Data supplement for Light et al

Methods

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

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 involved a reference group comprising the NSW Institute of Psychiatry, Mental Health Review Tribunal, Mental Health Coordinating Council, NSW Consumer Advisory Group - Mental Health Inc, NSW Health Mental Health, Drug and Alcohol Office, InforMH, and Carers NSW.

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. In the case of MHRT participants, the invitation was circulated by the Tribunal to all members.

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.

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**
Risk of harm of self or others: encompassing suicide,	*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

misadventure, neglect, exploitation or victimisation, and deteriorated physical health	*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 *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 *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 *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 *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*
<u>Risk of social adversity</u>: encompassing homelessness, poverty, isolation, deprivation, limited access to services and social goods	*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 *That those people, they run the risk then of damaging family relationships, or even assaulting family members, or getting 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 *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 *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

	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 *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
<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	*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 *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 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* *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 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
<u>Risk of compromised treatment</u>:	*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*

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	*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* *… 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 *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 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 *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

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.

Please note that legislation amending the *Mental Health Act* was passed by the Parliament of NSW and assented to 28 November 2014. At the time of writing, the *Mental Health Amendment (Statutory Review) Act 2014* changes had not yet come in to force. The amendments do not affect the extracts below.

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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