example, see the 'Barbie Savior' Instagram project: https://www.instagram.com/barbiesavior).

Conclusion

The ethical challenges in GMH humanitarian work have consistently demonstrated the limitations of normative ethics in the unprecedented and morally ambiguous situations that providers encounter in abundance. In contrast to reliance on predetermined norms, standards and protocols, a values-based framework allows for establishing the contextual relevance of professional values and suggests which to prioritise when approaching complex problems. The flexibility and situational congruency of this approach comes with a price: it places more responsibility on the provider in the decision-making process and elevates the roles of professional judgement, professional competency and personal integrity.

The time has come for the professional mental health associations to recognise GMH as a specialisation with its own unique scope of services and core professional competencies and to establish the standards of training, supervision and practice.

References

Arendt H. (1983) *The Life of the Mind* (Vols. 1 & 2). Mariner Books.

Cherepanov E. (2018a) *Ethics for Global Mental Health: From Good Intentions to Humanitarian Accountability*. Routledge.

Cherepanov E. (2018b) How global mental health is not international psychology: a discussion. *International Psychology Bulletin*, **22**, 46–49. Retrieved from https://div52.org/images/PDF/D52-IPB/IPB-2018-22-2-spring.pdf.

Inter-Agency Standing Committee (IASC) (2007) *Guidelines on mental Health and Psychosocial Support in Emergency Settings*. IASC.

Sphere Project. (2011) *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*. Sphere.

Summerfield D. (2004) Cross-cultural perspectives on the medicalization of human suffering. In *Posttraumatic Stress Disorder: Issues and Controversies* (ed. G. M. Rosen). John Wiley & Sons Ltd.

Wessells MG. (2009) Do no harm: Toward contextually appropriate psychosocial support in international emergencies. *American Psychologist*, **64**, 842–854.

PSYCHIATRY UNDER RESTRICTIVE CONDITIONS

Community treatment orders: international perspective

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The use of community treatment orders (CTOs) is available in more than 70 jurisdictions around the world. Although CTOs are used extensively, their effectiveness remains doubtful. We comment on the existing evidence and focus on components that influence the outcomes of CTOs internationally. It is essential to identify factors that affect the delivery of CTOs, and mixed methodologies may improve our understanding regarding their efficiency.

International community treatment orders use and outcomes

Community treatment orders (CTOs) were established with the aim of providing treatment to patients under supervision and outside a hospital setting, even involuntarily. The discussion regarding their efficiency has been an ongoing debate in recent years, yet their use is expanding worldwide without enough empirical evidence to support it. Legislative grounds for CTOs have existed for decades in various regions, including Australia, New Zealand, the USA, Asia, Canada, the UK and Switzerland, but rates of usage and legislation vary. Generally, the administration of CTOs differs with respect to duration, links to treatment, threshold for compulsion and patient admission history (Dawson, 2005). Their similarities lie in the general practice that is followed; a mental health specialist issues the order, the patient is placed on a CTO, and the order is renewed at specific time-frames over several years (Table 1). Therefore, their differing functions, not only internationally but also area by area, make it impossible to compare between studies.

Important reviews, randomised controlled trials (RCTs) and anecdotal evidence suggest no benefits of CTOs in terms of patients' interests, no reduction in relapse rates or hospital bed days, and no improvement in adherence or quality of life (Steadman *et al*, 2001; Burgess *et al*, 2006; Churchill *et al*, 2007; Kisely *et al*, 2011; Burns *et al*, 2013). The OCTET 3 year follow-up found an association between CTO use and engagement with services, but whether this was due to the effects of the CTO or the severe course of the mental illness was not clear (Puntis *et al*, 2017). Rugkåsa and Burns have pointed out that the problematic nature of CTOs on clinical, ethical, legal, economical and professional

Table 1
CTOs in Australia, New Zealand, USA, Canada and Switzerland, Scotland, England and Wales

Area, CTOs/population	Form	Terminology
Australia (Dawson, 2005), e.g. Victoria: 60 CTOs per 100 000	Psychiatrists have the major responsibility for initiating and extending CTOs, although the order's continuation is then reviewed by the Board	Australia operates a federal legal system, with nine separate jurisdictions, one at the federal level and one for each state or territory
New Zealand (Dawson, 2005), 44 CTOs per 100 000	CTOs may be made: • by a district court judge; or • by a clinician, who may switch a patient to a CTO from an involuntary in-patient order previously made by a judge	General administration is the responsibility of regional officials, called Directors of Area Mental Health Services, who are usually senior psychiatrists
USA (Brennan, 2009), e.g. New York: two CTOs per 100 000	The legislation varies between states; court-ordered AOT	The New York Office of Mental Health is responsible for state-wide oversight and monitoring of the AOT programme
Canada (Dawson, 2005), 2 CTOs per 100 000	The CTO is issued by a physician (who is usually a psychiatrist), not by a court or tribunal	Provincial statutes; a variety of mechanisms are provided for out-patient treatment to be administered without the patient's consent
Switzerland (Dawson, 2005)	Not much detail about out-patient treatment can be found in cantonal law. Oversight by a specially constituted Council in the canton with medical representation	Laws of the cantons concerning non-consensual treatment are diverse
Scotland (Dawson, 2005)	Central roles in the administration of the Scottish legislation of: • Mental Health Officers • Responsible Medical Officers • the Mental Health Tribunal for Scotland (the Tribunal)	Community care orders
England and Wales	Psychiatrists have the major responsibility for initiating and extending CTOs; patient may apply for a tribunal	

AOT, assisted out-patient treatment; CTO, community treatment order.

grounds (Rugkåsa & Burns, 2017) makes them inadequate for the purpose for which they were designed.

Most studies on the efficiency of CTOs have focused on outcome measures. In addition, the competing drive to reduce hospital use and the pressure on psychiatrists to manage risky behaviour is reflected by the quantitative focus of much research, e.g. hospital beds. It would be certainly rational to proceed with further RCTs to study the delivery of CTOs, but at this point it would be wise to stop and understand what we are trying to measure. Therefore, it is useful to examine global components that promote deficiencies of CTO use and attempt to improve them.

Factors that influence outcomes of CTOs

Targeting the right population

The use of CTOs tends to be higher for patients with psychotic disorders who lack insight and capacity to consent. Patients with low insight are more likely to experience relapse and be readmitted to the hospital (Churchill *et al*, 2007). Certainly, both patient factors (e.g. the nature of the illness, insight and personality factors) and CTO factors (e.g. conditions, duration, delivery and implementation) may all affect individual outcomes and overall efficacy. The utility of CTOs for substance misuse, personality disorders and management of risk of violence remains unclear (Ridgely *et al*, 2001), although it has been suggested that in the case of assisted outpatient treatment, they may reduce violence and risk of arrest (Link *et al*, 2011). However, it has been demonstrated that it would take 238 OPC orders to prevent just one arrest (Kisely *et al*, 2011).

It remains unclear for which populations CTOs are more successful. It may be that RCTs with negative results have not included the group of patients that could benefit the most. Determining the most appropriate populations may help clinicians to identify patients with similar characteristics, resulting in a successful treatment plan. It is, however, useful to consider the reasons behind the introduction of CTOs. Placing patients with traits of risky behaviours (based on genetic factors, patient's previous history and the nature of the disorder) will help supervision and monitoring on CTOs only if it can be combined with continuous clinical and therapeutic support, which could decrease the number of cases at risk for arrest. With this practice, ideally, the order could prevent patients from engaging in borderline behaviours. Second, such practice could eliminate the pressure on clinicians' side not to use a CTO, given the possibility of negative patient outcomes, e.g. harming themselves or others; this is a critical clinical consideration given the political and public pressures on clinicians. A CTO could be ordered only for patients with severe and persistent mental illness accompanied by high risk of

aggression; this could act as a protective mechanism with the appropriate support, together with monitoring the progression of the patient's mental illness. However, there are still steps to be taken to improve the delivery of CTOs, including the need to efficiently and significantly reduce the rate of arrest in patients with high-risk profiles.

Clinical decision-making

The 'potential for treatment compliance' appears to be the primary focus in decision-making. Assessing this requires consideration of many factors, including the type of mental disorder, insight, treatability, history of adherence, engagement with services and risk. Decisions may also be significantly dependent upon a patient's insight. If insight is viewed as a neurobiological deficit of illness and amenable to treatment, the potential for improvement of a patient that could allow them to recover decision-making capacity (DMC) could provide an ethical justification for enforcing adherence in the patient's best interests (Dale, 2010). One could argue that the best candidates for a CTO are patients who are able to consent. However, competent patients are not necessarily good candidates for a CTO. Patients with DMC have adequate insight to opt for voluntary community treatment without a CTO (Newton-Howes & Ryan, 2017). However, it is worth noting that while a patient's DMC puts them in a better position, insight is not necessarily connected with treatment adherence, especially if the patient has a history of high-risk behaviour or has a severe relapse profile (Dawson & Mullen, 2008). The decision to discharge someone from a CTO not only concerns the development of insight, but also clinical improvement, adherence to treatment, and reduced risk to self or others (Link *et al*, 2011).

Regarding patients with DMC, we are aligned with the opinion that those patients can express a preference for a future treatment when DMC might be lost, and that under such circumstances, treatment can proceed with a CTO (Szmukler, 2015). However, shouldn't all patients be able to consent to future treatment at the time that they retain DMC? What happens with patients who do not retain DMC but have not consented in the past to the possibility of such treatment? A solution is to decrease the rate at which patients with no DMC are considered for CTOs. Reforms of mental health acts in many Australian jurisdictions now discourage forced psychiatric treatment in patients who have DMC (Callaghan & Ryan, 2016). Although using CTOs in patients with no DMC is considered ethical by many, this is with the assumption that CTOs do bring about an improvement into a patient's mental status.

Perspectives of patients about treatment

Patients tend to be ambivalent about CTOs. There is actual and perceived coercion and restriction, but the prospect of a shorter in-patient stay is appealing and may be perceived as less restrictive. Studies from New Zealand have found that patients generally find CTOs supportive (Gibbs *et al*, 2005). For most, the restrictions did not unduly hinder them, and many valued the access to services. These orders can bring a sense of security and can be viewed as a step towards community stability, despite reduced treatment choice. Stability in the community can also reduce stigma, outweighing for some the associated feelings of restriction, but this would need parallel insight orientation work to have long-term benefits. Critical factors that affect patient experience include the quality of therapeutic relationships and support from services (Rugkåsa & Canvin, 2011).

A Norwegian study investigating positive patient outcomes reported that those experiencing assertive community treatment under a CTO had the highest recovery rates, compared with patients who were not placed under a CTO. In addition, those under a CTO found secure housing, sounder finances and access to the normal benefits offered by society to be of great importance (Lofthus *et al*, 2018). It is therefore essential to satisfy basic needs under a CTO, which may contribute to improved perceptions of patients towards their treatment. Other contributory factors towards a good recovery could involve flexibility, close communication, close monitoring of medication and social inclusion. Restriction under a CTO may be viewed more positively if there is flexibility and close communication regarding the treatment, which may change perceptions of CTOs as not just the enforcement of adherence to treatment but the provision of a safe environment for the patient's own clinical, personal and social recovery. Such changes in ordinal mental services would be difficult to achieve, but small steps towards this realisation could offer at least some improvement in the mental health of patients under a CTO, who might feel that their life is not progressing, which is negative for their recovery (Stensrud *et al*, 2015).

Conclusion

CTOs aim to improve engagement and treatment adherence. One perspective is that their paternalistic style contributes to patients becoming disengaged from mental health services, while another is that supervision might help patients to improve their mental health when recovery is difficult to achieve. It would, however, be valuable to research the area further to justify the use of CTOs at an international level and ensure they are targeting the most appropriate populations, while enhancing decision parameters and the conditions under which a patient is placed on a CTO. Clinical research tends to use quantitative approaches, but the use of mixed method designs in research on patients' recovery can offer improved insights and provide novel perspectives. Each patient experiences treatment, their own mental status, and mental health services in a different way; this may contribute to the mixed results reported by various studies, along with the difficulties of obtaining reliable data

and making comparisons across different methodologies. Thus, we need pluralistic approaches in addition to traditional study designs that can provide novel information regarding the delivery of CTOs.

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References

Brennan K. J. (2009). *Kendra's Law: Assisted Outpatient Treatment in New York*. New York State Office of Mental Health.

Burgess P., Bindman J., Leese M., *et al* (2006) Do community treatment orders for mental illness reduce readmission to hospital? An epidemiological study. *Soc Psychiatry Psychiatr Epidemiol*, **41**, 574–579.

Burns T., Rugkasa J., Molodynski A., *et al* (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet*, **381**, 1627–1633.

Callaghan S. & Ryan C. J. (2016) An evolving revolution: evaluating Australia's compliance with the convention on the rights of persons with disabilities in mental health law. *UNSWLJ*, **39**, 596.

Churchill R., Owen G., Singh S., *et al* (2007) *International Experiences of Using Community Treatment Orders*. Department of Health.

Dale E. (2010) Is supervised community treatment ethically justifiable? *J Med Ethics*, **36**, 271–274.

Dawson J. & Mullen R. (2008) Insight and community treatment orders. *J Ment Health*, **17**, 269–280.

Dawson J. B. (2005) *Community Treatment Orders: International Comparisons*. Faculty Of Law, University Of Otago.

Gibbs A., Dawson J., Ansley C., *et al* (2005) How patients in New Zealand view community treatment orders. *J Ment Health*, **14**, 357–368.

Kisely S. R., Campbell L. A. & Preston N. J. (2011) Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Syst Rev*, **2**, CD004408.

Link B. G., Epperson M. W., Perron B. E., *et al* (2011) Arrest outcomes associated with outpatient commitment in New York State. *Psychiatr Serv*, **62**, 504–508.

Lofthus A. M., Westerlund H., Bjørgen D., *et al* (2018) Recovery concept in a Norwegian setting to be examined by the assertive community treatment model and mixed methods. *Int J Ment Health Nurs*, **27**(1), 147–157.

Newton-Howes G. & Ryan C. J. (2017) The use of community treatment orders in competent patients is not justified. *Br J Psychiatry*, **210**(5), 311–312.

Puntis S. R., Rugkåsa J. & Burns T. (2017) Associations between compulsory community treatment and continuity of care in a three year follow-up of the Oxford Community Treatment Order Trial (OCTET) cohort. *BMC Psychiatry*, **17**(1), 151.

Ridgely M. S., Borum J. & Petrila J. (2001) *Does Involuntary Outpatient Treatment Work?* RAND Corporation.

Rugkåsa J. & Burns T. (2017) Community treatment orders: are they useful? *BJPsych Adv*, **23**(4), 222–230.

Rugkåsa J. & Canvin K. (2011) Community Treatment Orders: a qualitative investigation of patient experiences in England. *Psychiatr Prax*, **38**, 03034259.

Steadman H. J., Gounis K., Dennis D., *et al* (2001) Assessing the New York City involuntary outpatient commitment pilot program. *Psychiatr Serv*, **52**, 330–336. 57.

Stensrud B., Høyer G., Granerud A., *et al* (2015) "Life on hold": a qualitative study of patient experiences with outpatient commitment in two Norwegian counties. *Issues Ment Health Nurs*, **36**(3), 209–216.

Szmukler G. (2015) Is there a place for community treatment orders after the OCTET study? *Acta Psychiatr Scand*, **131**(5), 330–332.

MENTAL HEALTH LAW PROFILE

The Queensland mental health court: a unique model

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There is a longstanding but sometimes controversial belief that a person is not criminally responsible for a crime if they were suffering from a mental illness at the time of the offence. The Queensland Mental Health Court (QMHC) system, in which assisting clinicians have a central role, is underwritten by this belief. This paper describes the QMHC system.

Background

Mental health courts have operated in the USA for many years (McNiel & Binder, 2007; Wolff *et al*, 2011), the first one having been established in Florida in 1997 (Mikhail *et al*, 2001). Mental health courts also exist in Canada. However, to our knowledge, the process of the Queensland Mental Health Court (QMHC) model is unique worldwide. In Australia, individual states have legislative jurisdiction over a number of issues, including criminal justice and mental health systems. Legislation governing these areas is separate for each state. The current QMHC system was established as part of the Mental Health Act in 2000, the similar precursor Mental Health Tribunal having been established in 1985 (Queensland Government, 2014; State of Queensland, 2015). The recently updated Mental Health Act 2016 (which came into effect in March 2017) continued the QMHC,