



Rates of use of community treatment orders in Australia

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ABSTRACT

Objectives: The variable and changing rates of use of involuntary community treatment orders (CTOs) in the treatment of people living with mental illness are not well-documented or well understood. This new study sought to determine contemporary rates of use in Australia, where local jurisdictions were previously shown to have varied and shifting rates of use that were high by world standards.

Methods: Australian state and territory mental health review tribunals, health departments, and/or offices of the chief psychiatrist were surveyed for the most recent published annual data on the total number of individual people placed on a CTO and/or the total number of CTOs made.

Findings: Contemporary rates of CTO use in Australia range from 40.0 per 100,000 population (in Western Australia) to 112.5 per 100,000 (in South Australia). Since the last national survey, the rates of people subject to CTOs fell into in two jurisdictions (Victoria and Western Australia). However, rates of CTOs made were higher than previous figures in all jurisdictions reporting data. Use of CTOs in Australia varies considerably within and between jurisdictions.

Conclusions: Australian jurisdictions continue to use CTOs at high and varying rates, despite unresolved questions about their role and impact. Transparency and accountability around their use would be improved by regular and nationally uniform public reporting of CTO data. Further research into how and why CTOs are used may also provide opportunities to respond to factors driving their use and thereby reduce the use of coercion in mental health care.

1. Introduction

Controversy persists about the role and utility of involuntary community treatment orders (CTOs)¹ in the care of people living with mental illness. Operating under mental health legislation, CTOs permit and set out the conditions under which a person must accept treatment and management in the community by authorised mental health services and personnel. Arguments about their function and efficacy are multifaceted. They are commonly focussed on uncertainties about evidence for the clinical effectiveness of these legal mandates (Brophy, Ryan, & Weller, 2018; Kisely, Campbell, & O'Reilly, 2017; Rugkåsa, 2016), including unresolved epistemic questions about the purpose of CTOs and how to investigate their use (Kisely & O'Reilly, 2015; Light, 2014). Concurrent discussions of CTO use relate to ethical, human rights, and political concerns to do with the basis of CTO laws, their practical implementation, and the experiences of stakeholders (Brophy, Edan, et al., 2018; Brophy, Ryan, et al., 2018; Corring, O'Reilly, & Sommerdyk, 2017; Corring, O'Reilly, Sommerdyk, & Russell, 2018;

Kisely & O'Reilly, 2015; Light et al., 2017). In a recent critique of global mental health care, the UN Special Rapporteur on the right to health, psychiatrist Dainius Puras, warned that models of mental health laws that made exceptions to justify the use of coercion had “legitimized” and “normalized coercion in everyday practice, widening the space for human rights violations to occur” (United Nations Special Rapporteur, 2017).

Despite the polemic debates in which CTOs remain enmeshed, their use is widespread and, in some places, long-standing. CTOs exist in more than 75 jurisdictions worldwide (Rugkåsa, 2016), including all eight Australian jurisdictions, some of which have had CTO schemes operating for decades (for example, since 1986 in Victoria and 1990 in New South Wales). In 2015–16, about one in seven community mental health service contacts in Australia were delivered to people on a CTO (or its equivalent, see footnote 1) (Australian Institute of Health and Welfare, 2018). This represents more than 1.2 million involuntary community services provided to approximately 410,000 patients during the year, predominately people living with schizoaffective disorders,

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¹ In some jurisdictions, statutory orders for involuntary psychiatric treatment in community settings might be referred to as “treatment orders” (community), “community management orders”, “treatment authorities” (community), “psychiatric treatment orders”, “outpatient treatment orders”, or “outpatient commitment”.

schizophrenia, and bipolar affective disorder (Australian Institute of Health and Welfare, 2018). There is wide variation in the proportion of involuntary community services delivered in different states and territories—ranging from 1.7% in Western Australia to 37.6% in the Australian Capital Territory (ACT)—which according to the Australian Institute of Health and Welfare “most likely reflect the different legislative arrangements in place amongst the jurisdictions” (Australian Institute of Health and Welfare, 2018).

Difference between mental health laws is just one reason suggested in the literature as to why CTO rates of use vary so considerably between jurisdictions, both within Australia and worldwide. It is also recognised that there are likely multiple clinical, ethical and political factors driving the use of CTOs in any one jurisdiction, including the resourcing and organisation of mental health and other public services, and the perspectives of clinicians and others making decisions about the use of involuntary treatment (Brophy, Ryan, et al., 2018; Corring et al., 2018; Kisely & O'Reilly, 2015; Light et al., 2016; Light et al., 2017; United Nations Special Rapporteur, 2017). In Lawton-Smith's, 2005 review of CTO use internationally, reported rates ranged from two per 100,000 population (Ontario and Saskatchewan in Canada, and New York State in the United States) to 40–60 per 100,000 population (in the Australian states of Queensland and Victoria, and the District of Columbia in the United States, and New Zealand) (Lawton-Smith, 2005). Lawton-Smith also reported that the use of CTOs appeared to be rising and highlighted the limited nature of international data on the number of people placed on CTOs. In New Zealand, one of the other jurisdictions identified in 2005 as having high rates with 58 per 100,000, a subsequent review found this figure had risen to 84 in 2011 (O'Brien, 2014).

Within the context of growing utilisation and unresolved clinical, ethical and human rights controversies, there are calls for the use of CTOs to be reduced and/or eventually eliminated (Brophy, Ryan, et al., 2018; Mental Health Commission of NSW, 2014; United Nations Special Rapporteur, 2017). There is also a focus on how to improve the experience of patients subject to CTOs (Brophy, Edan, et al., 2018; Dawson, Lawn, Simpson, & Muir-Cochrane, 2016), and to enhance accountability around CTOs and the mental health system more generally through strengthened monitoring and reporting (Light et al., 2017; National Mental Health Commission, 2017; United Nations Special Rapporteur, 2017). As noted by Carney et al., the involuntary treatment of people with mental illness is “too important a matter not to be informed by reliable data” (p306–307) (Carney, Tait, Perry, Vernon, & Beaupert, 2011).

This paper reports on findings from a new study of rates of CTO use in Australia. This survey is a six-year update to the publication of the first national figures for CTO use in Australia, where local jurisdictions were shown to have varied and shifting rates of use that were high by world standards (Light, Kerridge, Ryan, & Robertson, 2012a). The previous study found rates of CTO use ranged from 30.2 per 100,000 population (in Tasmania) to 98.8 per 100,000 population (in Victoria). It also found, where data was available, that rates in Australia had increased over time (Light et al., 2012a).

With a view to presenting a contemporary picture of Australian CTO use, this paper reports the results of an audit of state and territory CTO rates.

2. Methods

The annual reports of Australian state and territory mental health review tribunals, health departments, and/or offices of the chief psychiatrist were accessed online and hand-searched for the most recent published data on CTOs. The offices of these institutions were also contacted by email to confirm or clarify: the annual data on the total number of individual people placed on a CTO and/or the total number of CTOs made; and/or any information that might be relevant to CTO usage during the reporting period (such as changes to local policy or

procedures).

The figures collected were then compared to data from Light et al.'s 2012 study of CTO rates in Australia, including the number of people subject to community-based orders per 100,000 population, and/or the number of CTOs made per 100,000 population (Light et al., 2012a). The data were also compared to Lawton-Smith's 2005 study of international jurisdictions, which included four Australia jurisdictions (Western Australia, New South Wales, Queensland, and Victoria) (Lawton-Smith, 2005). Consistent with the two previous studies, population figures from the Australian Bureau of Statistics² were used in the calculation for each jurisdiction.

3. Results

Figures on 2016/17 CTO rates were compiled for states and territories from a combination of jurisdiction annual reports or supplementary database reports provided on request. Table 1 details the data collected on the total number of CTOs made in a year, the total number of individuals on a CTO in a year, and the respective rates per 100,000 population calculated based on the jurisdiction's population.

The data shows that contemporary rates of CTO use in Australia vary considerably. The rate of people subject to CTOs ranged from 40.9 per 100,000 population in WA to 76.4 per 100,000 in Victoria, while the rate of CTOs made ranged from 108.4 per 100,000 population in Victoria to 66.1 in Queensland.

Not all jurisdictions were able to provide annual totals of CTOs made and of persons on CTOs, some were not able to provide either type of data, while one state provided a “snapshot” figure.

Three jurisdictions—Queensland, ACT, and Tasmania—have legal frameworks that enable a single involuntary treatment order, which can apply to community or inpatient treatment, or both, during the life of the order. As was the case in the 2012 CTO rates review:

- Queensland reported a snapshot figure of the total number of community category “Treatment Authorities” in place on a given day (also reflecting the total number of people on such orders on that day).
- It was not possible to include data from the ACT in the analysis. The *ACT Civil and Administrative Tribunal 2016–17 Annual Review* reported that there were 637 “Psychiatric Treatment Orders” made during the reporting period (a rate of 156.7 orders per 100,000 population). However, it was not possible to identify the proportion of orders that were community-based.

Data on the number of people in Tasmania on a CTO during the year was included in the 2012 review, however subsequent changes under the *Mental Health Act 2013* included the introduction of a single “Treatment Order” that can operate in the community or in a hospital. The differences between the old and new legislative schemes make comparisons of the previous CTO rate to now difficult, if not impossible, to make. The *Mental Health Tribunal Annual Report 2016/2017* states that 394 Treatment Orders were made during the reporting period (a rate of 75.9 orders per 100,000 population). It was not possible to identify the number or proportion of “community” category treatment orders.³

The Northern Territory reported 2015/16 CTO data (included in

² The ABS “Australian Demographic Statistics” estimates total resident population for states and territories and comprises all age groups. Though consistent with the figures used in previous CTO rates studies, caution should be used when comparing the results of these studies to rates in other jurisdictions where the population data used might be different (for example, limited to populations over 18 years of age).

³ These details were confirmed with the Mental Health Tribunal in correspondence with the author in September 2018.

Table 1

Australian CTO rates 2016–17: Annual number of CTOs made and/or number of people subject to CTOs per 100,000 population, by Australian state or territory.

State/territory	Population '000 ^a	Period of data collection for this study	Number of CTOs/year	Rate of CTOs made	Number of individuals under a CTO/year	Rate of people subject to CTOs
Australian Capital Territory	406.4	–	–	–	–	–
New South Wales	7797.8	2016/17	5362 ^b	68.7	3751 ^c	48.1
Northern Territory	244 (Dec15)	2015/16	178 ^d	72.9	–	–
Queensland	4928.5 (June17)	Snapshot 30/6/2017	3258 ^e	66.1	3258	66.1
South Australia	1717	2016/17	1933 ^f	112.5	–	–
Tasmania	519.1	–	–	–	–	–
Victoria	6244.2	2016/17	6769 ^g	108.4	4773 ^g	76.4
Western Australia	2567.8	2016/17	–	–	1052 ^h	40.9

^a Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, Dec 2016, available online: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/432B4729A87614B1CA2581A70015892B?opendocument>.

^b Mental Health Review Tribunal (NSW), 2016/17 Annual Report, MHRT: Sydney.

^c Communication from NSW Mental Health Review Tribunal, 1 August 2018.

^d Northern Territory Mental Health Review Tribunal Annual Report 2015–2016, MHRT: Darwin.

^e Annual Report of the Chief Psychiatrist 2016–2017 (Qld), State of Queensland: Fortitude Valley. Figure here represents number of “Community” category of Treatment Authorities (referred to as involuntary treatment orders [ITOs] under previous legislation) as at 30 June 2017. Note that the Mental Health Act 2016 commenced on 5 March 2017.

^f Chief Psychiatrist of South Australia 2016–17 Annual Report, Government of South Australia: Adelaide. The report details annual figures for “All CTOs” during the reporting period, including ‘Level 1’ CTOs (initially made by authorised professionals and then reviewed by the Tribunal) and ‘Level 2’ CTOs (made by the Tribunal on application). It also reports that during the year 485 people were subject to Level 1 CTOs and 1095 people subject to Level 2 CTOs, with some people subject to multiple orders. At the time of writing, it was not possible to confirm a total number of people subject to CTOs (given some people may have had both levels 1 and 2 during the year).

^g Communication from Department of Health and Human Services Victoria, 30 August 2018.

^h ‘Ensuring Safe and High Quality Mental Health Care’ - Annual Report of the Chief Psychiatrist of Western Australia (01 July 2016–30 June 2017), Chief Psychiatrist of WA: Perth.

Table 1), however 2016/17 could not be confirmed at the time of writing. Other stipulations or limitations related to the CTO data that was provided are detailed in the Table 1 notes.

Table 2 reports the 2016–17 rates in comparison with the two previous analyses of Australian rates of CTO use, based on Lawton-Smith's 2005 review and Light et al.'s 2012 survey (Lawton-Smith, 2005; Light et al., 2012a).

While most Australian states and territories had experienced significant increases between the 2005 and 2012 studies in their rates of people subject to CTOs, the new data show that in general the degrees of change in rates have subsequently lessened. Where data is available it shows there is still fluctuation in the rates of people subject to CTOs (rising in NSW and Queensland, and falling in Western Australia), however only one jurisdiction showed significant changes. The state of Victoria previously had the highest rate of people subject to CTOs in Australia (and potentially the world), rising from 55 to 98.8 per 100,000 in the 2012 review (Light et al., 2012a). This new data show that its rate has fallen to 76.4. This is still one of the highest rates in Australia, but the change over time is substantial.

The new data for the rate of CTOs made per 100,000 population

show that rates have increased since the 2012 study. The Northern Territory (NT) and South Australia (SA) previously reported figures on CTOs made, and their rates of use rose from 56.1 to 72.0 in the NT and from 51.3 to 112.5 in SA. Meanwhile, jurisdictions reporting data for the first time on CTOs made also showed enormous variation in rates of use: NSW (68.7), Queensland (66.1) and Victoria (108.4). These rates were also high compared to the 2012 NT and SA figures.

With both small and large increases in rates, and few noteworthy reductions to report, the new Australian figures suggest jurisdictions have maintained what were considered relatively high rates by international comparison.

4. Discussion

This study provides the second national snapshot of the rates of CTO use in Australian jurisdictions, providing a six-year update to earlier compiled published figures.

Consistent with previous reviews of CTO rates in Australia and internationally (Lawton-Smith, 2005; Light et al., 2012a), this analysis was limited by difficulties related to data availability and

Table 2

Australian rates of CTO use 2005–2017: Rates of CTOs made or people subject to CTOs per 100,000 population, by Australian state or territory, reported in 2005, 2012, and new.

State/territory	Rate of people subject to CTOs (Lawton-Smith, 2005)	Rate of people subject to CTOs (Light et al., 2012a)	Rate of people subject to CTOs – 2016–17	Rate of CTOs made (Lawton-Smith, 2005)	Rate of CTOs made (Light et al., 2012a)	Rate of CTOs made – 2016–17
Australian Capital Territory	–	–	–	–	–	–
New South Wales	37.4	46.4	48.1	–	–	68.7
Northern Territory	–	–	–	–	56.1	72.9 (2015/16)
Queensland	42.9 ^a	61.3 ^a	66.1 ^a	–	–	66.1 ^a
South Australia	–	–	–	–	51.3	112.5
Tasmania	–	30.2	–	–	–	–
Victoria	55	98.8	76.4	–	–	108.4
Western Australia	17.6	48.6	40.9	–	–	–

^a Rate based on a snapshot figure of data on a given day during reporting period, rather than total annual numbers.

comparability. These included differences between jurisdictions' data collection and reporting systems. Further, one jurisdiction described database management difficulties in the reporting period. These limitations mean that comparisons across jurisdictions need to be treated with caution. However, like the earlier national study (Light et al., 2012a), this analysis still provides the most complete contemporary picture of Australian CTO use and enables some comparisons between jurisdictions and different time periods.

With CTO utilisation rates previously among the highest in the world, this study shows that Australian rates of use continue to differ considerably between jurisdictions, to operate at high levels, and to vary over time. Rates of CTO use continued to rise in most jurisdictions, although the extent of increases was less than in the previous study period. A drop in rates of use was reported in two jurisdictions. In WA, reported rates dropped from 48.6 to 40.9 per 100,000 population, however the local Tribunal advised that the implementation of a new database system meant some data was indicative only. In Victoria, the rate of people subject to CTOs dropped, from 98.8 in 2012 to 76.4. Meanwhile, data on the number of CTOs made in that state found a rate of 108.4 per 100,000, among the highest rates in the new study and about double that previously reported in other jurisdictions. The relatively higher rates of CTOs made compared to rates of people subject to CTOs, which was the case in all jurisdictions with available data, suggest that the annual data includes multiple orders for some individuals (that is, pre-existing, new, and/or renewed CTOs in one year).

A principal conclusion of the 2012 study was that there needed to be steps taken to bring about regular and nationally uniform CTO data collection and public reporting. This is crucial to the transparency and accountability of mental health policy and law, to improving scrutiny of CTO use in the care of people living with mental illness (Carney et al., 2011; Light et al., 2012a), and to monitor progress in reduction and elimination of coercion (United Nations Special Rapporteur, 2017). The invisibility of CTOs in mental health policy—including lack of uniform national CTO data—potentially marginalises the people subject to such orders, their experiences, preferences and needs, and limits necessary oversight of mental health systems (Light et al., 2012a; Light, Kerridge, Ryan, & Robertson, 2012b). However, uniform national public reporting of CTOs in Australia has not yet happened. Opportunities exist to progress to such efforts. In NSW, for example, the Mental Health Commission now regularly reports on the use of involuntary treatment orders (including CTOs) as one of a number of mental health reform indicators. Its includes the indicator “Decrease the rate of involuntary treatment orders (inpatient and community) issued” as it believes that a high rate of orders “whether in hospital or in the community, is a marker of a system which is not intervening early or effectively in the course of a person's mental distress or increasing illness. [Involuntary] Treatment in hospital should be a last resort for people and their families. Involuntary treatment can be a very traumatising or re-traumatising experience for the person involved” (Mental Health Commission of NSW, 2018). In addition to the need for improved national reporting by public institutions, the findings of this study highlight the continuing gaps in knowledge about how and why CTOs are used, bearing out recent calls for additional and different types of evidence “regarding the patterns of CTO use and associated demographics” (Brophy, Edan, et al., 2018).

Given the limitations of the data, it is not possible to make claims based on this study about the adequacy or appropriateness of levels of CTO use in Australia. In the context of calls for reduction (and elimination) of coercion, these new figures suggest Australia is some way off such an objective in relation to CTOs. Australian Institute of Health and Welfare figures noted earlier (Australian Institute of Health and Welfare, 2018) also suggest that the proportion of involuntary community mental health services has not reduced in recent times—the figure of about one in seven has remained relatively stable in the 2010s.

Meanwhile, a range of issues continue to be proposed to explain the variation in CTO use between jurisdictions and over time. Brophy et al.

recently described the “often competing factors that potentially influence the prevalence of CTOs” in Australia, including: the effect of human rights instruments; variances in mental health laws; recovery-oriented policies; environmental factors, including population sizes and demographics; the (in)accessibility of inpatient beds and clinical community-based resources; and peer and service culture (Brophy, Edan, et al., 2018). These explanations are consistent with those proposed in other jurisdictions and at other times (Brophy & McDermott, 2003; Brophy, Ryan, et al., 2018; Corring et al., 2018; Dawson, 2007; Kisely & O'Reilly, 2015; Lawton-Smith, 2005; Light et al., 2016; Light et al., 2017), suggesting our understanding of and ability to respond to the factors driving CTOs remains uncertain.

In terms of legislative variation, since the 2012 study of CTO rates, seven Australian jurisdictions “repealed and replaced, or made significant changes to their mental health legislation, but all Australian jurisdictions have retained powers to make CTOs” (Brophy, Edan, et al., 2018). No jurisdictions contacted in this study suggested 2016–17 CTO data was affected by any specific legal changes. Recent reforms in some jurisdictions included ensuring a focus on recovery principles and consideration of a person's decision-making capacity in all decisions under the law. Whether and how such reforms affect the use of CTOs and other coercive types of treatment may take further time to be shown, and/or result in unexpected effects. For example, a recent study by O'Donoghue et al. found that CTO rates rose (and orders to revoke them fell) in the initial period (less than one year) following the implementation of a recovery-orientated model across four adult mental health services (O'Donoghue et al., 2016). The authors called for ongoing monitoring to confirm the reasons for changes in CTO use in this context, and suggested that clinical caution in the period of transition as well as service- and individual-level factors—such as inner city service areas and high rates of homelessness—may have been contributors to CTO use.

Two jurisdictions in this study used their annual reports to highlight public policy factors affecting the use of CTOs and other forms of coercion in differing ways. The NSW Mental Health Review Tribunal President's Report commented on the greater likelihood of people being treated involuntarily in an under-resourced community mental health system. “If community mental health is under-resourced then there will be cases where patients are not adequately supported and will risk becoming involuntary patients.” The President further commented that patients “can also find themselves coming into contact with the criminal justice system because of their deteriorating mental health. In other words, they commit acts of violence, are charged by the police, found unfit for trial or not guilty by reason of mental illness and then come to the Tribunal's attention as forensic patients.” (Mental Health Review Tribunal, 2017) Meanwhile, the WA Annual Report drew attention to how a lack of suitable accommodation for people in the community was limiting options for people to be placed on CTOs. “Having a stable form of accommodation is widely recognised as one of the most significant factors in achieving recovery for a person with a mental illness. Whilst reviewing the involuntary status of people who have been detained in authorised hospitals for considerable periods of time, the Tribunal is frequently told by treating teams that the patient does not need to remain as an inpatient for treatment reasons—but that, rather, the person remains in hospital only because no suitable accommodation can be found for the person in the community. In other words, the patient could be the subject of a CTO but for the fact that suitable arrangements cannot be made for the patient's care in the community because of the absence of supported accommodation.” (Mental Health Tribunal (WA), 2017) These analyses reinforce the multi-faceted explanations proposed in the scientific literature for variations in CTO use. They are also noteworthy in that this sort of open discussion by these public institutions about CTOs and the treatment of people living with mental illness is an emerging development since the 2012 study, and one that may make an important contribution to better understanding CTO use and influencing relevant public policies.

Finally, a number of additional questions are raised by the Australian legislative schemes that structure their involuntary treatment around a single order that can move between community and inpatient treatment settings. In the case of the ACT and Tasmania, this meant there was no “community” involuntary treatment order data available, although this might be possible in the future depending on their database systems and data collection practices. Queensland’s data collection, for example, enables it to report a snapshot figure of “community” orders in place among its general involuntary treatment authorities. Beyond numbers and scrutiny of CTO use, however, these “hybrid” orders raise broader questions about the distinction between involuntary community and inpatient treatment. A large part of the debates in the CTO literature about their role and effectiveness relates to questions about their purpose, including whether or should they be expected to keep people out of hospital. The premise of these single order schemes would seem to suggest that an involuntary patient moving between different treatment settings is not necessarily a “failure”, but a possibility expected in response to changing circumstances. At the same time, single treatment orders raise questions about the appropriate reach and duration of involuntary treatment and psychiatric coercion operating between hospitals and people’s homes. This cannot be interrogated further because of the data limitations in this study. However we are reminded to situate the focus of our examination of CTOs—including the ethical, human rights and political concerns—within the frame of coercion more generally.

5. Conclusions

Australian jurisdictions continue to use CTOs at high and varying rates, despite unresolved controversies about their role and impact. Transparency and accountability around their use must be improved by regular and nationally uniform public reporting of CTO data. Their use is shaped not only by legal frameworks or clinical decisions, but by social and political factors. Public reporting, together with further research into how and why CTOs are used, therefore may provide opportunities to respond to factors driving their use and thereby reduce coercion in mental health care.

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Declaration of interests

None.

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