

Involuntary psychiatric treatment in the community: general practitioners and the implementation of community treatment orders

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Background

There are no data about general practitioners' (GPs') involvement in involuntary psychiatric community treatment orders (CTOs). We examined stakeholder perspectives on the GP's role in this area.

Methods

Semi-structured interviews were conducted around CTO experiences with 38 participants: patients, carers, clinicians and Mental Health Review Tribunal members. Data were analysed using established qualitative methodologies.

Results

Sixteen participants specifically spoke about GPs. The analysis identified four themes in their accounts: GPs as 'instruments' of CTOs; GPs as primary caregivers within a CTO; GPs as 'outsiders'; and practical challenges for GPs. Within these themes, participants identified the value of GPs in the provision of care for people living with severe and persistent mental illness, the challenges of coercive processes and the dangers of GPs being isolated from them.

Discussion

GPs play an important role in the implementation of CTOs. Failure to better integrate GPs in the care of people on CTOs appears to be a significant shortcoming of its implementation.

The majority of mental health services for people living with severe and persistent mental illnesses are delivered in the community setting following the deinstitutionalisation of psychiatric services over recent decades.^{1,2} An estimated 600,000 people in Australia experience severe mental illnesses, which includes psychotic disorders such as schizophrenia and disabling forms of depression and anxiety.¹

Community-based mental healthcare is commonly provided through outpatient clinics, mobile treatment teams and day programs.¹ Patients with diagnoses of schizophrenia, depressive episodes and bipolar affective disorders receive most of the more than 7.1 million community mental healthcare service contacts delivered annually.² At the same time, an estimated 15 million general practice encounters are mental health-related.² The most commonly managed problems in primary care are depression and anxiety. Other frequently managed problems include schizophrenia and affective psychosis.²

The role of general practitioners (GPs) in the mental health system has been cultivated by health policy reforms that sought to expand community-based alternatives to psychiatric hospitals, and foster mental health promotion, mental illness prevention, and destigmatisation.¹ More recently, the national policy has sought to directly support GPs' engagement in the care of people living with severe and persistent illnesses, and with complex service needs through the multidisciplinary care coordination initiative *Partners in Recovery* (although the roll-out of this program was recently deferred).³

Mental health legislation in all Australian states and territories provides for the use of involuntary community treatment orders

(CTOs), which allow for unconsented psychiatric treatment outside hospitals. There is some variation in CTO terminology and processes between individual state and territory laws, and they are also known as community management orders or involuntary treatment orders (community category).

One in seven community mental health service contacts in Australia were classified as involuntary in 2011–12, most of which related to patients with diagnoses of schizoaffective disorders and schizophrenia.² Rates of CTO use in Australia vary across jurisdictions, but are increasing and high when compared to international figures.⁴ Despite the increasing use of CTOs, they are controversial because of an ambiguous evidence base, differing views on CTO objectives and ethical concerns regarding implementation.^{5–8}

There is little evidence regarding GPs' participation in CTOs and no Australian data on GP activity in this area, even though GPs may be involved in recommendations for, or the implementation of, orders.⁹ This article reports on the findings of a qualitative study of CTOs and describes stakeholder perspectives about the GP's role in this area.

Methods

This study was conducted in New South Wales, Australia, and referred to involuntary CTOs under the *Mental Health Act 2007* (NSW). Since this study was conducted, the New South Wales Parliament amended the legislation following a public review process. The amendments modified certain principles and procedural aspects of involuntary treatment (eg hospital or community based), but overall, the CTO provisions remained unchanged.¹⁰

The study examined clinical and legal CTO decision-making, and patient and carer lived experiences, aiming to identify potential improvements to CTO processes. The study was funded by NSW Health and conducted by researchers from

the Centre for Values, Ethics and the Law in Medicine (VELiM) at the University of Sydney. It also involved a reference group of clinical, consumer, carer, policy and Mental Health Review Tribunal (MHRT) representatives.

Participants and recruitment

Participants were recruited using a theoretical, purposive method of sampling. The study comprised four groups: patients currently or previously on a CTO; relatives or carers of a person currently or previously on a CTO; community mental health service clinicians; and MHRT members. Recruitment of each participant group involved the distribution of an invitation to participate through a variety of networks.

Patient and caregiver participants received a remuneration of \$40 during the interview. Patient participants were not recruited from, or interviewed in, clinical settings to maintain a clear distinction between their voluntary participation in this study and their involuntary treatment status.

The research was conducted with the approval of the University of Sydney Human Research Ethics Committee (protocol numbers 12583 and 14421) and Sydney Local Health Network Ethics Review Committee (protocol number X10-0338).

Data collection and analysis

In the semi-structured interviews, participants were prompted to speak from their unique understanding of CTO use by providing narrative accounts of their experiences of the process. This included asking participants how they, or someone they cared for, came to be placed on a CTO, what led to the order being put in place, what was involved and what was the experience like. When participants raised experiences or ideas that might clarify or scrutinise an emerging theme in the ongoing data analysis, the interviewers explored those further. The interviews were recorded, transcribed and de-identified. The data were managed using the NVivo 9 software.

The analysis utilised grounded theory and inductive methods described by Charmaz,¹¹ Corbin and Strauss,^{12,13} and Thomas.¹⁴ The process of data collection and analysis involved an initial coding process to sort data, then synthesis of the coding into more conceptually complete categories. The emergence of a number of themes was facilitated by the constant comparison of data and codes within, and between, interviews, and memo writing to scrutinise the nature of codes and developing categories. These themes formed the basis of the models of lived experience and CTO decision-making. The investigators sought to confirm data saturation by triangulation of the data,^{15,16} coded separately by two members of the team (MR and EL), and through discussion of the data among the investigators and stakeholder reference group members.

GPs emerged as a factor in many accounts of CTOs. Interview data specific to GPs were further analysed to identify themes. The subsequent analysis of issues related to general practice was done by the principal author (EL).

Results

Participants

Thirty-eight participants took part in interviews, which included five patients, six carers, 12 MHRT members and 15 clinicians.

Of the 11 patients and carers, six were men and five women from metropolitan and regional New South Wales. Among either the patients, or the relatives of the carers, were diagnoses of schizophrenia, depression, bipolar disorder and anxiety. Of the 12 MHRT members, four were psychiatrists, four were lawyers and four were from the social work, nursing, psychology and mental health service administration sectors. The clinicians sample included three psychiatrists, eight nurses, two social workers, one psychologist and one occupational therapist. The clinicians worked in inpatient and community mental health settings, and their clinical loads included adult mental health, youth mental health, older

persons' mental health and Aboriginal mental health. Participants worked in regional and metropolitan settings.

Results of qualitative analysis

Sixteen participants (four clinicians, two patients, six carers and four MHRT members) specifically spoke about GPs in their experiences with CTOs, and the treatment of severe and persistent mental illness in the community setting. Four themes were identified within these accounts:

- GPs as 'instruments' of CTOs
- GPs as primary caregivers within a CTO
- GPs as 'outsiders'
- practical challenges facing GPs.

GPs as 'instruments' of CTOs

Many participants spoke about GPs' involvement with CTOs, often describing how GPs usually had an instrumental role in their implementation. This included descriptions of GPs being tasked with delivering the legally mandated treatment, including providing depot antipsychotic injections:

'Often [case management is] in conjunction with the GP who might be the one that prescribes, or administers, the injection each fortnight ...' (clinician).

'[The CTO may order] they need to be reviewed by the treating psychiatrist, or keep an appointment with their GP... ' (MHRT member).

One consumer participant explained how his GP was among a number of people who were involved in decisions for him to be involuntarily treated, a process that left him feeling 'pretty helpless'.

GPs as primary caregivers within a CTO

GPs also appeared to occupy a more complex position in the direct care of people on CTOs. They were identified in the role of primary caregivers – as a clinical resource in the (often over-stretched) community mental health system for the care of people with complex needs receiving involuntary

treatment. This role was described in accounts of GPs who were directly involved in a CTO, and/or as members of a group of professionals engaged in the care of someone who may also happen to be on an order. The study found GPs enhanced patient care by managing often complex comorbidities, building strong therapeutic relationships and 'normalising' treatment.

'I felt she'd get more attention from the GP [when on the CTO] because she'd have to see him every fortnight for injections, so other health matters she could bring up when she saw the GP' (carer).

'He is disorganised though in medical care, he has some complex medical needs that complicate the matter, and often his care worker will take him to the GP' (clinician).

'... look this has worked really well for some clients, once they're stable, that they could be linked into their GP, rather than be part of the mental health service. And I mean that's good for a lot of clients because it's more normal, everyone goes to a GP' (MHRT member).

GPs as 'outsiders'

Participants also discussed their experiences of indirect GP involvement, including the value of a strong therapeutic relationship outside the effects of coercive CTO processes and the dangers of GPs being isolated from those processes.

GPs managing comorbidities and maintaining strong therapeutic relationships are particularly important issues for patients who often have complex medical needs in addition to mental illness. Many participants characterised GPs as the first point of contact and/or the gatekeeper in the mental health system, with some identifying education and funding programs that have fostered that role. However, some also believed GPs should not be relied upon as the only source of mental healthcare, or as a substitute for other specialist care.

Clinician, MHRT, and carer participants also described GPs as a point of contact for some patients outside of the CTO system. This view has raised some concerns about quality and safety including accounts of patients hiding CTOs from GPs, and GPs changing treatments and/or not realising the significance of CTOs.

'... most people don't tell their GPs [about their CTO] for some reason, and in fact lots of mental health clients that have depots, go to one GP for the depot and one GP for something else, because they don't want the other GP to know. ... [They believe the other GP will think] that they're mad.' (clinician).

An MHRT member described serious problems emerging when:

'the GP doesn't realise the significance of the order the person is on, or the person says they get all these side effects and they'll reduce [the medication]'.

The member said this had included forensic cases where a GP reduced the medication of a person on a CTO, after which the person became unwell and subsequently committed a violent offence.

Practical challenges facing GPs

Another theme that emerged in participants' accounts are concerns around the practical challenges for GPs involved in the procedural aspects of involuntary psychiatric treatment in the community, both in clinical and administrative terms. Some described the complexity of the administration of injectable antipsychotic medication, while others spoke of the difficulties in managing patient compliance and being responsible for assertive patient follow-up.

One clinician participant explained such issues meant some GPs refused to give ordered injections. The same clinician described a simple but effective administrative system set up in conjunction with GPs to support their management of patient compliance. It enabled GPs to systematically record

patient attendance and fax this to the case manager at the community health service:

'... when the client comes in they sign it, and they fax it to me, and then if I don't get the fax, then I can ring and start seeing what's going on.'

Discussion

Our findings suggest GPs have important and multifaceted roles to play in the implementation of CTOs, and the care of people living with severe and enduring mental illness. The results also revealed problematic lacunae at clinical and policy levels.

First, the extent of GPs' activity in this area is an unknown. This is despite their expected involvement, and the relevant scientific literature acknowledges GPs' involvement in such processes for patients with schizophrenia.⁹ There are no published Australian data on GPs' activity in this setting. CTOs are a little-known aspect of mental health policy,⁶ but the role of GPs in its implementation are even less so. The apparent lack of discourse in public policy over the use of CTOs in Australian jurisdictions raises questions about the transparency and accountability around CTO use. It also contributes to the current marginalisation of, and discrimination against, people living with mental illness.⁶ The apparent lack of information about the role of GPs in CTO implementation is just as problematic. The inclusion of GP participants was outside the scope of this study. Despite this, the emergent properties of our qualitative analysis enabled our observations to be formulated into a preliminary descriptive account and highlights the need for further enquiry. Our results will inform potential directions for a crucial next step in expanding the currently limited knowledge-base around CTOs. The inclusion of GPs' perspectives in future qualitative and quantitative research would be warranted.

Second, GPs seem to be on the margins of CTO systems, despite clearly having a vital role in community-based treatment of people with severe and

chronic illness. The results of our research coupled with the near absence of GPs in CTO policy and literature, suggests there are deficiencies in knowledge sharing and organisation that can have serious implications. This indicates there are opportunities to refine thinking around CTOs and engagement with GPs that can improve CTO implementation. This could include education and raising awareness by professional bodies (clinical and statutory), to assist GPs to understand the nature of CTOs, its legal significance, clinical and ethical considerations, and how they can operate at an organisational level. The use of CTOs remain a matter of clinical, ethical and legal dispute,⁴⁻⁷ and our research illustrates these uncertainties are just as salient for GPs as they are for psychiatrists and policymakers.

Conclusion

People living with severe and persistent mental illness face higher levels of health and social disadvantage. The move of the coordination of care outside hospitals and into the community setting is challenging.¹⁷⁻¹⁹ Failing to better integrate GPs in the care of people on CTOs appears to be a significant shortcoming in CTO implementation. We suggest reforms are needed to respond to the issues identified in this research. At a minimum, this should include resourcing to enable data collection and linkage to overcome the lack of knowledge about the extent and nature of GPs' activity in this area. Education and the creation of a policy space, where relevant stakeholders can come together to discuss the role and function of CTOs within a complex integrated health system is also required. When mental health laws empower the state to treat people involuntarily, reciprocal obligations exist to provide adequate and appropriate mental health services.²⁰ Better integration of GPs in CTOs is an important aspect of acting on this responsibility, and responding to the complexity of care and the inequities often faced by people living with severe and persistent illness in the community.

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References

1. Department of Health and Ageing. National mental health report 2013: Tracking progress of mental health reform in Australia, 1993-2011. Canberra: Department of Health and Ageing, 2013.
2. Australian Institute of Health and Welfare. Mental health services. Canberra: AIHW, 2013.
3. Department of Health and Ageing. Information paper 1: Partners in Recovery – Coordinated support and flexible funding for people with severe and persistent mental illness with complex needs. Canberra: Department of Health and Ageing, 2012.
4. Light E, Kerridge I, Ryan C, Robertson M. Community Treatment Orders: Rates of use in Australia. *Australas Psychiatry* 2012;20:478-82.
5. Light E. The epistemic challenges of CTOs: Commentary on . . . Community treatment orders. *The Psychiatr Bull* 2014;38:6-8.
6. Light E, Kerridge I, Ryan C, Robertson M. Out of sight, out of mind: Making involuntary community treatment visible in the mental health system. *Med J Aust* 2012;196:591-93.
7. Szmukler G. Ethics in community psychiatry. In: Bloch S, Green SA, editors. *Psychiatric Ethics*. Oxford: Oxford University Press, 2009;453-71.

8. Churchill R, Owen G, Singh S, Hotopf M. International experiences of using community treatment orders. London: Department of Health and Institute of Psychiatry, King's College London, 2007.
9. Harvey CA, Fielding JM. The configuration of mental health services to facilitate care for people with schizophrenia. *Med J Aust* 2003;178:S49–S52.
10. Mental Health Amendment (Statutory Review) Bill 2014 [NSW] (2014).
11. Charmaz K. *Constructing Grounded Theory – A Practical Guide Through Qualitative Analysis*. London: Sage, 2006.
12. Corbin J, Strauss A. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks (CA): Sage, 2008.
13. Strauss A, Corbin J. *Basics of Qualitative Research – Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks (CA): Sage, 1998.
14. Thomas D. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval* 2006;27:237–46.
15. Miles M, Huberman A. *Qualitative data analysis: A sourcebook of new methods*. Newbury Park (CA): Sage Publications, 1984.
16. Rosen A, Gorrell J, Cornish A, et al. Promoting Constructive Change in the Service System: A Qualitative Study of Change in Staff Attitudes with the Implementation of Early Intervention in Psychosis. In: Boydell KM, Ferguson HB, editors. *Hearing Voices: Qualitative Inquiry in Early Psychosis*. Waterloo, Canada: Wilfrid Laurier University Press, 2012:95–118.
17. Morgan V, Waterreus A, Jablensky A, et al. People living with psychotic illness in 2010: the second Australian national survey of psychosis. *Aust N Z J Psychiatry* 2012;46:735–52.
18. The Organisation for Economic Co-operation and Development. *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*. Paris: OECD Health Policy Studies, 2014.
19. Brophy L, Hodges C, Halloran K, Grigg M, Swift M. Impact of care coordination on Australia's mental health service delivery system. *Aust Health Review* 2014;38:396–400.
20. Brophy L, editor. *Achieving Reciprocity for People on Community Treatment Orders*. XXXIIIrd International Congress on Law and Mental Health 2013; Amsterdam: International Academy of Law and Mental Health, 2013.

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