Patient attitudes towards compulsory community treatment orders and advance directives

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Abstract

Objectives: The Mental Health Act 2001 was implemented in Ireland in 2006, however, within this new legislation there is no provision for compulsory community treatment or advance directives, which are now established practice in other countries. We aimed to determine the proportion of patients who believe that compulsory treatment may be justified, the preference for where the treatment should be delivered and factors which may influence this preference. We also sought to determine the proportion of people who would be interested in the option of having an advance directive in their future care plan.

Methods: Patients who had been admitted involuntarily in a 183 bedded psychiatric hospital in Dublin (St John of God Hospital) over a 15 month period were interviewed one year following discharge. A structured interview was used and included the Birchwood Insight Scale and Drug Attitude Inventory (DAI).

Results: Sixty-seven patients were interviewed, which resulted in a follow-up rate of 68%. A total of 56% of participants believe that there are situations in which involuntary treatment with medication may be justified. Of the participants 59% think that the person should be admitted to hospital if they are going to be administered medication without consent. A total of 41% of participants stated they would have preferred to have been treated at home rather than hospital and this was associated with having a diagnosis of an affective disorder or it being their first involuntary admission. Of the participants 84% expressed interest in having the option of an advance directive in their treatment care plan.

Conclusions: With the increasing community based provision of mental health services in Ireland a debate on compulsory community treatment orders and advance directives needs to take place amongst all stakeholders.

Keywords: Compulsory community treatment; Mental Health Act; Involuntary admission; Coercion; Advance directive.

Introduction

The practice of involuntarily admitting people severely affected by mental illness to hospital is established in most societies but has been the subject of much debate. Compulsory community treatment orders are more controversial as they deny people some of their civil liberties while at home and in the community.

Advocates state that compulsory community treatment orders are the less restrictive option for treatment and opponents argue that they are detrimental to the therapeutic relationship and bypass the need to discuss legitimate reasons for non-adherence with treatment. Opponents to compulsory treatment orders are also concerned that this strategy will reduce psychiatrists to agents of social control and re-enforce stigma.[1]

The new Mental Health Act in Ireland was implemented in 2006 and under this new legislation the patient receives legal representation, an independent psychiatric assessment and the involuntary admission is reviewed by a Mental Health Tribunal.[2] However within the new Mental Health Act 2001 there is no provision for compulsory community treatment orders, which are now used in a range of countries including England, the United States, Canada, Egypt, Australia and New Zealand.[3,4]

A Vision for Change advocates the move towards the provision of treatment and care for people affected by mental illness into the community and specifies that home based treatments should be the main method of treatment delivery.[5] This document also emphasises that a person should take a central role in the formulation of their own treatment care plan. A possible method to enhance this involvement of the patient in their own care is the concept of an advance directive. This is a document which enables a person to establish their treatment preferences should they, in the future, become unable to make those decisions or be unable to communicate their preferences to service providers.[6]

Aims

We set out to investigate attitudes to compulsory community treatment among patients who were previously involuntarily admitted under the Mental Health Act 2001. We

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Table 1: Demographics and clinical characteristics of patients interviewed

	Interviewed n = 67	Not-interviewed n = 31	Statistical test of difference of interviewed vs not interviewed	P Value
Gender				
Male (%)	33 (49)	17 (55)	t (96) = 0.51	0.61
Female (%)	34 (51)	14 (45)		
Mean age				
Males, years (range)	37 (18-67)	34 (21-68)	t (51) = 0.58	0.58
Females, years (range)	45 (22-77)	39 (18-54)	t (48) = 1.2	0.23
Admission source				
Catchment area (%)	42 (63)	21 (68)	$\chi^2(1, n = 98) = 0.24$	0.63
Private (%)	25 (37)	10 (32)		
Type of admission				
Admitted Involuntary Form 6	40 (60)	18 (58)	$\chi^2(1, n = 98) = 0.02$	0.88
Admitted Voluntary then detained under MHA2001 Form 23	27 (40)	13 (42)		
Marital status				
Single (%)	51 (76)	22 (71)	$\chi^2(2, n = 98) = 1.98$	0.16
Married (%)	8 (12)	7 (23)		
Separated, Divorced, Widowed (%)	8 (12)	2 (6)		
Diagnosis				
Schizophrenia/Schizoaffective Disorder (%)	38 (57)	19 (61)	$\chi^2(2, n = 98) = 1.4$	0.49
Affective Disorders (%)	24 (36)	8 (26)		
Other	5 (7)	4 (13)		

aimed to estimate the proportion who believe that compulsory treatment may be justified and the preference for where the treatment should be delivered. We also sought to determine the proportion of people who would be interested in being offered or receiving the option of having an advance directive in their future care plan. We also sought to determine if certain demographic or clinical characteristics, including age, gender, living arrangements, catchment area or private admission, diagnosis, the use of physical coercion, insight and attitudes towards medication were associated with a patient's preference of where they received treatment.

Subjects and methods

Setting

The study was set in a 183 bedded psychiatric hospital in Dublin (St John of God Hospital), which receives admissions from the local catchment area of Cluain Mhuire Mental Health Services, in south Dublin, Ireland, serving a population of 172,000. St John of God Hospital is also an independent private hospital and receives admissions from throughout Ireland. Follow-up interviews took place in outpatient clinics or in combination with domiciliary visits with community psychiatric nurses. Those that were not attending the psychiatric services one year after discharge were invited by post to attend a clinic to meet the researchers.

Participants

Patients admitted involuntarily to St John of God Hospital, from the local catchment area or privately from throughout Ireland, in a 15 month period between 01/04/2007 and 30/06/2008 and over the age of 18 years were included in the study. We selected patients who had been admitted involuntarily as these are patients most likely to be considered for a community treatment order. Patients who were initially admitted voluntarily but were then subsequently detained under the Mental Health Act 2001 were also included in the study.

Patients who were transferred to and from the only dedicated forensic psychiatric hospital in Ireland, the Central Mental Hospital were excluded from the study, due to stipulations from the local Ethics Committee. Patients with a diagnosis of dementia or intellectual disability, assigned by their treating Consultant Psychiatrist from ICD 10 Classification, were also excluded from the study.[7] Patients who were still involuntary at the end of the study period or who were transferred to another hospital, while still involuntary, were not included in the study.

Researchers made contact with patients when the involuntary admission order had been revoked and a discharge date had been agreed with the treating consultant psychiatrist. Patients were provided with an information sheet about the study and they signed a consent form if they agreed to be involved in the study which included a follow-up interview one year later. At the time of discharge, participants were interviewed regarding their experiences and attitudes towards involuntary admission of the Mental Health Act and the results of this have been published elsewhere.[8] Ethical approval was granted by the local ethics committee.

Instruments

Five psychiatrists (BOD, JL, MH, LOR, SD) interviewed the patients using a semi structured interview which included

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a short questionnaire that was previously used to measure patient's preference in relation to compulsory treatment in the UK.[9] The interviewing psychiatrist was never a member of the patient's treating team. The Birchwood Insight Scale was used to measure insight and comprises three main domains: recognition of the need for treatment, ability to re-label psychotic symptoms and recognition of mental illness.[10]

There were 18 patients in the study who did not experience psychotic symptoms and they were not asked the questions regarding relabelling of psychotic symptoms. Attitudes towards medication were assessed with the Drug Attitude Inventory (DAI), which is a self-report questionnaire consisting of statements about the perceived effects and benefits of antipsychotic medication with which the patient agrees or disagrees.[11]

The definition of an advance directive was explained to each participant as follows: "An advance directive is a statement of a person's preferences for treatment, should he or she lose capacity to make treatment decisions in the future."[12] The statement was clarified if requested.

Clinical information

Diagnoses were assigned by the treating consultant psychiatrists and coded from the ICD-10 Classification of Mental and Behavioural Disorders.[7] The use of physical coercion was determined if the police or the assisted admission team were involved in bringing the patient to the hospital or if restraint or seclusion was used at the time of admission. The use of restraint was determined by the 'Clinical Practice Form for Physical Restraint' and the use of seclusion was determined from the 'Register for seclusion'. Mechanical means of restraint was defined as the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient's body.[13] Seclusion was defined as the placing or leaving a person in any room alone with the exit door locked or held in such a way as to prevent the person from leaving.[13]

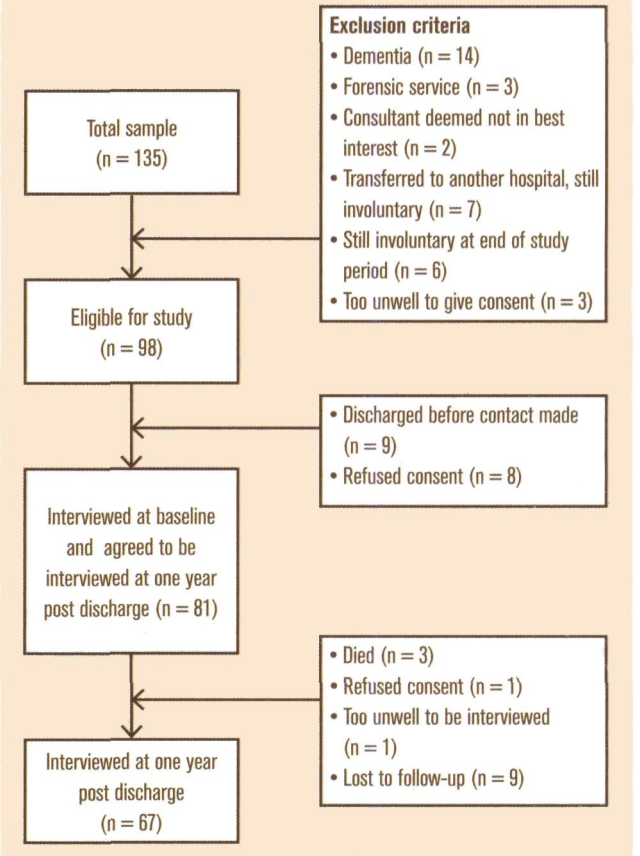
Information on whether the assisted admissions team or the police brought the patient to the hospital was obtained in the clinical notes. The assisted admission team provide assistance in transferring patients to the approved centre (hospital) if it is required and consists of three nurses and a driver. Social and demographic information was obtained from the patient's case notes.

Statistical analysis

Data were entered into SPSS version 15 for Windows. The demographic and clinical information of the patients who were interviewed and not interviewed were compared in *Table 1* to investigate if they differed significantly, using t-tests and chi-squared tests as appropriate. Logistic regression was used to determine predictive factors of preference of being treated at home or in hospital. This was a dichotomous category membership with answers either 'at home' or 'in hospital'.

For odds ratios of less than 1, we chose to invert these odds (1 divided by the odds ratio) to aid in the interpretation. For example, the values of the co-efficients reveal that a diagnosis of an affective disorder is associated with a decrease in the odds of preferring to be treated at home by a factor of 0.12. Rather than having a double negative, this was reported as a diagnosis of an affective disorder increases the odds of preferring to be treated at home by a factor of 8.33.

Figure 1: Flow chart of patients interviewed



Results

Sixty-seven patients were interviewed, which resulted in a follow-up rate of 68%. A flow chart of all patients admitted involuntarily in the study period is presented in *Figure 1*. Information on participants' characteristics and demographics is presented in *Table 1* and this contains comparisons with the patients who were eligible for the study but were not interviewed and those who were interviewed. Participants were interviewed a median of 423 days (range 219-653) after they were discharged from hospital.

Attitudes towards compulsory treatment in different settings

A total of 56% (n = 38) of previously involuntarily admitted patients think that there are situations in which involuntary treatment with medication may be justified. Of the respondents, 59% (n = 38) think that if medication is going to be administered involuntarily then the person should be admitted to hospital to enable this. Only 34% (n = 22) think that it would be possible to facilitate giving medication without consent in a person's home.

Preference for location of previous treatment

A total of 56% (n = 37) of participants who had been involuntarily admitted stated that it would have been their preference to have received treatment in hospital, while 41% (n = 27) would have preferred to have been treated at home.

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Table 2: Attitudes regarding compulsory treatment in different settings

Statement	Agree n (%)	Disagree n (%)	Don't know n (%)
Do you think that it is ever right to make a person take medication against their will?	38 (56)	17 (26)	12 (18)
Do you think that if someone needs to take medication against their will, they should be admitted to hospital before this can happen?	38 (59)	19 (30)	7 (11)
Do you think that if someone needs to take medication against their will, it would be possible for this to happen when they are in their home, without admitting them to hospital	22 (34)	31 (49)	11 (17)

Table 3: Logistic regression for preferences to be treated at home or hospital

	B	S.E.	Wald	df	p	Odds Ratio	95% CI for Odds Ratio	
							Lower	Upper
Gender	-1.36	0.83	2.66	1	0.10	0.26	0.05	1.32
Age	-0.01	0.04	0.03	1	0.87	0.99	0.93	1.06
Marital Status	2.69	1.46	3.41	1	0.07	14.70	0.85	254.41
Living arrangements	1.71	1.05	2.68	1	0.10	5.53	0.71	42.82
Public/Private	0.33	0.89	0.13	1	0.72	1.39	0.24	7.95
Diagnosis - Affective	-2.09	0.85	6.06	1	0.01	0.12	0.02	0.65
Diagnosis - Schizophrenia/ Schizoaffective	-0.35	1.42	0.06	1	0.81	0.71	0.04	11.51
First Involuntary Admission	-2.49	0.93	7.18	1	0.01	0.08	0.01	0.51
Physical Coercion	-0.06	0.73	0.01	1	0.93	0.94	0.23	3.90
Attitudes to medication (DAI)	-1.40	1.16	1.45	1	0.23	0.25	0.03	2.41
Insight - Birchwood	0.13	0.19	0.48	1	0.49	1.14	0.79	1.63

We had complete data for 59 participants. The model was significant (omnibus chi-square = 26.2, df = 11, p = 0.006)

We performed a logistic regression model to determine if any demographic or clinical factors were associated with a person's preference for their location of treatment. The preference for treatment at home was the dichotomous outcome variable and age, gender, marital status, living arrangements (alone or with others), diagnosis, whether the patient was admitted from the catchment area or privately, whether it was their first involuntary admission, level of insight and attitudes toward medications were used as predictor variables.

Two factors were statistically significant and associated with a preference to have been treated at home; diagnosis and it being the person's first involuntary admission. Those with a diagnosis of an affective disorder were more likely to report a preference to have been treated at home by a factor of 8.33 [95% CI 1.54 and 50]. If it was a person's first involuntary admission they were more likely to have preferred to have been treated at home by a factor of 12.5 [95% CI 1.9-100]. Two other factors neared statistical significance for stating a preference to have been treated, namely female gender and being married.

Attitudes towards advance directives

A total of 8% (n = 5) of participants were aware of the concept of an advance directive and all of these participants stated that they already had such an arrangement with their treating consultant psychiatrist. Participants were then read the definition of the advance directive, provided in the methodology. A total of 84% (n = 56) of participants replied that they would be interested in having the option of an advance directive in their treatment care plan.

Discussion

In a sample of people of who had previously been admitted involuntarily to hospital under the Mental Health Act 2001, we found that just over half believe that it may be right for someone to be given medication without consent and a similar proportion believe that the person should be admitted to hospital to enable this. The majority of patients expressed a preference to have been treated in hospital, however, those who experienced their first involuntary admission and those with a diagnosis of an affective disorder were more likely to express a preference to have been treated at home.

Limitations to this study are that it only examined peoples' preferences as to where they would have liked to have received treatment rather a distinct comparison of the two options. Also, participants may have been more likely to report a preference to have been treated at home if they had negative experiences when they were an inpatient and

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they may not have considered the negative aspects to being treated involuntarily at home. Another limitation to this study is that the questions focused on the involuntary administration of medication, when in practice compulsory community treatment orders usually involve the supervision of taking medication. In New Zealand, if it is required for medication to be administered involuntarily the patient is admitted to hospital for safety and ethical reasons.[14]

The strengths of this study are that it involved people who are most likely to be considered for a community treatment order in that they had previously had an involuntary admission to hospital. We also obtained a high follow-up rate in a cohort of people who often do not engage with the mental health services.

There are high readmission rates for people who have been admitted involuntarily, with a large study by Priebe et al, reporting a 14% involuntary and 11% voluntary readmission rate within one year.[15] Therefore any measure which could reduce readmission rates should be fully investigated. Studies examining the effectiveness of compulsory community treatment orders have resulted in interesting but conflicting findings. A cochrane review found little evidence to support their use in terms of readmission rates or clinical outcome measures.[16] While other studies found that compulsory community treatment orders result in reduced number and length of hospital admissions.[17,18] Other studies have found that compulsory community treatment orders do not reduce readmission rates but may increase them.[3,19,20]

However, another consistent finding is that the length of readmission is reduced.[3,21] A study by Seagal and Burgess reported that while total inpatient days are reduced the number of days a person is under restrictive care is doubled.[22] A possible explanation for the above findings is that community treatment orders result in the patient remaining in contact with the mental health services and then subsequent relapses of illness are identified earlier and result in shorter admissions.

Compulsory community treatment orders are a controversial matter. However it is unclear to what extent the public debate surrounding community treatment orders represent the preferences of those who may be affected by them. Another study examining views regarding community treatment orders among people affected by schizophrenia, family members of those affected, clinicians and members of the public, found a general consistency in viewpoints, with the first preference being to avoid involuntary hospitalisation and secondly to avoid violence and to maintain good relationships.[23]

The findings in this study are similar to those shown in Crawford and colleagues' work on an English cohort. A key difference in the findings was that a higher number of respondents from Ireland report that a person should be admitted to hospital should they require treatment with medication against their will (59% vs 39%).[9] The authors are only aware of one published qualitative study which examined service users' perspectives of compulsory community care and in this a range of themes emerged including paternalism, punishment, control but also safety and security.[24]

Perhaps a more positive method of engaging a person in their treatment and care is the concept of an advance directive, for which we found strong support in this study. However, a Cochrane review published in 2009 found no support for advance directives in terms of hospital admission rates or treatment adherence, however, it concluded that data is lacking greatly in this area and further research is required.[25]

The benefits of advance directives may be more qualitative and as such, research addressing this topic should reflect this. Advance directives can increase the autonomy of people affected by severe mental illness and can lead to higher levels of functioning and subjective improvements in psychological wellbeing.[6] Advance directives could reduce the need for an applicant of an involuntary admission, as the person may agree to admission in advance in the event that they have a severe relapse of their illness, thereby becoming their own applicant for involuntary admission. However, this option would need to be integrated into legislation to be facilitated.

In Ireland, there is no legislation provided for the practice of advance directives.[26] While it is possible for an individual to appoint another person to make decisions for them by creating an Enduring Power of Attorney, healthcare decisions are excluded from this facility.[27] In medicine and surgery, advance directives are usually confined to a refusal of future medical treatment.[28] However, in psychiatry, advance directives would predominantly focus on treatment during the acute phase of a mental disorder. This could lead to an ethical dilemma, if an individual declares that their wishes are to refuse treatment during an acute phase of their illness. A study by Owen et al in 2009 found that 83% of individuals, who had regained capacity, retrospectively agreed with the surrogate treatment decisions that had been made for them by doctors, in comparison to 41% in individuals who did not regain capacity.[29] Therefore, capacity and advance directives are intrinsically linked and with the proposed Mental Capacity and Guardianship Bill in the planning stages, this is an opportunistic time to debate the issue.

Conclusion

With the move towards increased provision of mental health services in the community in Ireland, a debate on compulsory community treatment orders should occur. This study has found that people who had previously been involuntarily admitted generally agree that involuntary admission is necessary in some circumstances but most did not feel that involuntary treatment should take place in the community. Participants were also very positive about the concept of advance directives.

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