THE URGENT NEED TO REVIEW THE USE OF CTOS AND COMPLIANCE WITH THE UNCRPD ACROSS AUSTRALIAN JURISDICTIONS

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In every Australian jurisdiction, legislation permits mental health service providers and/or mental health tribunals to force people with mental illness to engage in treatment, under Community Treatment Orders (CTOs). Despite considerable efforts made by every Australian state and territory to meet human rights obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2008; Maylea & Hirsch, 2017), Australia has rates of CTO usage that are very high by world standards (Light, 2019). Even within Australia, rates of CTO usage vary considerably between and within jurisdictions in spite of the legislation being very similar (Light, 2019; Adult mental health quarterly KPI report, 2019). This occurs in the context of mixed evidence about the efficacy of CTOs and a lack of clear understanding of their purpose (Segal et al., 2017; Kisely et al., 2017). The use of CTOs remains one of the most contentious issues in mental health service delivery. Not only is their efficacy unresolved, they also raise serious ethical and human rights concerns. The current debates, and attempts at reform, must be informed by valid and reliable data. This brief commentary will make the case for a research agenda that addresses the minimal research that has been undertaken to address the variations of CTO use across Australian jurisdictions.

The use of coercion in psychiatric treatment is controversial especially when it extends to people deemed well enough to be living in the community where it becomes much more difficult to justify the adverse effects on human rights (Newton-Howes & Ryan, 2017). Many of these human rights are set out by the CRPD. The introduction of the CRPD marked a radical shift in the international human rights landscape (Maylea & Hirsch, 2017). The CRPD provided the first legally binding international framework setting out the rights of people with disabilities, challenging the mental health field, in Australia and internationally, to engage in a more robust examination of forced treatment (Szmukler, Daw, & Callard, 2014). Under the CRPD, forced treatment of mental illness jeopardises several human rights, such as the right to equality before the law (Article 12); the right to liberty (Article 14) and the right not to be subjected to medical treatment without consent (Article 15). With Australia having ratified the CRPD, Australian State and Territory governments ought to respond to the obligations

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of the Convention to promote and uphold the rights of persons with disabilities, including those with 'mental impairments' (McSherry, 2014; McSherry & Waddington, 2017). Debates about the use of forced treatment of people well enough to live in the community are complex, encompassing clinical, social, policy-based, legal, philosophical and ethical concerns (Brophy & McDermott, 2003; O'Reilly, 2004; Dawson, 2005; Pridham et al., 2018; Brophy et al., 2018). While most human rights are not considered absolute, any limitations must be reasonable and justifiable.

If human rights are to be limited in providing mental health care, one would hope it is a) to apply an intervention underpinned by reliable evidence of efficacy and b) as a last resort. The evidence on forced community treatment is at best mixed. Segal and colleagues analysed data from the Australian state of Victoria and found that for individuals at risk of long-term psychiatric hospitalisation, the use of CTOs appeared to prevent additional hospitalisation and they therefore argue that CTOs provide a less restrictive alternative to hospitalisation (Segal & Burgess, 2009; Segal et al., 2017). By contrast, a Cochrane review (a systematic review of primary research in health care and health policy) by Kisely and colleagues found no evidence from randomised controlled trials (RCTs) that CTOs reduced health service use or improved social functioning, mental state, quality of life or satisfaction with care (Kisely et al., 2017). Although RCTs in relation to CTOs have been both criticised (Segal, 2017) and defended (Swartz & Swanson, 2017; Burns et al., 2017), non-randomised studies from outside of Victoria also by Kisely, found similar non-significant results when compared with appropriately matched controls (Kisely et al., 2005; Kisely et al., 2004; Kisely et al., 2020a). These findings have been confirmed in meta-analyses of other controlled non-randomised studies from Australia (Kisely et al., 2020a) and elsewhere (Barnett et al., 2018).

Work conducted by Kisely and colleagues highlights the possibility that forced community treatment may be applied to minority populations in an inequitable and possibly discriminatory manner. Recent research in the Australian states of Western Australia and Queensland indicated that the likelihood of forced treatment was increased by cultural and linguistically diverse (CALD) status (Kisely et al, 2018; 2020a). This was confirmed in a subsequent meta-analysis (Kisely et al 2020b). The likelihood of forced treatment in Queensland nearly tripled in cases where an interpreter was required (Moss et al, 2019). There is also evidence that forced community treatment disproportionately affects Indigenous Australians in Queensland (Kisely et al, 2020a), though not in Western Australia or the state of Victoria (Kisely et al, 2020b), and evidence from other jurisdictions is lacking.

Even if CTOs do provide some benefit, it may be because they act as an 'administrative mechanism which signals to community health services that these patients should have priority access to their care' (Newton-Howes & Ryan, 2017, p. 312) so that individuals on CTOs gain better access to, and engagement with, services (Kisely et al., 2017; Light et al 2016). Limiting human rights to remedy service system failures has been called 'Kafkaesque' (Newton-Howes & Ryan, 2017, p. 312), but this insurance policy approach to the use of CTOs persists.

The CRPD (Article 1) sets out general obligations placed upon all States Parties, including: 'to adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention'. Having high quality data on who is subjected to forced treatment, and on what grounds, is essential to ensure the nation is progressing towards fulfilling the 'administrative and other measures' component of its human rights obligations. Australia lacks this knowledge, despite having rates of CTO usage that are very high by world standards (Light, 2019) and rising (Rains et al 2019).

Echoing other sources (Burns & Dawson, 2009; Lawton-Smith, 2005; Light et al., 2012; O'Brien, 2014) data from the Australian Institute of Health and Welfare (2016) indicate that there are significant differences in how forced treatment is applied to people with mental health conditions between Australian jurisdictions. In 2014-15, rates per 100,000 ranged from 3.0 per cent in Western Australia to 14.6 per cent in Victoria, and 23.7 per cent in Queensland. Considerable variations within jurisdictions have also been reported (Adult mental health quarterly KPI report, 2019). For example, in Victoria, it is estimated that more than 25% of consumers of community mental health services are on CTOs at any given time (Light et al., 2012b), but this can vary depending on the service. A recent report (Adult mental health quarterly KPI report 2018-19) found that across Melbourne (Victoria's capital city) CTO rates can vary between 27% of mental health consumers at one service and 11% at another nearby service. The same report also presents the large differences in the use of CTOs between urban and rural services, where rates can be as low as 5%. The driving factors underpinning this variance remain unclear. The variance suggests that the implementation of CTOs is complex with multiple factors–including law, policy, practice, service culture and stigma–all playing a role.

Light and colleagues (2012) point out that CTOs are an 'invisible' element of mental health policy and thus the economic, social and human rights costs of forced community treatment are largely unknown. People subject to such orders are potentially marginalised and the transparency and accountability of the system for making and overseeing CTOs may be limited. People subject to CTOs are likely to miss out on essential safeguards, such as access to independent advocates (Weller et al. 2019). Despite recent revisions of mental health acts in Australian jurisdictions, Lawn and colleagues (2015, p. 14) declare that '[c]urrent Australian mental health legislation appears to focus on the process of imposing CTOs, with little accountability for what workers, services and patients do during the CTO period'.

It is essential to uncover whether the differences in justifications for CTO use are related to variations in laws, practices, or system funding and organisation. Gathering and analysing the demographic data as to who is placed on CTOs and gathering feedback from those with severe mental health conditions, their families, carers and supporters and mental health practitioners will help explain why such discrepancies exist. The National Mental Health Commission (2015) conducted a National Review of Mental Health Programmes and Services that found mental health services in Australia were fragmented and delivered within a complex system, with some confusion of responsibilities between state and federal health systems. For example, there are youth mental health agencies that provide similar services in Victoria, resulting in

confusion for professionals when making a referral. It is therefore unclear whether CTOs are being used to ensure access to services that would otherwise be unavailable to those with severe mental health conditions. There is a need for research to remedy this lack of knowledge and provide an understanding of the needs of those currently being placed on CTOs. Having high quality data on who is subjected to forced community treatment, and on what grounds, is a national and international health and human rights priority. It is knowledge that is likely to be of significant value to mental health service providers and may be used in the future to improve models of health care targeting people with severe mental illness. It will also benefit ongoing reforms to the mental health system and assist Australia to meet its obligations under the United Nations CRPD.

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