



Community Treatment Orders and Other Forms of 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 when 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 who suffer from a severe mental illness and who meet additional criteria 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

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have committed a criminal offence and are mandated to follow a treatment plan as a condition of their involvement with the criminal justice system.

Historical Perspective

Providing consistent care and treatment for so-called revolving-door patients has proven to be one of the major challenges of deinstitutionalization. Psychiatrists frequently encounter patients who experience remission of their acute symptoms when treated in hospital but who repeatedly discontinue treatment when discharged from the structured environment of the hospital. Refusal of treatment in turn leads to deterioration of the patient's clinical condition, which frequently results in involuntary rehospitalization. While much has been written about revolving door patients, little attention has been paid to the practical difficulties mental health professionals face in trying to readmit such patients once they meet committal criteria. These patients typically do not maintain contact with clinicians when they discontinue treatment. Consequently, the deterioration of their mental illness goes undetected by their treatment providers. Moreover, clinicians working in jurisdictions in which committal criteria are based on dangerousness cannot always identify the exact moment at which a person's illness makes danger to self or others likely. MOT was proposed as a less restrictive approach than permanent or repeated hospital detention to enable patients to be managed safely in community settings.

The CPA believes that when a patient, who lacks the capacity to make treatment decisions, is likely to be nonadherent to treatment leading to deterioration of the patient's condition and risk of serious harm to the patient or to others, it is clinically and ethically appropriate to consider a preemptive approach to reduce that risk. Mental health legislation should be structured in a way to ensure that these clinical and ethical requirements can be met.

Purpose of MOT

While MOT was originally proposed as a way to prevent frequent readmissions, psychiatrists view MOT as having a broader purpose of ensuring that the clinical needs of individuals with severe mental illness can be met in community settings when that illness prevents the patient from accessing needed care and treatment. Frequent episodes of illness disrupt an individual's life trajectory, preventing the achievement of educational, social, and vocational milestones. Psychiatrists advocate this long-term view, which supports the goals of recovery.² However, hospitalization may be required so that a patient

can be treated and attain a level of stability necessary to succeed in the community. Therefore, psychiatrists do not view the reduction of hospitalization as the primary goal of MOT. Indeed, successful outcomes under MOT may result in an initial increase in hospital admissions when patients, with a history of default from treatment and follow-up, are closely monitored by clinical staff after discharge from inpatient care.

MOT Schemes

There are important variances in the way in which MOT is implemented in different jurisdictions. In most US states, the courts can order an individual to follow a specified plan of treatment while living in the community.³ 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 usually initiated directly by a physician and can be reviewed by the appropriate jurisdictional board of review. 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 individuals usually continue to be involuntary patients of the hospital and must continue to meet the committal criteria while on leave of absence.

There are 2 basic models of MOT: 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 live in the community while doing so. 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 "shall 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. Some jurisdictions require that, before a person can be placed on preventive MOT, he or she must

have an established pattern of treatment nonadherence or of involuntary admissions.

Current Use of MOT

MOT is used in more than 75 jurisdictions, including Denmark, Norway, Sweden, England, Wales, Scotland, New Zealand, and all states in Australia.⁷ In the United States, OPC has been used in some jurisdictions for over 40 years.⁸ As of 2015, 46 states and the District of Columbia had commitment statutes permitting OPC.⁹

Most jurisdictions in Canada have conditional leave provisions that are time limited, but in British Columbia and Manitoba, conditional leave can be renewed indefinitely provided the patient continues to meet the inpatient criteria. Alberta,¹⁰ Saskatchewan,¹¹ Ontario,¹² New Brunswick,¹³ Nova Scotia,¹⁴ and Newfoundland and Labrador¹⁵ have provisions that support CTOs. In Quebec, a court can place an outpatient on an order to accept treatment.¹⁶

Is MOT Effective?

MOT involves the abridgement of civil rights and, in keeping with the principle of reciprocity,¹⁷ must be accompanied by benefits to those patients who are required to follow a treatment plan. The evaluation of the effectiveness of MOT is complex and requires specification of the type of MOT, the type of patient, and the outcomes that are desired.

Most research assessing the effectiveness of MOT has used the amount of hospitalization as the primary outcome measure. In part, this is based on the belief that hospitalization is a proxy for impaired function and in part by fiscal goals of governments, which wish to reduce hospitalization because it is generally more expensive than attempting to treat a patient in a community setting. As noted above, there are times when hospitalization is desirable and reduction in hospitalization may not be the most appropriate outcome. Alternative outcomes, such as quality of life, are harder to measure but are likely more relevant.

Evaluative studies of MOT may be characterized as mirror-image studies, controlled before-and-after (CBA) studies, and randomized controlled trial (RCT) studies. In mirror-image studies, subjects act as their own controls. These studies almost always show that MOT reduces hospital utilization. The mirror-image design can be undertaken retrospectively and does not require researchers to obtain consent from the subjects. Some mirror-image studies have included thousands of subjects and sometimes all individuals placed on MOT within a jurisdiction.^{18,19} An

important weakness of the mirror-image design is that it is susceptible to regression to the mean. Patients are often placed on MOT when they are unstable and experiencing repeated hospital admissions. Chance alone may lead to increased stability and reduced admission.

In CBA studies, investigators recruit a matched control group, which helps control for the effects of regression. While some CBA studies show reductions in hospitalization and improvement in other outcomes for subjects on MOT,²⁰ others report a similar reduction in hospitalization in the control group.²¹ In the CBA design, it is critical to select controls who are matched for relevant confounding variables. This is especially problematic when studying MOT as lack of insight and treatment refusal are often the reasons why patients are placed on a CTO.^{22,23} Unlike diagnostic and demographic variables, information on insight and treatment refusal is almost never systematically documented in the clinical record and hence unavailable to assist matching in retrospective studies.

All studies of MOT schemes in Canada have shown reduced hospitalization and other benefits for patients placed on CTOs.²⁴ However, none of these studies used an RCT design.

Randomized controlled trials are free from the problems of matching and regression and are seen as the gold standard to establish causality when studying simple interventions. There have been 3 RCTs of MOT.²⁵⁻²⁷

In the North Carolina RCT,²⁵ hospitalized patients with severe mental illness who were approved for discharge under an OPC order were randomly assigned to remain on OPC or to be “immunized” from OPC for the 12-month follow-up period. The researchers found that subjects on OPC did not differ from controls in frequency of rehospitalization or cumulative days in hospital during the 12-month follow-up period. However, subjects who underwent sustained periods of OPC for 180 days or more were less likely to be readmitted and spent less time in hospital than controls. While post hoc analysis raises the possibility that the patients who did not do well were not maintained on OPC, the researchers reported that patients who remained on OPC for 6 months or longer were more impaired at the start of the study than the patients who spent fewer than 6 months on OPC.²⁵

In the New York RCT, the state legislature passed a law to allow OPC to be undertaken for patients at a single hospital in New York City. Subjects randomized to OPC spent an average of 43 days in hospital in the 11-month follow-up period, compared with 101 days for subjects who were discharged without OPC.²⁶ This difference was

not statistically significant. The authors noted that this may have been the result of the failure to recruit a sufficient number of subjects.

The third RCT was a comparison of 2 different forms of MOT conducted in England.²⁷ Individuals who were involuntarily hospitalized were randomized to be released on CTOs or on conditional leave under Section 17 of the 1983 Mental Health Act of England and Wales.²⁸ This study found no differences in hospitalization in the 12-month follow-up period between these 2 forms of MOT. Because clinicians in this study were unconstrained in their clinical decisions, almost a quarter of patients initially randomized to conditional leave were actually discharged on a CTO. Indeed, by the end of the 12-month study period, both groups had spent considerable time under community compulsion: a mean of 241 days for the CTO group and a mean of 135 days for the conditional leave group. This makes it difficult to draw any conclusions about the effectiveness of MOT from this study.

Several other outcome measures have been studied. Patients on MOT are more likely to follow up with mental health services and to have more frequent contact with their clinicians.^{20,21,29-34} This improved contact with mental health services persists even after MOT is discontinued.^{29,30} Most studies show significant reductions in violent behaviour and arrest rates for patients placed on MOT.⁹ The North Carolina RCT showed a significantly reduced risk of being victimized for patients on OPC.³⁵ Other studies using large integrated databases suggest that MOT may reduce mortality rates.^{36,37}

The influence of diagnosis or type of treatment has been considered in only a few studies. Swartz et al.²⁵ reported that patients with nonaffective psychotic disorders were most likely to benefit from OPC. Some studies reported that patients on committal orders who were prescribed depot neuroleptics did better than those prescribed oral medication.^{38,39}

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.⁴⁰⁻⁴³ To date, there is no empirical support for the existence of these putative detrimental effects. However, lack of evidence for harmful effects may be because researchers have not looked 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.

What can we conclude about the effectiveness of MOT based on the conflicting evidence from these studies? Some commentators have suggested that only evidence from RCTs can help determine if MOT is effective.⁷ Such a position ignores the inherent limitations of RCTs to evaluate MOT. Unlike retrospective mirror-image or CBA studies, RCTs require subjects to provide informed consent. In the Burns RCT, 20% of patients referred as potentially suitable for the study refused consent. Presumably, many other patients were not referred to the study because of symptoms of their illness such as hostility or uncooperativeness that would make them poor candidates for an RCT. These may be the very individuals for whom MOT can provide the greatest benefits. Furthermore, the ethical dilemma of randomizing a group of individuals to be immune from a jurisdiction's law requires compromises that can undermine the validity of the study. For example, in the New York study, the police department refused to use their powers under the law that applied to a single hospital, thus removing any sanction for nonadherence.

Most important, MOT is a complex intervention. Unlike passive interventions, such as a medication treatment, complex interventions are active and achieve their effects through the actions, reasoning, and reactions of numerous participants. For MOT, these participants often include patients, clinicians, substitute decision makers, community agencies, police and courts, or review boards. Moreover, MOT statutes vary markedly between jurisdictions in terms of who can initiate them, the characteristics of patients who can be placed on them, the powers conferred on clinicians, and the bureaucratic burden required to initiate and maintain a patient on MOT.⁴⁴ Evaluation scholars reject a privileged position for RCTs when assessing complex interventions; rather, they recommend that a range of research methodologies is used to capture this complexity.⁴⁵⁻⁴⁷

An important additional source of information is the experience of clinicians who work with people with serious mental illness. Many clinicians report that they have found MOT to be effective for otherwise difficult to treat patients.^{23,48,49}

While none of the individual studies can be regarded as conclusive, taken together they support the view that MOT provides various benefits for a subgroup of patients with serious and persistent mental illness.⁵⁰ Instead of asking, "Is MOT effective?" a more meaningful question is, "What type of MOT, applied in what way, in which

settings, for which type of patient can improve which outcomes?” The following sections discuss features that can enhance the effectiveness of MOT and protect the rights of patients managed under MOT schemes.

Prior Hospitalization Requirements

All Canadian provinces that have legislated CTO, apart from New Brunswick, require that patients placed on a CTO meet the province’s inpatient committal criteria. However, several provinces also require that prior to being placed on a CTO, a patient has been hospitalized a specific number of times or for a specific number of days. For example, in Nova Scotia, before being eligible to be placed on a CTO, patients must have been involuntarily admitted on at least 2 separate occasions or for a total of at least 60 days in the previous 2 years. The requirement for prior involuntary hospitalization excludes many potential suitable patients from being managed on a CTO. With increasing pressure on inpatient beds, it is now uncommon for patients to spend several weeks in inpatient care. When CTO legislation requires that a patient meet the inpatient committal criteria, the addition of a requirement for prior hospitalization will result in some individuals being detained in hospital rather than being treated in less restrictive community settings. Prior hospitalization requirements are not included in the legislation of most other international jurisdictions. Canadian psychiatrists are concerned that this type of requirement limits the use of CTOs to patients who have chronic illness with established deficits and exclude its use for many patients where there is an opportunity to prevent adverse long-term effects caused by recurrent episodes of illness and delayed treatment. Alberta and New Brunswick have introduced provisions that allow people, who have a pattern of behaviour that will likely result in harm or deterioration, to be placed on a CTO without prior hospitalization. The CPA notes that many individuals with a severe mental illness that has caused them to be incarcerated in a jail would benefit from a period of management on a CTO but are ineligible because they have been in jail and do not meet the prior hospitalization requirements. The Alberta Act recognizes time in jail as equivalent to prior hospitalization, which is a practical compromise if prior hospitalization is required.

Consent and Treatment Authorization

The CPA believes that an assessment of treatment capacity is critical to any community treatment plan because 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 suffering from a psychotic illness who are likely to exhibit harmful behaviour in the community are excluded. We note that Saskatchewan, Nova Scotia, and Newfoundland and Labrador have adopted a strict test of capacity using the term *fully capable* in their inpatient committal and MOT criteria.

There may be circumstances in which a capable patient consents to place himself or herself under the restrictions of MOT. Such scenarios are included in the CTO provisions of the legislation in Ontario and New Brunswick.

Involuntary hospitalization in Canada is authorized by physicians except in Quebec, where it is authorized by a court, usually following an application by a physician. Similarly, physicians authorize MOT in most provinces. However, in Ontario and New Brunswick, the initiation of a CTO requires the consent of a capable patient or of a substitute decision maker if the patient is incapable. It is notable that in New Brunswick, if the substitute decision maker refuses to consent to a CTO, a psychiatrist can apply to a review board to provide the required consent if it is deemed to be in the best interest of the patient.⁵¹

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 2 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.

Irrespective of who provides consent for treatment, the psychiatrist should attempt to engage the patient and, when appropriate, the patient’s family and caregivers in the development of the mandatory treatment plan. In particular, these parties should be consulted about their treatment preferences, and when possible, these preferences should be included in the treatment plan. The treatment plan should be clear and concise so that the patient can easily understand what is expected. A copy of the treatment plan should be provided to the patient and, when appropriate, to the patient’s family and caregivers.

Duration of MOT

MOT is most frequently used in the management of patients with severe and persistent mental illness who lack an appreciation of a need for treatment. Mandatory treatment lasting a few months is unlikely to provide an enduring remedy for nonadherence to treatment by such patients. The researchers in the North Carolina RCT found that patients needed to be on OPC for a minimum of 6 months before they experienced improved outcomes.^{25,35,53} Further, in a large study in New York, researchers reported that subjects who were on OPC orders lasting 6 months or less had improved outcomes but only when assertive community treatment or case management services were continued.⁵⁴ In contrast, subjects who were on OPC for 7 months or longer maintained their improved outcomes after OPC ended irrespective of whether they continued to receive these intensive clinical services. Rohland et al.³² reported enhanced outcomes when OPC was extended for more than 1 year. While MOT should be continued only for as long as necessary, these research findings and a large body of clinical experience suggest that many patients require at least a year of mandatory treatment before stability is achieved.

Consequences of Nonadherence

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. The psychiatrist and/or other clinicians should attempt to obtain voluntary cooperation with the requirements of MOT prior to having a person detained. In some jurisdictions, this is explicitly required by legislation. For example, the Ontario legislation requires reasonable efforts are made to inform the patient that he or she is in breach of the CTO and to assist the patient to comply with the requirements of the CTO.⁵⁵

Nonadherence to mandated treatment itself does not constitute grounds for involuntary hospitalization. However, as noted above, patients who are subject to diversionary MOT continue to meet the jurisdiction's committal criteria; therefore, the psychiatrist will usually have the option to readmit the patient if the patient is refusing treatment. Conversely, a patient on preventive MOT does not necessarily meet the jurisdiction's inpatient committal criteria. Preventive MOT statutes are most compatible with legislation that permits civil

commitment for individuals at risk for mental deterioration.

Furthermore, even in jurisdictions that use diversionary MOT, physicians are likely to 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 himself or herself or to others) yet permits that patient to live in the community.

Adequacy of Services in the Community

While the CPA recognizes the need for judicious use of inpatient services, there are occasions when patients require inpatient care. MOT must not be used to avoid the costs of inpatient care when it is clinically indicated. Furthermore, compelling patients to take psychotropic medications must not be seen as an alternative to providing comprehensive mental health services. All patients who are managed under MOT schemes must have access to the full range of psychiatric services that they need. While some patients can be managed by a psychiatrist, or by a psychiatrist working closely with the patient's family physician, many patients who are placed on MOT schemes have complex needs that require frequent clinical contacts.²⁵ Assertive community treatment teams or intensive case management are often helpful in addressing these needs and encouraging patients to follow the treatment plans required by MOT. 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.

Most provinces have provisions that require that the services necessary to support CTOs are available in the community. 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.

Most patients on MOT are required to take medication and to attend appointments with clinicians.^{56,57} Other services, such as substance abuse counseling, skills training to reduce anger, or a period of day hospitalization, may be stipulated in a treatment order. Some patients require additional help and supervision to live safely in community settings, and a period of

residence in a group home may be included as part of a treatment order. Psychiatrists should consider the specific legal and ethical issues of including residential placement as part of a treatment order.⁵⁸

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 severe mental illness. Nevertheless, physicians should remain cognizant of the fact that all psychotropic medications may induce side effects. 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 carefully monitor for and treat side effects or 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 of 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 simply because their illness renders it impossible for them to seek treatment voluntarily.

Rights and Safeguards

Like civil commitment and mandatory inpatient treatment, MOT constitutes an abridgement of certain individual rights. It is therefore essential that the patient 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 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 mandatory annual

review. However, in situations in which a patient does not want to contest MOT, it may be more meaningful to have a psychiatrist from the review board conduct a chart review with the ability to solicit additional material or convene a full review board if a chart review raises concerns.

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.

Legislated intervals that require renewal of MOT certificates provide an additional 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.

Summary

The CPA believes that MOT is necessary to assist some patients with persistent deficits in insight to follow a treatment regimen while living in the community. The CPA recognizes advantages to the use of a diversionary model of MOT used in conjunction with inpatient committal criteria that include a deterioration criterion.

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 all patients according to their needs. The CPA recommends that all legislation supporting MOT contain a clause requiring that the appropriate outpatient services be available in the community.

Patients compelled to take treatment must be provided with the most clinically suitable treatment. Society should fund the cost of medication and other treatments that are ordered for patients on MOT.

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

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