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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 people 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 people who have committed an offence and are required to follow a treatment plan as a condition of a probation order, as well as people 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 so-called revolving-door patients has proved to be one of the major challenges of deinstitutionalization. Psychiatrists frequently encounter patients who respond to a course of treatment in hospital with remission of acute symptoms but who do not recover insight into the pathological nature of their illness. As a consequence,

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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 the patient's 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 is not monitored. Moreover, clinicians working 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 met.

MOT Models

There are important differences in the way in which MOT is implemented in different jurisdictions. In many US states, the courts can order an individual to follow a specified plan of treatment while living in the community.[2] This MOT model 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. A person may be placed on a CTO while an inpatient or while living in the community.

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 people 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 out- and inpatient care. Finally, some jurisdictions have provisions whereby a capable person can "commit himself or herself"to out- 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 MOT models: diversionary and preventive. In the diversionary model, the criteria for MOT are identical to the criteria for inpatient committal. Diversionary MOT can be viewed as an alternative to involuntary admission requiring that the person follow a treatment plan but enabling the person 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 preventive MOT 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 preventive MOT, he or she must have an established pattern of repeated admissions.

Current Use of MOT

In the United States, OPC has been used in some jurisdictions for over 30 years.[2] As of 2010, 42 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 three months), New Brunswick (limited to 10 days) and Newfoundland and Labrador. Saskatchewan was the first province to introduce CTOs in 1995,[8] followed by Ontario[9] in 2000, Nova Scotia in 2007,[10] Newfoundland and Labrador in 2007,[11] and Alberta in 2008 (not yet in force)[12].

These five Canadian provinces have adopted a model of CTOs that contains both preventive and diversionary elements. Patients must not only meet the criteria for inpatient committal but also 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 two or more occasions or for a cumulative period of 30 days in the previous three years; in Saskatchewan, the requirement is for three admissions or a total of 60 days in two years. The limited data available from Saskatchewan indicate that physicians in that province use CTOs sparingly.[13, 14] A precondition requiring prior

hospital use will reduce the use of CTOs. Where the CTO legislation requires a person to meet the inpatient committal criteria, adding a requirement for prior hospitalization will result in some individuals being committed to a hospital rather than being treated in a less restrictive community setting. The CPA is especially concerned that people whose mental illness has resulted in their incarceration in jail will not be eligible for a CTO because they have been in jail and do not meet the prior hospitalization requirement. The Alberta Act recognizes time in jail as equivalent to prior hospitalization and is a reasonable compromise if prior hospitalization is included.

Is MOT Effective?

MOT involves the abridgement of certain civil rights and, in keeping with the principle of reciprocity,[15] 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.

Much of the research that has employed control subjects (either minor-image studies of patients before and after starting on MOT or matched control groups) has been conducted in the United States and has evaluated the effectiveness of court-ordered OPC.[16-23] Numerous studies have examined conditional leave,[24-27] CTOs,[28, 29] and guardianship.[30] The results of three recent Canadian studies have been published: two from Ontario examining CTOs[31, 32] and one from Quebec examining OPC.[33]

The primary outcome measure used in all studies of MOT has been its ability to reduce hospital use. The appropriateness of hospitalization as an outcome measure for MOT has been criticized,[34] and some scholars have suggested that many patients with severe mental illness may benefit from spending longer periods of time in hospital.[35] 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[16-18, 20, 21, 25-27] found a statistically significant reduction in the frequency of hospitalization or in the cumulative number of days patients spent in hospital while on MOT. Several of the studies[16, 18, 20, 21, 25-27] used a mirror-image design, examining patients before and after the initiation of MOT. 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 likely experience reduced use in subsequent years. Studies[29, 36, 37] using matched control subjects have generally failed to show reduced hospitalization while on MOT; however, these studies have, in turn, been criticized for failing to match control subjects on important variables such as past or present treatment refusal and impaired insight.

Both of the studies from Ontario, one of which was a small mirror-image design[31] and the other a larger case–control design,[32] reported reduced rates of hospitalization. The study from Quebec, using a mirror-image design reported prolonged community tenure for patients while on court-ordered treatment.[33]

There have been two randomized controlled trials (RCTs) of OPC.[22, 23] 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 OPC[22] 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.[22] The second study[23] was conducted in North Carolina. 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 six months or longer 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 et al[23] reported that patients who remained on OPC for six months or longer were generally more impaired at the start of the study than the patients who spent fewer than six months on OPC.

Several 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 .[17, 19-21. 26, 29] This improved contact with mental health services appears to persist even after MOT is discontinued.[17, 19] Two studies report a reduction in violent behaviour for patients placed on MOT, [25, 26] although another reported no effect. [22] In the North Carolina RCT,[38] violent behaviour was reduced only for patients who were on OPC for at least six months. The North Carolina study[39] also reported a significantly reduced risk of being victimized for all patients on OPC: this reduction was greatest for patients on OPC for sustained periods. Exploratory studies have suggested that MOT may reduce mortality rates,[40] substance abuse, increase the likelihood of employment, and increase stability of residence. [25]

The influence of diagnosis or type of treatment has been considered in only a few studies. Swartz et al[23] reported that patients with nonaffective psychotic disorders were most likely to benefit from OPC. Two

studies reported that patients on committal orders who were prescribed depot neuroleptics did better than those prescribed oral medication.[28, 41]

What can we conclude about the effectiveness of MOT from these studies? Ideally, important variations of each model of MOT would be tested using an RCT 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,[42] 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, when taken together they do support the view that MOT provides various benefits for a subgroup of patients with serious and persistent mental illness. An important additional source of information is the experience of clinicians who work with people with serious mental illness. Many clinicians have reported that they have found MOT to be highly effective for individual patients[20, 43] or for specific subgroups of patients.[44]

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.[45–48] 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. Thus it is 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, the test for capacity in legislation must not be so low that patients with psychosis who are likely to exhibit harmful behaviour in the community are excluded. We note that in Canada, Newfoundland and Labrador, Nova Scotia and Saskatchewan have adopted a strict test of capacity using the term "fully capable" in both their inpatient committal and MOT criteria.[49, 50, 51]

There may be circumstances in which a capable patient consents to place him- or herself under the restrictions of MOT. Such scenarios are contemplated in the CTO provisions of the Ontario legislation.[9]

Who should authorize the treatment specified in a CTO 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.[52] 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. Conversely, 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 two models is beyond the scope of this paper, it appears that there are advantages and difficulties with both approaches.[52] 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 protection provided by 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 among Canadian jurisdictions, from a minimum of three months to a maximum of 12 months.[52] 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.[23, 38, 39] Rohland et al[21] also reported similar enhanced outcomes with the extended use of OPC in Iowa.

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 MOT 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. Conversely, a patient on preventive MOT does not necessarily meet the jurisdiction's inpatient committal criteria. Preventive MOT statutes are thus most compatible with legislation that permits civil commitment for individuals 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, even in jurisdictions that use diversionary MOT or leave of absence provisions, that 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 the physician 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 comprehensive mental health services in the community. Therefore, all patients who are managed under the various forms of MOT must have access to the full range of psychiatric services that they need. 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.

All five provinces that have introduced CTOs 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.[28, 53] Many patients on MOT also will require case management and follow-up appointments with a psychiatrist. Indeed, patients who need MOT 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 follow-up and adherence to treatment. Other services that may be stipulated in a treatment order could include such things as substance abuse counselling, a period of residence in a 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 people 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. Some side 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 behooves the prescribing physician to scrupulously monitor for side effects and consider alternative treatments. Where a substitute decision maker is involved he or she must be kept informed about any side effects experienced by the patient and alternative treatment options.

Should society compel unwilling people to accept scarce mental health services when there are other people 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 illnesses. It would not be ethically justifiable to withhold services from these vulnerable people 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 patient 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. The CPA believes that it is appropriate to include a provision for an annual mandatory review. As is the case for involuntary commitment, patients should have the right to appeal unfavourable decisions to the courts. Patients should have access to legal counsel, and this should be provided by the state when a 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 compelled to take medication in the community must be provided with the most clinically suitable medication. Society should fund the cost of medication, and other treatments, that are ordered for patients on MOT.

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

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