Community Treatment Orders: International Comparisons

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Summary

This report compares the laws concerning involuntary outpatient psychiatric treatment in a number of jurisdictions, with a view to assessing the adequacy of New Zealand's community treatment order regime.

Many of the issues examined concern the scope of the powers conferred by law on community mental health teams, to monitor the condition of patients under community treatment orders, to enter private premises for that purpose, and to treat such patients without their consent. The law in this controversial area is reviewed in Victoria, New South Wales, Switzerland, the UK and Canada. Conclusions are then drawn for NZ.

The research in the various jurisdictions was conducted by Prof. Dawson, of the law faculty of the University of Otago, during 2003, supported by an international research fellowship generously awarded by New Zealand Law Foundation.

Prof. Dawson concludes from this review that the structure of the NZ legal regime is satisfactory, and that NZ should continue to encourage the use of community treatment orders (CommTOs), under civil mental health legislation, particularly to avoid the unnecessary criminalisation of the mentally ill and to prevent the over-use of forensic mental health care.

In addition, the report emphasises that NZ law must protect involuntary patients' basic human rights. As a consequence, 'forced medication' outside properly supervised clinics or hospitals should not be authorised. Nor should the law confer overly-broad powers of entry into patients' private residences. Nor is it necessary for additional powers to be conferred on the courts to order a patient's residence at a specified address.

The scope of community treatment powers

The experience gained in Australasia in the last decade shows that it is sufficient for the operation of a CommTO regime to establish the following mix of duties and powers:

• to place a duty on the patient to accept psychiatric treatment, even if that duty is not matched by a power to 'restrain and medicate' the patient in a community setting
• to direct the patient to accept visits from clinicians and attend appointments
• to direct the kind (or 'level') of residence at which the patient should reside
• to enter the patient's residence at reasonable times and for purposes directly related to enforcement of the treatment regime
• to recall the patient swiftly to hospital
• to obtain police assistance in that process

• to provide treatment without consent in a hospital, or in a clinic that is continuously staffed by properly qualified health professionals.

On that basis, Prof. Dawson argues, NZ law should continue to encourage the use of community treatment orders. The focus of the regime should be on people with serious and continuing mental illnesses, not intellectual disabilities or personality disorders. The administration of the scheme should continue to be based on a regional structure, not the institution of the hospital. And the law should not impose excessive administrative burdens, or rigid legal criteria, or unreasonable liability, on clinicians who use CommTOs, unless the intention is to reduce significantly their willingness to use the scheme.

Two refinements to NZ's mental health legislation should still be considered, he suggests. A further legal test, of 'substantially diminished capacity' to consent to psychiatric treatment, should be added to the criteria governing all interventions under the Mental Health (Compulsory Assessment & Treatment) Act 1992, to harmonise the criteria governing involuntary psychiatric treatment with those governing other forms of medical care. And NZ law should abandon the concept of indefinite compulsory treatment orders, in favour of a system of mandatory, periodic reviews for all involuntary patients.

The comparative research

The issues of legal principle found to be most troubling in the various jurisdictions studied were the role of competency (or capacity) principles in the criteria governing involuntary outpatient care, and the precise powers of clinicians to 'enforce treatment' in community settings.

Other fault-lines found in the law included:

• whether use of CommTOs should be limited exclusively to patients with a history of prior hospital admissions and non-compliance with outpatient care, or whether they may also be extended to patients following their first hospital admission

• whether family members should be granted veto powers over a patient's treatment, in addition to consultation entitlements, when family members may have a conflict of interest with the patient

• the frequency and intensity of tribunal (or court) reviews

• the value of formulating special statutory treatment plans, which must be approved by a court or tribunal, when that practice may confuse lines of responsibility for the treatment of the patient

• the tendency to impose strong statutory duties on health providers, to furnish treatment to involuntary patients, when that approach may enhance providers' liability concerns.

The empirical research

A review of the empirical research conducted on the various CommTO schemes revealed some clear trends, which appear consistent with the position in NZ. The use

of CommTOs often increases after an initial 'bedding in' period, particularly if reductions occur simultaneously in the number of hospital beds, and there is an associated build-up of community teams. When the average length of involuntary hospitalisation falls below 2-3 weeks, the use of CommTOs seems to jump significantly, due to the early stage in treatment at which many patients are then discharged. Increasing the availability of community mental health resources also appears to increase the use of CommTOs, instead of decreasing the need for their use, as some would suggest.

Well-embedded schemes usually focus on certain categories of patient. Male patients tend to outnumber females, by about 60:40, and most involuntary outpatients are in the middle phase of their illness, have a diagnosis of schizophrenia, several prior hospital admissions and a recent history of non-compliance with outpatient care. A considerable proportion have concurrent problems with substance misuse, and a significant minority have experienced imprisonment or forensic care. In most jurisdictions, only a minority live in group homes or supported accommodation; most live alone in rented housing or with their families. Research in Melbourne, in particular, suggests that CommTOs can be successfully targeted in practice on patients identified in the psychiatric literature as the primary candidates for this form of care.

Although there are limitations in all studies that evaluate CommTO regimes, their results usually reveal: significant therapeutic benefits for patients; greater compliance with outpatient treatment, especially medication; and reduced rates of hospital admissions. Some also reveal: better relations between patients and families, or enhanced social contacts; reduced levels of violence and self-harm; and earlier identification of patients' relapse.

The empirical research also suggests, however, that CommTOs are strongly linked to the use of depot (or injectable) medication, which is disliked by many patients, and patients commonly complain that their treatment is dominated by the use of medication, with little access to other therapies. CommTOs tend to be issued for the maximum period permitted by law and discharge is likely to occur shortly before an independent review hearing would be held. When the patient's treatment is proceeding satisfactorily, clinicians seem to have a strong preference for maintaining the status quo, so discharge from the order may not be easy for patients to obtain. Overall, there may be a tendency for CommTOs to be used for too long, and as a defensive form of medical practice.

On the other hand, it is also widely believed that involuntary patients get some priority for care, that they receive more intensive treatment, that the order may help direct resources to them at an earlier stage in their relapse, and that it may facilitate their smooth readmission to hospital.

The context for the use of CommTOs

The research suggests that use of CommTOs is most likely to produce positive outcomes when the regime is well-embedded and has the full support of clinicians. A reasonably intensive level of community service must be provided, by clinicians who visit the patient at their residence and are committed to enforcement of the scheme. A good range of supported accommodation should be available, plus ready access to

treatment for substance misuse. Local inpatient and outpatient services must be well-coordinated, and there should be no financial barriers, or problems in reimbursement systems, that discourage use of the scheme. Continuity of staff is critical to good therapeutic relationships, and the staff should be assertive, have sound relations with the Police, and have a high degree of cross-cultural capability. The 'gaze' of the independent review procedures should be reasonably intense, but reviews should still be relatively informal, and not so frequent, or demanding of clinicians' time, that they act as virtual discharge mechanisms.

On the other hand, patients should not be effectively confined in sub-standard housing. Clinicians should avoid assuming that all patients on CommTOs must be administered medication by injection. CommTOs should not be over-used for patients with affective disorders, for whom their efficacy is uncertain, and whose capacity to consent may swiftly return after initial treatment. Nor should CommTOs be over-used when there is extreme pressure on hospital beds.

Nevertheless, Prof. Dawson concludes that even if all these indicators of good practice were to fall in line, implementing CommTOs would never be straight-forward. Their entire focus should be on patients who are difficult to engage voluntarily in their care. Clinicians should not therefore be unfairly blamed, or pilloried in the media, when untoward events occur, especially if people are to be encouraged to work in the difficult field of mental health care.

The report concludes with recommendations for NZ and extensive references.

Inquiries
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