How mental health clinicians view community treatment orders: a national New Zealand survey

Sarah Romans, John Dawson, Richard Mullen, Anita Gibbs

Objective: To determine New Zealand mental health clinicians' views about community treatment orders, indications for their use, their benefits, problems and impact on patients and therapeutic relationships.
Method: A national survey of New Zealand psychiatrists and a regional survey of non-psychiatric community mental health professionals for comparison.
Results: The great majority of NZ psychiatrists prefer to work with community treatment orders as an option. They consider they are used properly in most cases, can enhance patients' priority for care, provide a structure for treatment, support continuing contact and produce a period of stability for patients during which other therapeutic changes can occur. They consider these orders can harm therapeutic relationships, especially in the short term, but when used appropriately their overall benefits outweigh their coercive impact. The other mental health professionals surveyed have similar views. A minority of clinicians do not support their use.
Conclusions: The precise impact of community treatment orders on patients' quality of life remains an open question. Until that matter is more clearly resolved, New Zealand law should continue to authorise compulsory outpatient care, provided it is carefully targeted and adequate community services are available.
Key words: coercion, legal status, outpatient commitment, patient compliance.

Australian and New Zealand Journal of Psychiatry 2004; 38:836–841

Community treatment orders (CommTOs), authorised by mental health legislation, require patients to comply with psychiatric treatment outside hospital. They are available in all Australasian jurisdictions. Evaluating their use is very difficult, due to problems in isolating the element of compulsion in treatment for independent study [1] and in reaching agreement on clear criteria of success [2].

The legislation provides only a broad enabling framework. It designates the legal criteria for a CommTO and prescribes the review procedures, mandatory documentation and powers exercisable over compulsory outpatients. Numerous features of the context then affect the practical operation of the legal regime. Critical factors are likely to be the quality and structure of community mental health services, the availability of supported accommodation, the strength of clinicians' commitment to use the scheme and prevailing public attitudes to community mental health care [3]. In addition, there is room for the exercise of considerable clinical discretion

Sarah Romans, Shirley Brown Chair in Women's Mental Health Research

Centre for Research in Women's Health, Toronto, Canada

John Dawson, Professor (Correspondence)

Faculty of Law, University of Otago, PO Box 56, Dunedin, New Zealand. Email: john.dawson@stonebow.otago.ac.nz

Richard Mullen, Senior Lecturer

Department of Psychological Medicine, University of Otago, Dunedin, New Zealand

Anita Gibbs, Senior Lecturer

Department of Community and Family Studies, University of Otago, Dunedin, New Zealand

Received 1 August 2003; revised 15 April 2004; accepted 17 July 2004.

within the framework of the law. Even when a patient fits the criteria for a CommTO, for instance, clinicians must still decide whether the order would be valuable in the circumstances, and there is considerable room for discretion later in the process, concerning return to hospital and release from compulsory outpatient status.

This survey collected information about NZ mental health clinicians' views of their national CommTO regime. Clinicians' views are only expressions of opinion which cannot provide definitive evidence concerning the efficacy of the practices endorsed. Nevertheless, a study of their opinions will throw light on current practices.

Our principal aims were to assess the level of support for CommTOs among NZ clinicians and to determine their views on the importance of various factors in decisions about compulsory outpatient care, the mechanisms through which it may work, impediments seen to its use and its perceived impact on patients and therapeutic relationships.

The NZ CommTO regime was established by the *Mental Health (Compulsory Assessment and Treatment) Act* 1992. The criteria for a CommTO focus on: (i) serious mental disorder, coupled with; (ii) serious danger to the health or safety of the patient or others or seriously diminished capacity for self-care; plus (iii) the availability of appropriate outpatient care and social support. The order has an initial life of 6 months, though it may be continued following review by a court or tribunal. The order requires the patient to accept treatment as directed by their responsible clinician and authorises the patient's rapid return to hospital, with police assistance if required (section 29). In an earlier study, we found that a quarter of patients coming under the Act went on to be treated under a CommTO [4], almost always following an episode of inpatient care. At the time of this survey the regime was well-embedded, having operated for nearly 10 years.

Method

Sample

An identical postal survey was conducted of two groups of mental health professionals. The initial mail-out was in February 2002. Non-responders were sent a reminder a month later, then a further questionnaire. Responses received within three months were included in the analysis. No financial reward was offered. Approval was obtained from the Otago Ethics Committee.

The national psychiatrists' survey (n = 362)

All physicians registered with the NZ Medical Council as specialists in psychiatry in 2000 (n = 283) were sent the questionnaire. Also included were psychiatric medical officers of special scale (MOSS) (n = 79), who are physicians with significant psychiatric experience but not holding a specialist qualification in psychiatry.

The mental health professionals' (MHP) regional survey (n = 134)

We sent the same questionnaire to all community-based, publicly employed, mental health professionals (MPHs) in the province of Otago who were not psychiatrists: that is, to nurses, social workers, occupational therapists, Maori mental health workers and psychiatric registrars. Otago, in the South Island, has 180 000 people (roughly 5% Maori) and a significant rural component.

Survey

Design of the survey instrument was informed by a previous survey of a convenience sample of psychiatrists and trainees [4]. In addition, we reviewed the literature, consulted mental health consumers and Maori mental health professionals and held focus groups with three community mental health teams, seeking their views on central issues in use of CommTOs. The questionnaire was piloted with inpatient mental health nurses and then revised.

The survey contained three kinds of question, concerning:

- the characteristics of the respondent;
- the importance of certain matters in practice with CommTOs, using a five-point Likert scale (ranging from 1: very important, to 5: not important at all);
- respondents' level of agreement with certain statements about CommTOs, using either categories or a visual analogue scale (range 0–70).

Space to write open-ended comments was provided after most questions. The instrument is available from the researchers.

Statistical analysis

Statistical analysis was carried out using the Statistical Package for the Social Sciences (SPSS V.10). Possible differences between the opinions of subgroups of clinician participants were assessed with the Mann–Whitney U-test for ordinal (Likert scale) items and Student's t-test for continuous (visual analogue scale) data items.

Results

Responses received

Of 496 questionnaires sent, 284 usable returns were received, an overall response rate of 57.3%. There were 202 respondents (61% male, 39% female, one with gender missing) in the national psychiatrist survey and 82 respondents (40% male, 52% female, six with gender missing) in the regional survey of other MHPs. Nurses were the largest occupational category in the MHP group (n = 35).

Many written comments were received, of considerable richness and detail, suggesting this is a challenging area of practice which deeply engaged respondents.

Important matters in decision-making mechanisms

Twelve possibilities were presented for rating in importance on a 1–5 Likert scale. The results for psychiatrists are shown in Table 1. The resultant ranking for each item, for both psychiatrists and MHPs, is shown.

These responses indicate psychiatrists are focused on core clinical concerns in use of CommTOs. Ensuring clinical contact, providing authority to treat, rapid detection of relapse and ensuring compliance with medication received the highest ratings. There was little difference between responses of male and female psychiatrists. The other MHPs place the possibilities in a very similar order.

Mechanisms through which community treatment orders may work

The questionnaire presented nine possible mechanisms through which CommTOs may operate and asked participants to rate their importance on a 1–5 scale. Ensuring compliance with medication (mean: 2.10), signalling to patients they have a major mental illness (2.15) and ensuring a period of greater stability in patients' lives (2.24), received the highest mean ratings among psychiatrists. The other MHPs identified the same three mechanisms as the most important, though in reverse order. The other items rated, in order of perceived importance for psychiatrists, were: commits service providers to the patient (2.39); binds community services into place (2.45); gives others the confidence to care for the patient (2.83); mobilises social support for the patient (3.19); the patient gives up conflict areas to external agents (3.32); and encourages the patient to accept responsibility (3.42). Female psychiatrists rated the item 'ensuring a period of greater stability' as significantly more important than did male psychiatrists (mean 2.04 *vs.* 2.38, p = 0.02 Mann–Whitney).

Barriers to effective practice

Participants were asked to rate the importance of nine possible factors that might undermine the effectiveness of CommTOs. Psychiatrists gave the highest mean ratings to lack of adequate supported accommodation for people with challenging behaviours (mean: 1.77), substance abuse by patients (1.87) and failure to enforce medication compliance (2.01). Their ratings for other items were: lack of trained mental health staff (2.13); lack of injectable medication for some conditions (2.23); lack of access to psychological therapies (2.43); difficulty managing patients in rural areas (2.48); lack of patient access to recreational opportunities (2.78); and premature discharge by courts or tribunals (2.98). Female psychiatrists rated lack of supported accommodation as significantly more important than did male psychiatrists (mean 1.56 *vs.* 1.91, p = 0.026, Mann–Whitney). The other MHPs identified the same four items as the most important, in the same order, as psychiatrists.

This question produced 37 written comments, mainly identifying other problems in service provision (e.g. lack of inpatient beds and crisis staff, lack of employment or occupation for patients), unhelpful patient attitudes and behaviours and lack of family support.

Factors discouraging use

Respondents were also asked to rate the importance of seven listed matters which might discourage use of CommTOs. None was considered very important by psychiatrists, although concern for patients' civil liberties (mean: 2.65) and the degree of coercion (2.86) received some support, more than additional administrative burden (3.12), concern at being held responsible for patients' conduct (3.22), a preference for use of inpatient leave (3.37), cultural politics (3.44) or cost to the mental health service (3.88). Female psychiatrists rated concern for civil liberties as significantly more important than did male psychiatrists (means 2.40 *vs.* 2.79, p = 0.035, Mann–Whitney). The other MHPs identified as the most important the same two factors as psychiatrists.

Reasons for discharging patients from community treatment orders

Under the legislation, discharge from compulsory outpatient status should occur when the patient is 'no longer mentally disordered and fit to be released' (section 2). This still leaves considerable room for

Table 1. Key decision-making factors for psychiatrists in use of community treatment orders

	Factor importance					Statistics		
	1	2	3	4	5	Mean	Rank (P)	Rank (MHP)
Ensure contact with professionals	106	53	23	9	8	1.79	1	1
Provide the authority to treat	105	49	27	14	4	1.81	2	2
Rapid identification of relapse	86	64	35	10	4	1.90	3	4
Promote compliance with medication	67	79	37	10	5	2.03	4	3
Protect patient from consequences of relapse	64	77	41	12	5	2.08	5	4
Security for family and carers	39	69	62	26	2	2.41	6	6
Facilitate readmission	51	59	54	22	13	2.43	7	8
Reduce risk of violence to others	44	52	49	31	23	2.68	8	9
Reduce risk of self harm	39	55	47	32	25	2.74	9	7
Obligate service providers	25	45	59	49	20	2.97	10	10
Ensure police assistance	18	31	54	64	32	3.31	11	11
Reduce substance abuse	13	18	43	59	65	3.73	12	12

1 = very important, 5 = not important at all; (P), psychiatrists; (MPH), mental health professionals.

discretion on the part of responsible clinicians concerning the precise moment for discharge. We presented respondents with 15 more specific reasons (see Table 2).

Again respondents emphasized primary clinical concerns. Treatment compliance, improved insight, clinical improvement and decreased risk to others or to the patient were rated the most important reasons for discharge by psychiatrists. Risks of harm, to others or to the patient, were considered more important at the point of discharge than in decision-making about CommTOs overall (see Table 1). Female psychiatrists rated reduced substance abuse (mean 2.00 *vs.* 2.43, p = 0.002 Mann–Whitney) and enhanced social/cultural networks (mean 2.42 *vs.* 2.78, p = 0.030, Mann–Whitney) as significantly more important for discharge than did male psychiatrists.

Impact on therapeutic relationships

Respondents were asked whether they considered CommTOs helped, hindered or had no effect on therapeutic relationships with patients. Some participants did not answer this question, others gave more than one response. Of the psychiatrists, 85 reported that CommTOs helped (42.1% overall), 63 that it hindered (31.2% overall) and 51 that it had no effect (25.2% overall). There were no significant gender differences in responses to this item. The results for the other MHPs were comparable (48.6%, 30.1% and 16.7%, respectively).

Several themes recurred in the comments on this question. The effect on therapeutic relationships was seen to depend on the patient's attitudes and illness, on the way professionals approached and explained the reasons for the order and on the quality of contact between patient and family. Some commented that the order might have a negative impact initially, but it permitted engagement of the patient and with time, recovery and development of insight, many patients came to appreciate its use. A few respondents commented that giving evidence to a judge or tribunal, concerning the destructive effects of a patient's illness, could alienate the patient.

Priority for treatment

The statement 'Patients under CommTOs get a higher priority for treatment than they otherwise would' was rated on a 70-mm visual analogue scale, with 0 representing complete agreement and 70 complete disagreement. The mean score of the psychiatrists was 27.6 (SD = 18.6), showing moderate agreement with this proposition. Male and female psychiatrists gave similar responses (mean male 28.5, female 26.4). There was no association with age (Pearson's correlation –0.06, p = 0.5). The mean score of the other MHPs was 22.75 (SD = 16.2), indicating greater agreement, although this difference was not statistically significant (p = 0.054, Students t-test).

Appropriateness of use

The statement rated here was: 'CommTOs are generally used appropriately'. The psychiatrists' mean level of agreement was 20.45 (SD = 12.5), indicating a strong level of agreement. The means were similar for male and female psychiatrists (male 20.6, female 20.4). There was no association with age (Pearson's correlation –0.04, p = 0.63). The mean for the MHPs was similar (20.25).

Overall impact on patients

The proposition 'When CommTOs are used appropriately, their benefits are sufficient to outweigh any coercive impact on the patient' was also rated. The psychiatrists' mean rating was 16.0 (SD = 13.7), showing a very high level of agreement with that proposition. Again male and female respondents gave similar responses (mean male 15.7, female 16.6). There was no association with age (Pearson's correlation 0.07, p = 0.32). The other MHPs showed a similar level of agreement (mean 18.0).

Table 2. Importance for psychiatrists of reasons for discharge from a community treatment order

	Importance					Statistics		
	1	2	3	4	5	Mean	Rank (P)	Rank (MHP)
Compliance with treatment	116	68	11	5	2	1.53	1	2
Development of insight	113	66	11	5	2	1.56	2	3
Clinical improvement	113	62	16	4	2	1.58	3	1
Reduced risk to others	83	83	15	12	4	1.84	4	5
Reduced risk to self	79	84	20	8	6	1.87	5	4
Suitable accommodation and supervision	56	83	40	12	5	2.12	6	6
Reduced substance abuse	45	85	45	17	5	2.25	7	8
Improved whanau/family relationships	36	90	48	18	5	2.32	8	7
Employment	32	74	47	29	15	2.60	9	11
Enhanced social/cultural networks	15	86	59	28	9	2.64	10	9
Improved life style	25	72	53	31	11	2.65	11	10
To increase the patient's freedom	34	45	52	40	21	2.84	12	14
Suitable recreation (including exercise)	18	50	62	40	25	3.02	13	12
Patient's wish for discharge	14	50	61	49	23	3.09	14	15
Enhanced cultural identity	10	45	68	40	31	3.19	15	13

1 = very important, 5 not important at all; (P), psychiatrists; (MPH), mental health professionals; Whanau, Maori for an extended family group.

Preference for working with community treatment orders

Respondents were asked whether they would prefer to work in a system with or without CommTOs. Of the psychiatrists, 78.8% said they preferred a system with CommTOs, as did 84.8% of MHPs, while 9.3% of psychiatrists and 6.1% of the MHPs would prefer to work without. The remainder were unsure.

Being aware of the current debate about the introduction of CommTOs in England and Wales [5], where they are not authorised, we separately considered the responses of 55 psychiatrists working in NZ who said they were British-trained. Most (n = 42, 76%) preferred working in a system with CommTOs, five were undecided or indicated no preference and eight preferred a system without. For NZ-trained psychiatrists, the figure in favour of working with CommTOs was a comparable 74%.

Key themes in respondents' written comments

Several themes recurred throughout the comments. Doubts were expressed about the extent to which CommTOs could be (or were) enforced, particularly compliance with medication and abstinence from substance misuse. Some patients were felt to sabotage their care and the expectations of many lay people and judges, concerning the treatability of some conditions, were considered unrealistic. CommTOs were still thought to provide a useful structure for management of serious mental illness, presenting an opportunity to engage the patient in care and to promote family involvement. Many respondents considered the effectiveness of CommTOs was reduced by lack of suitable supervised accommodation, rehabilitation programs and acute beds, by poor integration of services, poor communication and the absence of an explicit power to control the patient's place of residence. There was concern about administrative burden on clinicians who manage patients under CommTOs and about enhanced liability for the conduct of patients supposedly under their control. Several comments suggested CommTOs existed more to reassure the public than for therapeutic reasons. Their stigma and coercive impact were common concerns. The central thrust of many comments was that the key to successful practice is getting a critical cluster of social, service and therapeutic factors aligned.

Discussion

Our central finding is the high level of endorsement of CommTOs by NZ mental health clinicians. Most see the CommTO as a useful tool in pursuit of core clinical goals for the seriously mentally ill. This view was shared by psychiatrists and other MHPs in the region of study. It was held consistently across age and gender lines and among psychiatrists in different parts of the country. There is, nevertheless, a small minority who disagree. They say they would prefer to work without CommTOs and are particularly concerned about the impact of coercion on the therapeutic alliance.

The prevailing view appears to be that CommTOs work in a largely structural and indirect fashion. They are considered to bind into place the necessary community service and to facilitate contact with the patient, medication compliance and early identification of relapse. They may support the involvement of families and other agencies in care and may have a significant impact on a patient's attitude to his/her illness. These complex effects may lead in turn to clinical improvement and enhanced insight, reducing harm. If that is so, CommTOs may be part of the solution to a major failure of deinstitutionalisation: lack of continuity of care.

Compulsion was not seen by respondents as a substitute for adequate service provision. On the contrary, success was seen to depend on the quality and extent of the community services provided. There is even the perception that compulsion may enhance service provision, with those under CommTOs receiving priority in poorly resourced systems. The order was seen by many to commit service providers to patients' care. 'It is not clear', said one respondent, 'who is under the order, the patient or the nurse'. Perhaps an order should not be required for this purpose, but if it does focus attention on patients most in need of treatment, despite their reluctance, it may correct a tendency of mental health services to shift their focus to those less difficult to engage.

With regard to the impact on the therapeutic alliance, the predominant view of respondents was that, while compulsion can harm relations with patients in the short term, the advantages of continuing treatment usually outweigh this problem and that where greater insight follows treatment, therapeutic relations will often improve in the end.

These findings derive strength from the national coverage of the study, careful preparation of the survey instrument, the clear preferences shown by respondents on many questions and the extent of agreement shown between professional groups. The opinions expressed relate to a well-embedded, national legal scheme.

There are still significant limitations to the study. The response rate was moderate. The possibility of bias therefore exists, if those more supportive of CommTOs were more likely to respond, though we see no reason why that should be so. This is a study of clinicians' opinions, in any case. It cannot tell us, in any definitive manner, whether CommTOs produce clinical improvement in patients. Its findings relate only to NZ. We plan to supplement this report with others documenting the views of patients and their families.

Nevertheless, the clear opinions expressed by our respondents provide indirect support for the positive conclusions about CommTOs reached in several studies elsewhere [6–8]. We found support for the view that effective practice is closely linked to intensity of service provision [6], and most NZ clinicians would endorse the results of studies that find many patients do not consider CommTOs overly coercive, at least in contrast with

compulsory inpatient care [9,10]. However, not all studies of patients' views reach that conclusion [11].

The higher priority given by NZ clinicians to matters of harm to others when they come to consider discharge from a CommTO and their comments about failure to enforce medication compliance, even with patients under these orders, suggest that the later stages of the CommTO process deserve more research attention.

The prospect that CommTOs may promote earlier identification of relapse and more rapid readmission raises questions about the proper criteria for evaluation. Many studies use reduced time in hospital as the measure of success [6,12]. If better contact promotes swifter identification of relapse, however, some patients under CommTOs may be admitted more frequently. Should that be considered a failure of the order, because time spent in hospital has not declined, when such patients have arguably received better quality care? Many patients' families might not consider that to be a failure at all. This shows how CommTOs may be viewed differently [2,10], precluding evaluation with any universal criterion. Another scenario is that early identification of relapse and active community treatment will avert the need for inpatient care, again a desirable outcome, but one hard to capture in official figures.

The existence of a small minority with strong reservations about CommTOs suggests considerable variation in practice is likely to occur. This should be accepted until the efficacy of CommTOs is better established, in light of the ethical questions involved [13,14]. The law should leave discretion concerning CommTOs in clinical hands.

Policy-makers who favour CommTOs principally to control of violent behaviour or for patients not considered treatable by most clinicians, will derive little support from this study. Our respondents saw reducing violence to others mainly as a secondary outcome of targeted clinical care.

The major question about CommTOs continues to be their overall contribution to health and quality of life [15]. Epidemiological studies, using databases that prospectively compare periods of treatment under compulsion with periods of voluntary care, for patients categorised by illness severity, seem promising [12]. Randomised controlled trials may be more rigorous [16], but random allocation to CommTOs or to discharge from them, poses ethical and legal problems [17]. Until quality studies of outcomes of CommTOs have been published, there seems no reason for experienced clinicians' views to be ignored.

We consider that until the debate about efficacy is resolved, New Zealand law should continue to authorise compulsory outpatient care, provided it is carefully targeted on the seriously mentally ill and an adequate community service is available.

Acknowledgements

Thanks to Nikki Ratter, Chris Ansley, Peter Herbison, Hine Forsyth, Aroha Noema and the staff of Te Oranga Tonu Tanga and survey respondents. Funded by the University of Otago and the Health Research Council of New Zealand.

References

1. Campbell M, Fitzpatrick R, Haines A *et al.* Framework for design and evaluation of complex interventions to improve health. *British Medical Journal* 2000; 321:694–696.
2. Dawson J, Romans S, Gibbs A, Ratter N. Ambivalence about community treatment orders. *International Journal of Law and Psychiatry* 2003; 26:243–255.
3. Swanson J, Swartz M, George L *et al.* Interpreting the effectiveness of outpatient commitment: a conceptual model. *Journal of the American Academy of Psychiatry and Law* 1997; 25:5–16.
4. Dawson J, Romans S. The use of community treatment orders in New Zealand: early findings. *Australian and New Zealand Journal of Psychiatry* 2002; 35:190–195.
5. Bindman J. Involuntary outpatient treatment in England and Wales. *Current Opinion in Psychiatry* 2002; 15:595–598.
6. Swartz M, Swanson J, Wagner H *et al.* Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *American Journal of Psychiatry* 1999; 156:1968–1975.
7. Power P. *Outpatient Commitment – Is it Effective?* MD Thesis. Melbourne: University of Melbourne, 1998.
8. Hiday V. Outpatient commitment: the state of the empirical research on its outcomes. *Psychology, Public Policy and Law* 2003; 9:8–32.
9. Scheid-Cook T. Controllers and controlled: an analysis of participant constructions of outpatient commitment. *Sociology of Health and Illness* 1993; 15:179–198.
10. Swartz M, Swanson J, Wagner H, Hannon M, Burns B, Shumway M. Assessment of four stakeholder groups' preferences concerning outpatient commitment for persons with schizophrenia. *American Journal of Psychiatry* 2003; 160:1139–1146.
11. Swartz M, Swanson J, Monahan J. Endorsement of personal benefit of outpatient commitment among persons with severe mental illness. *Psychology, Public Policy and Law* 2003; 9:70–93.
12. Preston N, Kiseley S, Xiao J. Assessing the outcome of compulsory psychiatric treatment in the community: epidemiological study in Western Australia. *British Medical Journal* 2002; 324:1244–1249.
13. Szmukler G. Ethics in community psychiatry. In: Bloch S, Chodoff P, Green S, eds. *Psychiatric ethics*, 3rd edn. Oxford: Oxford University Press, 1999; 363–382.
14. Peele R, Chodoff P. The ethics of involuntary treatment and deinstitutionalization. In: Bloch S, Chodoff P, Green S, eds. *Psychiatric ethics*, 3rd edn. Oxford: Oxford University Press, 1999; 423–440.
15. Swanson J, Swartz M, Elbogen E, Wagner H, Burns B. Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law* 2003; 21:473–491.
16. Swartz M, Burns B, Hiday V, George L, Swanson J, Wagner H. New directions in research on involuntary outpatient commitment. *Psychiatric Services* 1995; 46:368–379.
17. Dawson J. Randomised controlled trials of mental health legislation. *Medical Law Review* 2002; 10:308–321.