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Are our policies and laws leading to treatment delays for people with schizophrenia

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policy issue

Under Australian mental health laws, people with schizophrenia can only be involuntarily committed to a mental health facility if they are assessed and it is determined that their illness is making them dangerous to themselves or others.[1] To determine whether they are to undergo involuntary treatment, mental health workers must assess people against an 'Obligatory Dangerousness Criterion'. This criterion is an advance on methods used prior to the mid-1970s, when many countries authorised involuntary commitment to a mental health facility on medical certification alone, without court approval or any proof of an emergency situation.[2]

An Obligatory Dangerousness Criterion is now widely used in Australia, the USA, and some areas of Canada and Europe as the means by which patients are assessed for

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the appropriateness of involuntary (compulsory) treatment. There is no doubt the policy underpinning its use was well intentioned; an Obligatory Dangerousness Criterion was originally developed in an attempt to better balance the rights of the mentally ill with the need to protect the public. However, over time some experts have begun to raise questions about the utility of this criterion, suggesting that it sometimes means patients don't get access to necessary treatment as quickly as they should. The problem stems from the fact that in order to be classified as being dangerous to themselves or others, people generally need to have a history of violence or self-harm, and most patients in their first episode of psychosis do not have this kind of history.[3]

Up to 80 per cent of patients in their first episode of psychosis require inpatient treatment early in their illness. In many cases, admission to hospital has to be involuntary because few people recognise that their symptoms are due to an illness.[3] In community-based treatment, patients sometimes do not adhere to the treatment prescribed, and this may lead to consideration of compulsory community treatment orders. When people with schizophrenia do not adhere to or consent to treatment, their families, friends, mental health professionals and the legal system may have to wait for them to threaten, attempt, or complete acts that could, or do, result in harm, before they can be involuntarily admitted to hospital, or before compulsory community (outpatient) treatment orders are initiated.[4] In these circumstances, necessary treatment is delayed, and when psychosis is left untreated for lengthy periods, it adversely affects a person's psychological state and can lead to poorer outcomes.[5-7]

While many countries continue to use an Obligatory Dangerousness Criterion to determine whether involuntary treatment is justified, some countries have also begun to use other methods: the United Kingdom (UK) and some parts of Canada and Europe, for example. In these countries involuntary treatment is permissible even if patients have not been assessed as dangerous, but only if they have previously been deemed incapable of giving consent when it comes to matters of their own health and welfare.[8] As an example, to commit someone with schizophrenia to involuntary treatment in the UK, a formal application must be made by either an approved mental health professional or the patient's nearest relative. This application is then assessed by two qualified medical practitioners, one of whom must be approved for this purpose under the Act.

With some countries moving away from relying solely on an Obligatory Dangerousness Criterion to determine if involuntary treatment is justified, Australian policymakers should re-examine current mental health laws. If there are other policy options available that make inpatient psychiatric treatment more accessible, reduce the duration of untreated psychosis, improve treatment outcomes, and reduce dangerous behaviours in people with severe mental illness, they should be considered.

what does the evidence say?

Systematic reviews that compile the results of multiple independent studies in this field have been examined in this Evidence Brief. Because the reviews included in this Evidence Brief have adhered to rigorous guidelines for assessing the quality of studies included in the review, these systematic reviews provide the most robust evidence.[9]

what does the evidence say?

Findings from a 2008 systematic review published in *Social Psychiatry and Psychiatric Epidemiology* first raised concerns about the impact of an Obligatory Dangerousness Criterion on patient outcomes.[3] To assess its impact, the authors of this systematic review compared places where an Obligatory Dangerousness Criterion was used with those where it was not. In places where an Obligatory Dangerousness Criterion was used (USA, Australia, France, Germany, the Netherlands, and Ontario and Quebec in Canada), people tended to have untreated psychosis for 80 weeks, on average. In places where it was not used (Denmark, Finland, Ireland, UK, Norway, Italy, Spain, and British Columbia and Nova Scotia in Canada), the average duration of untreated psychosis was shorter, at 56 weeks. The authors of this review concluded that while the duration of untreated psychosis may be associated with a range of illness, patient, family and cultural factors, the use of an Obligatory Dangerousness Criterion was likely to be partly responsible for the longer periods of untreated psychosis seen in this review.

Two systematic reviews have also been published where the relationships between duration of untreated psychosis and clinical and social outcomes were investigated; one was published in the *Archives of General Psychiatry* in 2005 [5] and the other in *Schizophrenia Research* in 2009.[10] In these reviews, researchers found that people who had longer periods of untreated psychosis tended to have poorer responses to treatment, more severe symptoms, be more disabled by their disease, have poorer quality of life, and function at lower levels for up to 2 years after initial treatment. They were also less likely to go into remission. Another systematic review, published in *Social Psychiatry and Psychiatric Epidemiology* in 2008, also found that among patients experiencing their first episode of psychosis, there was a strong relationship between the duration of untreated psychosis and the propensity to commit homicide.[6]

Findings about the impact of untreated psychosis are reasonably consistent across studies where short-term outcomes are examined, but the impact over the longer-term is not clear. There has even been one recent study (published in 2010 in *Schizophrenia Research*) that found people who experienced longer durations of untreated psychosis had better outcomes than those with shorter periods of psychosis.[11] In this study, researchers followed people over 10 years and found that those who experienced longer durations of untreated psychosis were less likely to be receiving a disability pension, and spent less time in hospital and more time at work. These findings are not terribly robust, however, as the authors suggest that the unexpected findings could be due to the small sample size (89 participants) and other flaws in the study design.

The most recent systematic review conducted in this field was done in 2011 by the Cochrane Collaboration (an international and independent non-profit organisation dedicated to evidence-based health care). The review examined compulsory community treatment programs and included two randomised controlled trials (RCT) with a total of 416 participants. These trials were conducted in the USA where an Obligatory Dangerousness Criterion is used.[12] The findings showed that compulsory community treatment programs for patients with severe mental illnesses (including schizophrenia spectrum and other psychotic disorders) have no benefit over standard outpatient care. There was no demonstrable impact of compulsory community treatment programs on reducing hospital admission rates, law infringements or homelessness, nor on increasing medication compliance or treatment satisfaction. The only possible benefit of compulsory community

treatment programs found in this review was a reduction in rates of being a victim of criminal activity.

what is the quality of the evidence available?

The quality of studies in this field is generally good because many of them include a large number of patients. Overall, however, the evidence is only considered to be moderately robust as many studies show only small to medium effect sizes (a small to medium size portion of the patients reviewed show these effects, yet the effects are statistically significant).

Although systematic reviews are considered to be the highest quality evidence, they are only ever as good as the studies included in them. For example, the most recent 2011 Cochrane systematic review on compulsory community treatment programs was considered by the review authors to be only of moderate quality.[12] This was because the two randomised controlled trials (RCT) it included had certain limitations. They did not properly report how people were randomised to groups in the study; this is important because researchers need to make sure the group of patients receiving treatment is broadly the same as the control group. The studies included also did not adequately report how the people assessing outcomes remained impartial (or 'blinded') as to which study group people were in.

Despite these limitations, the Cochrane review pooled data from both RCTs and found that there was reasonable consistency across studies and little statistical variability. This increases the reliability of the findings.

The three other systematic reviews considered in this Evidence Brief are of lower quality because they only include observational studies, not RCTs. The 2008 systematic review assessing the relationship between the duration of untreated psychosis and an Obligatory Dangerousness Criterion included 47 observational studies with a total of 5849 participants.[3] The two other systematic reviews assessing the relationships between duration of untreated psychosis and clinical and social outcomes included 5 observational studies (with 446 participants) [10] and 26 observational studies (with 446 4490 participants) [5], respectively. Unlike RCTs where the randomisation process should make the two study groups broadly comparable, observational studies are not able to do this, making them of inherently lower quality due to the possible effects of these factors.[13]

what does this mean for policymakers?

Australia should examine the criteria used in other jurisdictions for determining whether patients with schizophrenia should be committed to involuntary treatment, either to inpatient or community services. While the evidence in this field is not clear cut, the best available evidence does show that the use of an Obligatory Dangerousness Criterion can have a detrimental effect on patients suffering from schizophrenia because it can delay timely access to treatment. The criterion has been shown to be particularly problematic for patients in their first-episode of psychosis, and over the short to medium term. Any impact on long-term outcomes for patients is yet to be determined. Because it is likely to be some time before there is strong evidence on the long-term impact of an Obligatory Dangerousness Criterion, there needs to be a broader discussion in Australia about how we should address the challenge of committing people to involuntary treatment when they

cannot or will not consent to voluntary treatment.

key readings

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