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The many faces of risk: a qualitative study of risk in outpatient involuntary treatment

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ABSTRACT

Objective: This study aimed to derive a conceptualisation of risk in outpatient involuntary psychiatric treatment that has utility and meaning for stakeholders.

Methods: Thirty-eight participants –patients, caregivers, clinicians and legal decision makers – participated in qualitative interviews about their experiences of outpatient involuntary psychiatric treatment. Interview data was analysed using a general inductive method.

Results: Six types of risk were identified: ‘actual harm’, ‘social adversity’, ‘therapeutic outcome/compromised treatment’, ‘the system’, ‘interpersonal distress’, and ‘epistemic’. There were overlaps between the discourses on risk, but variation in how different aspects of risk were emphasised.

Conclusions: Based on the findings, a comprehensive model of “risk” contextualized to outpatient involuntary treatment is proposed. It incorporates the domains of “risk of harm to self or others”; “risk of social adversity”; “risk of excess distress”; and, “risk of compromised treatment”. This model may have instrumental value in the implementation and the scrutiny of risk-based mental health laws.

I know the risk is real, is absolutely real, because I've tried to commit suicide.
[Patient]

We think that it's our risk, or we'll take the risk, but it's not our risk. I don't lose my job, I don't lose my family and my home and my brain and end up in hospital and end up with no friends. It's not my risk [to take]. [Clinician]

Introduction

In mental health legislation provisions for involuntary treatment, the 'harm principle', first advanced in John Stuart Mill's *On Liberty*(1) to delineate when state coercion of individuals may be justified, is usually defined in terms of the construct of 'risk'.

'Risk' has multiple meanings in different disciplinary contexts, although all approaches deal with areas where the probability of an outcome of interest, concern or importance is uncertain(2, 3). The notion of 'risk assessment' in psychiatric practice is usually considered as the process of categorising individuals by their perceived likelihood of causing serious harm to themselves or others.

The move toward risk-based involuntary treatment laws in the US and Commonwealth countries during the 1970s and 1980s was associated with an emphasis on civil liberties and a move away from medical paternalism(4). Coercive treatment was only justified in the name of preventing significant harm.

Risk remains the primary feature of laws in many jurisdictions(4, 5), justifying involuntary treatment in both inpatient and outpatient settings. There are however a number of criticisms of its use, including that: risk assessment – using actuarial approaches to categorise people by relative likelihood of future harm to self or others (such as suicide or violence) – has poor predictive value and little clinical utility(6, 7); a legal test of risk of harm will subject some people to coercive treatment unnecessarily, while for others it will delay or deny access to treatment(7); laws can stigmatise and inaccurately stereotype people living with a mental illness as dangerous or violent(5, 8).

There is also the challenge of putting into practice an elusive concept that is open to a multitude of interpretations(2). Though it has positive elements, risk frequently speaks to an evaluative process that seeks to estimate the probability of a negative event. It can therefore be subject to biases that may, for example, overestimate risk of violence posed by people living with mental illness. Risk can also be ambiguous in different health care settings. Many considerations of 'risk of harm' and mental illness focus only on acute and severe disturbances of mental state necessitating inpatient hospital detention. For involuntary treatment of less acute illness in longer-term community-based outpatient settings, these concepts of 'risk of harm' have less apparent value.

This qualitative study aimed to derive a comprehensive model of risk in involuntary outpatient treatment that is credible and meaningful among patients, caregivers, clinicians and legal decision-makers. Such a model seeks a nuanced understanding of risk which can inform clinical practice, policy and law.

Methods

This study was conducted in New South Wales (NSW), Australia, from July 2009 to July 2012 and referred to involuntary "community treatment orders" (CTOs) under the NSW *Mental Health Act* (2007). Like other Australian and many international jurisdictions, NSW involuntary treatment law is often conceptualised by clinicians as risk-based and provides that unconsented psychiatric treatment cannot be delivered unless, due to a mental illness, a person requires protection from serious harm

to self or others. Please refer to the appendix (located at the end of this article) for more details about the CTO provisions of the NSW *Mental Health Act*.

The study aimed: to identify how mental health professionals, patients, caregivers, and legal decision makers conceptualise 'risk' in the context of decisions about involuntary psychiatric treatment in the community setting; and to derive a comprehensive model of risk that has use and meaning to stakeholders. The study was conducted by researchers from the Centre for Values, Ethics and the Law in Medicine (VELiM) at the University of Sydney. It obtained ongoing involvement of clinical, consumer, caregiver, policy and Tribunal representatives.

Participants were recruited using a theoretical, purposive method of sampling, framed around the development of a comprehensive model of the concept of risk. The researchers therefore recruited people from four groups: patients currently or previously on a CTO; relatives or caregivers of a person subject to a CTO; mental health clinicians; and members of the legal body overseeing involuntary psychiatric treatment (the MHRT). The investigators sought to build a sample of maximum variation, rather than a representative sample. Recruitment within each participant group involved the distribution of an invitation to participate through a variety of networks.

After provision of a participant information statement, and an opportunity for questions about the project and the conduct of interviews, written informed consent was obtained from each participant. Patient and caregiver participants received \$40 at interview towards costs of participation. Patient participants were not recruited from or interviewed in clinical settings as the investigators sought to maintain a clear distinction between their voluntary participation in the study and their involuntary treatment status.

The research was conducted with the approval of the following committees: University of Sydney Human Research Ethics Committee (patient and caregiver interviews – protocol number 12583; MHRT member interviews – protocol number 14421); and Sydney Local Health Network Ethics Review Committee (formerly former Sydney South West Area Health Service) (protocol number X10-0338).

In the conduct of the in-depth semi-structured interviews, the investigators prompted the participants to speak from their unique understanding of CTO use by providing narrative accounts of their experience of CTO processes.

The interviews were recorded digitally, transcribed, and de-identified. The data was managed using the NVIVO9 computer program. The investigators utilised the general inductive method(9) of data analysis. In this method, the interviews are coded initially using initial, *a priori* codes (in this case, a code of 'risk'). As the data is coded, themes are identified and a coding structure then develops. This facilitated the emergence of a number of risk themes among participant groups, which formed the basis of the model of risk.

The investigators sought to confirm data saturation by triangulation(10, 11) of the data coded separately by two members of the team (MR and EL) and through discussion of the data among the investigators and stakeholder reference group members at regular research meetings.

Please refer to the appendix accompanying this article for an expanded description of this study's methods.

Results

Five patients and six caregivers participated in interviews. Six were men and five women from metropolitan or regional/rural areas. Among either the patients or the relative of the caregiver were diagnoses of schizophrenia, depression, bipolar disorder, and anxiety. One issue of note was the difficulties in recruiting patients subject to CTOs through non-clinical pathways: the yield of suitable participants was lower than anticipated; moreover, several suitable participants later withdrew or were unable to participate due to deterioration in their health.

Twelve MHRT members participated in the interviews: four psychiatrists, four lawyers, and four other 'suitably qualified' members from social work, nursing, psychology, and mental health service administration fields. Fifteen clinicians participated in interviews: three psychiatrists, eight nurses, two social workers, one psychologist and one occupational therapist. The various clinicians had worked in inpatient 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.

Analysis of the participants' accounts of risk revealed six themes: 'actual harm', 'social adversity', 'therapeutic outcome/compromised treatment', 'the system', 'interpersonal distress', and 'epistemic'. There were significant overlaps in the interdisciplinary perspectives of clinicians and tribunal members, and between those of patients and caregivers, and those perspectives were integrated as the analysis progressed. See Table 1 for details of the themes of risk identified in clinician/tribunal member and patient/caregiver participant accounts.

Table 1: Themes of risk from participant interview data

Perspective	Risk theme	Description
Patients and caregivers	Social adversity	Material disadvantage such as financial insecurity, homelessness, isolation, exclusion, or vulnerability in the community; and 'legal problems' such as committing a crime or having behaviour while ill criminalised
	Actual harm	Often conceptualised as harm to physical integrity: suicide and misadventure two obvious manifestations, although iatrogenic harm also highlighted
	Symptomatic distress	The harm of distressing symptoms of severe mental illness, which left a person feeling 'threatened', 'frightened', or 'distracted', often manifesting as detrimental neglect in parts of their life
	Therapeutic outcome	Impaired or poor therapeutic outcome, including worsened or additional psychiatric and medical comorbidities. Included effects of a person's lack of insight into being ill, as well as the impact of coercive, 'chaotic',

		and/or inadequate psychiatric services
	'The system'	Problems posed by the effects of severe mental illness on the interaction with the mental health system, including problems with accessing services and of an 'unsatisfactory patient journey', often experienced as a 'powerlessness' and vulnerability within the system
	Interpersonal distress	Distress in interpersonal settings due to severe mental illness: adversely affecting established relationships; exploitation in many forms such as financial or sexual; increasing vulnerabilities associated with mixing with antisocial peers
Clinicians and tribunal members	Actual harm	Intuitive notions of actual harms: death by suicide or misadventure, harm to others, damage to property, self-neglect, decline in health, or damage to property
	Social adversity	Beyond 'actual harm', referring to impairment of social role or disadvantage in the social system and the adverse consequences this involved
	Epistemic	Questions of knowledge of the phenomenon and challenges of arriving at a substantive definition of risk, prediction or quantification of the risk posed by a person's mental illness, and how risk may be determinative of clinical treatment and legal decisions
	Compromised treatment	The impact of a patient's mental illness upon the nature and potential benefits of their clinical care

There were overlaps between all the discourses on risk – particularly in regards to actual harm, social disadvantage, and the problems posed by the health system – but still variation in how participant groups emphasised the causative properties of different aspects of risk. For example, clinicians were often more influenced in their thinking by notions of actual harm and epistemic questions of the quantification of risk, whereas patients and caregivers were motivated more in light of the distress of mental illness and the social and interpersonal disadvantage that emerged from such illnesses.

Discussion

Using an inductive method of qualitative research, this study sought to describe how patients, caregivers, clinicians and mental health review tribunal members conceptualise 'risk' and to derive a model of risk in the context of outpatient involuntary psychiatric treatment.

A model of risk that accommodated the way that the different study participants understood risk required the integration of the different risk discourses. Grounded in these rich and varied accounts from participants' real world experiences, a model was systematically developed identifying four domains: 'risk of harm of self or others' encompassing suicide, misadventure, neglect, exploitation or victimisation, and deteriorated physical health; 'risk of social adversity' encompassing homelessness, poverty, isolation, deprivation, limited access to services and social goods; 'risk of excess distress' emerging from the symptoms of mental illness, interpersonal conflict, coercive inpatient treatment, and from the traumatic affronts to the self of severe psychotic or mood disturbance; and 'risk of compromised treatment' manifesting as delays or loss of treatment opportunities and/or iatrogenic harm from treatment decisions, emerging as more severe illness, psychiatric and medical comorbidities, and an inability to participate in their recovery.

In considerations of risk and involuntary outpatient treatment, all the model's domains apply but they will not be equally important all the time. Each element may have greater or lesser importance depending upon: who it involves (for example, the patient, caregiver, clinician, or legal decision-maker) and the context (for example, the clinical diagnosis, history or setting).

Our findings and model are consistent with the literature about the multidimensional nature of risk, particularly in the mental health setting where a 'rich stew' of risk discourses mean that several meanings of risk are weighed and countenanced by treating professionals(12). Like Ryan's(13) study of factors of perceived risk related to people who experience mental illness in the UK, this study also determined that the multidimensional character of risk covered both risk *faced* and *posed by* people living with mental illness.

In graduating arguments for and against involuntary psychiatric treatment in the community beyond the limited scope of harm (that is, beyond solely violence or "dangerousness"), the model offers a number of potential improvements for practice. It offers opportunity for improved communication and informed decision-making. It allows broader consideration of grounds to justify decisions to initiate, renew or cease involuntary community-based treatment. It also provides a suitable framework for developing proposed treatment plans, and it increases transparency and accountability of decisions about involuntary treatment.

By describing risk in context, these findings also offer opportunities for informed debates on relevant policy and ethical issues. Risk sits at the centre of ongoing deliberations on involuntary psychiatric treatment: about reform of policies and legal criteria (including pushes away from risk to capacity-based systems(4, 5)); and about unresolved ethical and epistemic questions of what we are trying to do (and not do) when using involuntary outpatient treatment orders(14). There is an often homogeneous discussion of risk and this model allows for elaboration of what people are concerned about.

Conclusion

Risk-based mental health laws are recognised as being problematic in terms of clinical utility and the potential for treatment losses and stigmatising illness. And yet, consideration of risk remains an important and irreducible feature of mental health care. It is important therefore that we have ways of communicating about risk that have meaning to people, that decrease rather than increase stigma and discrimination, and that are broadly shared by different stakeholders.

This study has derived an empirically based model of risk that may have instrumental value in any jurisdictions that have risk-based laws for involuntary treatment in the community setting. It also

enables an important contextualised understanding of NSW's well-established system (more than 20 years old) which has high rates of use by international standards(15).

A better understanding of how involuntary community treatment systems work in practice – including how key concepts such as risk are applied – is worthwhile as part of any efforts to improve how mental health policy and services respond to people with severe and chronic mental illness. The model provides some architecture for public and professional discourse around matters of importance to do with community mental health services and involuntary psychiatric treatment.

We all know of course that risk, well, one man's fish is another man's poisson. The definition of risk can vary enormously. [Tribunal member]

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Appendix: ‘The many faces of risk: a qualitative study of risk in outpatient involuntary treatment’

This appendix provides more information for interested readers of the article ‘The many faces of risk: a qualitative study of risk in outpatient involuntary treatment’ on the study’s methods, data set, and legislative context.

Methods

The following text expands on the information provided in the main article about the study’s qualitative methods.

The study was conducted in New South Wales (NSW), Australia, from July 2009 to July 2012 and referred to involuntary “community treatment orders” (CTOs) under the *NSW Mental Health Act* (2007). Like other Australian and many international jurisdictions, NSW involuntary treatment law is often conceptualised by clinicians as risk-based and provides that unconsented psychiatric treatment cannot be delivered unless, due to a mental illness, a person requires protection from serious harm to self or others. Decisions on CTO applications are made by an independent Mental Health Review Tribunal (‘MHRT’), based on applications from a clinician, a mental health facility director, and/or a primary caregiver of a person.

The research questions were formulated as: “How do mental health professionals, patients, caregivers, and legal decision makers conceptualise ‘risk’ in the context of decisions about involuntary psychiatric treatment in the community setting?”; and, “Can a comprehensive model of ‘risk’ that is consensually valid across participant groups be formulated?”. The study was conducted by researchers from the Centre for Values, Ethics and the Law in Medicine (VELiM) at the University of Sydney. In addition to the investigation team comprising backgrounds in psychiatry, law, and nursing, the study obtained ongoing involvement of clinical, consumer, caregiver, policy and Tribunal representatives.

Participants were recruited using a theoretical, purposive method of sampling, framed around answering the research questions and informing the development of a comprehensive model of the concept of risk. The researchers therefore recruited people from four groups: patients currently or previously on a CTO; relatives or caregivers of a person subject to a CTO; mental health clinicians; and members of the legal body overseeing involuntary psychiatric treatment (the MHRT).

The investigators sought to build a sample of maximum variation, rather than a representative sample. Maximum variation sampling involves developing a sample in which as many different subgroups of different participant groups are included. This does not allow justification of claims to generalisability of study findings. Rather it enabled the investigators to describe and understand a range of experiences and different perspectives, and to build a comprehensive model of risk in the context of involuntary psychiatric treatment in a community setting. This involved an iterative process of data acquisition and analysis in which the analysis of early interviews informed the conduct of subsequent interviews. In the patient and caregiver groups, the study aimed to recruit people with a range of CTO experiences, including but not limited to current or past CTOs, those ordered in different geographic locations, or those relating to people with different diagnoses of mental illness. The study also sought to include participants from different disciplines and professional histories in the clinician and MHRT member groups.

Recruitment involved a variety of methods. Clinicians were recruited through distribution of an invitation issued by health service managers. Potential participants (clinicians) were also recruited using the ‘snowball’ method, through which the study was recommended to subsequent participants through professional networks or relationships. In the case of patient and caregiver

participants, an invitation was circulated through non-government organisations (Carers NSW, the Mental Health Coordinating Council, and NSW Consumer Advisory Group – Mental Health Inc). This was further disseminated through their own networks and individual recommendations. Patient and caregiver participants received \$40 at interview towards costs of participation. In the case of MHRT participants, the invitation was circulated by the Tribunal to all members.

After provision of a participant information statement, and an opportunity for questions about the project and the conduct of interviews, written informed consent was obtained from each participant.

The research was conducted with the approval of the following committees: University of Sydney Human Research Ethics Committee (patient and caregiver interviews – protocol number 12583; MHRT member interviews – protocol number 14421); and Sydney Local Health Network Ethics Review Committee (formerly former Sydney South West Area Health Service) (protocol number X10-0338).

The investigators conducted in-depth semi-structured interviews in a variety of sites. In the case of clinician participants, interviews were conducted in clinical sites within the former Sydney South West Area Health Service. MHRT participants were interviewed either at the MHRT offices in Sydney or, where appropriate, in their other workplaces. Interviews with patient and caregiver participants were held in offices of the NSW Consumer Advisory Group – Mental Health, Carers NSW, and Mental Health Coordinating Council. Patient participants were not recruited from or interviewed in clinical settings as the investigators sought to maintain a clear distinction between their voluntary participation in the study and their involuntary treatment status.

In the conduct of the interviews, the investigators prompted the participants to speak from their unique understanding of CTO use by providing narrative accounts of their experience of CTO processes. In the case of clinicians or MHRT participants, this involved their reflection upon specific examples of dilemmas in decisions around CTOs in their professional experience. In the case of patients and caregivers, this involved a process of constructing a personal narrative of their direct and indirect experiences of the use of CTOs.

The interviews were recorded digitally and transcribed. Transcripts were then de-identified, removing any details that might identify individual participants and compromise participant confidentiality. Given the interviews were conducted in specific sites, the investigators opted not to report age ranges to protect confidentiality. In the clinician sample, details of disciplines and clinical settings were noted, but they have not been reported as characteristics of any individual participant in order to protect their confidentiality.

The investigators analysed the data using the NVIVO9 computer program which enables different coding strategies and cross checking of different concepts across the sample. The investigators utilised the general inductive method(1) of data analysis. In this method, the interviews are coded initially using initial, *a priori* codes (in this case, a code of 'risk'). As the data is coded, themes are identified and a coding structure then develops. After a process of 'open' coding of the data(2, 3), the codes were collapsed into different categories. This process included an intermediate step of generating visual models of the coded categories and then clustering them around a central theme. This facilitated the emergence of a number of themes, which formed the basis of the models of risk among the participant groups.

The investigators concluded that the data had reached saturation at the time of the analysis of the interview of the 35th participant. A further four interviews were conducted to test this assumption

and complete the process of maximum variation sampling. The investigators sought to confirm saturation by triangulation of the data coded separately by two members of the team (MR and EL) and through discussion of the data among the investigators and stakeholder reference group members at regular research meetings. Triangulation, often an intrinsic aspect of qualitative research, usually involves comparisons of data sources, investigators, study theories, and/or methods and is used to check and establish validity and completeness of an analysis(4-6).

Model of risk - interview data

The model of risk developed in this study was grounded in accounts from participants’ lived experiences. It integrates the different risk discourses that emerged from the patient, caregiver, clinician and Tribunal member interview data (see Table 1 in the main article). The following table presents the model’s four domains alongside exemplars of participant quotations from the data set.

Domain and description	Examples from data
<p><u>Risk of harm of self or others:</u> encompassing suicide, misadventure, neglect, exploitation or victimisation, and deteriorated physical health</p>	<p><i>I know the risk is real, is absolutely real, because I’ve tried to commit suicide. So I know that it’s, you know, really real. I didn’t try and hurt anyone, I took a whole load of pills... Patient</i></p> <p><i>Well I mean it very much depends on the individual, but exploitation of a financial manner, or sexual exploitation...[it] does happen, and then it’s very difficult for people to get believed. Clinician</i></p> <p><i>We’re locking more people up, and a lot of people in gaols, and you probably know, that a lot of people in prison have a mental illness, and they’re not being adequately treated. ... usually they’re more recipients of harm than harming others, proportionally much more so. Caregiver</i></p> <p><i>Yeah there are times in my life, like I’ve been hospitalised five or six times, so all those times I’ve been at risk of dying and stuff... Patient</i></p> <p><i>Risk can be things that are terrible and punishable by law, or if you’ve done something like a murder, or attacked someone, or violence, that’s a risk. So a risk of harm to others, or a risk of harm to self. Clinician</i></p> <p><i>The trouble is, this particular person won’t do that [make the choice to engage with treatment], and so, and when he doesn’t take medication he gets very sick very quickly, and then it means another long hospitalisation.’ Clinician</i></p>
<p><u>Risk of social adversity:</u> encompassing homelessness, poverty, isolation, deprivation, limited</p>	<p><i>No, I went downhill, I went right downhill, I turned; I was homeless for the first time in my life. I didn’t get schizophrenia until I was about 32, 33, so it didn’t come along until then. And for seven years I was really in trouble... Patient</i></p> <p><i>That those people, they run the risk then of damaging family relationships, or even assaulting family members, or getting</i></p>

<p>access to services and social goods</p>	<p><i>AVOs because they've attacked a neighbour, or losing their housing commission, or losing their jobs, and doing further damage to the functional status. MHRT/clinician</i></p> <p><i>So from having previously worked fulltime, to sitting in his bathroom with a foil cap on, was a massive social deterioration. ...he had lost his capacity to fulfil his role that he had previously undertaken, and had no expressed insight into that loss of role, and loss of function. Clinician</i></p> <p><i>Well you're helping people to assimilate, without being a threat to the community. It's nice just to be in touch with someone, a lot of people are lonely and live alone and whatnot, and sometimes we just need someone to talk to, and the case manager can sometimes put us in touch with other people to help us... Patient</i></p> <p><i>They won't give housing to someone just because they need a house, the person has to prove that they can maintain the tenancy, and that includes paying the tenancy, maintaining the physical structure of the tenancy, which some of our clients sometimes verge on not doing. So we can understand that, Housing have had terrible experiences where someone has been very unwell in their homes... But more and more we're being told, semi-officially, 'oh this person can't have housing unless they've got a case manager or unless they've got a CTO. Clinician</i></p>
<p><u>Risk of excess distress:</u> emerging from the symptoms of mental illness, interpersonal conflict, coercive inpatient treatment, and from the traumatic affronts to the self of severe psychotic or mood disturbance</p>	<p><i>He'll tell you about delusions about people draining blood from his penis, about being bashed up by people with baseball bats, these are all these frequent delusions... Clinician</i></p> <p><i>And the situation is that the doctors or any of the hospital staff can't touch the patient, so they had to call the Police, even in the hospital grounds. ... And in the hospital grounds the Police had to get hold of him, use the capsicum spray, that's how they could get him back into hospital. Caregiver</i></p> <p><i>I had about three or four different voices in my head at once, and one was a girl's voice, and they were running my life. It took up all my time, and even when I was trying to go to sleep, I could hear voices, so it was affecting my sleep totally. I'd wake up in the middle of the night and hear voices, and instantly as I wake up there's this woman's voice talking to me and it drove me mad. I ended up breaking the window. Patient</i></p> <p><i>If he wasn't distressed by his illness, I probably wouldn't have been as passionate about it. If he was happily mad, and no risk to himself or no risk to others, and he isn't a risk of harm to</i></p>

	<p><i>self or others. ... But it's the distress, for me it's the distress he experiences when he's unwell, and seeing the deep level of regret he feels, when he leaves that distressed mental state and that's what makes me think he needs it. [Clinician]</i></p>
<p><u>Risk of compromised treatment:</u></p> <p>manifesting as delays or loss of treatment opportunities and/or iatrogenic harm from treatment decisions, emerging as more severe illness, psychiatric and medical comorbidities, and an inability to participate in their recovery</p>	<p><i>Well physical health, that's an interesting one isn't it, because when you think about, once again; well medication that we're actually getting these people to take, or forcing onto them, is toxic medication, really a lot of it, it's going to make people gain a lot of weight, it's going to make people have medical issues, if not immediately, certainly down the track, but I don't know what the alternative is. Clinician/MHRT</i></p> <p><i>... you need to look at the therapeutic relationship, so if it's going to damage the therapeutic relationship with the case manager or the client, then you need to consider whether six months [CTO duration] would be better as opposed to 12 months. MHRT member</i></p> <p><i>She's at high risk of harm to herself because of her drug use. She's at high risk of exacerbating comorbid conditions. She's had open heart surgery and a mitral valve repair, because of her drug use. She's had septicaemia endocarditis because of her drug use. She's had all these major things because of drug use, and they have still persisted over 20 years of saying that her major health problem is schizophrenia. The rest of the health system don't see anything else but schizophrenia. Caregiver</i></p> <p><i>I have a chronic illness as well, so in that way there's some insecurity about the future, and how long I can sustain myself. ... Well actually I can tell you I'm a renal patient, I have a transplant that's ten years old, sometimes I feel like I'd rather just see doctors for renal reasons, and have less to do with mental health, which would keep my life simple. Patient</i></p> <p><i>Now what I've experienced, while they had pretty good care in the hospital, there is no arrangement for after they are discharged from the hospital, to rehabilitate. In the hospital it is under the control of the nurses, at this time you take your medication, at this time and do this. Then suddenly you're thrown out in this boarding house, in the company of others, it's very hard to get on because [X] is very highly medicated. ... That's something that I wrote a letter to the health minister about, because putting all this hard work that I see in the hospital, and then throw it out the window. Caregiver</i></p>

Community Treatment Orders under the NSW Mental Health Act

In the Australian state of New South Wales (NSW) a Community Treatment Order (CTO) is a legal order made by the state's Mental Health Review Tribunal. Under a CTO a patient may be ordered to accept treatment, care and management to be provided in the community by a nominated mental health facility. CTOs are intended to allow people, who might otherwise be detained in a mental health facility, to live in the community and receive treatment, care and support in a less restrictive setting(7).

The legislative criteria for involuntary outpatient treatment in NSW are set out in sections 50 to 67 of the *Mental Health Act 2007*(8). A copy of the Act can be found at http://www.austlii.edu.au/au/legis/nsw/consol_act/mha2007128/index.html The following extracts about determining the use of CTOs and requirements for involuntary treatment may be of particular interest to readers.

Section 53 Determination of applications for community treatment orders

(3) The Tribunal may make a community treatment order for an affected person if the Tribunal determines that:

(a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and

(b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it, and

(c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.

(3A) If the affected person has within the last 12 months been a forensic patient or the subject of a community treatment order, the Tribunal is not required to make a determination under subsection (3) (c) but must be satisfied that the person is likely to continue in or to relapse into an active phase of mental illness if the order is not granted.

(4) The Tribunal may not make a community treatment order at a mental health inquiry unless the Tribunal is of the opinion that the person is a mentally ill person.

Section 13 Criteria for involuntary admission etc as mentally ill person or mentally disordered person (cf 1990 Act, s 8)

A person is a mentally ill person or a mentally disordered person for the purpose of:

(a) the involuntary admission of the person to a mental health facility or the detention of the person in a facility under this Act, or

(b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a mental health facility, if, and only if, the person satisfies the relevant criteria set out in this Part.

14 Mentally ill persons

(cf 1990 Act, s 9)

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

(a) for the person's own protection from serious harm, or

(b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

Useful information about the implementation of the Act is also available from the NSW Mental Health Review Tribunal (www.mhrt.nsw.gov.au), which publishes guidelines and information sheets about CTO applications and treatment plans. Treatment plans form the basis of a CTO and should satisfy the criteria of the Act of least restrictive, safe, effective care that a facility is capable of implementing. Depending on individual circumstances it may detail a patient's obligations to be in contact with a treating team (at a facility or by home visit) and accept medication and/or therapy, counselling, management, rehabilitation and other services, as well as obligations on the treating team.

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