



CPA Position Paper

Mandatory Outpatient Treatment

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The Canadian Psychiatric Association (CPA) believes that mandatory outpatient treatment (MOT) has benefits in certain clearly defined situations, and the CPA supports the use of MOT if specific legal rights and safeguards are in place. This paper outlines the CPA's views on important ethical and practical issues associated with the provision of compulsory treatment in the community.

Definition of MOT

In this paper, MOT is used to describe legal provisions that require individuals with a mental illness to comply with a treatment plan while living in the community. Excluded from this definition, and from further consideration in the paper, are individuals who have committed an offence and are required to follow a treatment plan as a condition of a probation order, as well as individuals who have been found not criminally responsible for a crime and whose treatment is monitored by Criminal Code Review Boards.

Historical Perspective

Providing consistent care and treatment for "revolving-door" patients has proved to be one of the major challenges of deinstitutionalization. The revolving-door patient typically responds to a course of treatment in hospital with remission of acute symptoms but does not recover insight into the pathological nature of his or her illness. As a consequence, the patient repeatedly defaults from treatment when discharged from the structured environment of the hospital. Refusal of treatment in turn leads to a deterioration of his or her clinical condition, which ultimately results in involuntary rehospitalization. Much has been written about the costs to the mental health system of managing these patients (1). Less attention has been given to the practical impediments mental health professionals face in attempting to readmit these patients once they meet committal criteria. Patients often do not maintain contact with clinicians when they discontinue treatment, and consequently, the deterioration of their mental illness goes unseen. Moreover, clinicians working

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in jurisdictions where the committal criteria are based on dangerousness cannot always identify the precise moment when a person's illness makes dangerousness likely. The CPA believes that, when a patient has demonstrated a pattern of repeated nonadherence to treatment followed by decompensation to a level that requires involuntary inpatient admission, it may be clinically and ethically appropriate to take a preemptive approach to reduce the risk of serious harm to the patient and, although less common, to others. Mental health legislation should be structured in a way that ensures that these clinical and ethical considerations are addressed.

Models of MOT

There are important differences in the way in which MOT is implemented in different jurisdictions. In many states in the US, the courts can order an individual to follow a specified plan of treatment while living in the community (2). This model of MOT is usually called outpatient committal (OPC). In contrast to OPC, which is initiated by a judge, albeit often at the request of a physician, community treatment orders (CTOs) are generally initiated directly by a physician. An individual may be placed on a CTO while an inpatient or while living in the community. CTOs are in use in Ontario and Saskatchewan and in several other jurisdictions worldwide.

Conditional leave, sometimes called conditional discharge, is another commonly used form of MOT in which involuntary inpatients are allowed to leave hospital with the stipulation that they comply with specified conditions while living in the community. These individuals usually continue to be involuntary patients of the hospital and thus must continue to meet the committal criteria while on leave of absence. Many jurisdictions have legislation allowing the courts to appoint a guardian to make binding decisions for an incapable person that cover both outpatient and inpatient care. Finally, some jurisdictions have provisions whereby a capable individual can "commit himself or herself" to outpatient or inpatient treatment at a future time when they have lost capacity through a type of advanced directive often called a Ulysses contract (3).

There are two basic CTO models: diversionary and preventive. In the diversionary model, the criteria for a CTO are identical to the criteria for inpatient committal. The diversionary CTO can be viewed as an alternative to involuntary admission requiring that the person follow a treatment plan but enabling him or her to remain in the community. The diversionary model thus permits treatment in the least restrictive setting: an important principle guiding the structure of mental health legislation (4,5). An example of the diversionary model is the New Zealand Mental Health Act, which directs that the court must "make a community treatment order unless the Court considers that the patient cannot be treated adequately as an

outpatient, in which case the Court shall make an inpatient order" (6). In contrast to the diversionary model, a patient can be placed on a preventive CTO even though he or she has not deteriorated to the point of meeting the jurisdiction's criteria for involuntary admission. However, many jurisdictions require that, before a person can be placed on a preventive CTO, he or she must have an established pattern of repeated admissions. Thus, the legal eligibility criteria for a preventive CTO often include a requirement that the person has met a threshold for the amount of prior involuntary hospitalization.

Current Use of MOT

In the US, OPC has been used in some jurisdictions for almost 30 years (2). As of 1999, 40 states and the District of Columbia had commitment statutes permitting OPC, although the use of these provisions varies markedly between states (7).

Conditional leave provisions are contained in the mental health acts of Alberta, British Columbia, Manitoba, Prince Edward Island, the Yukon, Ontario (limited to 3 months), and New Brunswick (limited to 10 days). Saskatchewan was the first province to introduce CTOs in 1995 (8), followed in 2000 by Ontario (9).

Saskatchewan and Ontario adopted a model of CTOs containing both preventive and diversionary elements. In both provinces, patients must meet the criteria for inpatient committal and also must have experienced a specified amount of psychiatric hospitalization in the recent past. In Ontario to be eligible for a CTO, a person must have been a patient in a psychiatric facility on 2 or more occasions or for a cumulative period of 30 days in the previous 3 years; in Saskatchewan, the requirement is for 3 admissions or a total of 60 days in 2 years. As of the time of writing, there are no data available from Ontario on the use of CTOs. The limited data available from Saskatchewan indicate that physicians in that province use CTOs sparingly (10).

Is MOT Effective?

MOT involves the abridgement of certain civil rights and, in keeping with the principle of reciprocity (11), must be accompanied by benefits to those patients who are required to follow a treatment plan. Unfortunately, the evaluation of the effectiveness of MOT is more complex than it at first appears, requiring specification of the type of MOT, the type of patient, and the outcomes that are desired.

Most of the research that has employed controls (either mirror image studies of patients before and after starting on MOT or matched control groups) has been conducted in the US and has evaluated the effectiveness of court-ordered OPC (12–19). A number of additional

studies have examined conditional leave (20–23), CTOs (24,25), and guardianship (26).

The primary outcome measure used in all studies of MOT has been its ability to reduce hospital utilization. The appropriateness of hospitalization as an outcome measure for MOT has been criticized (27), and some scholars have suggested that many patients who meet criteria for MOT may benefit from spending longer periods of time in hospital. However, if the primary reason for introducing MOT is to stop readmissions of revolving-door patients then reduction of hospitalization is the key outcome. Most studies found a statistically significant reduction in the frequency of hospitalization or in the cumulative number of days patients spent in hospital while on MOT (12–14,16,17,21–23). Several of the studies used a mirror-image design, examining patients before and after the initiation of MOT (12,14,16,17,21–23). This methodology has been criticized for not considering the possible influence of regression toward the mean: patients are often placed on MOT because they are extremely high users of hospital services and by chance alone would experience reduced use in subsequent years.

Recently, the results of 2 randomized control trials have been reported (18,19). In a New York study, patients randomized to OPC spent an average of 43 days in hospital in the 11-month follow-up period compared with 101 days for the group who were discharged without a treatment order (18). This difference was not statistically significant. However, the authors indicate that failure to reach statistical significance was probably the result of having too few patients in the study (18). The second study was conducted in North Carolina (19). There were no differences in readmission rates or total days spent in hospital between patients placed on court-ordered OPC and those who were not. The researchers noted that patients who remained on OPC for 6 months or more used significantly fewer hospital days. While such post hoc analysis raises the possibility that the patients with the poorest functioning were not maintained on OPC, Swartz reported that patients who remained on OPC for 6 months or longer were generally more impaired at the start of the study than the patients who spent fewer than 6 months on OPC (19).

Many other outcome measures have been studied. There is a consistent finding that patients on MOT are more likely to follow-up with mental health services (13,15–17,22,25). This improved contact with mental health services appears to persist even after MOT is discontinued (13,15). Two studies report a reduction in violent behaviour for patients placed on MOT (21,22), although another reported no effect (18). In the North Carolina randomized control study, violent behaviour was reduced only for patients who were on OPC for at least 6 months (28). The North Carolina study also

reported a significantly reduced risk of being victimized for all patients on OPC: this reduction was greatest for those patients on OPC for sustained periods (29). Finally, one study suggested that conditional leave might reduce substance abuse, increase the likelihood of employment, and increase stability of residence (21).

The influence of diagnosis or type of treatment has been considered in only a few studies. Swartz reported that patients with nonaffective psychotic disorders were most likely to receive benefit from OPC (19). Two recent studies reported that patients on committal orders who were prescribed depot neuroleptics did better than those prescribed oral medication (24,30).

What can we conclude about the effectiveness of MOT from these studies? Ideally, important variations of each model of MOT would be tested using a randomized controlled design before implementation. Clearly, this is impractical. Randomization of subjects so that they are immune from the provisions of a legal statute is exceedingly complex (31), and we cannot expect a rash of new studies to guide us in developing appropriate policies for MOT.

While none of the individual studies reported can be regarded as conclusive, they do support the view that MOT provides a variety of benefits for a subgroup of patients with serious and persistent mental illness when taken together. An important additional source of information is the experience of clinicians who work with the seriously mentally ill. Many clinicians have reported that they have found MOT to be highly effective for individual patients (16,32) or for specific subgroups of patients (33).

Critics have suggested that MOT may have many negative consequences, such as the undermining of the therapeutic relationship or the encouragement of professionals to bypass less coercive means of achieving compliance (34–37). To date, however, there is no empirical support for the existence of these putative detrimental effects. The lack of evidence for harmful effects could result from a failure to specifically look for the proposed negative effects. It is thus important that studies addressing such concerns are designed and conducted in ways that will assist policy makers and clinicians to minimize putative negative effects of MOT.

Consent and Treatment Authorization

The CPA believes that it is inappropriate to compel a person who is capable of making treatment decisions to adhere to a plan of treatment in the community. However, there may be circumstances in which a capable patient consents to place himself or herself under the restrictions

of MOT. We note that such scenarios are contemplated in the CTO provisions of the Ontario legislation (9).

Who should authorize the treatment specified in an outpatient treatment order in the more typical scenario where the patient is incapable? Two models of treatment authorization for involuntary inpatients are used in Canada: the “state” model and the “private” model (38). In the state model, an appointee of the state (a court, tribunal, hospital administrator, or hospital physician) makes decisions for an incapable patient and, in some jurisdictions, for a capable involuntary patient. In contrast in the private model, the decisions are made by the patient, if capable, or by a substitute decision-maker who represents the patient, if the patient is incapable. While a full discussion of the merits of each of these 2 models is beyond the scope of this paper, it appears that there are advantages and difficulties with both approaches (38). It is likely that most jurisdictions will opt to use the same model of treatment authorization for patients on MOT as for involuntary inpatients.

Duration of MOT

Legislated intervals for renewal of the certificates for MOT provide an added assurance that the physician and others involved in the care of the patient regularly review the appropriateness of the treatment plan and consider whether the patient could comply with the plan in the absence of a treatment order. The duration between renewals should strike a balance between the safeguard of frequent review and the difficulties associated with imposing an excessive administrative burden on clinicians. How long should that interval be? MOT is most appropriately used in the management of patients with severe and persistent mental illness who have ongoing impairment of insight. Brief periods of mandated treatment are unlikely to provide a lasting remedy for nonadherence to treatment by such patients. One possible approach would be to link renewal to the duration of certificates for civil commitment. However, it is notable that the maximum duration that a patient can be committed based on a single certificate varies amongst Canadian jurisdictions from a minimum of 3 months to a maximum of 12 months (38). Other information that may guide legislators is research, which is reviewed above, showing that patients who spent extended periods (180 days or longer) on OPC in North Carolina have the best outcomes (19,28,29). Rohland reported similar enhanced outcomes with the extended use of OPC in Iowa (17).

Consequences of Nonadherence

In most jurisdictions, the consequence of nonadherence to MOT is the possibility of readmission to hospital. Legislation usually permits a physician to authorize law enforcement officers to take a person who is not

complying with MOT into custody and to transport him or her to a hospital for assessment. Typically, nonadherence to mandated treatment does not, of itself, constitute grounds for hospitalizing a person if he or she does not meet the jurisdiction’s inpatient committal criteria. However, as noted above, patients who are subject to diversionary CTOs or conditional leave statutes usually continue to meet the jurisdiction’s committal criteria, and thus the psychiatrist will have the option of readmission if the patient is nonadherent. In contrast, a patient on a preventive CTO does not necessarily meet the jurisdiction’s inpatient committal criteria. Preventive CTO statutes are thus most compatible with legislation that permits civil commitment for individuals who are at risk for mental deterioration. Continuing nonadherence to treatment by a patient with a history of multiple involuntary admissions will often place the patient at risk of deterioration.

It appears likely that, even in jurisdictions that use diversionary CTOs or leave of absence provisions, physicians will be more comfortable allowing individuals to reside in the community when they meet criteria for deterioration rather than for dangerousness. A physician assumes significant liability when he or she identifies a patient as dangerous (either to themselves or to others) yet permits that patient to live in the community.

Adequacy of Services in the Community

MOT must not be used to avoid the costs of inpatient care and treatment when these services are clinically indicated. Moreover, compelling patients to take psychotropic medications must not be seen as an alternative to providing a comprehensive package of mental health services in the community. Therefore, all patients who are managed under the various forms of MOT must have access to a full range of psychiatric services. The CPA is especially concerned to avoid situations where the provision of psychotropic medication, by relieving patients of acute symptoms, facilitates discharge to the community only for these patients to become neglected in inferior accommodation because of lack of assertive follow-up and rehabilitative services.

Ontario and Saskatchewan have included provisions within their mental health acts that require the services necessary to support CTOs to be available in the community and require the patient to be capable of complying with the mandated treatment. Similar provisions for conditional leave are contained in the British Columbia and Manitoba mental health acts. The CPA strongly endorses the inclusion of these provisions in legislation supporting CTOs and conditional leave.

Research indicates that most patients on MOT are required to take medication as part of their treatment order (24,39). Many patients on MOT also will require

case management and follow-up appointments with a psychiatrist. Indeed, patients who need to be on a treatment order to live in the community often have complex needs that may be best served by a multidisciplinary team. Assertive community treatment teams may be especially helpful in encouraging adherence to treatment and follow-up. Other services that may be stipulated in a treatment order could include such things as substance abuse counselling, a period of residence in a high-support group home, and day hospital placement.

The CPA believes that, when patients are compelled to take psychotropic medications, the treating physician and society must ensure that the best available treatment is provided. Financial considerations should not limit a physician's ability to choose what he or she believes will be the safest and most efficacious treatment for these patients. Moreover, it is illogical to expect patients to pay for treatment that they do not want. Thus, a system must be in place to cover costs of medication for these patients.

Psychotropic medications have had a remarkably beneficial impact on the lives of individuals with serious mental illness. Nevertheless, physicians should remain cognizant of the fact that all psychotropic medications can induce side effects, which sometimes affect patients' quality of life. Further, some negative effects, such as weight gain and the risk of tardive dyskinesia, increase with duration of use. When a patient is compelled to take medication treatment it behoves the prescribing physician to scrupulously monitor for side effects and consider alternative treatments. The substitute decision-maker must be kept informed about any side effects experienced by the patient and alternative treatment options.

Should society compel unwilling individuals to accept scarce mental health services when there are other individuals in society who would willingly accept these services but cannot access them? The CPA notes that, in all areas of medicine, individuals with the most severe illness are given priority access to scarce resources. Patients are eligible for MOT because they have severely debilitating illness. It would not be ethically justifiable to withhold services from these vulnerable individuals because their illness renders it impossible for them to seek treatment voluntarily.

Rights and Safeguards

MOT is similar to civil commitment and mandatory inpatient treatment in that it constitutes an abridgement of certain individual rights. It is thus imperative that the person should have access to an independent review of the need for MOT. This can most effectively be achieved by using the same procedures to review MOT as are used to review civil commitment and treatment incapacity. These procedures should include the right of the patient, or other

interested parties, to request a review to determine whether the criteria for MOT continue to be met. It is important to include a proviso for an annual mandatory review. As is the case for involuntary commitment, patients should have the right to appeal unfavorable decisions to the courts. Patients should have access to legal counsel, and this should be provided by the state when the patient's financial resources are limited. All patients who are placed on MOT should receive a formal explanation of their rights. For patients who are placed on CTOs while living outside of hospital, rights advice would be provided in the community.

Summary

The CPA believes that MOT is useful in assisting some patients with persistent deficits in insight to follow a treatment regime while living in the community. The CPA recognizes advantages to the use of a diversionary model of MOT, including the availability of involuntary hospitalization as an option for nonadherence to the requirements of the treatment order.

MOT must not be viewed as an alternative to the provision of appropriate services. A comprehensive package of psychiatric and community support services must be available to patients. The CPA recommends that all legislation supporting MOT contain a clause requiring that the services needed to support outpatient management be available in the community.

Patients who are compelled to take medication in the community must be provided with the most suitable medication irrespective of cost. Society should fund the cost of medication (and other treatments) that patients on MOT are expected to take.

Patients and other interested parties should have the option to request a review of the need for MOT by an independent tribunal. All patients on continuing MOT should have a mandatory annual review by the independent tribunal. Patients placed on MOT must be provided with information about these legal rights.

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