



Involuntary outpatient treatment in patients with severe mental illness: A one-year follow-up study



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ABSTRACT

Introduction: Involuntary outpatient treatment (IOT) aims to ensure adherence to therapy in patients with serious mental disease who are unaware of their illness and for whom treatment discontinuation carries a high risk of relapse.

Objectives: To evaluate the effectiveness of IOT in preventing relapse among patients with serious mental disease. **Method:** A retrospective observational study was carried out on all of the patients (n = 140) receiving IOT in the city of Valencia, Spain. Hospital service uses (emergency care, admissions and mean stay times) during the 12 months before and after the introduction of IOT were compared.

Results: Patients with schizophrenia, delusional disorder or schizoaffective disorder showed a significant reduction in the number of admissions and days spent in the psychiatry ward during the year of IOT. The reduction in the number of visits to the emergency department was only significant for the patients with schizophrenia.

Discussion: We conclude that involuntary outpatient treatment may be effective for patients with serious mental disease who are unaware of their illness and for whom treatment discontinuation carries a high risk of relapse.

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1. Introduction

Involuntary outpatient treatment (IOT) or community treatment orders aim to ensure adherence to therapy in patients with serious mental disease who are unaware of their illness and for whom treatment discontinuation carries a high risk of relapse with the appearance of aggressive or disruptive behaviors (self- or other-directed) and frequent needs for emergency care or repeated admissions to hospital.

Frequent failure to take prescribed medications and, in certain cases, the existence of substance abuse (alcohol or other substances) contribute to episodic worsening of the psychiatric disease and can lead to the appearance of disruptive or violent behavior. Likewise, the course of the untreated disease may lead to the patient being incapable of self-care or to the development of behaviors that put the patient or others at risk.

As a result of the above considerations, certain countries employ compulsory interventions or court rulings to ensure adherence to therapy in patients with serious mental disease.

Such involuntary outpatient treatment of subjects with serious mental disease is a common practice in countries such as the United States, Canada, the United Kingdom, Australia, New Zealand and Israel. In

general, such legislation does not mandate the compulsory administration of medication, although Australia is an exception (Kisely, Campbell, & Preston, 2005).

Extended leave provisions or supervised discharge is applied in countries such as France (test leave) and Germany (Barrios Flores, 2008). In England and Wales, the introduction of the new Mental Health Act in 2007 abolished supervised discharge, which has been replaced by supervised community treatment. This treatment allows for the discharge of patients who no longer need to continue treatment in the hospital and can continue therapy in the community, although the possibility of a compulsory return to hospital is present if the patients fail to comply with the community treatment orders (Department of Health, & Ministry of Justice, UK, 2007; Kousoulou, Whybrow, & Hayes, 2008).

Canadian and Australian studies have reported prevalences of IOT of 5–15 cases per 100,000 inhabitants in the general population. In the United States, this figure is approximately 3 cases per 100,000 inhabitants in the general population, which represents 9.8% of all new admissions and 7.1% of the outpatient population (Kisely et al., 2005).

It has been postulated that once IOT becomes available, it will be applied to increasing numbers of individuals and progressively expand the margins of the designated population it is applied to, despite the fact that the formal standard for its application remains constant (Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006). It is fundamental to

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further research to determine, from a clinical perspective, to whom IOT should be targeted (Geller et al., 2006).

In recent years, IOT experiences have been launched in various Spanish cities (San Sebastián, Barcelona, Valencia) with the aims of improving treatment adherence in individuals with severe mental illness and avoiding the extremes of hospitalization and civil incapacitation (Hernández-Viadel, Pérez-Prieto, Cañete-Nicolás, & Lera-Calatayud, 2006).

In Valencia, IOT has been used since 2003. In the absence of specific legislation, the legal coverage of these judicial actions is based on Article 763 of the Law on Civil Procedure of 2000, which regulates involuntary psychiatric admission; while not explicitly referring to outpatient treatment, such legal coverage is interpreted to encompass and include the latter.

The treatment plan is established in the court order, along with its control mechanism and supervisory healthcare set-up. The judge must be informed of progress, follow-ups, and the need to extend, change or cease the treatment at least every three months. The maximum duration of the measure is 18 months, and it may be renewed for the same period of time.

In normal practice, therapeutic plans focus on drug adherence, which is usually accomplished using depot treatments. If the patient fails to adhere to this treatment, the court is informed and attempts to contact the patient, using police when necessary to force the patient to take the treatment. The psychiatrist then must consider whether hospitalization is necessary. The Spanish national health system offers universal care for all citizens, and thus all patients have direct access to their medication. Patients subjected to IOT receive no special monitoring, but certain mental health services are using personalized programs for continued care related to severe mental health patients. Nevertheless, it must be underscored that there is no assertive community treatment or case management policy in Valencia.

1.1. Effectiveness of IOT

Most observational studies report decreases in the number of emergencies, admissions and the duration of hospital stays after the initiation of IOT or compulsory community treatment (Fernandez & Nygard, 1990; Geller & Grudzinskas, 1998; Hiday & Scheid-Cook, 1989; Munetz, Grande, Kleist, & Peterson, 1996; Ridgely, Borum, & Petrilá, 2001; Zanni & DeVea, 1986).

The effectiveness of IOT has been evaluated in randomized controlled studies by contrasting patients subjected to IOT with control groups (Steadman et al., 2001; Swanson et al., 2000, 2001; Swartz et al., 1999, 2001). Two studies of this kind have been published, and the results are contradictory. Swartz et al. (1999) reported improvement in patients with serious mental disease who maintained compulsory treatment for longer periods of time that were accompanied by intensive community treatment. In contrast, Steadman et al. (2001, 1998) found no significant differences in the between experimental and control groups, but there are major methodological problems with this study, thus it may not counterbalance the North Carolina study: firstly, there were more drug abusers in the outpatient commitment group despite randomization; second, the sample size ($N = 142$) was too small to obtain significant differences from the controls, as there were more substance abusers in the IOT group; finally, as the law is so new, enforcement mechanisms were not in place.

Other studies have measured the degree of satisfaction with the application of IOT among professionals, relatives and patients (Crawford, Gibbon, Ellis, & Waters, 2004; Hernandez-Viadel, Cañete-Nicolás, Lera-Calatayud, Pérez-Prieto, & Roche Millan, 2007; Hernandez-Viadel, Lera-Calatayud, Cañete-Nicolás, & Pérez-Prieto, 2007; Swartz et al., 2003). In general, professionals and relatives perceive IOT to be a positive decision for the management of these patients. However, patient opinion is less homogeneous. In a study carried out by our group, nearly one-half of the interviewed patients recognized IOT as beneficial for

their management (Hernandez-Viadel, Cañete-Nicolás, et al., 2007; Hernandez-Viadel, Lera-Calatayud, et al., 2007) or preferred IOT to hospital admission (Crawford et al., 2004).

In June 2009, the results of the IOT program applied in New York state were published (Swartz, Swanson, Steadman, Robbins, & Monahan, 2009). This program reduced the number of admissions and the durations of hospital stays and reduced the probability of arrest. Sustained improvement after the conclusion of IOT is more likely if the court ruling is maintained for at least 12 months.

The aim of the present study was to provide information on the effectiveness of IOT. Similar to other studies, we chose hospital service use (emergencies, admissions and days of stay) as the outcome measures. We evaluated whether IOT increased adherence to treatment and thus prevented relapse. We hope that, with the application of this legal measure, the frequency of emergency care and admissions and the mean durations of stays will decrease.

2. Method

This is a retrospective observational study that involves all patients who received IOT in the city of Valencia (Spain) at the start of the survey (the 31st of August 2008). Access to data on this population was authorized and facilitated by court number 13 of the city of Valencia, which is in charge of internment and civil incapacitation procedures. The collection of information was completed based on the data from patients' clinical histories. The researchers went to all hospitals that attended to the relevant patients and examined the patients' electronic clinical histories or registrations in emergency rooms and psychiatric wards when electronic clinical histories from the hospital were unavailable. All of the patients were 18 years or older. We compared hospital service use (emergency care, readmissions and durations of stay) between the 12 months before and after the initiation of IOT for each patient. Dates for these 12-month periods differed for each patient.

For each patient, we documented age, sex, diagnosis according to DSM-IV classifications, the number of psychiatric emergencies, the number of admissions (voluntary and involuntary), and the mean duration of the stay. The data were analyzed using the SPSS statistical package, and statistical significance was set at $P < 0.05$.

Ethical considerations and funding: The study was carried out in accordance with the principles of the Declaration of Helsinki and ethical legislation regarding the medical profession. This survey was carried out without any institutional influence, and received no external funding.

3. Results

This study comprised a sample of 140 patients who were subjected to IOT. The average IOT duration was 29.2 months (SD 16.5). By the end of inclusion for this study (the 31st of August 2008), the patients had been receiving IOT for an average of 20 months (SD 14.3), with a range of 0 months (patients starting IOT at that moment) to 56 months. IOT was prolonged in 70 patients (more than 18 months), 41 of whom received IOT for less than 18 months, and in 7 patients, IOT was not stopped at the request of the psychiatrist after that psychiatrist deemed treatment no longer necessary. In 22 patients, the available information was incomplete (e.g., because the mental health service failed to inform the court as to whether the patient was receiving IOT; consequently, the duration of IOT was not definite).

Our subjects were predominately male 66% ($n = 93$) versus 34% ($n = 47$) females. The mean patient age was 41 years (range: 21–75).

The duration disease ranged from 1 to 51 years, with an average of 15 years.

The DSM-IV axis I diagnoses are specified in Table 1. Schizophrenia was the most frequent diagnosis (67.9% of all patients). Fifty patients (36.2%) had a secondary diagnosis of substance abuse or dependency. Such substance abuse or dependency was present in one-half of the

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