Community Treatment Orders in Victoria: a clinico-ethical perspective

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Objective: *The aim of this paper is to outline the impact of Community Treatment Orders over a 20-year period on service delivery and clinical practice in Victoria.*

Conclusions: *Community Treatment Orders, as utilized in Victoria, have undermined optimal service delivery and supported paternalistic, reductionistic clinical practice. The psychiatric profession has failed to advocate adequately for better mental health resourcing and human rights protection of those subject to Community Treatment Orders.*

Key words: *Community Treatment Orders, mental health services, Victoria.*

Victoria has been internationally recognized for its program of de-institutionalization and transition to community-based mental health care. This process has unfolded over the last two decades in parallel with the enacting of the current Mental Health Act. Community Treatment Orders (CTOs) were introduced into the Act to aid the change in locus of care. Currently, there are approximately 3000 patients on CTOs and this figure has been stable for over a decade. However, the number of CTO reviews has continued to grow, indicative of a greater number who are exposed to their coercive effect at some point.[1] In contrast to the vigorous, ongoing debate among the legal fraternity about CTOs, mental health professionals in Victoria have largely focused on attempts to quantify the impact of CTOs on aspects of service delivery, such as re-hospitalization/relapse rates, adherence to community care, and consumer/carer satisfaction.[2–5] The long-term systemic influence on service delivery and clinical practice has not been thus far considered.

MENTAL HEALTH LEGISLATION AND PROCESS ISSUES

At the time the current Mental Health Act in Victoria came into being, the average length of stay (LOS) on inpatient units was of the order of 4 weeks. A review of involuntary detention by the Mental Health Tribunal was set at 4 weeks, thus usually allowing a review prior to discharge. Due to the ready availability of CTOs, the average LOS has been reduced progressively to around 11 days. Experience from the UK indicates that crisis resolution teams alone do not reduce compulsory admission rates or LOS.[6] During this same period, the time for a review – due to the increased demands on an overstretched Mental Health Review Board – has increased to 8 weeks. Both changes have been driven by lack of adequate resources – fewer beds means more use of CTOs to ease bed pressure and so more patients needing review by the Mental Health Review Board.

At the time of the hearing, the patient, often in a sub-acute state of recovery from a severe, usually psychotic, mental disorder, is expected to mount a defence against highly educated medical practitioners who are well versed in the mental health system and review process. Patients are

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given the opportunity to have legal representation if they have the ability at the time to organize this for themselves. Evidence suggests that where legal representation is automatically provided, there is a significant increase in numbers discharged by the tribunal.[7] The general impression is one of brief reviews – 30 minutes is allocated to read the material, interview all parties, answer questions raised by one party against the other, reach a decision and feedback the tribunal's decision! – stacked against the patient in favour of the service so as to be seen to be doing the right thing. The use of single-member tribunals for reviews of annual extension of CTOs is also noteworthy in this regard (unless of course the patient manages to hire legal representation when magically a three-person tribunal is felt to be necessary). Little wonder that patients become inured to a sense of hopelessness that they are regarded as individuals whose rights are being protected. The duration of a CTO (12 months) also affords the service generous latitude in keeping patients on involuntary status for significant periods without review, ''just in case'' they might become non-compliant. Furthermore, their long duration has also created the errant perception among services that the CTO can be utilized at times as a more convenient mechanism for readmission in case of relapse rather than having to re-certify the patient, a clear breach of the proper function of CTOs.

IMPACT ON CLINICAL CARE

It was hoped that CTOs would allow treatment of the acutely mentally ill by assertive community treatment teams and thus avert the use of hospitalizations. In reality, it has been the case that if the person is acutely unwell then use of a CTO has not been practicable and patients are invariably in need of hospitalization if they meet the criteria for involuntary detention.

As previously mentioned, the use of CTOs has enhanced the service's capacity to shorten inpatient stays to a degree that has been criticized as undermining good care.[8] Consequently, inpatient units only house patients in the most acute stages of illness, resulting in a disturbed milieu whereby assaults, use of seclusion and prn medications are everyday occurrences. Some patients become initially increasingly disturbed due to the environment. Also, little opportunity for the patient to slowly recover and regain insight before returning to their own environment or to see others recovering is afforded. They return home, isolated from others in their situation early in the recovery process. Staff can struggle to provide care and understanding as their time is taken up with behavioural control strategies. Developing and retaining skills necessary to building rapport and a collaborative therapeutic alliance are sacrificed. Demoralization and high staff turnover are the result.

The use of CTOs upon discharge from inpatient care sets the stage for future contact with the community-based service. The case manager is placed in the dual role of supervisor of involuntary treatment and collaborator in care. All too often, this tension is resolved in the patient's mind by seeing the case manager as primarily serving the interest of the mental health system. The case manager is left feeling a sense of futility with little to accomplish other than to play the role of enforcer and lacking therapeutic efficacy. The use of CTOs also has the by-product of increasing the use of long-acting injectible forms of antipsychotic medication with their attendant problems and the associated distress for the patient. Not surprisingly, Victoria has one of the highest rates for use of such medications.[9] In addition, CTOs allow for a severely disabled person to be kept in the community in deleterious environments where more basic freedoms from homelessness, hunger and exploitation are ignored, in the absence of any explicit obligation on the state.

Finally, with CTOs, learning and growth through experiencing the adverse consequences of one's actions is sabotaged (developmentally a particularly crucial step for young adults). Relapse prevention and risk management (often poorly assessed and addressed by use of ad hoc untested locally developed measures[10]) are reified instead. As such, the case manager is not allowed the opportunity to engage in a long-term relational-based approach to enhancing compliance and engagement. The increasing focus on episodes of care, often with pressure to discharge from the service, leads to an over-emphasis on positive symptom control over longer term concerns and relevant variables such as family work, personality traits and other important symptoms that may all have more to do with long-term disability and subjective quality of life.

IMPACT ON THE MENTAL HEALTH PROFESSION

The move from large institutions with the mainstreaming of public psychiatric services has fragmented what was previously a more cohesive group of professionals (e.g. the now defunct State Employed Psychiatrist Association, which provided a forum to discuss public mental health concerns). Smaller units with fewer staff are much easier to mould to a service agenda. As a consequence, along with other changes in employment practices, the profession has become more attuned to carrying out the demands of the service and in the process has been denuded of its advocacy role.

Individually and collectively, the use of CTOs speaks to a controlling rather than compassionate aspect of the self. As a result, the unconscious and at times conscious tendency is to perceive the client as having less human value than ourselves. Abrogation of responsibility for finding alternative and creative solutions is too easily supported. Pejorative terms come into being

to both exclude undesirable elements and evade responsibility for tackling difficult to hold patients or parts of them that are difficult to manage. The classic example is the re-labelling of challenging behaviours as 'behavioural' or 'personality' and thus legitimizing rejection, particularly when resources are limited. Michael Perlin, a New York legal academic recognized for his work on the rights of the disabled, terms this 'sanism' – the adopting of illogical terms as rational to serve the agenda of the powerful and to distance the disabled.

DISCUSSION

A comprehensive review of the international experience of coercive community mental health care on behalf of the UK Department of Health in 2007 came to the conclusion that ''evidence for the benefit of CTOs is lacking ... further research is needed''.[11] A recent analysis citing Victorian data also sounded a cautionary note.[12] Furthermore, a review of mental health legislation and detention rates across Europe concluded ''nearly 20-fold variations in detention rates were found in different parts of Europe. Criteria for detention ... were broadly similar. Variations in detention rates ... appear to be influenced by professional's ethics and attitudes, socio-demographic variables, the public's preoccupation about risk ... and the respective legal framework''.[13] Yet Victoria has been actively engaged in their use with an almost religious, unquestioning zeal.

It seems appropriate, then, to consider these sociologically determined values in understanding how the legislation is both derived and implemented in a local context. Charlesworth, a noted local international human rights legal academic, highlights the lack of universal human rights in the Constitution.[14] Rather, it was a pragmatic piece of legislation designed to court the states into federation with a cornerstone being their right to exclude undesirables, most notably those of a different cultural or racial persuasion, in essence a moral majority outlook. The corollary is that the state is a benevolent entity working in the individual's best interest (i.e. the Parens Patriae model). This highly utilitarian paternalistic approach has informed subsequent socio-political mores and does have the advantage of allowing a problem-solving methodology that creates the impression of dynamic pragmatism. However, the downside is that a short-term narrowly focused view is necessarily emphasized in favour of broader contextual concerns and long-term implications (think of the invasion of Iraq by a US led coalition as an extreme example). Mental health legislation is shaped and implemented within this socio-historical framework with implicit assumptions about the relationship between the state's representatives (the public mental health system) and the mentally ill individual. Not surprisingly, then, the CTO provisions of the Mental Health Act, in comparision to similar pieces of legislation, strongly favours the former's interests and pays lip-service to the latter's rights. Over time, this state of affairs becomes accentuated and normalized. Corrective amendments have been suggested so that it not only conforms to the letter of human rights legislation but also supports best human rights practice.[6]

The psychiatric profession, through its various bodies and alliances, has a pivotal role in highlighting concerns that impact on ethical and optimal clinical care. It is questionable that we have lived up to our responsibility for this population. In particular, the responsibility of the state to compensate for the deprivation of liberty or use of coercion by the provision of well-resourced beneficial and humane options is a particular area where psychiatrists have a lead advocacy role. In this regard, that the majority of the profession do no work in the public mental health system and rarely have much to do with the Mental Health Act does not help matters. Understandably, when there are many other agendas and battles to be fought, it is easy to forget the least empowered.

CONCLUSION

Few would doubt that the move to a community-focused model of mental health care has been a major step forward. However, CTOs, as envisioned, implemented and currently utilized in Victoria, confer extensive powers without proper accountability, coupled with minimal levels of protection of individual rights. As a consequence, over the last two decades they have perpetuated a controlling attitude that diminishes the citizenship status of the subject and the responsibility upon the state to provide optimal care. CTOs operate as a paper straightjacket and instutionalization in the community is too often the endpoint. Staff are placed in reductionist paternal roles that undermine a more holistic collaborative stance and creative struggle to find novel approaches – the quality of psychiatric practice suffers. It is contentious whether research can truly answer questions about use of involuntary treatment that rest primarily on ethical and social discourses. For, just as being able to reliably quantify does not ensure validity, the converse is also true. Studies can help to describe the individual trees but are less able to 'see the wood'. Hopefully this article will resonate with some and aggravate others so that further thinking and debate can ensue on a controversial issue that has received inadequate attention from the psychiatric profession locally.

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