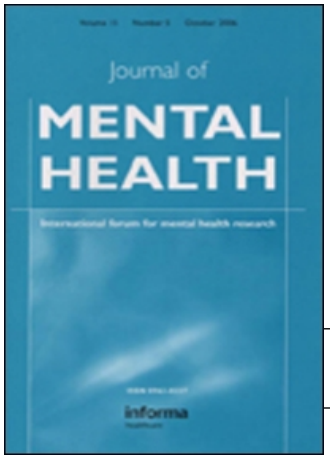

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Insight and use of community treatment orders

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Insight and use of community treatment orders

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Abstract

Background: Judgments about insight and compulsory treatment are routine, though contentious, aspects of psychiatric practice. But how should judgments about patients' insight inform involuntary treatment decisions?

Aims: To explore the role played by judgments about patients' insight in reasoning concerning the use of community treatment orders (CTOs) in New Zealand.

Method: Interviews were conducted with 42 patients treated on CTOs, their clinicians, and carers, concerning reasons for involuntary outpatient care. Their comments concerning patients' insight were analysed to investigate how they used the concept in reasoning about involuntary care.

Results: Lack of insight was viewed as an important indicator for compulsory outpatient treatment, due to the perceived link with treatment compliance. There was also a common perception that outpatients could progressively gain insight during sustained treatment on a CTO. Obtaining good insight was not necessarily viewed as an indicator for discharge from a CTO, however, if the patient posed continuing risks of harm, or had a rapid or severe relapse profile.

Conclusion: The patient's potential for treatment compliance appeared to be the primary focus of involuntary treatment decisions. Improved insight acted as one important indicator that such compliance would occur.

Keywords: *Insight, community treatment orders, outpatient commitment, mental health legislation*

Introduction

Impairment of insight is a common feature of many mental disorders. It is central to concepts of psychosis, the kind of mental condition for which involuntary treatment is most often employed. Lack of insight is highly characteristic of schizophrenia, across cultures, and may be the most reliably present feature of that disorder (Wilson et al., 1986).

Even though lack of insight is not usually mentioned in legal standards for involuntary treatment, it plays a key role in the reasoning of review tribunals, in New Zealand (NZ) (Diesfeld, 2003), Australia (Freckelton, 2003), and England (Peay, 1989; Perkins et al., 2000), and in compulsory hospitalization decisions in the USA (McEvoy et al., 1989a). Clinicians may argue that impaired insight supports the need for a treatment order, by affecting a person's willingness to cooperate with treatment, or as a sign of illness severity. This may cause concern about improper reliance on covert standards for involuntary treatment that are not found in the text of the law. As Freckelton puts it: '"lack of insight' is

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a term that can be unhelpfully inexact and is not a criterion for detention'' (cited in Diesfeld, 2003, p. 371).

The concept of insight

While insight may be loosely defined as a person's awareness of their mental disorder, there is considerable uncertainty in the literature about its precise features and boundaries (Lewis, 1934; Amador et al., 1993). Efforts to represent it in terms of simple measures have had some success. David defines it as a combination of three elements: recognition one has a mental illness, relabelling certain mental events as pathological, and compliance with treatment (David, 1990).

Some problems with the concept, relevant to compulsion, remain. First, it has been criticized for lacking clear definition. As a result, attributions of poor insight may be difficult to challenge in legal proceedings. Diesfeld writes: ''From an advocate's perspective, it is extremely difficult to dispute the absence of insight . . . if the term is undefined'' (Diesfeld, 2003, p. 360). What of a patient who agrees with her psychiatrist that she has a mental illness and needs treatment, but does not accept the diagnosis. Does she have insight or not?

Secondly, judgments about insight seem dependent on the patient's attitude to treatment. This is a logical connection, because scales that purport to measure insight include measures of treatment compliance, but circular reasoning may result if treatment adherence is used both to measure insight, and attributed to degree of insight, at the same time.

Thirdly, attribution of poor insight may reflect a failure to enter into the patient's subjectivity: neglect, for example, of commonly-held views within the patient's culture concerning the causes of abnormal mental phenomena, or failure to understand the patient's individual perspective on their treatment needs (Beck-Sander, 1998).

Fourthly, it seems that showing insight demands capitulation from the patient, because, when judging insight, clinicians seem unavoidably to use their own views, not the patient's, as the point of reference. This may be uncontroversial in florid psychosis but is more contentious when applied to less disturbed patients living outside hospital.

These difficulties with the concept come into sharp relief when it forms the foundation of an involuntary treatment decision.

Evidence and insight

Legal standards rarely mention lack of insight, so is it illegitimate to rely on evidence about insight when making involuntary treatment decisions? Not necessarily, provided the distinction between *relevant evidence* and *legal criteria* is properly maintained.

Observers of review tribunals have noted the crucial role played by evidence of insight in detention and discharge decisions. Insight might even become a ''de facto discharge criterion'' (Deisfeld, 2003, p. 371) or a ''substitute criterion for release'' (Freckelton, 2003, p. 53), permitting a tribunal to ''side step'' the criteria in the Act (Perkins et al., 2000, p. 122). This would be particularly illegitimate if: the tribunal failed to acknowledge such reliance on insight in its written decisions; patients had to prove they had insight before being released; or it led to arbitrary application of the law.

These objections may be exaggerated. It is common in legal proceedings for certain categories of evidence to be adduced repeatedly to satisfy particular legal tests. This does not mean reliance on such evidence displaces the ruling test, provided the evidence is indeed relevant to satisfaction of that test. When applying mental health legislation, for example, courts and tribunals often receive evidence concerning a prior pattern of hospitalization on

the part of the patient. This may not be mentioned in the Mental Health Act, and may not be required for involuntary treatment to proceed, but such evidence may help establish that the broad standards, typical of mental health law, are met. The issue is simply the relevance of the evidence, not whether it mimics the language of the law.

Evidence about insight may help determine a patient's capacity to consent to treatment, their likely adherence to medication, the potential course of their illness, and whether voluntary treatment would be viable. These are all factors that may properly be taken into account in applying mental health law.

Recent studies have found a strong association between impaired insight (or "appreciation" of illness) and impaired capacity to make treatment decisions (e.g., Grisso & Appelbaum, 1998). When studying inpatients, Cairns and colleagues found, for example, a "strong association . . . between lower insight scores and mental incapacity", and noted there was "conceptual overlap" between the two notions (Cairns et al., 2005, p. 383).

The association with treatment adherence is less well-established. Several studies have found poor insight associated with poor medication adherence in mental illness (e.g., Trauer & Sacks, 2000). In schizophrenia, good insight has been associated with improved outcome (McEvoy et al., 1989b; Amador et al., 1993), reduced hospitalization, and better social adjustment (Yen et al., 2002), and poor insight with greater risk of aggression (Buckley et al., 2004), poorer quality of life, and poorer interpersonal relationships (Lysaker et al., 1998). Other studies have reached different or inconclusive results (e.g., Mintz et al., 2003). McCabe and colleagues (2000) found no reliable association between compliance and awareness of illness or relabelling of symptoms.

Clearly no automatic association can be assumed between impaired insight and non-compliance with treatment. Nevertheless, research concerning the correlates of insight can usefully inform the application of involuntary treatment standards. Perhaps it is simply the ubiquitous significance of evidence about insight that produces the situation wherein the concept may seem to be more important in the legal process than the text of the law.

Insight and involuntary treatment

Several studies have found insight more impaired in compulsory than voluntary patients (McEvoy et al., 1989a; David et al., 1992). It is not clear whether this holds for outpatients (McEvoy et al., 1993).

There is some evidence that involuntary treatment improves insight. For instance, compulsorily hospitalized patients often develop a positive attitude later to their involuntary treatment (Gardner et al., 1999). We previously reported that most patients subject to CTOs judged their treatment beneficial overall. Only a small minority of those interviewed wholly opposed their involuntary care (Gibbs et al., 2005). Nevertheless, some caution must be exercised in interpreting such studies: they may be biased if only patients considered competent (and therefore insightful) participated in the research, and patients wholly opposed to their treatment may be reluctant to take part.

Some degree of insight may be necessary for involuntary outpatient treatment to be workable. The role of community compulsion has been described, for instance, as "persuading the persuadable" (Pinfold et al., 2001), and we have reported that clinicians using CTOs often consider some collaboration with the patient is required to have any prospect of success. Patients who are absolutely determined to avoid treatment and contact with health professionals are usually considered unsuitable candidates (Mullen et al., 2006b).

We found family members of those on CTOs commonly noted improvements in patient insight during involuntary outpatient care (Mullen et al., 2006a). Furthermore, NZ psychiatrists, in our national survey, rated insight a ''very important'' factor in discharge from a CTO, and the order was considered a useful way to communicate to a patient that they had a serious illness (Romans et al., 2004).

Some patients with good insight endorse use of the CTO in their case as an ''insurance policy''. People with episodic disorders, for instance, may use CTOs like advance directives, to ensure that in a relapse they will be compulsorily admitted at an early stage.

There are many possible interactions, therefore, between patients' insight and the involuntary treatment process.

Method

Every person in the NZ province of Otago subject to a CTO for more than 6 months without readmission to hospital in the preceding 2 years was identified for inclusion. Those persons, their family members, psychiatrists and key workers (mainly experienced community nurses), were invited to participate in wide-ranging, semi-structured interviews regarding their experience of compulsory outpatient treatment and reasons for its use. These interviews were recorded, transcribed, coded, and analysed, and have formed the basis of earlier qualitative reports (Gibbs et al., 2005; Gibbs et al., 2006; Mullen et al., 2006a; Mullen et al., 2006b). The methods used are fully described elsewhere (Gibbs et al., 2005; Gibbs et al., 2006). All participants gave their consent. The study was funded by the Health Research Council of NZ and approved by the Otago research ethics committee. Patients' names have been changed in this report.

Results and limitations

One hundred and three patients with significant recent experience of CTOs were identified. Nineteen were excluded due to poor capacity to participate in research. Eighty four were approached, 34 declined to participate, and a further 8 failed to complete the process. Forty-two (50% of those approached) completed the process and approved our contacting their family and clinicians. Nearly 200 interviews were conducted.

The patients had a mean age of 38 years and mean duration of contact with mental health services of 14 years. Twenty two remained on the CTO at interview; 20 had been discharged. All had been hospitalized at some time and the great majority had a history of psychotic mental disorder.

Insight was not the primary focus of these interviews, was not defined for this purpose, and was not raised with all participants. It was frequently discussed, however, being mentioned in 20 of 42 interviews with psychiatrists as an important factor in use of CTOs.

There are therefore significant limitations to these methods. This is a post hoc analysis of limited data. More comments might have been made about patients' insight if this had been an explicit focus of the study, and the exclusion of patients from participation who lacked capacity or declined to take part may have biased the data. Clinicians interviewed about patients who lacked capacity might have been less optimistic about the role of CTOs in promoting insight, and patients who declined to participate might have been more opposed to their involuntary care. Furthermore, we were unable to compare the characteristics of patients who participated with those who did not, as we could not gather personal data of non-participating patients without their consent.

Nevertheless, because insight was frequently discussed in our interviews in fact, we report here the central themes identified concerning relations between patients' insight and involuntary outpatient care. The aim is to explore how participants used the concept in this novel context. The interview data are supplemented with case vignettes.

Major themes in the interview data

For patients still on a CTO, the major theme concerned lack of insight as a reason for continuing involuntary care, due to the perceived link between poor insight and poor treatment compliance. Some patients were considered to have shown no improvement in insight despite their treatment on the CTO. Typical comments were:

> *Martin's psychiatrist*: The clinical reasons for using the CTO were that he had a recurring psychotic illness with clear safety issues and ongoing lack of insight into his illness and the need for regular medication.

> *Fred's psychiatrist*: It hasn't made any difference to his insight. He tells me about psychotic experiences. He hears voices from the sky and doesn't accept my explanation that they are hallucinations.

In contrast, the most common theme, regarding patients recently discharged from the CTO, concerned the progressive development of their insight during sustained outpatient care. The order was seen to promote this outcome, via sustained engagement between patient and health team; ongoing discussion about illness and treatment; continuing oversight of medication; reduction in acute symptoms; and improved social relations.

In addition, most patients interviewed seemed to accept that they had an illness of some kind, for which continuing assistance was required. They might only have a limited understanding of their condition, they might not use the same language to describe it as their clinicians, and they might retain considerable ambivalence towards the notion that they had a mental illness requiring ongoing medication. But most patients could clearly identify the difficulties likely to be encountered if they abandoned treatment and became acutely unwell, including serious disruption to personal relationships, resuming dangerous levels of substance misuse, and falling foul of the criminal law. Many seemed to appreciate the fact that more rapid intervention from the health service was likely on a CTO. So, despite their reservations about medication, most patients seemed prepared to acquiesce in their treatment to avoid worse alternatives, especially forced hospitalization and contact with police. Several were adamant the CTO had kept them ''out of jail'' or saved their life.

Jeff's position fits the common profile of those placed on CTOs (Churchill et al., 2007) and illustrates these themes:

> *Jeff* had a diagnosis of schizophrenia and a lengthy history of contact with services, including several compulsory admissions. His illness was characterized by delusions, withdrawal, self-neglect, poly-substance abuse, and victimization. He had convictions for drunk driving and been considered ''threatening'' by his family, but was known to respond well to medication. He had been treated for several years under a CTO without readmission, formed a stable relationship, and been discharged to voluntary care. Comments in his notes for the previous decade reported he was ''developing'' insight and ''starting to acknowledge'' he had a mental illness. ''Improved insight'' and compliance were specifically recorded as reasons for his eventual discharge from the CTO.

Jeff was skeptical about the diagnosis and the value of medication but agreed he had been "over the edge" and medication "kept it at bay". The CTO helped him "get over the hurdles in my life", stopped him "going off the rails", and "you got care straight there". Under the CTO, "They dictate the rules. You have to abide by them. But they got me out of a lot of trouble. I just accepted it and kept the peace". He would now seek treatment, he said, on his own.

Jeff's sister said that under the CTO "he was able to develop better insight into his illness because he was weller longer", and could now develop sound relationships. "His insight might not be the same as the psychiatric people . . . but it works for him. He has developed a sense that: 'I don't sleep well and I have other responsibilities and the world is more than just me'".

Jeff's psychiatrist said the CTO "gave him a period of stability where, instead of having to recycle back through hospital every two years, he could rebuild his life" and form long-term relationships. By controlling acute symptoms, it broke Jeff's pattern of substance abuse, because previously "he would start using a lot of cannabis when unwell". It had created an "opportunity for him to start to realize, 'I have an illness and it impacts on my life and I have more to lose than gain if I stop my medication and get unwell again'. There was recognition he didn't want to go back to hospital. Acknowledging that was the change for Jeff".

Descriptions of insight

Many clinicians, and some family members, used the specific term "insight" to describe the patient's attitude to their situation and how that changed over time. They focused mainly on whether the patient accepted they had an illness for which continuing medication was required. It was often said only partial insight had been achieved:

Sasha's key worker: She has enough insight to know she has a mental disorder, but whether she knows how to respond to her illness is another matter.

Patients commonly used metaphors to describe their situation or focused on aspects of their behaviour that caused others concern. One said, "I have schizophrenia", another, "I have a mental illness. My god, I've said it". More typically, they described their mental life in colloquial phrases, like "over the edge", "off the rails", "out of line", "fired up", "not on a even keel", "not coping", or "losing it".

Relabelling of symptoms as pathological was occasionally observed:

Jason: I believed I had invisible lightning bolts under my fingernails when the KKK and the Nazis were chasing me, and I was shooting them. I really believed it.

Most patients clearly understood that others thought they needed treatment and refusal might compromise their health, relationships, and ability to live outside hospital.

Libby: I needed to adjust to living in the community.

Helen: I know if I don't do it I will be sick.

Not all patients were confident they would accept treatment if the order was discharged.

Karen: I might refuse my injection otherwise.

Patient endorsement of the CTO

Several patients endorsed, in retrospect, use of the CTO:

> *Dave*: I would have been a loose cannon and drinking and smoking dope all the time.
>
> *James*: At the time I thought it was a waste of time. Now I look back on it, I think it was quite good because I have come out of it now.
>
> *Bill*: You've got to know whether you need to take your medication or not. I would have done something stupid, tried to harm myself probably.

Some clinicians' comments almost suggested capitulation of the patient was required:

> *Henry's key worker*: He came to the point where he was able to say, ''I need to be on the Act''.

Loretta illustrates the position of a patient with an episodic disorder who believes their insight may subsequently fail:

> *Loretta* had a diagnosis of severe bipolar disorder. She had been hospitalized compulsorily several times early in her illness but failed to continue medication as a voluntary outpatient. When brought to hospital a fourth time, in handcuffs, by police, after a disturbance with a public figure, she was placed on a long-term CTO. Her acute episodes were characterized by ''bouts of mania'', ''extreme religiosity'', ''marked inability to care for self or children'', assaults on police and staff, and fear on the part of her children. Her health improved with medication administered by injection but she remained ''extremely ambivalent about follow-up'' and was briefly readmitted several times under the CTO.
>
> Loretta supported the CTO. She considered its purpose was to ensure rapid readmission to hospital in a relapse. She believed she had an illness and needed medication but would lose that understanding if again unwell: ''What you see when you get high tells you there is nothing wrong with you. I feel pretty special and special people don't take medication''. She said, ''I don't like being on one but I accept that is best for me and my family and for the people I go and see when I am unwell. It is the only way I would stay compliant probably. I know if I get unwell I will be readmitted without preamble. The police are less likely to be involved. The first time I was admitted was such an atrocious experience''.
>
> Loretta's psychiatrist considered her insight had improved through medication administered by injection under the CTO. This prevented her becoming ''really disintegrated and ending up staying many weeks in hospital''. Following lengthy treatment, ''She does have insight. She knows she is unwell. She rang me once and said I need to go to hospital. Because she was on drugs she had some understanding when something was going wrong. Before she thought psychological help was enough, which helps, but it would be very difficult to manage without medication. The relationship with the children is better and I know she has friends''.

Very few patients described the Act's use as an outright abuse or conspiracy, or condemned the mental health service completely, though many reported anger and distress at certain experiences, particularly forced medication and coerced hospital

admission. Perhaps greater opposition would be found amongst those patients who declined to be interviewed.

The educational or communicative functions of a CTO

Several participants said placement on a CTO – including particular features of the process, such as comments made by a judge or tribunal at a hearing – could contribute to a patient's insight, by communicating unequivocally to them the seriousness with which others viewed their condition or the urgency with which treatment was required. One patient's mother reported: ''it made him look in depth at what he was doing''. Nurses said: ''it hammers things home'', ''it was a clear message'', ''it helped bring home to him the potential risk he might reoffend''. Some patients described their regular contact with the clinical team as a vital source of ''feedback'' or ''reinforcement''.

Insight and risk

In the reasoning of many clinicians and family members, lack of insight, poor treatment compliance and elevated risk of harm were clearly associated and constituted a combined set of reasons to commence or continue a patient's treatment on a CTO. For instance, Simon's psychiatrist said:

> His life is full of crises. He has poor social judgment and ends up being charged by the police with sexual assault or whatever . . . , not recognizing he can't go into the community and survive without support. So we used the Mental Health Act to insist on support and not stand back when he gets into unsafe situations.

Use of the CTO, in such cases, was seen to reduce the adverse consequences for the patient or others of harmful behaviour, the risk of suicide or self-harm, or the risk of reoffending and imprisonment. With former forensic patients, in particular, the guarantee of support from psychiatric services that the CTO was seen to convey could give accommodation providers, or family members, the confidence to take a potentially dangerous patient who lacked insight into their care.

With Liam, who had been convicted of offences against children, the CTO was seen to ''underpin the rehabilitation plan''. It also met the courts' expectation that a person with that background ''would not be discharged next week'', which gave the courts the confidence to divert such persons to mental health care.

Blair had previously assaulted his wife and children when acutely unwell. On discharge to his family's care, he was placed on a CTO, said his psychiatrist, to address ''his wife's anxiety about non-compliance'' when he did not appreciate the severity of his illness. The CTO was used ''to preserve family relationships''. It was ''like an insurance policy for his wife. If things aren't working she has some leverage''.

Even where a person's insight had recovered on a CTO, continuing concerns about risk could lead to the order's maintenance where: there was a history of serious offending, particularly concerning children; the person had a rapid relapse profile, or was living alone, and not under close observation; or they might require rapid readmission to hospital care.

> *Dion's psychiatrist*: He becomes sick easily and when sick drinks more and rapidly deteriorates.

Concern was voiced that patients could be maintained for too long on CTOs, for such reasons, as a defensive practice, so as "not to rock the boat", even when the patient had gained insight, was compliant with treatment, and their involuntary treatment was no longer justifiable on clinical grounds:

> *Isaac's psychiatrist*: He's one of my most risky patients. It seems irrational, but the sensible thing to do, to have him under compulsory treatment just in case. But I don't think it makes any difference actually, as he is very happy to accept help.

> *Andrew's psychiatrist*: In forensic services, you are not in a hurry to unbundle people from the Act, especially if it is perceived violence.

> *Errol's psychiatrist*: There seems to be a rule of caution. It is like an investment if it has taken a long time to get them stable. In hindsight, we might have got him off it earlier.

Insight and discharge from the CTO

For clinicians, the critical pointers to the patient's discharge from the CTO seemed to be the absence of acute symptoms and probable compliance with treatment. Improved insight was an important indicator that those conditions had been fulfilled.

> *Steve's key worker*: We are looking at taking him off the Act because his insight has improved. He knows his disorder, he knows he has an illness, he knows his early warning signs.

Nevertheless, it was clear that obtaining good insight was neither a necessary nor a sufficient condition for discharge from a CTO. The key to discharge was probable compliance with treatment, and clinical practice seemed in line with research that shows no clear association between insight and compliance. In addition, some patients who were prepared to accept certain kinds of treatment were kept on the order solely to ensure other kinds of treatment, or levels of medication, were maintained.

Bob provides an example of a person discharged by clinicians from a CTO despite their view that his insight remained very limited.

> *Bob* had suffered brain damage in an accident several decades before, producing a changed personality and paranoid delusions. He had a long history of contact with services, including forensic care. His driving and firearms licences had been revoked, and his former wife had obtained a protection order under family violence legislation. He was placed on a CTO by the community forensic team.
>
> Bob was adamant his entire treatment was unnecessary. He said the CTO "dubbed me a third class citizen", was "completely restrictive" and "a massive hindrance", and his eventual discharge from compulsion took "a huge load off my shoulders". He denied he had been ill and considered his psychiatrist "out of her tree". He initially accepted treatment solely due to the order – "I was abiding with the law" – but would now accept medication because he trusted the nurse's judgment and wished to avoid further hospitalization.
>
> This nurse thought Bob's limited insight was a key reason for using the CTO. Without it, Bob would not let him in the door: "He has great trouble acknowledging he has an illness. It all depends on how you discuss things with Bob".

Bob's psychiatrist considered him "completely insightless": into the brain injury, "the paranoid delusions about the Police", and "particularly into the need for medication". Bob had repeatedly abused her for "ruining his life", but developed a "sort of double book-keeping", permitting cordial relations with nurses, because they "helped him with practical things", like the welfare authorities and cleaning his house, "so he will happily let them in and with a bit of token grumbling take depot [medication] from them".

Bob was eventually "able to remarry and reintegrate into the community" and sufficient trust was established for the order to be discharged: "That was a really difficult decision", said the psychiatrist, "I was very aware of the new marriage and all he had to lose".

In some cases, it seems, trust and compliance can be established during involuntary outpatient treatment, regardless of whether insight is achieved. This supports David's view that "Insight clearly aids compliance but what is peculiar . . . is that patients can have no insight into illness yet still accept and derive benefit from medication" (David, 1990, p. 800).

Discussion

This material reveals a wide range of connections being drawn between participants' judgments about patients' insight and use of CTOs. One well-established chain of reasoning was often employed, however, in which patients' insight was linked to compliance with treatment and specified social support, and to perceptions of risk.

The concept of insight participants employed was clearly shaped by our focus on involuntary treatment. Clinicians, in particular, said they were looking for sufficient appreciation, on the part of the patient, of the advantages of treatment to be confident that reasonable compliance with treatment would occur. If so, *involuntary* treatment would no longer be required. Insight was linked, in this chain of thought, firstly to compliance, and then to the need to use the powers conferred by law.

Such thinking can be directly related to the usual criteria for involuntary treatment found in a Mental Health Act. The NZ Act, for example, specifically requires that involuntary treatment be "necessary" before a CTO can be made (MH Act NZ, 1992, section 27(3)). Human rights principles suggest the same approach: that treatment without consent be clearly justified and less restrictive options be considered first. So, where the patient has sufficient insight to accept voluntary treatment, *compulsion* would be unnecessary, and not the least restrictive option, so may not be lawful. There is nothing illegitimate in linking judgments about insight, in this manner, to the application of mental health law.

Moreover, clinicians did not appear to rely on impaired insight as an inflexible indicator for involuntary outpatient care. Other indicators were also considered, and it was *the likelihood of treatment compliance itself,* above all, that seemed their main concern.

Nevertheless, many participants endorsed the view that treatment under a CTO could promote a patient's understanding of their illness, through the "package" of measures, or the "structure" of treatment, it could maintain. CTOs were seen to permit the patient's condition to be stabilized for a sustained period, creating the conditions under which insight was most likely to evolve, by permitting access to the patient, engagement with treatment, control of acute symptoms, continuing psycho-education, and the maintenance of significant relationships. The main aim was continuity of treatment, in contrast with a previously intermittent and crisis-driven pattern of care.

While we agree therefore that impaired insight should not constitute a covert or rigid criterion for involuntary outpatient treatment, and agree that improved insight should not be a mandatory test for discharge from a CTO, we still consider informed judgments about insight may properly be taken into account – as one relevant consideration – when making decisions about involuntary outpatient care.

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