Uses of Community Treatment Orders in New Zealand: early findings

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Objective: To assess the uses of Community Treatment Orders (CommTOs) in New Zealand.
Method: A retrospective study of patients' records held by the regional administrator of mental health legislation and a survey of psychiatrists attending a conference in Dunedin.
Results: Males under Community Treatment Orders (CommTOs) outnumbered females 6 : 4; a high proportion were considered to have a major psychotic disorder; and one fifth remained under a CommTO for more than a year without inpatient care. Among the psychiatrists, there was a high level of agreement that, when used appropriately, the benefits of CommTOs outweigh their coercive impact on the patients; the most strongly supported indicator for use was the promotion of compliance with medication. The rate of use of CommTOs in Otago is remarkably similar to the rate in Victoria, Australia.
Conclusions: Records suggest that a significant proportion of patients under CommTOs are not soon readmitted; and many clinicians in New Zealand consider CommTOs to be a useful strategy for managing the community care of long-term patients with schizophrenia and major affective disorders.
Key words: civil commitment, Community Treatment Orders, mental health legislation.

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Recently, the mental health legislation of many countries has been revised to reflect the trend towards community-based psychiatric care. In many jurisdictions, the law now provides for Community Treatment Orders (CommTOs) or for outpatient commitment [1–3], authorizing long-term treatment outside hospital without the consent of the patient. New Zealand's *Mental Health (Compulsory Assessment and Treatment) Act* 1992 establishes a CommTO regime under which outpatients may be required to accept psychiatric treatment as directed and to receive visits from health professionals. They may also be returned, at the discretion of clinicians, to inpatient care. Subject to six monthly formal reviews of the patient's status, the CommTO may be extended for an indefinite period.

There are two main routes into a CommTO in New Zealand: (i) by order of a judge, after a hearing approximately one month after compulsory admission; and (ii) by transfer from an Inpatient Order by the Responsible Clinician. A judge may bring about a CommTO if the patient is 'mentally disordered' (section 2), an order is 'necessary', outpatient care would be appropriate and available, and the social circumstances of the patient in the community would be adequate (sections 27, 28). The Responsible Clinician can switch a compulsory inpatient to a CommTO when 'the patient can continue to be treated adequately as an outpatient' (section 30).

The effect of the CommTO is to 'require the patient to attend . . . for treatment' by a designated service and 'to accept that treatment'; and the order authorises the staff to enter private premises 'for the purpose of treating the patient' (section 29). The extent of the legal duty imposed on the service to provide care is not clearly

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specified, but such a duty of care could be grounded in the common law or implied from the statement in the *Act* that all compulsory patients are 'entitled to medical treatment and other health care appropriate' to their condition (section 66).

The evidence for the effectiveness of CommTOs is still equivocal. A recent study of outpatient commitment in New York found no significant differences between experimental and control groups on subsequent measures of rehospitalization, arrest, quality of life, symptomatology or compliance with treatment [4]. Many service providers believed that the coercive elements of outpatient commitment would improve patient compliance, but no evidence was found to support that view. In contrast, an ambitious study of outpatient commitment in North Carolina found that it can reduce hospital readmissions and total hospital days when compulsion is sustained and combined with intensive treatment, particularly for individuals with psychotic disorders [5,6].

The three aims of this research were to: (i) identify broad patterns in the use of CommTOs in Otago; (ii) describe the characteristics of these patients, particularly those under CommTOs for more than a year without readmission; and (iii) obtain the views of psychiatrists on use of these orders.

Methods

The Otago files study

All records concerning the committal process held in the office of the regional administrator of the *Act* in Otago in the South Island of New Zealand were perused by medical records staff. Disidentified data were extracted to a protocol sheet from the official certificates and from clinical reports prepared for the Court. The reports are free form, with the clinician having near total responsibility in selecting information to provide.

The records of all persons committed in Otago between 1 November 1992 (when the current *Act* came into force) and 24 April 1998 were studied. The passage of each person through the legal process, and their discharge and readmission patterns were noted. Demographic and clinical data were coded (including age, gender, ethnicity, psychiatric diagnoses and substance abuse). Reports of recent aggression to self or others, and involvement with the courts, police or forensic psychiatric services were noted. Hospital files were not studied. Diagnostic information was collapsed into the categories provided by the Short List Diagnostic Groups of ICD-9 [7], with extra items added where necessary (e.g. eating disorders). In the absence of any previously published research on the use of CommTOs in New Zealand, we thought it was worth reporting these data.

The survey of psychiatrists

The annual meeting of the New Zealand branch of the Royal Australian and New Zealand College of Psychiatrists in Dunedin in September 1999 presented an opportunity to study the views of psychiatrists and registrars on the use of CommTOs. They were asked how strongly they agreed with the statement 'when CommTOs are used appropriately, their benefits are sufficient to outweigh any coercive impact on the patient'; and to rate, on a 1–5 scale, the significance 13 indicators for use 'would have for your decision-making concerning the use of CommTOs'.

Non-parametric statistics were used to analyse the results, as some of the distributions on the rating of the decision-making factors were non-normal. Means and standard deviations for agreement with each factor and the benefits of CommTOs statement were calculated. The mean scores for each factor for gender and type of practice (psychiatrist/registrar, North/South Island, short/long years of practice) were compared. The correlation matrix of the decision-making items was factor analysed, with principal components extraction and varimax rotation. All statistical analyses were performed with SPSS 9.0.0 (SPSS, Chicago, IL, USA).

Results

The Otago files study

The sample

One thousand and thirteen persons entered the compulsory assessment process in Otago in the 5.4-year period studied, which was an average of 187.6 persons per year, or 104.2 per 100 000 population (Otago having a stable population of 180 000). Of these, 259 (25.6%) persons went on to be treated under a CommTO during the period studied.

A total of 692 new judicial orders were made: 423 (61%) Inpatient Orders and 269 (39%) CommTOs (concerning 259 persons, with several placed under an order more than once). During the five complete years studied, the numbers of new CommTOs created by judges in Otago were: 25 (1993), 22 (1994), 45 (1995), 49 (1996) and 53 (1997). The annual numbers tended to increase, with an average of 38.8 CommTOs per year, or 21.6 per 100 000 population.

Gender, age and ethnicity

Of the 259 persons treated under a CommTO in Otago, 156 were men (60.2%) and 103 were women (39.8%). One male-to-female transsexual was classified as female. The average patient age was 40.0 (SD = 13.45), with a median of 37.0 and a mode of 27.0. The youngest was 16 and the oldest 86.

Most patients under CommTOs were recorded to be of Pakeha (or European) ethnic origins (77.2%), with 14.3% Maori, 1.9% Pacific Islanders and 0.8% of Asian origins. For 15 patients, this information was not recorded. According to recent census data the Maori proportion of the Otago population aged 15 years and over is 4.8%.

Diagnosis

A very high proportion of patients were considered to have one of the major psychotic disorders: schizophrenia (54.8%), affective (25.9%) or schizoaffective (5.4%) psychosis. Small groups received

other diagnoses, for example, alcoholic psychosis (1.5%), anorexia nervosa (1.5%), postpartum psychosis (0.8%) and the personality disorders (0.8%).

Other clinical characteristics

Other clinical characteristics recorded for these 259 individuals include delusions (53.7%), hallucinations (36.3%), mood disorder (39.0%), aggression (38.2%) and suicide attempts (27.4%). The comorbidity patterns recorded were drug abuse (19.3%), alcohol abuse (15.4%) and either drug or alcohol abuse (28.2%).

Forensic involvement

The following indicators of forensic involvement were noted: charged with a crime (13.1%), involved with Police (12.0%), processed under the *Criminal Justice Act* 1985 or transferred from prison to hospital (13.1%) and under the care of the forensic mental health team (9.7%). In 16.6% of cases, one or more of these indicators was found.

Patterns of use of CommTOs

It is possible to categorize the uses of CommTOs by reference to the pathways of patients through the compulsory treatment process and their length of stay under different sections of the *Act*. We divided these into three categories as follows:

(1) Short-term. Patients who came under compulsory assessment and later went to a CommTO, but were then discharged from compulsory treatment within a year, without any further use of compulsion in the period studied. We also included four patients who had been under a CommTO for less than a year when data collection closed. Nearly one-fifth (47, 18.1%) were in this general category.

(2) Long-term with readmission. Patients placed under a CommTO during a pattern of use of psychiatric services on a compulsory basis of more than a year, but whose CommTO never ran for more than a year before readmission to inpatient care. This group formed nearly half the sample (117, 45.2%).

(3) Long-term stable. Patients whose CommTO ran for more than a year without readmission to inpatient care. Fifty-three (20.5% of the sample) were in this category.

A further 6.9% were committed patients on leave under the 1969 *Act* who were deemed to be under a CommTO at the introduction of the 1992 *Act* and were discharged fully within the following year. In 9.3% of cases the patients' records were incomplete. The patients in these two final groups were excluded from the following comparisons.

Comparisons between groups

The characteristics of patients in the short term (n = 47) and in the two long-term categories (combined; n = 170) were compared. Long-term patients under CommTOs were significantly more likely than short-term patients to be recorded as having alcohol problems (18.2% *vs* 6.4%; $\chi^2 = 3.92$, df = 1, p = 0.05), to have a diagnosis of schizophrenia (61.2% *vs* 31.9%; $\chi^2 = 12.7$, df = 1, $p < 0.001$), and to have displayed recent aggression to others (42.9% *vs* 25.5%; $\chi^2 = 4.68$, df = 1, p = 0.03). There were trends towards greater male representation in the long-term groups, and higher representation of those with forensic indicators and of Maori compared to Pakeha, but these did not reach statistical significance in this small sample. There were no significant differences in affective disorder or self-harming behaviour.

We then compared the two long-term groups. Those in the stable group (n = 53) were significantly more likely than those in the readmission group (n = 117) to be recorded as having been deluded (69.8% *vs* 47.9%; $\chi^2 = 6.23$, df = 1, p = 0.01), as having a diagnosis of schizophrenia (77.4% *vs* 53.9%, $\chi^2 = 7.53$, df = 1, p = 0.006), and significantly less likely to have a diagnosis of affective disorder (18.9% *vs* 43.6%, $\chi^2 = 8.65$, df = 1, p = 0.003).

The survey of psychiatrists

Sample

There were 55 completed replies from the survey of psychiatrists, a response rate of 79.7%. Forty-two were qualified psychiatrists, 10 were psychiatrists in training (registrars), one was a Medical Officer of Special Scale in psychiatry and two did not complete this item. Twenty-nine practised in the North Island of New Zealand, 21 in the South Island and three outside New Zealand (two missing data points). The Medical Council of New Zealand has informed us that there were 279 specialists in psychiatry registered, holding a practising certificate and present in New Zealand in 1999. The 39 qualified psychiatrists surveyed (42 less 3 not practising in New Zealand) constitute 14.0% of that number. Twelve respondents said they were involved very often with the use of CommTOs, 19 quite often, nine sometimes, 10 occasionally, four never.

Benefits of Community Treatment Orders statement

The mean score of agreement with the statement that 'when used appropriately the benefits of CommTOs outweigh any coercive impact on the patient' was 1.9 (SD = 0.8), with a range of 1–4. South Island psychiatrists agreed more strongly with this statement than did those practising in the North Island or overseas. (South Island: mean rank = 20.05; North Island: mean rank = 27.68, $\chi^2 = 4.06$, df = 1, p = 0.04).

Indicators for use of Community Treatment Orders

The mean values and standard deviations for each factor for the whole sample in descending order of importance are shown in Table 1.

Frequency of use of Community Treatment Orders

Psychiatrists who said they were involved with CommTOs often or very often considered the authority to treat without the patient's consent as more important than did practitioners who used CommTOs less often (very often/often mean rank = 23.03; sometimes/occasionally/never mean rank = 31.62, Mann–Whitney U-test = 218.00, p = 0.03). Practitioners with frequent use also considered the ability to facilitate readmission to hospital to be less important than those using the *Act* less often (very often/often mean rank = 29.81; sometimes/occasionally/never mean rank = 21.62, Mann–Whitney U-test = 223.00, p = 0.05).

Table 1. Mean values for indicators for use of Community Treatment Orders from most to least important

	Mean	SD
To promote compliance with medication	1.87	1.06
To provide authority to treat without consent	2.08	1.22
To protect patients from the consequences of relapse in their illness	2.23	1.15
To ensure contact between patient and mental health professionals	2.30	1.19
To reduce the risk of violence to others	2.32	1.22
To reduce the risk of self harm	2.40	1.28
To ensure rapid identification of relapse	2.47	1.20
To provide greater security for family/caregivers	2.68	1.01
To facilitate readmission to inpatient care	2.83	1.20
To enhance obligations of service providers to patient	3.15	1.27
To ensure police assistance	3.47	1.22
To deflect legal liability for unlawful coercion	3.72	1.31
To reduce substance abuse by the patient	3.72	1.15

In relation to each factor, respondents used the full range of scores from 1 to 5; 1 = 'very important' for the use of Community Treatment Orders; 5 = 'not important'.

Factor analysis

The factor analysis generated four factors that accounted for 65.0% of the variance (details are available from the authors). One factor dealt with reducing the consequences of the illness (protect patients from consequence, reduce violence and reduce self-harm), the second dealt with service issues (facilitate readmission, ensure police assistance, deflect liability, reduce substance abuse), as did the third (rapid identification of relapse, ensure contact with patient, enhancing provider obligations). The final factor included authority to treat without consent, ensuring contact and providing greater security for family and caregivers.

Written comments

Respondents were invited to give written answers to two further questions: (i) 'what other reasons for the use of CommTOs would you consider important'; and (ii) 'are there reasons for using CommTOs that you think are important at present but should not be'.

To the first question, the most interesting responses concerned promoting the patient's own sense of security (e.g. 'patients request to remain on them for their own reassurance or as part of their own personal risk management plan'). Other groups of comments concerned the need to signal clearly to the patient the seriousness of their condition, the desirability of treatment in the least restrictive setting, the ability to influence the patient's social circumstances (including housing), and the way the order committed service providers to the patient (e.g. 'As a point of commitment by the clinician: "I won't let you sack me!"'). The relative 'toothlessness' of the order was a common concern. Some respondents wished to see its power extended to the control of patients' money.

To the second question, concerning inappropriate uses of CommTOs, several comments concerned their use in response to political or media pressure, and to provide ready access to services when this should not require compulsion. Several respondents said that CommTOs were improperly used on patients with personality disorders or behavioural problems, or in cases of habitual self-harm; one said that CommTOs were improperly used instead of establishing a therapeutic alliance.

Discussion

Otago files study

The main shortcoming of this study arises from the fact that the information was garnered from clinical reports written by clinicians for the purpose of administrative reporting and for use by judges. There are likely to be significant omissions in these reports, as there was no set format. Data on clinical characteristics should be viewed as minimal figures. It is likely that higher rates of characteristics such as suicidality would be found if patients had been directly interviewed or relatives contacted.

However, a general picture of a 5-year CommTO caseload in one region of New Zealand can be drawn from this information. The profile of the patients studied is very similar to those under equivalent orders in Victoria, Australia, and in the USA. This view is confirmed by the finding that the annual rate of use of CommTOs in Otago (at 21.6 per 100 000 population) is very similar to the rate in Victoria, Australia, provided by Power, who wrote: 'in 1996 the number of [CommTOs] issued to patients in New South Wales represented 43 per 100 000 population, while in Victoria in 1994 [the number] represented approximately 20 per 100 000 population' [2,p.10]. These figures may provide some foundation for service planning in other places, such as England, where introduction of CommTOs is being considered.

The trend towards increased use of both Inpatient Orders and CommTOs in Otago over the period studied

might perhaps be explained by more expansive interpretation of the civil commitment criteria in response to hardening public perceptions of the problems posed by discharged patients.

It is hard to make direct comparisons between the CommTO populations studied internationally due to the diverse range of characteristics analysed, but age, gender, broad diagnostic groupings, comorbidity and aggression are frequently noted. In these areas the Otago figures are consistent with international trends, except for substance abuse, where higher rates of comorbidity have been found in the USA [4,8]. The over-representation of males in the Otago group, at 60%, is consistent with studies in Victoria (Australia), Israel and the USA, where figures between 56 and 66% were found [4,9–12], though a lower proportion of males (50%) was recently found in North Carolina (USA) [5]. With regard to diagnosis, the terminology employed is not directly comparable, but consistently high rates of psychotic disorders are found [4,5,9,10,12].

The differences in Otago between the short and the long-term groups seem to suggest that clinicians do keep patients under compulsory treatment for longer periods when they are considered to present risk factors for violence [13–16].

There is a significant group of long-term patients under CommTOs whose recorded characteristics include a diagnosis of schizophrenia, delusions, alcohol abuse and past acts of aggression to others, who were nevertheless maintained in community settings for more than a year without inpatient care.

Given the frequency with which CommTOs are used in Otago, it is clear they are considered by clinicians to be a useful strategy in managing transitions between hospitals and the community of long-term patients with psychotic disorders. The results of the survey suggests the same conclusion may be drawn at the national level.

The survey of psychiatrists

This was a convenience survey of practitioners who use the legislation in New Zealand. They included psychiatrists with a range of professional experience from throughout the country who may be seen as representative of those invoking the *Act*. The respondents seemed to have no difficulty ranking the indicators. Most agreed with the general notion that when a CommTO is used appropriately the benefits outweigh the coercive effects. Contrary views have recently been expressed in the United Kingdom by MIND [17] and by Moncrieff and Smyth [18].

We found a regional difference in the strength of support for the 'benefits of CommTOs' statement. There has been discussion among psychiatrists about regional differences in judicial decisions, although there are no data at present to support this. It seems such variations may extend to clinical reasoning.

The factor analysis suggests the 13 indicators for use of CommTOs might be collapsed into four in future surveys. The results presented here are based on a limited set of official records and a small survey. Further research is obviously needed, though more powerful research designs (e.g. randomization to CommTO or not) appear to us to present considerable ethical and legal difficulties [19,20]. Any future research is therefore likely to present only an approximate picture of the CommTO phenomenon.

Even considering the international literature, we seem to be only inching towards answers to the central questions this form of treatment delivery presents. What will count as success in compulsory community treatment? How can this be measured in field settings? Is any particular regime in fact a success when measured in those terms, and, if so, does success in those terms outweigh the coercive impact of CommTOs on those patients?

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