)
Dependency	11.7 (5.1)	11.7 (4.8)
Loss	13.8 (6.2)	11.7 (5.2)
Total negative score	106.50 (46.4)	95.5 (35.9)
Positive subscales: mean (SD)		
Positive personal experiences	19.4 (5.6)	17.8 (7.1)
Good aspects of relationship	14.5 (3.4)	14.3 (4.4)
Total positive score	33.4 (8.0)	32.2 (10.1)

As discussed in the paper, we did not find a significant association between the ECI and having experience of caring for a person on a CTO although the trend was towards a more negative ECI score for those with experience of a CTO. The lack of significant difference gives some comfort that carers in Victoria do not find the experience of caring different from their counterparts in the United Kingdom.

Table 7.2. Mean RKI scores: current vs. comparison studies

Recovery Knowledge Inventory (RKI) scores	Current study (N=58)	Comparison studies: Meehan & Glover (2009) [299] (N=64)¥	Comparison studies: Bedregal et al. (2006) [268] (N=144)
RKI-total- mean (SD)	3.11 (.50)	3.19 (.85)[1]	–
RR- mean (SD)	3.23 (.74)	3.59 (.57)[2]	3.88 (.71)
NLP- mean (SD)	2.75 (.51)	2.56 (.54)[3]	2.78 (.74)
RSP- mean (SD)	3.86 (.58)	3.85 (.43)[4]	4.15 (.53)
ERC- mean (SD)	2.59 (.87)	2.82 (.85)[5]	3.13 (1.03)

Note: ¥ = control group only scores used; RR=roles and responsibilities; NLP=non-linearity of the recovery process; ERC=expectations regarding recovery; RSP=role of self-definition and peers in recovery.
[1] t(44) =1.07, p=0.29 (two-tailed); [2] t(44) =3.26, p=0.002 (two-tailed); [3] t(44) =2.50, p=0.02 (two-tailed); [4] t(44) =0.12, p=0.91 (two-tailed); [5] t(44) =1.77, p=0.08 (two-tailed).
Note the difference between finding from Carer questionnaire and comparison study in the area of Roles and responsibilities, suggesting that this carer group had difficult in in differentiating the roles and responsibilities of each party – in this case carer and loved one with mental illness.

The survey included space for comment by the carer. A sample of comments shows the spread in experience and view:

- *I care for 2 sons with schizophrenia and my father with dementia*
- *Having a person with mental illness in the family is awful for both sufferer and family. I am a firm believer in CTO but my son thought it was an invasion of his civil rights*
- *The concept of recovery-oriented care puts a positive slant on the mental health problem. It gives the sufferer hope.*
- *My son's illness is 24/7 care especially when he is unwell. There is no centrelink support. CTOs have been a life saver in the past (literally). Recovery oriented care should go hand in hand with CTO. My greatest wish is for him to live independently and cope with life.*
- *I see mental health as a 'trap'. People lose independence and have no choice as to take medication as they can be forced to take it - blackmailed with threat of loss of their children it they don't do exactly as they are told. With sufficient family support I believe sufferers should be able to experiment with other avenues than medication regarding their health. E.g. exercise, nutrition, lower*

> *doses of medication. For adults, it is like do I have control of my life or does someone else? This is my observation of my daughter's experience.*

The full survey is included in Appendix 1.

7.3. Carer experience of Community Treatment Orders: Implications for rights based/recovery oriented mental health legislation.

7.3.1. Abstract

Objective: To determine the views and experiences of carers of people with severe mental illness in regard to Community Treatment Orders (CTO)

Method: Questionnaires were posted using the mailing lists of two well established carer support organisations in Victoria. The questionnaires included information about the person with a mental illness, the carer and their experience of care (ECI) and knowledge of recovery (RKI).

Results: Two hundred and seventy-eight questionnaires were sent and 63 returned of which 62 provided valid data. Those who responded were predominantly female (90%) and older (mean age 63 years) and were the carer of a person with a severe and recurrent mental illness. Sixty percent had experience of caring for a person on a CTO. Most felt the CTO had been of benefit and in 89% the person relapsed and needed further treatment when the CTO was stopped.

Conclusion: Mental health legislation is shifting to bring a greater focus on rights, individual choice, and autonomy in line with recovery-oriented care. This study describes the impact of severe mental illness and decisions in relation to CTO on carers.

Keywords: Community Treatment Orders, carers, recovery

7.3.2. Introduction

In many countries mental health services have increased their focus on community-based services and services provided in the ‘least restrictive environment’. This has been accompanied by a decreased availability of inpatient services, especially long stay beds[1] [300]. Mental health legislation has supported the move to community-based services through the introduction of Community Treatment Orders (CTO) which provide a structure whereby involuntary treatment can be provided in the 'least restrictive' environment of community compared to inpatient services. More recent changes in mental health service delivery have seen a focus on recovery oriented care[2] [219].

Victoria has recently introduced new legislation which explicitly includes a requirement to consider the person's 'recovery outcomes' when considering whether to make an involuntary treatment order[3] [301]. The Act, which commenced on the 1st July 2014, introduces a number of principles to guide the interpretation of its provisions, including allowance of a 'degree of risk' when deciding whether a person has capacity and/or meets criteria for involuntary treatment. The Act emphasises supported decision making and introduces the ability to make advance statements and utilise the support of a nominated person when unwell. There is explicit direction to reduce the use and duration of involuntary orders, and the power to make these decisions has shifted from the treating consultant psychiatrist to the external Mental Health Review Tribunal. These changes are likely to mean that CTOs are used less often and for shorter periods. However, we know little about how carers might view these changes.

Studies to date have been limited, often only considering small groups of engaged carers through focus groups or direct interview[4-6] [302-304]. We undertook a survey of carers regarding their experience of CTO and experience of caring, as well as their understanding, approval, and knowledge of recovery-based care.

7.3.3. Background

Community Treatment Orders have been available in Victoria for over two decades. Their use is now well established although there continues to be debate regarding their effectiveness[7,8] [8, 305]. In general, the criteria for imposing treatment under such an order include the presence of mental illness, an assessment that treatment is needed, and because of the illness there is a risk of harm to self or others. In Victoria up to 5000 people are managed under a CTO per annum[9] [306]. The CTO provides a legal framework that requires adherence to treatment in order to avoid treatment in the more restrictive environment of an inpatient unit. Anecdotally, carers have been critical of where the threshold is set for admission to an inpatient service or acceptance for treatment by state funded mental health services. Inquiries into the adequacy or otherwise of mental health services often comment on lack of or difficulty in access related to limited capacity and rationing of services, and poor information sharing between provider, consumer and carer[10,11] [307, 308]. Successive National Mental Health Plans have commented on the need for carers to be included in decisions made at a policy and individual service planning level[12] [309].

The Victorian Mental Health Act 2014 is explicit in its intent to support a recovery orientation. This concept of personal autonomy and choice grew out of the consumer movement in the USA. There is a potential conflict between a recovery orientation that supports individual decision making and an acceptance of a degree of risk, and coercive treatment under a CTO.

Early work on the impact of having a family member with severe mental illness concentrated on the 'burden' felt by families. More recent work has considered caregiving within a 'stress-appraisal-coping' framework to include positive aspects of the caregiving relationship[13,14] [96, 310]. Studies of how family members and/or carers view CTO suggest that they are generally supportive and perceive a positive benefit for the mentally ill relative, their relationships and access to the clinical team[15,16] [106, 108].

The material described in this paper forms part of a larger study considering the effect of new legislation with an explicit emphasis on Recovery, and whether the rate of CTO and subsequent service utilisation is impacted by this change.

7.3.4. Methodology

Carers were approached through the mailing lists of two well-established carer support organisations and requested to complete a questionnaire that covered demographic details, experience of CTO and service contact. The questionnaire included the Experience of Caregiving Inventory (ECI)[13] [96] and the Recovery Knowledge Inventory (RKI)[17] [268]. The ECI is a 66 item self-administered questionnaire that includes eight negative scales – difficult behaviours, negative symptoms, stigma, problems with services, effects on family, need to back-up, dependency, and loss; and two positive scales – positive personal experiences and good aspects of relationship. The RKI is a 20-item self-administered questionnaire and covers four domains – roles and responsibility in recovery, non-linearity of the recovery process, the roles of self - definition and peers in recovery, and expectations regarding recovery. The project received consent through the relevant ethics committee.

Two hundred and eighty questionnaires were posted, two were returned to sender unopened. Sixty-three completed or partially completed questionnaires were returned. Valid data was available for sixty-two individuals providing a response rate of 23%. Statistics analysis was performed using SPSS. Specifically, the relationships between the ECI and RKI were examined using Pearson correlation analysis, two tailed, Comparisons between the scores obtained on the ECI and RKI in the current study and previous studies were made using one-sample *t*-tests. All p values < .05 were considered statistically significant.

7.3.5. Results

Respondents

Those who responded to the questionnaire were generally female (90%) and had an average age of 63 years. Eighty-two per cent were the parent of a person with mental illness. The type of support provided included financial, supervision of medication (58%), and assistance with activities of daily living (26%). Fifty-four percent described their level of involvement with mental health services as a lot or intense. Sixty-seven per cent said that CTO should be included in mental health legislation, 29% were not sure and 4% were not in favour of CTO.

Persons being cared for

Most of the people cared for were unemployed or on a disability support pension (82%), and most were either living in the parental home or in private rental supported by parents (77%). In over 90% the person cared for had a diagnosis of a severe and recurrent mental illness such as schizophrenia, bipolar affective disorder, or recurrent mood disorder and 99% were on some form of medication for their illness. Seventy-four percent had received treatment as an involuntary patient.

Carers' experience with mental health services and CTOs

Forty per cent of carers were either not satisfied or only a little satisfied with mental health services, with only 11% very satisfied. Sixty-three per cent had experience of caring for a person on a CTO. Fifty per cent thought there had been general improvement while the person cared for was on a CTO and 58% thought there was improvement in symptoms. Table 7.3 summarises the longitudinal treatment outcome of those discharged from a CTO as described by carers.

Table 7.3. Longitudinal treatment outcomes for persons after discharge from CTO, as reported by their carers

Item	Yes n (%)	No n (%)	Comment
Experience of CTO	39 (63)	23 (37)	
Discharged from CTO	37 (95)	2 (5)	
Relapsed if stopped treatment	29 (88)	4 (12)	Incomplete response
Required readmission if relapsed	28 (88)	4 (12)	Incomplete response
Required involuntary admission if admitted	17 (63)	10 (37)	

Note: CTO = Community Treatment Order

Scores on ECI and RKI

We did not find a significant association between scores on the ECI and experience of CTO although the trends suggested that experience of a CTO was positively correlated with the negative ECI score. There were no significant associations between scores on the RKI and ECI. When compared with other studies involving the carers of people with severe mental illness, there was no significant difference in the scores obtained on the ECI[18-20] [97, 297, 298, 311]. The RKI has mainly been used to examine the understanding of recovery concepts by staff and trainers[17,21] [268, 299]. Our findings on the RKI were generally consistent with those from other studies although there was a significantly ($p<.01$) lower appreciation of the separation of roles and responsibility in this group of carers compared to participants in an earlier study where the participants were clinical staff rather than carers[21] [299]. The means and standard deviations of the total ECI and RKI scores of this study are presented in

Table 7.4.

Table 7.4. Means and standard deviations of total RKI and ECI scores for respondents

Measure	Mean ± SD
RKI score	3.09 ± 0.07
ECI positive score	33.44 ± 8.00
ECI negative score	106.50 ± 46.41

Note: RKI = Recovery Knowledge Inventory; ECI = Experience of Caregiving Inventory.

7.3.6. Discussion

This study sought to explore the views and experience of people who care for persons with severe mental illness in the context of current mental health policy and service planning. In particular we were interested in better understanding carer views on CTOs and their understanding of one of the main shifts in recent years – a greater emphasis on individual rights and on the concepts embraced by recovery-oriented care. The participants were volunteers who responded to a questionnaire sent out by established carer support organisations. Thus, it could be assumed that this was a group already interested and engaged in mental health services delivery and in mental illness. We had a 23% response rate, again probably biased towards those with greater engagement and who had experience of caring for a person on a CTO.

The results showed that those who responded were likely to be older and to have cared for the person for a number of years and through a number of episodes of illness. Many were still directly involved in that they lived with the person and provided substantial support. Most of those who responded had been exposed to CTO and there was general support for CTO. A CTO is a legal construct, and the person must be discharged from the CTO when they no longer meet the criteria under the Act[3] [301]. Our results suggest that discharge is often followed by non-adherence with treatment, and non-adherence with relapse and subsequent readmission.

Our findings on the ECI showed consistency with previous studies, for example Campos et al[18] [311], most of which involved selected carers of persons currently receiving treatment for a particular illness. There was also overall consistency between this study and earlier work on the RKI[17,21] [268, 299] although participants in this study had a lower appreciation of the separation of roles and responsibility. This may reflect this study considering the knowledge of carers while the other studies engaged clinical providers. We could assume that the closer relationship between carer and consumer lead to more emphasis on interactions related to roles and responsibilities. However, the comparable results suggest that the carer respondents had an awareness and understanding of recovery concepts similar to clinicians. Perhaps this is not surprising as those who responded were likely to be engaged and informed carers.

We do not yet know what impact the 2014 Act will have on the rate or duration of CTO, nor do we know whether the greater emphasis on carer engagement and involvement of nominated persons will result in carers feeling that their needs for information and inclusion are realised. This study illustrates the level of support provided by carers in supporting those with severe mental illness, and the impact on the carer.

The findings reported should be considered within the limitations of this study. Due to a low response rate, it reports the views of a relatively small number of carers selected by their engagement with support organisations and therefore may not be generalizable to the larger community of carers. It is difficult to ascertain whether the skew in older and female status of the respondents is representative given the method of sending out the questionnaire. This does not diminish the relevance of their views and suggests that policy makers, service planners and service providers should include carers in their decisions regarding how services are delivered and in education and training activities. The carers' reports are retrospective in nature and there may be issues with recall bias.

While empirical research has been ambivalent at best regarding the overall benefit of CTO, this study suggests that from the perspective of carers, while the person is on a CTO there is benefit, and that in many cases this benefit is lost once the CTO is removed. In particular, there appeared to be a high risk of relapse and readmission with all the impact of that for the person and their family when the person was discharged from the CTO. Further research once the 2014 Act has been in place for some time is needed to monitor whether carers, especially those of persons with severe and recurrent mental illness, remain supportive of the proposed changes to limit the use and duration of CTO.

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Chapter 8. Discussion

8.1. Introduction

Writing almost 40 years ago, Kathleen Jones noted that too often the criticisms of mental health service delivery are not that the place is bad or the motives of those who provide care suspect, but that the funding and capacity are manifestly inadequate [116]. She opined that laws provide the enabling framework within which policy and practice develop. This thesis has considered how mental health law and policy influence service delivery in Victoria over the past thirty years. The focus has been on severe mental illness and the utilisation of mental health legislation to provide compulsory care, especially in the community. The thesis has considered the increasing shift to greater reliance on community-based services and community supports, including the impact this has had on carers. The candidate has also considered how substance use affects the use of compulsory orders, particularly in the context of anecdotal increase in the use of methamphetamine in those presenting to mental health services.

But there is also a wider context that needs consideration, the growth in population in Victoria has not been met by congruent growth in investment in mental health infrastructure or workforce. This is evident in nationally collected data as described in the commentary noted previously [295]. The level of concern regarding the current system is such that the government established a Royal Commission which released its interim report in November 2019 [12]. The terms of reference and initial progress of the commission are discussed later in this chapter.

In the context of real reduction in both recurrent and capital expenditure, the aims of policy and legislation are seen to be under extreme pressure, with resultant impact on the use and clinical effectiveness of compulsory treatment, and the aims of reducing its use. These complexities are considered in the original work contained within this thesis.

8.2. Summary of main findings

The thesis brings together four studies which covered particular aspects of mental health treatment and care.

Study 1 considered treatment under the *Mental Health Act (1986)* and the mode of discharge from involuntary/compulsory status. It found that where the order came to an abrupt end, most likely in the context of poor discharge planning with associated risk that the person would disengage from treatment, it was more likely that the person would relapse and again require treatment as a compulsory patient. This was relevant both for those who were taken off the order by the external review body, and those whose order expired because they failed to engage with treating services. The risk of going back on an order was also greater for younger people and for people living in urban locations. The study supports the importance of engagement and treatment planning to minimise the risk of relapse and to support better physical health outcomes. This should be an aspect of treatment that is not linked to the person being under mental health legislation, but is evident in treatment plans for all persons with severe mental illness who receive treatment from public mental health services. Greater engagement with family and community, and more rewarding occupation is likely if the person is receiving treatment that is most tailored to their needs.

Study 2 considered treatment under the *Mental Health Act (2014)* which set a higher threshold for instituting compulsory care, and more rigorous oversight and external review. In the most recent annual report, the MHT noted that 7% of orders were revoked [249]. This was slightly more than in Study 1 where 5% were taken off the order by the Mental Health Review Board and the order expired in a further 7%. This study also found that those who had the CTO revoked by the Mental Health Tribunal or expired were more likely to go back on a CTO over the subsequent two years. The study also found an overall reduction in the number and duration of orders when comparing the two mental health acts. Unexpectedly, there was an increase in the number of CTOs varied by the treating psychiatrist to an inpatient order under the *Mental Health Act (2014)*. These findings also highlight the importance of engagement and continuation of treatment in reducing the risk of relapse of illnesses such as schizophrenia. The study found that even when the decision to take a person off an order is made by the treating psychiatrist, it was likely that the person would have at least one other period under a CTO in the subsequent two years. The implication is that community services are inadequate or unable to provide the level of care and support to keep people with severe mental illness engaged and adherent to necessary treatment. This is consistent with evidence given to the Royal Commission into Victoria's mental health system where both service recipients and service providers described the limited services available in the community [12].

The findings are also consistent with research documenting the experience of those living with psychosis [312]. What is not yet clear is what can or will be done to improve services to increase both access and intensity. The interim report by the Commission includes significant recommendations to increase bed numbers and the clinical workforce, but both will take some years to realise. The report also concludes that the funding for mental health services is manifestly inadequate [12].

Study 2 found a reduction in use and duration of compulsory treatment when comparing the *Mental Health Act (2014)* with the *Mental Health Act (1986)*. It is not clear whether this is reflective of a greater emphasis on rights, or related to the paucity of service availability, but it is reasonable to assume there is a relationship between the quality and accessibility of services, and the need to impose compulsory care. An interesting recent finding from Norway which has a comparatively well-funded mental health system and rates of CTO that are lower than in Australia and New Zealand, is that many of those on out-patient commitment orders voluntarily accept treatment [313]. It should be noted that the law in Norway provides for separate out-patient commitment and involuntary treatment.

Study 3 considered the impact of co-morbid use of substances on the use and duration of compulsory orders. There has been considerable research on what factors influence the use of compulsory treatment including demographic factors, diagnostic or clinical factors and social factors. It is clear that there are considerable differences in the rates of compulsory treatment within and between jurisdictions [287]. Substance use is frequently cited as a factor that is associated with increased risk of compulsory treatment, and a factor that makes community treatment more challenging. In particular, the use of methamphetamine has been associated with increased levels of violence leading to greater use of restrictive interventions [246, 314]. It is clear is that substance use is very common in those with severe mental illness and does worsen treatment response and prognosis [30, 83].

While there have been efforts to improve the capacity of mental health services to provide treatment for both mental illness and substance use, this remains patchy. In Victoria services to address alcohol and drug use are largely managed separately from those targeted to mental illness. Strengthening the relationship between drug treatment services and mental health services was supported in both the Victorian annual report

2017-18 and the Auditor-General report on access to mental health services [10, 315]. Study 3 supported provision of treatment that was inclusive of intervention to address substance use. There was an additional diagnosis of substance use disorder in almost 50% of those who had been on a CTO of at least three months duration and those with substance use were more likely to go back on an order, especially if diagnosed with schizophrenia. The findings support greater capacity in drug treatment services to provide treatment to those with mental illness and/or greater integration between services, especially for those likely to be subject to compulsory orders. This has previously been noted in the research literature [26, 187, 270].

The final study (Study 4) in this series focussed on the views of carers. Many commentators have noted that the reduction in inpatient capacity and move away from stand-alone institutions has increased reliance on community supports and community services. There has been particular impact on carers. The experience of care-giving, including consideration of compulsory care in the community has been explored in a number of ways over many years [88, 95, 108, 109]. This study focussed on carers who were involved in carer support and advocacy organisations. The study incorporated a posted survey and obtained a 23% response rate (high by standards of modern surveys). Those who responded tended to be older and to have provided care over many years. The care provided included financial and accommodation support as well as emotional and personal support. They expressed disappointment in mental health services. The majority had experienced caring for a person who was on a CTO and most described that the person improved while on a CTO and that the impact or burden on them as carers was lessened while the person was on a CTO. The findings regarding knowledge of recovery principles of care and experience of care-giving were largely consistent with earlier studies. This study found high scores on the negative domains of the Experience of Caregiving Inventory, and lower scores in the roles and responsibility items on the Recovery Knowledge Inventory, suggesting that this carer group had difficult in in differentiating the roles and responsibilities of each party – in this case the carer and their loved one with a mental illness.

8.3. Strengths and limitations of the studies

This thesis is largely informed by interrogation of the Victorian mental health data set CMI/ODS across two distinct time periods. The CMI/ODS is a valuable resource since it includes all contacts with the state funded system, and incorporates legal status and diagnosis. The material extracted allowed consideration of a person's longitudinal contact with state funded mental health services. By selecting a cohort that had been on a CTO for a minimum duration of three months and following their service utilisation for a further two years, the study provided a valuable perspective of the level of engagement (or lack of engagement) with mental health services. The two distinct time periods allowed comparison between mental health legislation initially introduced in 1986 and more recent legislation introduced in 2014. The large size of both extractions meant that interventions that affected a relatively small proportion could be statistically analysed.

The studies underpinning this thesis happened at a time of considerable change. A ministerial portfolio for mental health was established in late 2006; reform of mental health legislation was a priority for the first Minister for Mental Health, and her successor. The candidate worked within the public service and in a leadership role in the provision of mental health services during this time. This close involvement with policy, service development and service delivery brings added depth to the findings of the studies. The work is limited in that it only considers mental health service delivery and legislation in Victoria. Provisions for CTO exist in all other states and territories but there are differences in both legislation and in mental health services between the states, and the results given here cannot be extrapolated to other jurisdictions. The data set does not include information on the intensity or quality of the care provided. Although a person must meet all criteria under the Act to be made a compulsory patient, the studies did not include consideration of whether CTOs were being used for those who were unlikely to benefit from the CTO. This is certainly a consideration of the treating team and is considered at the external review. The candidate did not consider whether there had been an improvement in mental state during an episode of care, although outcomes measures such as the Health of the Nation Outcome Scale (HoNOS) are completed in most services. The studies do not include how the service was experienced by the patient/consumer or carers. The studies do not consider whether the patient presented with suicidal ideation and do not cross reference with the Victorian suicide register. The data did not allow consideration of whether the patient was legally represented during their hearing before the Mental Health Review Board or Mental Health Tribunal which may have impacted the decision and outcome of the hearing. In addition, although the data allowed some differentiation between urban and rural settings, the study did not include differential consideration of areas where there had been significant population growth, or where there were different ethnic groups.

The strength of the study involving carers is that the survey allowed direct comment on the experience of providing care to a person with severe mental illness. By choosing to promote the survey through well-established advocacy groups, there was a greater likelihood that the carer would be familiar with the impact of mental illnesses such as schizophrenia and the use of compulsory treatment, including under a CTO. The instruments which supplemented the survey allowed comparison with other studies. The benefit of using a highly selected group also limits the generalisability of the findings, although the views expressed by those surveyed were consistent with the evidence given to the Royal Commission by carer witnesses [12] (Chapter 9). The study is also limited by the relatively low response rate of 23%. The survey was carried out in 2013, before the implementation of the *Mental Health Act (2014).* In combination, the studies provide a multi-faceted view of how mental health services have evolved and the impact of legislation. It should be noted that the studies do not consider how staff have experienced the changed in legislation and the tension that often exists between the expectation of carers, and the views of the patient or consumer.

8.4. Clinical implications of the studies and future directions

The results of the studies have a number of implications for clinical practice and service development. The over-arching policy directions over the previous decade or more have been an attempt to shift to earlier intervention in the presentation of severe mental illness and to shift care from inpatient facilities to the community. This has been promoted as providing care in a less restrictive manner. Reduction in bed-based services was particularly marked in the drug and alcohol sector, and service delivery largely shifted from health providers to non-government organisations. The main administrative changes to public mental health practice have been the institution of greater external oversight including legal representation, and constraints on clinical decision-making. But, in the candidates' experience, there have also been important changes in who and how mental health services are provided. Increased pressure on the system related to population growth has resulted in greater throughput with care being more episodic. This has been associated with more dis-continuity of care and the likelihood that patients and their carers will encounter a range of different clinicians across different episodes of care.

The finding that a person who transitions abruptly from receiving treatment as a compulsory patient to being voluntary is more likely to experience a relapse and return to requiring treatment under compulsion, emphasises the importance of clinical engagement. Treating clinicians have a responsibility to do their best to establish a therapeutic engagement, even when the patient may be actively trying to evade treatment and avidly denies that they have a mental illness. The treating psychiatrist also has a responsibility to ensure that the patient and his or her legal representative and carers have the best understanding possible of the importance of treatment and risks associated with relapse, and of the early warning signs so that treatment is sought earlier in a relapse. Making decisions that have a material impact on the lives of the patient and others is not easy, and is appropriately subject to review and oversight. Communicating such decisions and their rationale is more difficult when there is limited opportunity for therapeutic engagement because of high case-loads and involvement of different staff across one or more episodes of care. The carer survey reinforced the importance of engagement with carers and provision of relevant information and support.

There is potential for future work to further explicate aspects that effect how mental health legislation is used, and how compulsion can be reduced while still improving access to services and the effectiveness of those services. We need to better understand not just when a person has contact with mental health services, but their experience of the service and what is actually being provided. Often patients and carers complain that they are repeatedly asked by a moving cast of clinicians about their current symptoms or problems but not really given guidance in how to cope with these or how to minimise their impact, and not supported to re-present early on in any relapse. It is likely that with improved funding, there would be better staffing and improved continuity of care allowing a stronger relationship to develop between patient and practitioner. This is a feature of treatment in the private sector, where the same practitioner may be sought over multiple episodes of care

While the aetiology of severe mental illness remains obscure and the treatments available less than perfect, further research on the delivery of care and how care is experienced would assist in the development of appropriate services and in the training and preparation of clinical staff. It would also be helpful to better understand the experience and attitudes of psychiatrists and other clinicians to the use of compulsory treatment and oversight by the Tribunal. Taken together, the studies included in this thesis illustrate that if the stated aim of reduction in the use of compulsory orders in Victoria is to be realised, legislative change alone is unlikely to be effective. Improved engagement with the treating clinician and psychiatrist by both patient and carer, availability of longer and more intensive treatment in the community, and better integration of mental health and drug and alcohol services will also play a role. This will depend on better funding to allow better staffing, and also improved service systems and models of care. This area is a major consideration for the current Royal Commission.

Future studies could also directly compare treatment outcomes between services with different profiles. For example, in Victoria there is a range of beds per capita and staffing levels per capita. Determining whether this influences the degree of engagement and likelihood of relapse or need for compulsory care would assist in service planning. While there have been recent considerations of possible links between involuntary admissions and socio-economic variables, there has not been detailed consideration of this in relation to community treatment [316].

This thesis considered data from the state-wide clinical service utilisation data set. It did not examine cross-linkages with other data such as suicides, incarceration, or contact with the criminal justice system. Further examination of these areas would also be worthwhile. If greater engagement with clinical treatment – even if under compulsion – does reduce the risk of offending or of suicide, then these issues should be taken into account when determining policy and practice.

8.5. Study results in context

This thesis was written a decade after the ratification by Australia of the United Nations Convention on the Rights of Persons with Disabilities. Although Australia qualified the ratification with a declaration that explicitly allowed for substituted decision-making in some circumstances, there continues to be discussion on how completely compliant our laws are, especially in relation to the compulsory treatment of those with mental illness. As recently as 2013, the Committee on the Rights of Persons with Disabilities made observations on the report by Australia which included:

The Committee recommends that the State party repeal all legislation that authorises medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities , or imposition of compulsory treatment, either in institutions or in the community , by means of Community Treatment Orders [207].

The development of rights-based legislation brought with it increased oversight to limit arbitrary decision making by the treating psychiatrist. Under the *Mental Health Act (1986)* the Mental Health Review Board provided the main external oversight. When the legislation was reformed in the *Mental Health Act (2014)*, the Board was elevated to a decision-making Mental Health Tribunal and oversight was increased with the addition of an Independent Mental Health Advocacy service and a specific Mental Health Complaints Commissioner [238]. Both the 1986 and the 2014 Acts include criteria which must all be met for a person to be made an involuntary or compulsory patient. These criteria are considered by the admitting psychiatrist and subsequently by the Board or Tribunal. In the vast majority of patients considered the Board/Tribunal members and the treating psychiatrist are in agreement. In most cases the order is terminated when the treating psychiatrist determines that the criteria are no longer met, and discusses with the patient how care can be continued under voluntary or informal status. In spite of the level of oversight and the consistent pattern of determinations, the literature remains polarised between those who are opposed to compulsory treatment in the community (for example, the OCTET group [177]) and those who strongly support such intervention (for example, Swanson and Swartz [185]). While there will no doubt continue to be debate, the practical reality is that mental health services are now heavily reliant on compulsory treatment in the community as a means of ensuring that people with severe mental illness access effective treatment.

The studies that make up this thesis were carried out before the announcement of a Royal Commission into Victoria's mental health services. This is further discussed below. The thesis contributes to other work in this area by providing further evidence of what happens after a CTO is ended, and the extent to which further episodes of care are required. The work adds to other studies which illustrate the impact of comorbid substance use on the need for compulsory treatment and for health services more generally. It is likely that the Royal Commission will make recommendations that impact on the provision of care in the community for those with severe mental illness. The Mental Health Tribunal carries out its legislative responsibilities with considerable thought and deliberation in balancing the competing interests and rights of the individual and the community. There may need to be greater nuancing of these interests, and consideration of how mental health legislation intersects with other community mental health supports, such as housing and accommodation, family and carer experience, and engagement with the justice system.

8.6. The Royal Commission into Victoria's mental health system

The studies which make up this thesis were carried out before the publication of a report by the Victorian Auditor-General which was very critical of the lack of planning and engagement with mental health services by the Department of Health and Human Services [10]. They also pre-dated the announcement on the 24th October 2018 by the Victorian government that they would hold a Royal Commission into Victoria's mental health system. The Royal Commission was established in early 2019 and sought submissions as well as holding a number of community meetings. The Commission was given broad Terms of Reference and required to make an interim report by November 2019 and a final report by November 2020. The Terms of Reference, set by the Victorian Government, were:

1. *How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.*
2. *How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages.*
3. *How to best support the needs of family members and carers of people living with mental illness.*
4. *How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health.*
5. *How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.*
6. *Any other matters necessary to satisfactorily resolve the matters set out above* [317].

The number of submissions received was overwhelming – over 2,500 [318]. Submissions came from individuals, community agencies, advocacy bodies, health services and others. They spoke to the level of concern about access to services, the quality and safety of services and the tragic outcomes that families experienced when services were not available. Some of these touched on the distress and frustration experienced when a person was clearly in need of help but had not yet met the threshold for compulsory treatment [105].

The submission from the Mental Health Tribunal outlined some of the challenges experienced by clinicians and tribunal members trying to follow the spirit and letter of the *Mental Health Act (2014)* in such a constrained system. They noted how the gulf between the level of demand and level of resources had impacted on the implementation and intended operation of the Act [319]. The Tribunal submission said:

> *A person's status under the Act should only be about defining the legal relationship that exists between the person and her or his treating team at a point in time, it should not determine the scope or elements of care and support provided to individual consumers. Restricted autonomy should not be a hidden cost of attaining access to services, and voluntary engagement should not limit the availability of intensive, even assertive support. ... Using the Act as a resource allocation tool also appears to have resulted in a profound distortion of how it is intended to respond to mental health crises. The Tribunal frequently observes an inverted bar governing assess to and exit from compulsory treatment. Put simply, voluntary consumers must become extraordinarily unwell before services will initiate a compulsory intervention. However, for compulsory patients, services can be reluctant to switch to voluntary engagement even after significant recovery. This illogical approach to the allocation of resources ignores the fact that on its own terms the Act has focus on preventing mental health crises, and instead positions compulsory interventions under the Act as a response that 'mops up' after a crisis has occurred. (p4)*

The candidate was called as a witness to the Royal Commission and her submissions and direct consultation informed the report from the Victorian Auditor-General. Thus, the work of this thesis has already had a direct impact on further policy and service development in Victoria.

8.7. Conclusions

This thesis has considered aspects of treatment and care provided to people with severe mental illness under mental health legislation, especially in relation to CTOs. The studies which form the basis of the thesis have demonstrated that the rhetoric of minimising the use of compulsory treatment cannot be achieved only by moving to a more rights-based legislation. Service capacity and delivery need to be considered, including provision of integrated care to address drug and alcohol use, and the greater engagement with families. The findings that those whose CTO expired or was terminated by the external review body were more likely to require treatment under an order over the next two years, and that more people treated under a CTO under the *Mental Health Act (2014)* required a return to inpatient care, suggest that more intensive engagement and treatment in the community is required. Hopefully these are areas that will also be considered by the Royal Commission in its ongoing deliberations and result in service improvement for those people with severe mental illness who from time to time need the protections of mental health legislation in order to receive appropriate care.

The nature of illnesses such as schizophrenia means that early intervention is often not possible. People come late and often reluctantly to treatment, such that use of a mechanism such as a CTO may be unavoidable. Often presentation is through adverse interaction with the community, with involvement of police and other emergency staff. It is simplistic to suggest that those in the throes of untreated psychosis should not receive treatment if they do not provide consent or are unable to provide consent. But much more can be done to lessen the longer-term disability and distress to persons, family, and community. Much more can be done to better tailor treatment and support provided in the community to encourage and facilitate earlier presentation to try to minimise the use of compulsion, and to support those who provide care and succour in the community. This is especially important in the period where a person is transitioning from compulsory care to receiving treatment as a voluntary patient.

As discussed in this thesis, there have been significant changes in mental health policy and service delivery since the heady days of the National Mental Health Strategy in 1992 (although some commentators noted early in its implementation an increasing distance between what was promised and what was delivered through supposed reforms [284]). It is difficult to determine whether, as intended by those who advocated for mental health legislative change in Victoria, success in achieving the aim of reduction in the rate and duration of compulsory treatment does represent advancement in care. Unfortunately, the change in legislation occurred at a time of declining service availability such that the good intentions of greater emphasis on recovery-oriented services and person-centred care may have been confounded by reduced access to appropriate services. From a practitioner's perspective, there is a very real risk that we are no longer able to provide the duration, intensity, or accessibility of services that those with severe mental illness and their families should rightly expect. There is a concern that the apparent reduction in use and duration of CTO is not because there is better engagement or better outcomes, but rather because there is reduced access to services. The recognition by government that mental health services have fallen behind acute health services and need greater investment is welcomed. Further research is needed to explore the relationship between policy intentions, impact of legislation and service context, and to link this to patient outcomes.

Victoria's mental health system is at a cross-roads. The government has undertaken to accept all recommendations made by the Royal Commission. These changes will play out over the next two years, although capital investment to build more capacity and operational investment to staff those services will take much longer. While the benefits or otherwise of CTOs remains hotly contested, the issue of adequacy of services is something that can and should be addressed. In the opinion of the candidate, while we are not able to prevent severe mental illness and do not have a cure, there will continue to be a need for compulsory treatment. When a person's rights are limited in the context of compulsory treatment, it is appropriate that there is external review and oversight. But how compulsory treatment is imposed can and should be improved. It is hoped that the studies included in this thesis make some contribution to considering how such improvements can be developed.

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Appendices

Appendix 1a. Carer questionnaire

CARER PERSPECTIVE QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. Please send your reply back to: A/Professor Ruth Vine, Director of Clinical Services, Inner West Area Mental Health Service, Level 4 641 Mt Alexander Rd, Moonee Ponds 3039.

We have included a glossary at the end of this questionnaire.

1. Have you ever had experience of caring for a person on a community treatment order (CTO)? Please tick the appropriate box.

☐☐No ⟶☐ Please complete the rest of this questionnaire.

☐ Yes ⟶ Please complete the rest of this questionnaire.

- How long have you been a carer? ___________
- What is the total amount of time you have

been a carer of a person on a CTO? ______

General Information about the person you are caring for

We would like to ask some basic information about the person for whom you are a carer. Please tick √ the appropriate box:

2. His/her age ________________

3. His/her gender ☐ male ☐ female

4. What is the highest level of education that he/she has completed?

☐ ☐ Yr 9
☐ ☐ Yr 10
☐ ☐ Yr 11
☐ ☐ Yr 12
☐ ☐ Apprenticeship/TAFE
☐ ☐ University

5. What is his/her usual occupation? ____________________________________

CARER PERSPECTIVE QUESTIONNAIRE

6. What is his/her current employment status?

☐ student ☐ ☐ employed ☐☐ unemployed ☐ home duties

☐ disability support pension ☐ ☐ aged pension

☐ Other (please specify) _______________

7. What is his/her diagnosis?

☐ Schizophrenia ☐ Bipolar disorder ☐ drug-induced psychosis

☐ mood disorder (e.g., depression) ☐ personality disorder

☐ Other (please specify) _______________

8. Is he/she currently taking any medication for their mental illness? (see glossary for more detail)

☐ No ☐ Yes →

If yes, what medication is he/she taking? Tick all that apply

☐ Antipsychotic

☐ Antidepressant

☐ Anxiolytic

☐ Mood stabilizer

☐ Other (please specify) _______________

☐

9. If yes to Q.8, how is the medication taken? Tick all that apply.

☐ Orally (by mouth) ☐ By injection

CARER PERSPECTIVE QUESTIONNAIRE

10. Does he/she take their medication as required?

☐ No ☐ Yes ☐ Don't know

11. What best describes his/her current form of accommodation?

☐ ☐ private residence
☐ ☐ private rental accommodation
☐ ☐ public housing
☐ ☐ shared accommodation
☐ ☐ transitional housing
☐ ☐ other (please specify) ______________

12. What are the current mental health services he/she has access to? Tick all that apply.

☐ PDRSS (psychiatric disability and rehabilitation support service)

☐ public mental health service (bed based/community based/outreach)

☐ private psychiatrist

☐ psychologist

☐ GP

☐ other (please specify) ______________

13. In what form is he/she being currently treated?

☐ voluntary inpatient
☐ involuntary inpatient
☐ voluntary community
☐ involuntary community

14. Has he/she <u>ever</u> been treated as an inpatient (in a psychiatric ward)?

☐ No ☐ Yes ☐ Don't know

CARER PERSPECTIVE QUESTIONNAIRE

15. Has he/she ever had involuntary treatment?

☐ No ☐ Yes ☐ Don't know

Information about your involvement with mental health services

We would like to ask about your experiences with mental health services as a carer.

16. Please circle on the scale below, your level of involvement as a carer with mental health services.

1.	2.	3.	4.	5.
no involvement	a little involvement	Some involvement	A lot of involvement	Intense involvement

17. How satisfied are you with how the mental health service shares and provides information with you regarding the illness of the person for whom you are a carer?

1	2	3	4	5
Not satisfied at all	A little satisfied	Somewhat satisfied	Moderately satisfied	Very satisfied

18. Do you think that community treatment orders (CTOs) which provide for involuntary treatment in the community should be included in the Mental Health Act ?

☐ No ☐ Yes ☐ not sure

19. How would you rate the impact of the CTO on the recovery of person for whom you are a carer? Please circle the number:

1	2	3	4	5
No improvement	A little improvement	Some improvement	A moderate amount of improvement	A lot of improvement

20. Do you think being on the CTO was associated with improvement in the symptoms of the mental illness for him/her?

☐ No ☐ Yes ☐ not sure

21. Do you think being on the CTO was associated with improvement in his/her daily functioning?

☐ No ☐ Yes ☐ not sure

22. Do you think being on the CTO was associated with is improvement in his/her social relationships?

☐ No ☐ Yes ☐ not sure

23. Do you think being on the CTO was associated with is improvement in his/her relationship with you?

☐ No ☐ Yes ☐ not sure

24. Has he/she ever been on a CTO more than once?

☐ No ☐ Yes ☐☐☐ Not sure

25. Has the person for whom you are a carer <u>ever</u> been discharged from their CTO?

☐ No ☐ Yes ☐ not sure

If the answer to Q.25 is yes, please answer Q.26-29, otherwise, skip to Q.30.

26. If the answer to Q.25 is yes, what was the outcome after discharge? Tick all that apply.

☐ continued contact with mental health service
☐ has contact with GP
☐ has contact with private psychiatrist
☐ stopped treatment

CARER PERSPECTIVE QUESTIONNAIRE

27. If the answer to Q.25 is yes, who made the discharge?

☐ mental health service
☐ mental health review board
☐ don't know

28. If he/she stopped getting treatment, did they suffer a relapse (i.e. become sick again)?

☐ No ☐ Yes

29. If yes to Q.28, did he/she need to be re-admitted to hospital?

☐ No ☐ Yes → If yes, what was his/her patient status?

☐ voluntary

☐ involuntary

Now we would like to hear about your experience with the Mental Health Review Board (MHRB)

30. Have you ever attended a MHRB hearing?

☐ No ☐ Yes → ☐ If yes, did you feel your concerns were listened to?

☐ No

☐ Yes

31. If yes to Q.30, was the outcome what you wanted?

☐ No ☐ Yes

Were you pleased with the outcome?

☐ No ☐ Yes

CARER PERSPECTIVE QUESTIONNAIRE

Recovery Oriented Care

Now we would like to ask about your understanding of Recovery Oriented Care (please see the attached questionnaire). It refers to personal recovery rather than recovery from symptoms as in clinical recovery and emphasises personal choice and autonomy in decision-making. See Glossary for further detail.

32. Do you think you understand what Recovery Oriented Care is?

☐ No ☐ Yes ☐ not sure

33. Do you think it is a good model of care for the person for whom you are a carer?

☐ No ☐ Yes ☐ not sure

General Information about you

We would like to ask some basic information about you. For the following questions, please tick √ the appropriate box wherever required:

34. Your age ____________

35. Your Gender: ☐ male ☐ female

36. What is the highest level of education that you have completed?

☐ ☐ Yr 9
☐ ☐ Yr 10
☐ ☐ Yr 11
☐ ☐ Yr 12
☐ ☐ Apprenticeship/TAFE
☐ ☐ University

CARER PERSPECTIVE QUESTIONNAIRE

37. What is your usual occupation? ______________________________

38. Your current employment status?

☐ student☐ ☐ employed ☐☐ unemployed ☐ home duties

☐ disability support pension ☐ ☐ carer's pension

☐ Other (please specify) ___________

Now we would like to ask information about your role as a carer

39. How long have you been a carer? ___________ months ___________ years

40. Are you the sole carer?

☐ Yes ☐

☐ No ☐ →

If No, who do you share the caring role with? Tick all that apply.

your ☐ spouse/partne☐ ☐ brother/sister ☐ grandparent

☐ Other family members

☐ Other (please specify)_________________________

41. What is your relationship to the person for whom you are a carer?

☐ spouse/partner ☐☐ brother/sister ☐ grandparent

☐ Other family members

☐ Other (please specify _________________________

CARER PERSPECTIVE QUESTIONNAIRE

42. Do you live in the same residence as the person for whom you are a carer?

☐ No ☐ Yes

43. What are the main tasks you perform as a carer? Tick <u>all</u> that apply.

☐ supervise medication
☐ assist with daily household chores (e.g., cooking, housework, shopping, paying bills)
☐ drive to appointments
☐ Other tasks (please specify) ________________

44. We would like to hear about any other comments you may have regarding the issues raised in this questionnaire.

____

____

____

____

THANK YOU

Thank you again for taking the time to complete this questionnaire and for participating in this project.

CARER PERSPECTIVE QUESTIONNAIRE

Glossary

Carer – A carer is a person of any age who provides personal care, support and assistance to another person because the other person has a disability related to a mental illness. Carers may include the consumer's family as well as other people significant to the consumer.
The term carer does not apply if the personal care, support and assistance is provided under a contract of service or in the course of undertaking voluntary community work.

CTO – Community Treatment Order. An order made under the Mental Health Act which requires a person who meets criteria for involuntary treatment to accept prescribed treatment and attend the named mental health service in the community.

ITO – Involuntary Treatment Order – An order made under the Mental Health Act which allows a service to detain and treat a person with a severe mental illness who meets the criteria for involuntary treatment

Medication – treatment prescribed by a medical practitioner for the treatment of mental illness.

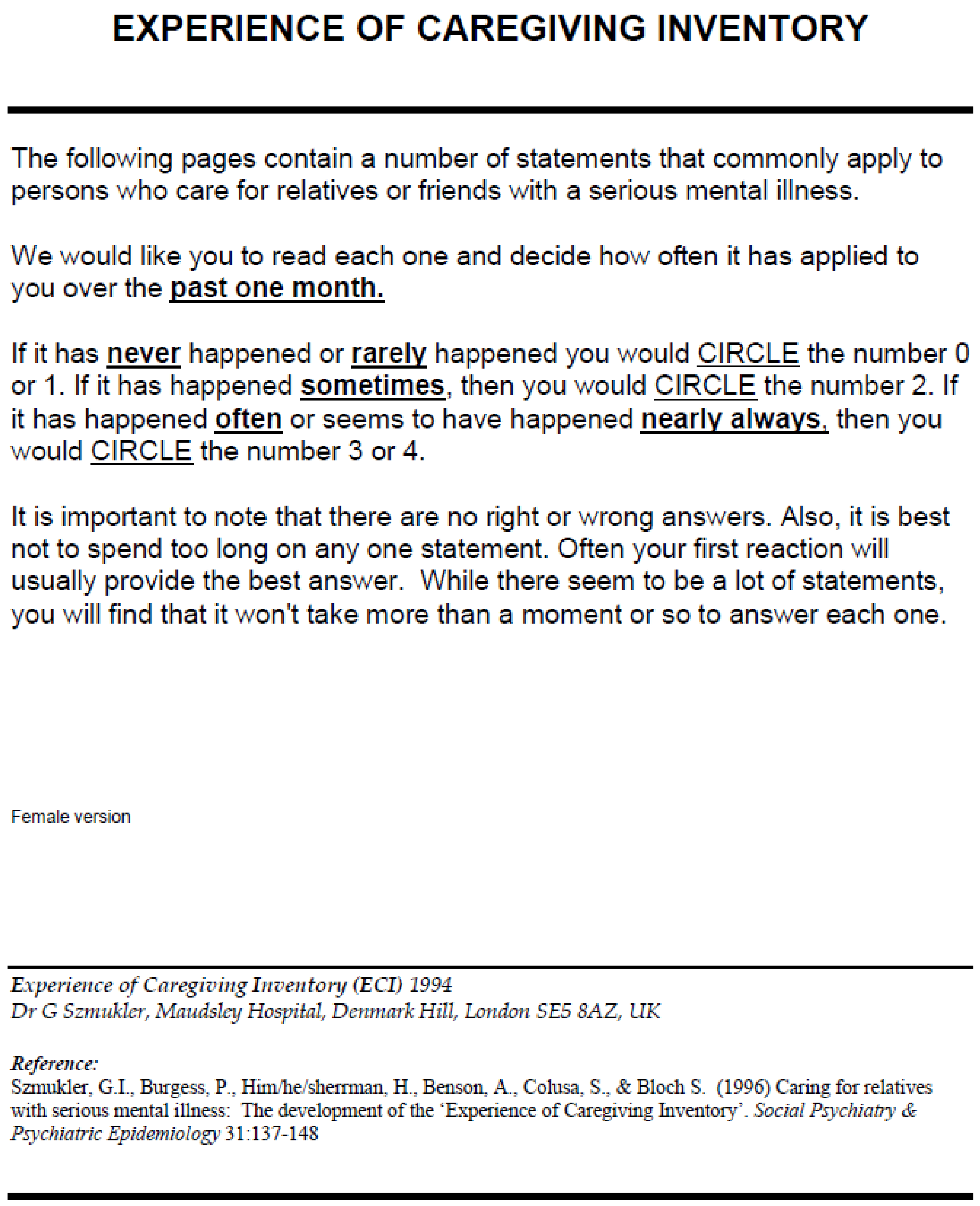
- Antipsychotic medication is usually prescribed for an illness such as schizophrenia. Examples include Olanzapine, Quetiapine, Clozapine, Zuclopenthixol.
- Antidepressant medication is prescribed for depression. Examples include fluoxetine, venlafaxine, sertraline and amitriptyline.
- Anxiolytic medication is prescribed for anxiety related illness. Examples include diazepam, lorazepam.
- Mood stabilisers are prescribed for bipolar affective disorder. Examples include lithium and sodium valproate

PDRSS – Psychiatric Disability and Rehabilitation Support Services – Community based services provided by non-government agencies to provide home based support, day programs and residential rehabilitation.

Recovery
Recovery is a personal process of changing one's attitude, values, feelings, goals, skills and/or roles. It involves developing new meaning and purpose as the person grows beyond the effects of psychiatric disability. Personal Recovery is often distinguished from clinical recovery which relates to a lessening of symptoms and return of functioning.

Recovery Oriented Care.
This involves placing greater emphasis on a person's strengths and wishes. It encourages the person to express their choices and to have greater autonomy in making decisions about treatment and their life in general. Recovery oriented care emphasises supported decision making and advance care planning so that the person is able to express their desires and preferred treatment options even if their capacity to make decisions is impaired.

Appendix 1b. Experience of caregiving inventory



EXPERIENCE OF CAREGIVING INVENTORY

The following pages contain a number of statements that commonly apply to persons who care for relatives or friends with a serious mental illness.

We would like you to read each one and decide how often it has applied to you over the **past one month.**

If it has **never** happened or **rarely** happened you would CIRCLE the number 0 or 1. If it has happened **sometimes**, then you would CIRCLE the number 2. If it has happened **often** or seems to have happened **nearly always,** then you would CIRCLE the number 3 or 4.

It is important to note that there are no right or wrong answers. Also, it is best not to spend too long on any one statement. Often your first reaction will usually provide the best answer. While there seem to be a lot of statements, you will find that it won't take more than a moment or so to answer each one.

Female version

Experience of Caregiving Inventory (ECI) 1994
Dr G Szmukler, Maudsley Hospital, Denmark Hill, London SE5 8AZ, UK

Reference:
Szmukler, G.I., Burgess, P., Him/he/sherrman, H., Benson, A., Colusa, S., & Bloch S. (1996) Caring for relatives with serious mental illness: The development of the 'Experience of Caregiving Inventory'. *Social Psychiatry & Psychiatric Epidemiology* 31:137-148

During the past month how often have you thought about:

0 = never
1= rarely
2= sometimes
3= often
4= nearly always

PLEASE CIRCLE

1. your covering up his/her illness 0 1 2 3 4
2. feeling unable to tell anyone of the illness........ 0 1 2 3 4
3. his/her difficulty looking after money 0 1 2 3 4
4. having to support him/her 0 1 2 3 4
5. what sort of life he/she might have had 0 1 2 3 4
6. his/her risk of committing suicide 0 1 2 3 4

7. I have learnt more about myself 0 1 2 3 4
8. I have contributed to others understanding of the illness........ 0 1 2 3 4
9. being unable to do the things you want to do 0 1 2 3 4
10. how health professionals do not take you seriously 0 1 2 3 4
11. his/her dependence on you 0 1 2 3 4
12. helping him/her to fill in the day 0 1 2 3 4

13. I have contributed to his/her wellbeing 0 1 2 3 4
14. that he/she makes a valuable contribution the household 0 1 2 3 4
15. the effect on your finances if he/she becomes more seriously ill 0 1 2 3 4
16. dealing with psychiatrists 0 1 2 3 4
17. him/her always being at the back of your mind 0 1 2 3 4
18. whether you have done something to make him/her ill........ 0 1 2 3 4

19. that he/she has shown strengths in coping with his/her illness 0 1 2 3 4
20. I have become more confident in dealing with others........ 0 1 2 3 4
21. how family members do not understand your situation........ 0 1 2 3 4
22. that he/she is good company 0 1 2 3 4
23. I have become more understanding of others with problems 01 2 3 4
24. how he/she thinks a lot about death 0 1 2 3 4

25. his/her lost opportunities........ 0 1 2 3 4
26. how to deal with mental health professionals 0 1 2 3 4
27. feeling unable to have visitors at home 0 1 2 3 4
28. how he/she gets on with other family members........ 0 1 2 3 4
29. backing him/her up when he/she runs out of money 0 1 2 3 4
30. how family members do not understand the illness........ 0 1 2 3 4

31. how he/she deliberately attempts to harm him/herself 0 1 2 3 4
32. I have become closer to some of my family 0 1 2 3 4
33. I have become closer to friends 0 1 2 3 4
34. I share some of his/her interests 0 1 2 3 4
35. I feel useful in my relationship with him/her........ 0 1 2 3 4
36. how health professionals do not understand your situation 0 1 2 3 4

During the past month how often have you thought about:

0 = never
1= rarely
2= sometimes
3= often
4= nearly always

PLEASE CIRCLE

37. whether he/she will ever get well 0 1 2 3 4
38. feeling the stigma of having a mentally ill relative........ 0 1 2 3 4
39. how to explain his/her illness to other 0 1 2 3 4
40. others leaving home because of the effect of the illness 0 1 2 3 4
41. setting him/her up in accommodation........ 0 1 2 3 4
42. how to make complaints about his/her care 0 1 2 3 4

43. I have met helpful people........ 0 1 2 3 4
44 I have discovered strengths in myself 0 1 2 3 4
45. feeling unable to leave him/her home alone........ 0 1 2 3 4
46. the effect of the illness on children in the family 0 1 2 3 4
47. the illness causing a family breakup........ 0 1 2 3 4
48. him/her keeping bad company 0 1 2 3 4

49. how his/her illness effects special family events........ 0 1 2 3 4
50. finding out how hospitals or mental health services work 0 1 2 3 4
51. doctors knowledge of the services available to families 0 1 2 3 4
52. the difficulty getting information about his/her illness 0 1 2 3 4

During the past month how often have you thought about him/her being:

53. moody........ 0 1 2 3 4
54. unpredictable 0 1 2 3 4
54. withdrawn 0 1 2 3 4
56. uncommunicative........ 0 1 2 3 4
57. not interested........ 0 1 2 3 4
58. slow at doing things 0 1 2 3 4
59. unreliable about doing things 0 1 2 3 4
60. indecisive........ 0 1 2 3 4

61. irritable........ 0 1 2 3 4
62. inconsiderate 0 1 2 3 4
63. behaving in a reckless way 0 1 2 3 4
64. suspicious........ 0 1 2 3 4
65. embarrassing in appearance........ 0 1 2 3 4
66. behaving in a strange way 0 1 2 3 4

Appendix 1c. Recovery knowledge inventory

Date: ________________ Code: ________

RECOVERY KNOWLEDGE INVENTORY

What is your understanding of the recovery process? Please rate the following items using the scale below:

1	2	3	4	5
Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree

1.	The concept of recovery is equally relevant to all phases of treatment.	1	2	3	4	5
2.	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	1	2	3	4	5
3.	All professionals should encourage clients to take risks in the pursuit of recovery.	1	2	3	4	5
4.	Symptom management is the first step towards recovery from mental illness/substance abuse.	1	2	3	4	5
5.	Not everyone is capable of actively participating in the recovery process.	1	2	3	4	5
6.	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	1	2	3	4	5
7.	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	1	2	3	4	5
8.	The pursuit of hobbies and leisure activities is important for recovery.	1	2	3	4	5
9.	It is the responsibility of professionals to protect their clients against possible failures and disappointments.	1	2	3	4	5
10.	Only people who are clinically stable should be involved in making decisions about their care.	1	2	3	4	5
11.	Recovery is not as relevant for those who are actively psychotic or abusing substances.	1	2	3	4	5
12.	Defining who one is, apart from his/her illness/condition, is an essential component of recovery.	1	2	3	4	5
13.	It is often harmful to have too high of expectations for clients.	1	2	3	4	5
14.	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.	1	2	3	4	5
15.	Recovery is characterized by a person making gradual steps forward without major steps back.	1	2	3	4	5
16.	Symptom reduction is an essential component of recovery.	1	2	3	4	5
17.	Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	1	2	3	4	5
18.	The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	1	2	3	4	5
19.	The more a person complies with treatment, the more likely he/she is to recover.	1	2	3	4	5
20.	Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.	1	2	3	4	5

Developed by the Yale Program for Recovery and Community Health, New Haven , CT

Appendix 2. Contextual issues in the implementation of mental health legislation

Abstract

Mental Health services in Victoria, Australia have seen major reform over the past 30 years. Rights based mental health legislation and major structural changes supported a reduction in bed-based services and the development of a strong community mental health sector from the mid 1990's. Community Treatment Orders were established in the Mental Health Act (1986) and widely used across the State. Reformed legislation in 2014 brought greater emphasis on supported decision making and recovery orientation. Funding for mental health services did not keep pace with significant population growth, with consequent reduction in bed availability and intensity of community-based services.

This paper considers the impact of funding and service availability on the intended policy and practice directions of mental health legislation with particular consideration of the impact on the utilisation of Community Treatment Orders.

Introduction

Australia is a Federation with responsibility for mental health services shared between the Commonwealth and State governments. There has largely been bi-partisan agreement in regard to mental health policy and plans. Reform of mental health services in Australia, commencing in the early 1990's, was driven by the National Mental Health Strategy which included development of the First National Mental Health Plan, the Statement of Rights and Responsibilities and the National Mental Health Policy in 1992 [129, 320]. The First National Mental Health Plan focussed on the structural move from stand-alone institutions to mainstreamed inpatient and community based mental health services. This was consistent with changes occurring throughout the developed world. Subsequent Plans included greater emphasis on partnership and consumer engagement. Victoria introduced the Charter of Human Rights and Responsibilities in 2006 [118]. The Charter included provisions regarding the right to personal integrity and freedom of movement which directly relate to the provision of compulsory care. It also provided for conditions required when rights could be limited, also relevant to treatment under

Mental Health legislation. This paper will consider the impact of mental health reform on service delivery in the context of funding constraints and policy and operational issues in other public service areas.

Mental health reform in Victoria

Within Australia, Victoria, was in the vanguard of reform of mental health services in the 1980's and 1990's. Closure of the large stand-alone psychiatric facilities was accompanied by the establishment of a range of community and mainstreamed bed based services [117, 143]. Legislative reform through the *Mental Health Act* (1986) (MHA) introduced external review of involuntary detention through the establishment of the Mental Health Review Board, and the introduction of Community Treatment Orders (CTO) to better support care and treatment in the community [229]. By 2003 all mental health inpatient beds other than forensic beds had been moved to general hospital sites, and an age based, area based mental health system was well established. Victorian mental health providers embraced the shift to community based services, including the use of CTO [7]. In 2006 the Victorian government appointed a Minister for Mental Health – one of the first States in Australia to do so. While ostensibly the appointment of a separate Minister for Mental Health may have suggested an increased focus on services for mentally ill people, the separation from Health may have led to less focus by government on clinical mental health services.

Victoria has continued to be a signatory to National initiatives, the most recent of which is the Fifth National Mental Health Plan [144]. Further reform in policy and associated service directions is evidenced by the enactment of new mental health legislation in 2014, *Mental Health Act 2014* (Vic) [14] with an explicit recovery orientation focus and full compliance with the Charter of Human Rights and Responsibilities. The MHA 2014 places greater emphasis on supported decision making and external oversight, explicitly seeks to reduce the number and duration of compulsory treatment orders, and emphasises that treatment should be provided in the least restrictive way. The differences between the MHA 1986 and MHA 2014 are outlined in Table 1. The major differences in relation to CTO pertain to who can make the order and for what duration, and the criteria for making a Treatment Order.

Table 1. Comparison between MHA 1986 and MHA 2014

	MHA 1986	MHA 2014
Naming	Involuntary patient	Compulsory Patient
External review	MHRB* – Within 8 weeks and annually. Reviews decision by Authorised Psychiatrist	MHT* - Within 28 days and when order due to expire Makes Order and sets duration
Order stages	Recommendation, Treatment order made within 24 hours. Duration 12 months unless discharged by Authorised Psychiatrist or MHRB	Assessment Order – 24 hours Temporary Treatment Order – 28 days Treatment Order – Inpatient Order max 6 months Community Treatment Order max 12 months
Criteria	Has mental illness; needs immediate treatment; unable or unwilling to consent; risk of harm to self and others; no less restrictive means.	Appears/has a mental illness; needs immediate treatment to prevent serious risk of harm to self/others; no less restrictive means
Capacity	Unable or unwilling to consent to treatment one of 5 criteria	Presumption of Capacity
Decision making	Substituted decision making	Supported decision making strongly encouraged
Mechanisms to assist patient	Right to a second opinion, but could be from within service	Independent Mental Health Advocacy Second Psychiatric Opinion Scheme Mental Health Complaints Commission Nominated persons Advance care direction
Consent to ECT	Authorised psychiatrist consents if patient lacks capacity	MHT must approve if patient lacks capacity and ECT deemed least restrictive
Overarching policy		Explicit reference to Recovery Orientation, tolerance of degree of risk Explicit push to minimise use and duration of Orders

* MHRB – Mental Health Review Board; MHT – Mental Health Tribunal

We have examined a series of patient outcomes under the MHA 2014 compared with the MHA 1986. We found that the introduction of the MHA 2014 has been associated with a reduction in the number and duration of compulsory orders made (Vine et al, submitted for publication). We found a 25% reduction in the number of days on a compulsory order in the two years after being discharged from a CTO under the MHA 2014 compared with the same period under the MHA 1986. The index CTO was also shorter under the MHA (2014) compared with the MHA 1986. There was a substantial reduction in the number of orders made in the 2 years following discharge from a CTO under the MHA 2014 compared with those under the MHA 1986. Compared with 1.5 CTO made over 2 years under the MHA 1986, only 1.1 CTO were made under the MHA 2014

But alongside these apparently positive signs of reduced reliance on compulsory care are a number of areas causing increasing concern. We found that those discharged from a CTO by the Authorised Psychiatrist (AP) under the MHA 1986 were less likely to require treatment as an involuntary patient in the subsequent two years than those discharged by the Mental Health Review Board (MHRB) or whose orders had expired [321]. We hypothesised that this related to more considered treatment planning and patient engagement. This was no longer so under the MHA 2014. The AP was more likely to place a person who was on a CTO back under an inpatient order. We found that almost 30% of CTO 'ended' by being varied to an inpatient treatment order by the AP. This was a significant change from the findings under the MHA 1986. There are several possible explanations for this finding, including the possibility that people are being placed on a CTO too early in the course of treatment, or that community services are not available in sufficient intensity or accessibility to adequately support persons to remain in the community, or that the overall expectations of the Charter have influenced practitioners to minimise the use of compulsory orders. The data we obtained provided evidence of change, but we could not attribute this change solely to a change in legislation and policy. This highlights the importance of examining the context in which legislative change occurs in order to understand any effects of new mental health legislation.

Contextual issues in Victoria

Despite the commitment to improved mental health services, the last decade or more has not seen growth in funding to clinical mental health services in Victoria proportional with population growth. Victoria had the highest per capita expenditure on mental health in 1994/95 and was still ahead of New South Wales in 2008/09 (Australian Institute of Health and Welfare, 2017). By 2015/16 Victoria had the lowest per capita spend on mental health across Australia (AIHW 2017, Table EXP 4). This occurred as a result of significant population growth, without matching growth in funding for mental health.

This relative decline affected both bed based and community services. Victoria made a massive shift from institutional beds to beds located in acute general health services. In 1993/94 only 7.9 beds of a total of 34.2 per 100,000 were located in general hospitals, but by 2008/0918.1 of a total 22.9 were mainstreamed acute beds. This shift in bed location was also associated with an actual reduction in the number of beds, especially long stay beds. The acute bed base dropped from 18.1 per 100,000 in 2008/09 to 17.2 in 2015/16 (AIHW 2017, Table FAC 13) compared to the national average of 29.4 These dramatic reforms from a largely stand-alone asylum style institution based service to inpatient services co-located with acute beds were initially associated with the implementation of a range of crisis and continuing care clinic and out-reach community mental health services [322]. However, the problems in access to services are also evident in community-based services. In 2015/16 Victoria had the lowest number of full-time equivalent staff with only 121.5 per 100,000 population compared with the national average of 132.9 (AIHW 2017, Table FAC 37). Measurement of community contacts was impacted by industrial action in 2015/16, but even taking this into account there seems to be a reduction in service availability. Service contacts per 1000 population were 332 in Victoria, suggesting less intensive service availability compared with 393 nationally (AIHW 2017, Table CMHC 2).

In summary, on a per capita basis, in Victoria we are spending less, have fewer beds and fewer staff across community and bed based services than comparable States in Australia [3] (Table 2). We also have a lower bed day cost. In a recent review of quality and safety assurance in Victoria, the authors singled out mental health services as requiring adequate funding to deliver safe and timely care [256]. It should be noted that the Victorian government has substantially increased funding to community mental health services in the 2017/18 and the 2018/19 budgets, but it will take several years of such increases and further investment in bed-based services to bring Victoria back to the national average.

Table 2. Comparative mental health services (AIHW)

Per capita number/funding/EFT	1994/95 Victoria	1994/95 National Average	2008/09 Victoria	2008/09 National Average	2015/16 Victoria	2015/16 National Average
Recurrent expenditure per capita*	128.25	113.9	192.98	203.78	197.30	226.52
Acute Public beds in general hospitals per capita**	7.9	12.9	18.1	17.7	17.2	18.0
Total Beds per capita**	34.2	39.6	22.9	30.5	21.9	29.4
FTE equivalent staff per capita***	114.3	102.9	117.7	128.5	118.2	133.3
Proportion of community accessing clinical services****			1.13%	1.6%	1.08%	1.8%
Population (million)*****	3.32	18.07	5.44	21.69	6.24	24.13

* AIHW Mental Health Services in Australia. Table EXP.4; ** AIHW Mental Health Services in Australia. Table FAC 13; *** AIHW Mental Health Services in Australia. Table FAC 37; **** AIHW Mental Health Services on Australia Table KPI 8.1; Victoria's mental health services Annual Report 2016/17; ***** Australian Bureau of Statistics

These proportional changes in population in the absence of increased capacity in community and bed-based services have resulted in increased pressure on state funded health services. The results include increased throughput with a higher threshold for acceptance and shorter length of stay in inpatient units. An example from NorthWestern Mental Health in Melbourne where one of the authors works is that there were 621 admissions to a 25-bed unit in 2011/12, while the same unit had 704 admissions in 2016/17. There were 1092 admissions in 2011/12 to a 50-bed unit, but this increased to 1394 in 2016/17. The increased rate of throughput is reflected in overall increases in acuity, and higher proportion of new, previously unknown patients. While there is not data to indicate whether services have improved, the sense from services is that the increased pressure on throughput has not supported the aims of person-centred care.

These population changes mean that a comparatively lower proportion of the population accesses public mental health care. Victoria's mental health services annual report shows that the proportion of the population accessing state funded mental health services has fallen from 1.13% to 1.08% [286]. This is far lower than conservative estimates of the prevalence of severe mental illness in our community [259]. As a consequence of a number of changes in sentencing practices, there has been a substantial increase in the prison population [263]. There are also anecdotal concerns at the rising number of mentally ill persons in prison and homeless crisis services, increased rates of readmission, sexual and physical aggression on inpatient units, and blockages in Emergency Departments [260-263]

It is possible that some of the changes we noted between the MHA 1986 and MHA 2014 are related not to the impact of policy change, but to very different pressures on access and flow. There may have been improvements in treatment such as the introduction of medication with fewer side effects, and improved psychological and family therapies but we also need to acknowledge societal changes such as increased rates of methamphetamine abuse, homelessness and family dysfunction. Pressure on in-patient units in turn puts increased pressure on community services. Shorter length of stay means that patients are likely to be comparatively unwell when discharged.

Conclusion

Much has changed since the heady days of the National Mental Health Strategy in 1992, with some commentators noting early in its implementation an increasing distance between what was promised and what was delivered through supposed reforms [284]. It is difficult to determine whether, as intended by those who advocated for mental health legislative change in Victoria, success in achieving the aim of reducing rates and duration of compulsory treatment, represents advancement in care. Unfortunately, as this change occurred at a time of comparatively reduced service availability the good intentions of greater emphasis on recovery-oriented services and person-centred care may have been confounded by reduced access to appropriate services. From a practitioner's perspective, there is a very real risk that we are no longer able to provide the duration, intensity or accessibility of services that those with severe mental illness and their families should rightly expect. There is a concern that the apparent reduction in use and duration of CTO is not because there is better engagement or better outcomes, but rather because there is reduced access to services. The recognition by government that mental health services have fallen behind acute health services and need greater investment is welcomed. Further research is needed to explore the relationship between policy intentions, impact of legislation and service context, and to link this to patient outcomes.

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