

Factors influencing the rate of use of community treatment orders

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Abstract

The mental health laws of many jurisdictions provide an enabling framework for the use of community treatment orders (CTOs), or outpatient commitment (as it is called in the USA). But the legislation does not usually say when CTOs *must* be used. That remains a matter for the discretion of clinicians. So the argument is made here that the rate at which CTOs are used in practice depends on the manner in which clinicians exercise that discretion when implementing the CTO regime. Furthermore, it is suggested that clinicians will exercise that discretion, to place a person on a CTO, when they believe the overall balance of advantage favours that option. Several factors are then identified as relevant to that calculation: the powers provided to treat involuntary outpatients; the threat of liability being imposed on clinicians for the conduct of patients in the community; the structure and quality of the mental health services available; the perceived impact of coercion on therapeutic relationships; the expectations of third parties; and past patterns of involuntary outpatient care. These factors provide a complex network of influences on the exercise of clinical discretion in the use of CTOs. Interaction between these factors produces a dynamic and fluid situation. So widely varying rates of use of CTOs can develop in different jurisdictions with otherwise similar legal traditions, and rapid changes can occur in the rate of use of CTOs, over time, even within a single jurisdiction, without any change occurring in the law.

Key words: community treatment order; outpatient commitment; mental health law; civil commitment; Mental Health Act.

In many countries, including Scotland, community treatment orders (CTOs) now authorise involuntary outpatient care. The legislation empowers community teams to follow seriously ill patients in the community and to recall them rapidly to hospital care. The patients are usually required to accept medication and attend outpatient appointments. Their residence may be controlled and other conditions imposed on their community status, with the main mechanism of enforcement being the threat of return to inpatient care.

This is a potentially coercive regime, and whether the law in England and Wales should confer greater powers of this kind has been the subject of considerable debate in the context of the drafting of the Mental Health Bill (Richardson, 1999; Joint Committee, 2005). Nevertheless, the mental health legislation provides only an enabling framework. Many factors interact with that framework to determine the rate at which CTOs are actually used. Even in jurisdictions with similar legislation considerable differences are therefore found in the numbers of people placed under involuntary outpatient care, as the following figures show.

Box One

Variations in the Rate of Use of CTOs

People under CTOs per 100,000 population

Victoria, Australia (2005)	60
District of Columbia, USA (2004)	54
New Zealand (2003)	44
Queensland, Australia (2004)	43
Maricopa County, Arizona, USA (2004)	31
Western Australia (2004)	10
Tennessee, USA (2004)	10
Ontario, Canada (2003)	2

Source: Lawton-Smith S. *A Question of Numbers*. London: King's Fund, 2005.

A. The scope of clinical discretion

So what explains these variations? Why is there such a gap, for instance, between the rate of use of CTOs in Victoria and Ontario, when these parts of the British Commonwealth share many other legal and social traditions? The key factor, in my view, is the manner in which the responsible psychiatrists exercise their discretion when using the CTO regime. There is no standardised use or standardised dose of involuntary outpatient care. So clinicians exercise considerable discretion in its use, and this is recognised in the open texture of the legal regime.

The legislation will usually say, for instance, that a patient 'may' be placed on a CTO, in certain circumstances, and that the clinician 'may' later apply for the order to be renewed. But the law does *not* say when a CTO 'must' be used. That remains a matter of discretion. So the manner in which clinicians exercise that discretion, at the numerous points in the process, determines the effective life of the regime.

Box 2

Discretionary decisions in the use of CTOs

Responsible clinicians:

- decide whether to recommend a patient for a CTO
- negotiate with family members and community providers concerning the patient's care
- play a central role in formulating the outpatient treatment plan
- prescribe and monitor the patient's medication
- complete many documents, such as reports for tribunals reviewing the patient's status
- decide whether to recall the patient to hospital
- decide whether to initiate any power of entry into private premises
- decide to call social workers or the Police to assist
- decide when to discharge the patient to voluntary care.

In making these judgments, the critical matter seems to be whether the clinicians consider that the balance of advantage favours the use of involuntary outpatient care. This general calculation seems influenced in turn by four main factors:

- the legal structure of the CTO regime;
- the extent of the community mental health services available;
- clinicians' views about the impact of coercion on relations with outpatients;
- the expectations of third parties for use of the scheme.

The interaction between these factors presents a dynamic and fluid situation. This explains why the rate of use of CTOs varies so much from place to place, and why it varies over time in single jurisdictions, even without any change in the law (Dawson, 2005).

A. The legal context for the use of CTOs

Naturally, if the CTO legislation is well-designed, it is more likely to gain clinicians' support. So the law and psychiatrists' attitudes to CTOs are intertwined. The critical matter concerning psychiatrists' perceptions of the law seems to be whether they consider the CTO scheme confers sufficient authority on mental health teams to treat involuntary outpatients to outweigh the additional burden of administration involved. This overall equation – marginal authority to treat, balanced against extra 'paperwork' – seems to be the central driver of clinicians' views (Franklin et al, 2000; Atkinson et al, 2000).

The duration of the order is also important. If a CTO only lasts for 6 months, before its renewal through a formal process is required, fewer people are likely to be on a CTO at any time, than if the order lasted for a year. This can be partly explained by reference to the equation above. A longer CTO confers greater authority to treat outpatients, and less administration is required concerning its periodic renewal, so the balance of advantage tips further in favour of involuntary outpatient care.

Questions of professional liability also arise, particularly any liability imposed on clinicians for failure to monitor or treat patients properly under the CTO regime. If the courts were to expand the scope of professional negligence, to impose liability of that kind, especially liability for any violence inflicted by the patient on a third party, clinicians would probably avoid any engagement with the scheme.

A. The community mental health infrastructure

The service context is also critical, especially the balance established between hospital and community care. Clinicians will be reluctant to recommend patients for CTOs unless a

community service of sufficient quality and intensity is available to address seriously ill patients' needs. The number of patients placed on CTOs is therefore likely to increase (rather than decline) as community services expand, as has occurred in Australia (Dawson, 2005).

Vital service elements seem to be:

- the coordination of hospital and community care, to ensure patients on CTOs can readily be readmitted to hospital, when required;
- the commitment and skills of community psychiatric nurses;
- the availability of supported accommodation for patients with complex needs;
- the cross-cultural capabilities of community teams;
- continuity in therapeutic relationships;
- the absence of financial barriers to the use of involuntary outpatient care;
- the ready availability of social workers and the Police in emergencies.

A. The impact of CTOs on therapeutic relationships

Some clinicians take the view that the impact of a CTO on a patient, particularly the sense of coercion and stigma, and the constant threat of return to hospital, may so damage therapeutic relationships that involuntary outpatient treatment is counter-productive. If that view was widespread, it would greatly reduce the use of CTOs.

There is not much evidence to support these views in the research, however. When studied, patients under CTOs have been found to experience both advantages and disadvantages simultaneously, and many do not oppose their treatment under the scheme (Gibbs et al, 2005). In a survey sent to all New Zealand psychiatrists, concerning their national CTO regime, ten years after its introduction, the dominant view was found to be that 'compulsion can harm relations with patients in the short term, [but] the advantages of continuing treatment usually outweigh this problem, and where greater insight follows treatment, therapeutic relations often improve in the end' (Romans et al, 2004). The factors rated most highly in the use of CTOs were as follows:

Box 3

Key Decision-Making Factors in the Use of CTOs for Psychiatrists working in New Zealand

Surveys sent, 362; returned, 202; response, 57%

1 = very important, 5 = not important at all

To ensure the patient has contact with mental health professionals	1.79
To provide the authority to treat the patient	1.81
To permit rapid identification of relapse	1.90
To promote compliance with medication	2.03
To protect patients from the consequences of relapse	2.08

Source: Romans, Dawson et al (2004) 38 *ANZ J Psychiatry* 836-841

A. The expectations of third parties

Responsible clinicians do not make decisions to use CTOs in isolation. They experience the burden of others' expectations. Their colleagues' views, the risk management policies of their service, the attitudes of patients' families – all are relevant. Supported accommodation providers may insist that a challenging patient be placed on a CTO to guarantee access to

mental health services when they accept that person into their care. The Police may insist that a person be placed on CTO before they will drop minor charges and permit diversion of an offender to psychiatric care. The attitudes of the public to deinstitutionalisation, and the potential for violence on the part of the mentally ill, count in the equation. The views of all these parties are relevant and their positions are often influenced by prior patterns of use of involuntary outpatient care, including the prior use of long leave or supervised discharge schemes. Sudden changes in public attitudes can occur, spurred by tragedies, inquiries and media activity. These matters may not be easily quantified, but they all seem to influence how clinicians use the law.

A. Conclusions

Numerous factors therefore influence clinical discretion in the use of CTOs. The design of the legislation, the context for the implementation of the scheme, prior patterns of involuntary outpatient care, and changing patterns of community expectation, are all relevant. But the central factor still seems to be the reasoning of psychiatrists about the balance of advantage CTOs present for the delivery of effective outpatient care. If responsible clinicians believe the CTO would confer significant marginal authority on the community team, to provide a useful community service to a patient in need of treatment, and using the CTO in those circumstances would be within the expectations of their peers, they would tend to use it, *unless* its use would expose their team to excessive administrative burden, or unacceptable exposure to liability, or they felt the use of coercion might harm unduly their long-term relations with that patient. This is the kind of reasoning clinicians seem to employ when making the critical decisions to initiate or continue a patient's treatment under the scheme.

If, on the other hand, the CTO regime does not provide significant extra authority to treat outpatients compared with voluntary care, or the 'paperwork' is intolerable, or no adequate community service is available, or the prospect of liability for patients' conduct in the community is too threatening, clinicians may simply avoid placing patients under the scheme.

There is little point, therefore, in introducing a CTO regime that does not have the general support of psychiatrists and community mental health teams. If it does not have their confidence, the scheme will be little used in practice, and it will make little impact on the overall delivery of mental health care.

Practice Points

- Clinicians exercise considerable discretion when using community treatment orders.
- There is, as yet, no standardised use or standardised dose of involuntary outpatient care.
- The critical calculation is whether the marginal authority to treat outpatients provided by the CTO regime outweighs the extra paperwork involved.
- Clinicians working with well-embedded CTO regimes often consider the long-term advantages for therapeutic relationships outweigh the short-term disadvantages of using coercion in treatment.
- If the courts impose liability on clinicians for the conduct in the community of patients under CTOs, clinicians will probably avoid engagement with the scheme.

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Further reading

Several North American journals have published special issues on CTOs or outpatient commitment. See *Psychology, Public Policy and Law*, Volume 9, 2003; and *Psychiatric Services*, Volume 52, 2001. A further special issue on CTOs will soon be published by the *International Journal of Law and Psychiatry*.

The most definitive RCT of involuntary outpatient treatment is:

Swartz M, Swanson, J, Wagner H, Burns B, Hiday V, Borum R. Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *Am J Psych* 1999; 165: 1968-75.

Special committees of the American and Canadian Psychiatric Associations have reviewed the evidence concerning CTOs:

Gerbasi J, Bonnie R, Binder R. Resource document on mandatory outpatient commitment. *J Am Ac Psych Law* 2000; 28: 127-44.

O'Reilly R, Brooks S, Chaimowitz G, Neilson G, Carr P, Zikos E, Leichner P, Beck P. CPA Position Paper: mandatory outpatient treatment. *Can J Psych* 2003; 48, Insert 1-6; available at: http://www.cpa-apc.org/Publications/Position_Papers/mandatory.asp