

In debate

Community treatment orders are not
a good thing

Simon Lawton-Smith / John Dawson and Tom Burns

Summary

Does politicians' enthusiasm for community treatment orders lie primarily in the area of public protection? If so, can such orders reduce homicide rates? Is there adequate evidence of their value, given their adverse effects on individual liberty? This well-researched and provocative debate will enlighten

readers on these and many more of the complicated questions surrounding this issue.

Declaration of interest

S. L-S.: none / J. D. and T. B.: none

For

One of the most controversial measures in the UK government's Mental Health Act 2007, covering England and Wales and expected to come into effect in autumn 2008, is the replacement of supervised aftercare powers with new supervised community treatment powers.

Under supervised community treatment, patients compulsorily detained in hospital for treatment may, on discharge, be placed on a community treatment order, requiring them to comply with certain conditions, including taking their medication. Unlike existing supervised aftercare powers, supervised community treatment includes the sanction of conveying a non-compliant patient to hospital for compulsory treatment in effect as an out-patient, without the necessity of formal readmission.

It would take a brave, and possibly foolhardy, person to dismiss the introduction of community treatment orders in England and Wales out of hand. Equivalent systems have existed elsewhere for some years, most notably in North America and Australasia. Community treatment orders have been promoted as a less restrictive alternative to hospital detention, although given the restrictions they can impose on patients, this is open to challenge.¹ They are intended to allow chronically mentally ill patients to live safely in the community, enhancing opportunities for social inclusion and halting the 'revolving door' of multiple hospital admissions.

No community treatment order systems have as yet been disbanded (though some have hardly ever been used and a number have been subject to subsequent legislative tinkering) and many are enjoying – if that is the right word – year on year increases in the number of people subject to them.² So they must be doing something right. Or are they?

I would suggest that there are four good reasons for challenging the onward march of community treatment order systems. First, the lack of a convincing evidence base; second, the danger of an overall increase in compulsion; third, unresolved ethical concerns; and fourth, the distraction that a community treatment order system may cause to finding solutions based on voluntary support and treatment.

The evidence base

Reviews of the international research literature have found many methodological limitations and no robust evidence about either the positive or negative effect of community treatment orders on key outcomes such as hospital readmissions, length of hospital

stay, improved medication adherence or patients' quality of life,³ and have queried whether community treatment orders are an effective alternative to standard care.⁴ Although not opposing community treatment orders in principle, the Royal College of Psychiatrists has pointed out that 'studies from abroad do not show community treatment orders to be the panacea the Government makes them out to be. Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale.'⁵

There is some evidence of support for community treatment orders from clinicians and patients' families.⁶ Even some service users accept that they can bring benefits, generally in terms of accessing services they might otherwise not get, and avoiding compulsory hospital admission.^{7,8} A review of community treatment orders in Ontario, Canada, cites 'undeniable' benefits for individuals and families, such as the maintenance of treatment during periods of poor insight and the ability to secure stable housing.⁷ Similar positive findings have been found in New York State.⁹ However, it has not been possible to say whether the benefits arise from the legal authority of a community treatment order, or simply from patients having access to a high level of service provision. So should we be extending compulsory powers if well-resourced voluntary community services could produce the same benefits?

Given the inconclusive evidence base, some might suspect that politicians' enthusiasm for community treatment order legislation primarily lies in concerns about public risk. 'Stranger danger' in particular occupies the media and public imagination, and in England the murder on the London underground of Jonathan Zito by Christopher Clunis looms large over the debate, despite occurring 15 years ago.

Do community treatment orders – compared with good voluntary community support – reduce the level of violence among mentally ill people living in the community? There is little firm evidence to believe so,³ and one study suggests that 238 people would need to be placed on a community treatment order to avoid one arrest.⁴ Will the introduction of community treatment orders in England and Wales reduce the number of homicides committed by someone with a mental illness? Possibly. But although any intervention that might prevent even one homicide must be considered seriously, homicides by people with a mental disorder are very difficult to predict. A study in England has shown that many perpetrators had not previously been in contact with services or had last been assessed as at low risk.¹⁰ Community treatment orders are therefore unlikely to have a significant impact on the total number of these incidents. There has been no discernable reduction in the overall rates of homicides by people with a mental illness in Canada, Australia or New

Zealand as a result of community treatment orders, which have been in place in those countries for some years.

Increased compulsion

Community treatment orders will almost inevitably increase overall use of compulsion in England and Wales. The Department of Health estimates that on average patients will stay under community treatment orders for 9 months.¹¹ However, this may prove an underestimate, with concerns that it will be easier to be put on a community treatment order (initially for 6 months) than taken off it. In New York State, for example, almost two-thirds of the patients who were subject to a court order had their commitments renewed after the first 6 months, for an average commitment period of 16 months.⁹

Even if 9 months proves correct, this is a significantly longer than the length of time the average patient is treated in hospital – around 3.5 months.¹¹ This means that at any one time there are likely to be more patients subject to supervised community treatment and detention in hospital than are currently subject to just detention in hospital.

Furthermore, although community treatment orders are intended for a small number of so-called ‘revolving door’ patients who do not adhere to medication regimens and experience multiple hospital detentions,¹² the 2007 Act allows patients to be discharged on a community treatment order after their first compulsory admission for treatment. A history of recurring hospitalisation is not necessary. This significantly increases the scope of who may be placed on a community treatment order.

Ethical concerns

Community treatment orders pit patient autonomy against professional paternalism, raising serious ethical concerns. The 2007 Act is risk-based, not capacity-based. Given that the majority of psychiatric in-patients have the capacity to make treatment decisions,¹³ community treatment orders will commonly be imposed on people who have capacity. If health legislation can in general be considered discriminatory against people with mental disorders as opposed to physical disorders,^{14,15} then community treatment orders will simply reinforce that discrimination. This paternalistic shift runs directly counter to the government’s welcome efforts to increase patient choice in mental health.¹⁶ We should also not forget that community treatment orders will compel patients to take medication that will be effective to differing degrees and could have seriously debilitating side-effects.

A distraction?

Finally, a system that allows for the regular use of community treatment orders may distract services from finding voluntary solutions to manage hard-to-engage patients, and focus scarce resources on the few rather than the many. Should community treatment orders become the norm for people who have at some point been detained for treatment in hospital, then less thought needs to go into how to provide good-quality support on the therapeutic basis of trust and willingness, rather than coercion. Essentially, community treatment orders might be seen as an admission that community mental health services have failed to offer patients with chronic mental health problems the type of support they would want to engage with.

In the circumstances, practitioners and regulators in England and Wales need to proceed with great caution to ensure that community treatment orders do not become used beyond their intended remit. However, we should also be questioning whether the introduction and expansion of community treatment order

systems more generally can be justified, and whether the debate – and scarce resources – should not rather be refocused on improving voluntary community mental health services for all those who need them.

Simon Lawton-Smith

Against

We maintain the view, despite the case made by Simon Lawton-Smith, that to use a properly regulated community treatment order regime is just as legitimate as to use compulsory hospital care. Treatment without consent, wherever it occurs, is open to abuse. It can be used too widely, for too long, or for the wrong reasons, and it can be implemented in a manner that contravenes human rights. The history of institutional care provides many examples. We therefore agree that compulsory treatment should be used with caution.

It does not follow from the need for such caution, however, that the walls of the hospital should constitute an impenetrable boundary – erected by law – between voluntary and involuntary care. There is no compelling reason for involuntary treatment to be linked indelibly to particular buildings any more. Instead, the law should match the current structure of service delivery. Properly regulated involuntary care should be permitted in the community because this is where most treatment now proceeds, including the treatment of a small but well-recognised group of patients who remain unwell, with serious mental illness, over long periods of time, and are repeatedly readmitted to in-patient care.

The option of involuntary out-patient treatment should be available to clinicians working with such patients, provided they act within proper legal criteria, adequate forms of professional accountability exist, the patients have ready access to second opinions and independent review, and no power of forced medication in the community is provided. Under these conditions, it is no less justifiable, in our view, to use a community treatment order regime than to use compulsory in-patient care.

The research shows that Australasian and North American clinicians have largely succeeded in directing their involuntary out-patient schemes towards this highly selected patient group. The Churchill report concludes: ‘There is remarkable consistency in the characteristics of patients on community treatment orders across jurisdictions in very different cultural and geographic settings’. The patients ‘are typically males, around 40 years of age, with a long history of mental illness, previous admissions, suffering from a schizophrenia-like or serious affective illness, and likely to be displaying psychotic symptoms, especially delusions at the time.’³

Clinicians in England and Wales are capable of focusing their new scheme on this group of patients, in the exercise of their discretion. To suggest that all such patients can be attracted voluntarily to treatment by offering good-quality services is to ignore the problem of impaired insight. This is highly characteristic of schizophrenia¹⁷ and central to concepts of psychosis,¹⁸ the kind of mental condition for which involuntary treatment is most often employed. Research on assertive outreach teams in London showed that much improved services did not reduce compulsion.¹⁹

Much opposition to community treatment orders has stemmed from the belief that antipsychotic medication would be forcibly administered to resisting patients in their own homes. No such power is conferred by the new legislation, but nor is any such power necessarily required for clinicians to have the confidence to use such schemes. Community treatment orders have proved acceptable both to clinicians and to the wider society

in Australasia without the existence of any such power.²⁰ The Victorian Community Treatment Order Guidelines expressly state:

'it is not acceptable to use physical force to impose treatment in any community setting . . . [nor] to use the presence of the others (especially police) to coerce a person to take treatment in the community. If such a degree of force is considered necessary . . . [the community treatment order] should be revoked and the person must be admitted to an inpatient unit'.²¹

This is little different from the process followed in England and Wales under the current leave and supervised discharge schemes.

The shift made by the Mental Health Act 2007 to a comprehensive supervised community treatment regime is a change in degree only from the current law. The principal powers conferred are: to require the patient to attend out-patient appointments; to direct the kind or place of accommodation at which the patient will reside; to supervise treatment; and to recall the patient swiftly to hospital, without the need for formal recertification to occur. These powers should give clinicians the confidence to make selective use of the new regime.

Lawton-Smith correctly notes that a recent review of the research concludes there is no firm evidence that community treatment orders prevent hospitalisation.³ However, there are many problems with the research base on compulsory out-patient care. Many studies in the area fail to meet the most rigorous standards of evidence-based medicine. Their results may also be influenced by the time or context in which they took place. Kisely *et al* studied the Western Australian community treatment order regime in the very first year of its implementation, for instance.^{22,23} Different results might have been found by researching a well-embedded community treatment order regime.

Caution is required in applying the cannon of evidence-based medicine too rigidly to complex interventions of this kind, particularly when outcomes are highly dependent on local health-care structures and social service provision.^{24,25} The randomised controlled trial may be the gold standard of evaluation research, but it is enormously difficult to apply to compulsory interventions²⁶ and it may even distort the structures studied. Less rigorous, but appropriate and carefully executed, research approaches have yielded a good understanding of how community treatment orders are applied, and a broad understanding of their acceptability to those affected. In our reading, the balance of evidence leans towards community treatment orders being a worthwhile intervention for a widely recognised patient group.

Work on patient perspectives on community treatment orders in New Zealand suggests that opposition to involuntary out-patient treatment may be overstated.⁸ Many patients with significant experience of the regime said they preferred treatment under it to in-patient or forensic care. They experienced more freedom and control over their lives. They valued the sense of security attained and the assurance of support from health professionals and accommodation providers. A minority of patients studied remained adamantly opposed to their involuntary treatment. Most viewed the community treatment order regime as a stepping-stone towards a more stable pattern of life.

A national survey of New Zealand psychiatrists⁶ found that most considered community treatment orders a useful structure to bind community mental health staff, providers of supported accommodation and out-patients to a sustained programme of care. Community treatment orders were thought to facilitate continuing contact and negotiation with the patient, medication adherence, early identification of relapse, and family involvement in care. They were not seen as a substitute for adequate community services, but as directly dependent on the quality of services available. A small minority of clinicians disagreed. They were particularly concerned about the impact of community treatment orders on the long-term therapeutic alliance.

Many dilemmas will still confront clinicians using involuntary out-patient care.²⁷ They must determine who should be placed on a community treatment order, the breadth and detail of the treatment plan, the indicators for recall to hospital, and the right time for the patient's discharge to voluntary care. Nothing suggests these decisions will be easy, but nor are they necessarily more difficult than those associated with involuntary hospital care. In both cases, the heavy-handed use of legal powers may be counterproductive and may subvert the patient's responsibility for their own treatment.

What the research suggests is that the new supervised community treatment regime should be used in a selective, flexible and cautious manner by clinicians in England and Wales. It does not suggest that clinicians should be denied completely the option of using involuntary out-patient care.

John Dawson and Tom Burns

For: rebuttal and conclusion

Much of Dawson & Burns' argument rests on there being a 'small but well-recognised group of patients who remain unwell, with serious mental illness, over long periods of time, and are repeatedly readmitted to in-patient care'. It is hard to disagree. But in that case why does the Mental Health Act 2007 allow community treatment orders to be imposed on patients outside this group?

They also suggest that some patients, through impaired insight, will avoid engagement even with good-quality community services. This is very pertinent, and again it is hard to disagree. But in that case why does the Act not include impaired insight as one criterion for the imposition of a community treatment order?

Although some clinicians clearly find community treatment orders helpful, there remains no professional consensus. In one study involving more than 1000 psychiatrists in England and Wales, 46% favoured compulsory treatment in the community, while 34% were opposed to it.²⁸ Debates held in London at the Royal College of Psychiatrists in 1994 and the Institute of Psychiatry in 2000 both concluded with around a two-thirds majority against the introduction of compulsory community treatment.²⁹

If the government has not wholly convinced mental health professionals in England and Wales about the merits of community treatment orders, they have utterly failed to convince mental health service users, whose opposition to the legislation has been vociferous. Should we so easily brush aside service user concerns? In the words of Mary O'Hagen, who initiated the service user movement in New Zealand and was the first chair of the World Network of Users and Survivors in Psychiatry, 'community treatment orders are oppressive and corrupting – it's tragic that other countries are following Australia and New Zealand's example' (M. Hagen, personal communication, 2007).

Let us assume that community treatment orders become as commonly used in England and Wales as they are today in the Australian state of Victoria or in New Zealand. Numbers of people subject to a community treatment order in England and Wales would rise in time to some 31 000 and 23 000 respectively, over and above patients compulsorily detained in hospital. This compares to the 14 000 or so people currently compulsorily detained in hospital, suggesting a two-fold or even three-fold increase in the numbers of patients subject to compulsion.

Of course this calculation is deliberately provocative. It makes no allowances for the differences in legislation, demography, geography or health service provision and practice between the countries involved. But it does serve to highlight the danger of

community treatment order ‘mission creep’, fuelled by a combination of widely drawn legislation, a desire to reduce expensive bed use and pressure from the media to ‘play safe’. One international review of community treatment orders has pointed out that their original use, to manage people with chronic mental illnesses who were non-adherent with medication, ‘has now expanded to manage a number of people with less chronic illnesses who might relapse without close community care’.³⁰

Should clinicians be allowed the option of imposing compulsory community treatment? Dawson & Burns make a persuasive case, in strictly limited circumstances. But we should constantly be challenging its use both in individual cases and within whole healthcare systems. It must never become simply the easy option for difficult-to-engage patients, nor deflect funders, commissioners and providers from establishing excellent patient-centred community mental health services based not on coercion, but on need, accessibility and trust.

Simon Lawton-Smith

Against: rebuttal and conclusion

We are pleased Simon Lawton-Smith agrees that we make a persuasive case for the use of community treatment orders in strictly limited circumstances. Our response is limited to the main points in his rejoinder.

First, opposition within the profession. The 34% of psychiatrists in England and Wales who opposed the proposal in 2000 presumably had no direct experience of community treatment orders. When they have such experience, opposition seems to abate. New Zealand psychiatrists (a broadly similar breed), when surveyed 10 years into their regime, considered community treatment orders ‘a useful tool in the pursuit of core clinical goals for the seriously mentally ill’, mainly because they permitted continuity of care.⁶ The 55 British-trained psychiatrists, working in New Zealand, who responded, expressed their support by exactly the same margin – a ratio of 8:1. Professionals are rightly conservative, but direct experience of community treatment orders seems to reassure them. The same process, albeit starting from a more negative posture, seems to occur with service users. Blanket opposition is ameliorated by experience and a more nuanced evaluation emerges, especially when full cohorts of users are approached for their views.⁸

Second, the legal criteria for community treatment orders. These could have been more rigorously drawn, but Lawton-Smith accepts that the evidence shows community treatment orders have usually been used with a well-defined and appropriate clinical group. The ambivalence of British psychiatrists about them surely counts against their overuse. But how community treatment orders are used, within the law, will still be largely determined by psychiatrists and forcing them to work within rigid rules carries its own risks. Exceptional cases always arise: former forensic patients needing community placement, and those with a rapid relapse profile, or the sole care of small children, for example. The rules should be broad enough to leave some discretion with clinicians in such cases.

Third, the spectre of overuse. Lawton-Smith uses figures from states with a high rate of use of community treatment orders to suggest compulsion would double, or even treble, overall, in England and Wales. We agree that compulsion may increase, but this is not inevitable: compulsion may be redistributed, at least in part, between in-patient and out-patient care. But what if it does increase? Would that necessarily be a bad thing, if it is matched by significant benefits to users and carers from better psychiatric care? There is no obviously ‘right’ number of people

to put under compulsion: it all depends on the overall advantages, in particular service contexts, of specific legislative schemes.

Consider the matter at the personal level. Assume your brother has resistant schizophrenia and lives alone in a room near you. He is poorly adherent with medication and regularly needs compulsory treatment for serious self-neglect and acute relapse (the ‘typical’ community treatment order candidate). Here are two scenarios based on Lawton-Smith’s figures: he spends 6 months in hospital involuntarily, receiving a depot antipsychotic to restore his health and then 6 months at home ‘free’, refusing medication and slowly deteriorating before another admission occurs; or he spends the whole 12 months at home, effectively treated on depot and required to keep weekly contact with services, subject throughout to a community treatment order. Which is preferable, and which the more humane and dignified response? Which puts more restrictions on his liberty? This is the choice with community treatment orders. We think they should be available. Few professionals seem to disagree once they have experience of their use.

This is not an empirical debate, but one about whether it is a ‘good thing’ to have the option of using a properly regulated community treatment order regime. We believe it is a good thing, and while Simon Lawton-Smith is right to remind us to be vigilant, he, surprisingly, seems to believe so too.

John Dawson and Tom Burns

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References

- 1 Atkinson JM, Garner HC. Least restrictive alternative – advance statements and the new mental health legislation. *Psychiatr Bull* 2002; **26**: 246–7.
- 2 Lawton-Smith S. *A Question of Numbers: The Potential Impact of Community-based Treatment Orders in England and Wales*. King’s Fund, 2005 (http://www.kingsfund.org.uk/publications/kings_fund_publications/a_question_of_1.html).
- 3 Churchill R, Owen G, Singh S, Hotopf M. *International Experiences of Using Community Treatment Orders*. Department of Health, 2007 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072730).
- 4 Kisely S, Campbell L A, Preston N. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Syst Rev* 2005; (3): CD004408.
- 5 Royal College of Psychiatrists. *Second Reading Briefing on the Mental Health Bill 2006, House of Commons: 16th April 2007*. Royal College of Psychiatrists, 2007.
- 6 Romans S, Dawson J, Mullen R, Gibbs A. How mental health clinicians view community treatment orders: a national New Zealand survey. *Aust N Z J Psychiatry* 2004; **38**: 836–41.
- 7 Dreezer & Dreezer Inc. *Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act*. Ontario Ministry of Health and Long-Term Care, 2005 (http://www.health.gov.on.ca/english/public/pub/ministry_reports/dreezer/dreezer.pdf).
- 8 Gibbs A, Dawson J, Ansley C, Mullen R. How patients in New Zealand view community treatment orders. *J Mental Health* 2005; **14**: 357–68.
- 9 Appelbaum P. Assessing Kendra’s Law: five years of outpatient commitment in New York. *Psychiatr Serv* 2005; **56**: 791–2.
- 10 National Confidential Inquiry. *Avoidable Deaths: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness*. University of Manchester, 2006 (http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths_full_report.pdf).
- 11 Department of Health. *Mental Health Bill: Regulatory Impact Assessment*. Department of Health, 2006 (<http://www.dh.gov.uk/en/>)

- Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_062689).
- 12 Department of Health. *Mental Health Bill. Briefing Sheets on Key Policy Areas: Supervised Community Treatment*. Department of Health, 2006 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134229).
 - 13 Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M. Mental capacity in psychiatric patients. Systematic review. *Br J Psychiatry* 2007; **191**: 291–7.
 - 14 Dawson J, Szmukler G. Fusion of mental health and incapacity legislation. *Br J Psychiatry* 2006; **188**: 504–9.
 - 15 Szmukler G, Holloway F. *Maudsley Discussion Paper No.10. Mental Health Law: Discrimination or Protection?* Institute of Psychiatry, 2001 (<http://admin.iop.kcl.ac.uk/maudsley-publications/maudsley-discussion-papers/mdp10.pdf>).
 - 16 Care Services Improvement Partnership. *Our Choices in Mental Health*. Care Services Improvement Partnership, 2006 (<http://www.csip-plus.org.uk/CPT/Our%20Choices%20Doc%20-%20Final.pdf>).
 - 17 Mintz A, Dobson K, Romney D. Insight in schizophrenia: a meta-analysis. *Schizophr Res* 2003; **61**: 75–88.
 - 18 David A, Buchanan A, Reed A, Almeida O. The assessment of insight in psychosis. *Br J Psychiatry* 1992; **161**: 599–602.
 - 19 Priebe S, Fakhoury W, White I, Watts J, Bebbington P, Billings J, Burns T, Johnson S, Muijen M, Ryrie I, Wright C. Characteristics of teams, staff and patients: associations with outcomes of patients in assertive outreach. *Br J Psychiatry* 2004; **185**: 306–11.
 - 20 Dawson J. Fault-lines in community treatment order legislation. *Int J Law Psychiatry* 2006; **29**: 482–94.
 - 21 Chief Psychiatrist. *Community Treatment Order Guidelines*. Mental Health Branch, Victorian Government Department of Human Services, 2005 (http://www.health.vic.gov.au/mentalhealth/cpg/comm_treat_order_guidelines.pdf).
 - 22 Kisely SR, Xiao J, Preston NJ. Impact of compulsory community treatment on admission rates. Survival analysis using linked mental health and offender databases. *Br J Psychiatry* 2004; **184**: 432–8.
 - 23 Kisely S, Smith J, Preston N, Xiao J. A comparison of health service use in two jurisdictions with and without compulsory community treatment. *Psychol Med* 2005; **35**: 1357–67.
 - 24 Slade M, Priebe S. Are randomised controlled trials the only gold that glitters? *Br J Psychiatry* 2001; **179**: 286–7.
 - 25 Wright C, Catty J, Watt H, Burns T. A systematic review of home treatment services. Classification and sustainability. *Soc Psychiatry Psychiatr Epidemiol* 2004; **39**: 789–96.
 - 26 Dawson J. Randomised controlled trials of mental health legislation. *Med Law Rev* 2002; **10**: 308–21.
 - 27 Mullen R, Dawson J, Gibbs A. Dilemmas for clinicians in use of Community Treatment Orders. *Int J Law Psychiatry* 2006; **29**: 535–50.
 - 28 Crawford MJ, Hopkins W, Henderson C. Concerns over reform of the Mental Health Act. *Br J Psychiatry* 2000; **177**: 563.
 - 29 Pinfold V, Bindman J. Is compulsory community treatment ever justified? *Psychiatr Bull* 2001; **25**: 268–70.
 - 30 Rolfe T. *Community Treatment Orders: A Review*. Department of Health, Western Australia, 2001 (http://www.health.wa.gov.au/mhareview/resources/documents/A_Review_of_CTOS_T_Rolfe.pdf).