

How shortcomings in the mental health system affect the use of involuntary community treatment orders

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Abstract

Objective. The aim of the present study was to examine stakeholder perspectives on how the operation of the mental health system affects the use of involuntary community treatment orders (CTOs).

Methods. A qualitative study was performed, consisting of semi-structured interviews about CTO experiences with 38 purposively selected participants in New South Wales (NSW), Australia. Participants included mental health consumers ($n = 5$), carers ($n = 6$), clinicians ($n = 15$) and members of the Mental Health Review Tribunal of NSW ($n = 12$). Data were analysed using established qualitative methodologies.

Results. Analysis of participant accounts about CTOs and their role within the mental health system identified two key themes, namely that: (1) CTOs are used to increase access to services; and (2) CTOs cannot remedy non-existent or inadequate services.

Conclusion. The findings of the present study indicate that deficiencies in health service structures and resourcing are a significant factor in CTO use. This raises questions about policy accountability for mental health services (both voluntary and involuntary), as well as about the usefulness of CTOs, justifications for CTO use and the legal criteria regulating CTO implementation.

What is known about this topic? Following the deinstitutionalisation of psychiatric services over recent decades, community settings are increasingly the focus for the delivery of mental health services to people living with severe and persistent mental illnesses. The rates of use of involuntary treatment in Australian community settings (under CTOs) vary between state and territory jurisdictions and are high by world standards; however, the reasons for variation in rates of CTO use are not well understood.

What does this paper add? This paper provides an empirical basis for a link between the politics of mental health and the uptake and usefulness of CTOs.

What are the implications for practitioners? This paper makes explicit the real-world demands on the mental health system and how service deficiencies are a significant determinant in the use of CTOs. Practitioners and policy makers need to be candid about system limitations and how they factor in clinical and legal justifications for using involuntary treatment. The results of the present study provide data to support advocacy to improve policy accountability and resourcing of community mental health services.

Received 3 April 2016, accepted 3 June 2016, published online 15 July 2016

Introduction

In its national review of mental health programs and services,¹ the National Mental Health Commission concluded that the mental health system, as it currently stands, does not prioritise people's needs, is slow to respond, fragmented and uses resources poorly. Stigma persists, and people with lived experience, families and support people often have a poor experience of care.¹ According to the Commission, the most prominent theme to emerge from the wide range of submissions to its 2014 review was that:

...the way the mental health 'system' is designed and funded across Australia means that meaningful help often is not available until a person has deteriorated to crisis point. This is either because no mental health supports are accessible to them, they do not exist in their area, or they are inappropriate to their needs. Along the way they may have lost their job, their family or their home.¹

A less recognised² but significant consequence of people's mental illness deteriorating to crisis point is involuntary treatment. In Australia, a significant amount of involuntary psychiatric treatment is delivered in the community setting. Involuntary community-based treatment occurs in all Australian states and territories under local mental health legislation.³ More than 8.7 million community mental health care service contacts are provided each year in Australia, of which more than 1.1 million (14%) are involuntary.⁴ This reflects the frequent delivery of mental health care outside hospitals, which is due, in part, to a process of deinstitutionalisation of psychiatric services over recent decades. It also reflects the unmet needs of people living in the community with severe and enduring mental illness who were already lost to institutionalised care. As a result, voluntary and involuntary community-based clinical services are increasingly the focus for the delivery of mental health care to people living with severe and persistent mental illnesses. However, shortcomings in the process of deinstitutionalisation, largely political and economic, mean the development of community

mental health services has been inadequate and is being eroded.⁵⁻⁹

Although approximately 70 jurisdictions worldwide have schemes enabling involuntary community treatment orders (CTOs),¹⁰ they remain extremely controversial. There is much debate arising from what is a heterogeneous evidence base for their effectiveness, as well as a range of ethical, legal and political dilemmas raised by their use, including issues surrounding the use of coercion and the accountability of health practitioners and policy makers to provide adequate mental health and other social services.

The rates of use of CTOs in Australia vary between jurisdictions and are high by world standards;³ however, the reasons for the variation in rates of CTO use in Australia (and internationally) are not well understood.^{3,11,12}

Methods

The present study was conducted in New South Wales (NSW), Australia, and referred to involuntary CTOs under the Mental Health Act 2007 No8 (NSW).^{*} The study examined clinical and legal CTO decision making, as well as patient and carer lived experiences, aiming to identify potential improvements to CTO processes.

Participants and recruitment

Participants were recruited to the study using a theoretical, purposive method of sampling and comprised four groups: (1) patients currently or previously on a CTO; (2) relatives or carers of a person currently or previously subject to a CTO; (3) community mental health service clinicians; and (4) Mental Health Review Tribunal (MHRT) members. Recruitment of each participant group involved the distribution of an invitation to participate through a variety of networks: non-governmental organisations to reach consumers and carers, health service managers for clinicians and the MHRT to its members. Study information was disseminated further by individuals to their own networks and by participant recommendation to others.

^{*}Following the present study, NSW Parliament amended the Act. The Mental Health Amendment (Statutory Review) Act 2014 [NSW] modified certain principles and procedural aspects of involuntary treatment (hospital or community based), but overall the CTO provisions themselves remained little changed.

Patient and caregiver participants received A\$40 at interview. Patient participants were not recruited from, or interviewed in, clinical settings to maintain a clear distinction between their voluntary participation in the study and their involuntary treatment status. The research was conducted with the approvals of university and health service human research ethics committees.

Data collection and analysis

A semi-structured interview was used to prompt participants to speak about their understanding of CTOs and provide accounts of their experiences of CTO processes. This included asking participants how they, or someone they cared for, came to be placed on a CTO, what led up to the order being put in place, what was involved and what the experience was like. The interviews were audio recorded, transcribed and de-identified. Data were managed using NVivo 9 (QSR International).

The analysis used grounded theory methods as described previously.^{13–15} The iterative process of data collection and analysis involved an initial coding process to sort data, then synthesis of the coding into more conceptually complete categories. Constant comparison of data and codes within and between interviews, and writing of memoranda to scrutinise the nature of codes and developing categories, facilitated the emergence of several themes. These themes formed the basis of the models of lived experience and CTO decision making.^{16–18} The investigators sought to establish the validity and completeness of the analysis through triangulation,^{19,20} which can involve the use of different investigators and stakeholders (as the present study did), data sources, study theories and/or methods.^{19,20}

The operation of the mental health system emerged as a factor in many accounts of CTOs, and interview data specific to the system was analysed further to identify themes. The subsequent analysis of issues related to the mental health system was performed by the principal author.

Results

Participants

Thirty-eight participants took part in interviews, including five patients, six carers, 12 MHRT members and 15 clinicians. Of the 11 patients and carers, six were men and five were women from metropolitan or regional or rural areas. Among patients and relatives of carers were diagnoses of schizophrenia, depression, bipolar disorder and anxiety. Of the 12 MHRT members, four were psychiatrists, four were lawyers and four were ‘community members’ from other relevant fields, including social work, nursing, psychology and mental health service administration. The clinician sample included three psychiatrists, eight nurses, two social workers, one psychologist and one occupational therapist. The various clinicians had worked in in-patient and community mental health settings and their clinical loads included general adult mental health, youth mental health, older person’s mental health and Aboriginal mental health. Participants worked in regional and metropolitan settings.

Results of qualitative analysis

In speaking to consumer, carer, clinician and MHRT member participants about their experiences of CTOs, the present study identified a range of factors associated with how CTOs are used

and experienced. One of the dominant issues that emerged across the interview data was the notion of the ‘system’. The ‘system’ was commonly spoken about as an entity in which mental health services are delivered. This entity was not so much a single institution or context, but the setting in which mental health services are provided. It comprised individual facilities and programs, as well as professionals (clinicians, management and policy makers) responsible both for the care of individuals and for the organisation and operation of the system as a whole.

These accounts of involuntary treatment and of the operation of the mental health system raised two main claims about CTOs, namely that: (1) CTOs are used to increase access to care; and (2) CTOs cannot remedy non-existent or inadequate services.

CTOs increase access to care

Across all participant groups, many people spoke about the role of CTOs in increasing access to care for people living with mental illness. CTOs were frequently acknowledged as a deliberate strategy to counter known deficiencies in the ‘system’, acting as a compulsion on the ‘system’ (rather than just on the patient) to engage in treatment.

I’ve come to realise that with the dwindling resources in the mental health area, for people like my son [a CTO] is the only way to access the service. (Carer)

I often think a CTO is a CTO on the staff rather than on the client, and sometimes they will virtually tell you, if there wasn’t a CTO they wouldn’t be bothering to see the person or following them up very assiduously. (MHRT member)

So sometimes we use a CTO to get a person guaranteed on the books, and it’s not about the client at all, it’s just because we really want them to have mental health follow-up, and that’s a way of doing it. (Clinician)

Participants saw this as both a positive and negative aspect. Those with positive views acknowledged that the ‘system’ inevitably had imperfections and that the dual role of CTOs in ‘engaging’ both patient and ‘system’ was beneficial: prompting and coordinating programs and services that focused on supporting the patient and the management of their health.

I think in an ideal world, we would have enough staff to manage all of the people that are out there in the community effectively, but we don’t. So, it’s a way of prioritising. . . (Clinician)

Rather than necessarily raising concerns about accessing services before a CTO, many consumer participant accounts acknowledged the benefits that followed a CTO in terms of access to clinical and social services and supports, which often stopped when a CTO ended.

I think having a case manager helps, like she was trying to find me accommodation and give me advice about exercise and health, and quitting smoking and those sorts of things. So having a case manager was good. But when the CTO finished, the case manager lapsed. (Consumer)

Most of those with negative views tended to acknowledge those positive perspectives, but raised concerns about the use of coercive treatment laws to respond to 'system' inadequacies, undermining potentially voluntary care and least restrictive principles of the mental health legislation.

...people are often put on CTOs possibly with some legal legs, but you know also as a stop gap to get the person care in a system that's rationing its resources, and prioritising people on involuntary treatment over people on voluntary treatment, which is one of the most non-sensible things I've ever seen.' (Clinician)

CTOs and the 'system's' ability to respond

Although CTOs were generally seen as a tool to access services and provided a safety net where there were gaps in mental health system resources, participants also spoke about the limitations of CTOs and the fact that if the 'system' had no ability to respond, then CTOs could do little more. People gave examples from their own experiences of how the system's capacity affected the implementation of a CTO, resulting in 'non-existent', more restrictive or inadequate care.

System capacity was raised frequently in the context of geographic location. Participants acknowledged the demands on rural mental health services and identified the burden on services as a significant aspect of whether the system could respond to people's needs, including the option of a CTO. One carer participant identified the problems raised when her son moved to a rural area of NSW, where a CTO was not even possible because there was no one to administer it.

So he was just in no man's land, until he became so ill that the police picked him up and he had to go to hospital. (Carer)

The carer recognised the pressures on professionals working in an over-stretched system, such as the mental health nurse who had been working in the rural area when her son first moved there:

...she was really overworked. . . She went on stress leave for 3 months and didn't come back, and they can't find anyone to replace her.

A clinician participant practising in a rural area spoke about how the limited capacity of their rural service affected the care they provided to patients. This included 'escalating' care and using more restrictive options, such as hospitalisation, because they were unable to implement community treatment (whether voluntary or involuntary). The same clinician described how a discussion of case studies with colleagues from an outer metropolitan community mental health service 'opened my eyes so much' to the differences in the ways different services could respond to patients:

...there's no way that we could do that [visit a patient every day or second day]. So therefore the least restrictive method we could take is actually detain them and take them into hospital.

The process of health system access was often described by consumers and carers in terms of the value of opportunities to

foster constructive, personalised therapeutic partnerships with mental health professionals. However, one carer participant summed up concerns expressed by a few participants about the quality and appropriateness of care received while under involuntary treatment orders:

...the doctor pulled me inside and said '[Y], I was wondering if you could tell me how [X] was when she was well, as there's nothing written in her notes'. So she's been maintained in a community mental health service, on a fortnightly depot injection, and the only thing that's recorded is the fact that she's been given an IMI [intramuscular injection] injection. (Carer)

Several consumer participants raised similar concerns about problems with communication and engagement with professionals, which had worsened their journey through a CTO.

[On the first CTO]. . . they put me on to three or four different psychiatrists in [health centre Z], one after the other, and then I had the second episode, and then [Dr Y] took over, and he actually apologised and said, 'I don't think we've treated you the way we should have treated you, because you're going to a new person and you're having to tell the same bloody story again, so you're starting from the beginning again, rather than moving on'. (Consumer)

Discussion

The results of the present study highlight the need to take into account the overall 'performance' of the mental health system in any meaningful examination of involuntary community treatment. Indeed, the operation of the mental health 'system' is critical to questions about the usefulness of CTOs, ethical justifications for their use, the legal criteria regulating their implementation and the policy accountability of involuntary treatment schemes.

This study makes clear that failings in the mental health system may be correlated with increasing CTO rates. This is highly significant because it resonates with concerns about the inappropriateness of attempts to increase coercion to compensate for under-resourced services²¹ and about the expectations placed by CTO policies on the state to provide adequately organised, resourced community mental health and other social services, and to ensure that the treatment provided under CTOs is focused on the patient's needs.²²⁻²⁵ It also lends weight to concerns that the mental health system may 'rely' on unnecessary coercion in community-based care, and is not sufficiently concerned with appropriately resourcing non-coercive efforts to engage patients in treatment.^{22,23,26,27} In this regard, it is of note that these issues are the focus of the Mental Health Commission of NSW's recommendation for policy reform aiming to decrease the rate of CTO use, which argues that high rates of involuntary orders 'is a marker of a system which is not intervening early or effectively. It indicates a need to rebalance the system and move away from a reliance on coercive forms of care'.²⁸ In an annual progress report, the Commission stated that the rate of CTOs has stayed 'relatively stable' since 2008-09 (whereas the rate of

involuntary in-patient treatment has nearly doubled because of changes in procedures).²⁹

It is important to note that the provision of more and better-resourced mental health services would not necessarily mean CTOs would no longer be required; nor does it suggest that CTOs serve no purpose. The research literature highlights that CTOs are procedural instruments (they are not a treatment) and that a consistent effect of their use is increased patient contact with clinical services in the community.^{30,31} The results of the present study are consistent with those conclusions. This increased clinical contact may explain, in part, research findings where CTOs have reduced all-cause mortality, victimisation and hospital readmissions or length of stay.^{30–34} However, although CTOs may enable access to mental health services, there is a multitude of reasons why they may be used and, as participants in the present study reported, one reason is to try to counter deficiencies in mental health care. Furthermore, these findings also showed that resort to CTOs alone could not surmount instances of non-existent or inadequate services.

Therefore, the present study provides a compelling argument for policy strategies that improve the accountability and transparency of CTO schemes and the broader mental health system. Such strategies necessitate developing a more accurate picture of the system and informing the public of both the existence and extent of CTO use, thus informing deliberations about how and why they should be used. Like many jurisdictions, NSW mental health law provides that a person can only be subject to a CTO if, due to a mental illness, that person requires protection from serious harm to self or others (Mental Health Act 2007 No8 (NSW)). The NSW Act (s53) also specifies that the CTO must represent the least restrictive kind of safe and effective care reasonably available, that the person has previously refused treatment and would benefit from a CTO and that a mental health facility have an appropriate and implementable treatment plan (Mental Health Act 2007 No8 (NSW)). The present study found that the influence of ‘system’ factors is significant to how practitioners think about the practical application of risk-of-harm justifications for CTOs and the legislative criteria for least restrictive care and capability of services to implement treatment.

Legislation provides a framework for achieving policy goals.³⁵ However, earlier research has highlighted the near absence of a policy account of CTOs in Australia and the problems associated with that shortcoming.² Recent national policy reviews^{1,36} have drawn attention to the ‘complexity, inefficiency and fragmentation of the mental health system’³⁶ and to the needs to people with severe and persistent illness and complex care needs. However, none has included involuntary treatment in its analysis or proposals for reform.

The present study illustrates the importance of a more comprehensive mental health policy that articulates the principles and objectives of CTOs, to better direct their implementation and appropriate scrutiny.

Limitations

A limitation of the present study is that it was conducted in a single jurisdiction (NSW). This limits the generalisability of findings, but they are likely to be relevant to other jurisdictions

because of similarities in the implementation of CTO schemes and the needs and experiences of patients with severe and persistent illnesses. Another limitation of this research was the small number of mental health consumer participants recruited and proceeding to interview. The range and depth of experiences gathered from the interviews, coupled with the opportunity to check the validity and completeness of the ongoing data analysis with stakeholder representatives, meant we were able to make claims to data saturation.

Conclusion

CTOs can, of course, only exist within a system and their usefulness is therefore affected by that system. Even if a CTO scheme is well designed, if it operates in a dysfunctional system it will not paper over its deficiencies and may exacerbate them. Consistent with other research, the present study indicates that any serious consideration of involuntary psychiatric treatment in NSW and other Australian jurisdictions requires careful monitoring.^{2,3,29} Nationally, there should be a process developed to acquire reliable and uniform data on involuntary treatment services in the community setting.³ From the perspective of the ‘system’, the present study also identifies the need for a process of review of the functioning of mental health systems and the effect on the operation of involuntary community treatment policy and legislation.

Conflicts of interest

The authors declare there are no conflicts of interest.

Acknowledgements

This study was funded by a discretionary grant from the Mental Health, Drug and Alcohol Office of NSW Health. The views expressed in this paper are those of the authors and do not necessarily reflect those of NSW Health or members of the project’s stakeholder reference group (Carers NSW; InforMH; NSW Institute of Psychiatry; Mental Health Coordinating Council; Mental Health Review Tribunal; NSW Consumer Advisory Group – Mental Health Inc.; and NSW Health Mental Health, Drug and Alcohol Office).

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