What Clinicians Say About the Experience of Working With Individuals on Community Treatment Orders

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Objective: Community treatment orders (CTOs) refer to a variety of legal schemes that require a person with a serious mental illness to follow a plan of treatment and supervision while living in the community. Use of CTOs has been controversial, and they have been the subject of a considerable amount of quantitative and qualitative research. This article reports the results of a systematic review of qualitative studies focused on understanding the views and experiences of clinicians who work with individuals on CTOs.

Methods: Relevant databases and gray literature were searched for articles that used a qualitative methodology for data collection and analysis to examine clinicians' perspectives. CTOs were defined as various legal schemes, including court-ordered outpatient commitment and renewable conditional-leave provisions initiated while a person is an inpatient in a psychiatric unit. Mandatory treatment and supervision required after a person has been charged with or convicted of committing a criminal offense was not considered.

Results: Fourteen articles met inclusion criteria. They represented the views of more than 700 clinicians from six international jurisdictions. Three themes were identified: endorsement of the benefits of CTOs despite tensions both within and between clinicians concerning several aspects of CTOs; belief that medication compliance is a central aspect of CTOs; and acknowledgment that there is room for improvement in CTO implementation, monitoring, and administration. Strategies for reducing tensions and improving administration of CTOs are discussed.

Conclusions: Clinicians view CTOs as providing benefits to their clients but struggle with the coercive nature of these tools.

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Community treatment orders (CTOs) are legal statutes that require a person with a serious mental illness to follow a plan of treatment and supervision while living in the community. In this article, we use the term CTO to describe various legal schemes, including court-ordered outpatient commitment and renewable conditional-leave provisions initiated while a person is an inpatient in a psychiatric unit. Mandatory treatment and supervision that may be required after a person with a mental illness has been charged with or convicted of committing a criminal offense is not considered here.

Quantitative research on CTOs has mostly focused on outcomes studies. These studies have produced inconsistent findings, and their interpretation is contested (1,2). A number of surveys have examined the reasons clinicians use CTOs and their views of the benefits and risks of CTOs (3–7). Qualitative research can provide a fuller understanding of the feelings, values, and perceptions of clinicians about the use of CTOs and take into account the context in which CTOs are applied. Although qualitative studies cannot resolve the debate about whether CTOs are effective, they can potentially spawn hypotheses about the types of situations in which CTOs are likely or unlikely to work. In this article, we report the findings of a systematic review of qualitative studies that have examined the views and experiences of clinicians who work with individuals who are on CTOs.

METHODS

Qualitative systematic review is a method for integrating or comparing the findings from qualitative studies. The accumulated knowledge resulting from this process may lead to the development of a new theory, an overarching narrative, or a wider generalization of previous research. A qualitative systematic review looks for themes or constructs that exist across individual qualitative studies. The goal is not to add studies together but to broaden understanding of a particular phenomenon (8). In chapter 20 of the *Cochrane Handbook for Systematic Reviews of Interventions* (9), it is noted that a synthesis of the evidence from qualitative research can explore questions such as how people experience

illness, why an intervention does or does not work, and for whom and in what circumstances an intervention is likely to be effective?

Ethics approval was not required because there was no direct involvement of individuals. We searched PsycINFO, MEDLINE, EMBASE, and CINAHL and the gray literature. Gray literature refers to publications of reports from government and various nongovernment organizations. For inclusion in the review, research studies had to have used a qualitative method of data collection and analysis. Mixed-method studies that used both quantitative and qualitative methods were included provided the qualitative component met the criteria above. [A complete list of search terms used is included in an online supplement to this article.]

All the generated abstracts were read by one of the authors (CS). If the abstract contained an indication that the study used qualitative methods to examine stakeholder perspectives about CTOs, the article was retrieved and read in full by two of the authors (DC and ROR). A decision about whether inclusion criteria were met was made by consensus. The number of study participants, methods, focus of the inquiry, and country of origin were recorded.

Two authors (DC and ROR) then recorded the themes and subthemes reported in the articles independently by using the constant comparative method to compare and contrast themes and identify themes and the relative prominence of the themes. Several iterations of this comparative analysis were performed until there was consensus on the themes found in the literature and the prominence and strength of one theme relative to another. Saturation was achieved when it became clear that there were no new themes emerging from the results of the studies.

RESULTS

Search Results

This study is part of a larger study that looked at the perspectives of three major stakeholder groups: those who were subjects of CTOs (10), family members of individuals on CTOs (11), and clinicians who worked with individuals on CTOs. In the larger study, we identified 43 articles that described views about CTOs of any of the three stakeholder groups. Seventeen of these articles and reports described the views of clinicians. In two studies, the voices of different stakeholders were merged so that it was not possible to distinguish the perspectives of clinicians from the perspectives of other stakeholders (12,13). The findings from two published articles were combined because they reported results from the same study (14,15). Twelve articles published in academic journals (15–26) and two government-sponsored reviews from Ontario, Canada (27,28), included in this review are listed in Table 1. Together these 14 studies incorporated the views of more than 700 participants from six countries.

Themes

We identified three themes, which are presented below. A sample of quotes from the original research has been provided to illustrate the themes. It is important to note that not all papers included direct quotes.

There are benefits for individuals on CTOs despite the tensions that exist within and between clinicians. Professionals struggled with the tension of wanting to support a person's right to self-determination while also recognizing the benefits that service users may realize when placed on a CTO. Clinicians saw CTOs as providing the necessary stability to facilitate rehabilitation. Specifically, they saw CTOs as providing a supportive framework and structure that improved compliance and engagement with and between clinicians. Clinicians believed that this structure facilitated discharge, improved relationships with families, and improved quality of life.

As one clinician noted, "Two people that I have on a CTO right now are on it because of clear noncompliance with treatments, and it's made quite a remarkable difference for both of them. . . . It has made a remarkable difference in their stability and their functioning, so I think it has been of great value . . . to improve their quality of life and really get them on the road to better things" (18). As an approved mental health professional stated, "CTOs are most appropriate for people who would benefit from a sense of structure, they know that things will kick into place quickly when they get unwell" (24).

Many clinicians worried about the effect of the CTO on their relationship with the service user, but they also saw the benefits that occurred. As a case coordinator said, "CTOs could lead to increase of mistrust, especially if the patient does not have a good understanding of their illness and is not willing to be involved with mental health services. Is it ethical to impose restrictions in the community? Still, it has helped some patients engage and take treatment" (23).

The recovery approach has been increasingly emphasized in mental health care (29). Many clinicians wondered how compulsory treatment could be compatible with recovery, and this concern sometimes resulted in tension both within and between team members. However, many clinicians felt that it was possible to balance the principles of recovery with the need for treatment. As a social worker noted, "It's about being flexible, it's about being creative, and it's about giving people a go. Just because you have a mental illness doesn't mean that you're excluded or exempt from normal consequences. Applying recovery principles to concepts of CTOs is a good way to get someone off a CTO" (17).

Medication compliance is an important condition of CTOs. Clinicians viewed nonadherence to medication as the key cause of recurrent illness and saw medication adherence as the solution. Many stated that the usual CTO conditions focused on medication adherence and contact with the clinical team to ensure enforcement. As a mental health

TABLE 1. Studies included in a systematic review of clinicians' views of community treatment orders (CTOs)

Study	Country	Focus	N of participants	Methods
Lawn et al., 2015, 2016 (14,15)	Australia	Moral framings and metaphors and CTOs	10	Interviews
Brophy and Ring, 2004 (16)	Australia	Efficacy of CTOs in Australia	18	Focus groups
Courtney and Moulding, 2014 (17)	Australia	Involuntary treatment and recovery	10	Interviews
O'Reilly et al., 2006 (18)	Canada	Impact of legislation	78	Focus groups
Dreezer and Dreezer, Inc., 2005 (27)	Canada	Mandated legislative review	216	Interviews
Malatest and Associates Ltd., 2012 (28)	Canada	Mandated legislative review	78	Focus groups
Gibbs et al., 2006 (19)	New Zealand	Clinicians' views of CTOs in New Zealand	90	Interviews
Stensrud et al., 2016 (20)	Norway	Staff experiences with outpatient commitment (OPC)	22	Focus groups
Canvin et al., 2014 (21)	United Kingdom	Experiences with CTOs	25	Interviews
Lawton Smith, 2010 (22)	United Kingdom	Supervised community treatment	>40	Survey
Rawala and Gupta, 2014 (23)	United Kingdom	Use of CTOs in inner London	Not reported	Focus groups
Stroud et al., 2015 (24)	United Kingdom	CTO user experiences	44	Interviews
Scheid-Cook, 1993 (25)	United States	OPC in North Carolina	>50	Interviews
Sullivan et al., 2014 (26)	United States	Case management and OPC	19	Interviews

nurse put it, "I have a lady who has lots of experience of stopping taking medication. She becomes manic. Then there's a long period of time before she comes for treatment, and that gives her a chance to let herself go in many arenas. Then she takes a long time to recover. So with the contact we now have [outpatient commitment], we can avoid these unfortunate side effects, if one can call them that" (20). A psychologist noted, "Most people have a history where you can look back and see they got worse after they stopped taking their medication. They all have a history where voluntary cooperation has been tried. So there's been a discontinuation of medication and deterioration. So it's a way to ensure they get the treatment they need" (20).

A related view held by many clinicians is that medication is a necessary component of rehabilitation. One treating clinician said, "It is the final piece in a biopsychosocial jigsaw for some people, and what it usually does is it forces them to take their medication, and that's not a bio-reductionist statement; it gives them an excuse to take their medication, which gives them the ability to engage with a psychological and social care package" (24).

There is still room for improvement. CTOs were seen by many clinicians as excessively cumbersome to administer because of the complexity of the procedures. A psychiatrist noted, "They are effective, but difficult to renew! This defeats the purpose. They have become a big time drain on psychiatrists [paperwork and hearings]" (28).

Resource issues such as difficulties in arranging good community support because of a lack of available of housing or a lack of available services after hours were frequently mentioned. In addition, a lack of clarity about the conditions that could or should be included in the CTO were cited in several studies. As a psychiatrist described the situation, "We might specify a residence if that's a particularly important element that needs to be in place. It may be supported accommodation . . . there is often some confusion about whether you can [or cannot include it in an order]; and I've seen people who've had it on them. . . . I don't think, as far as I'm aware, that it's the right use [of a CTO]" (21).

Issues regarding the effectiveness of tribunals and hearings were noted, as was the need for ongoing education for individuals on CTOs, doctors, tribunal members, and family members. A psychiatrist said, "With too little involvement with familial carers in particular . . . more often than not patients are reluctant to attend tribunal reviews as they have a poor understanding of and fear of readmission risk to themselves and often refuse legal representation and often refuse to meet the medical member of the tribunal prior to the hearing. This means the case is heard in the absence of the patient and often a legal representative, and the medical member is unable to challenge the evidence of the detaining authority as he has no direct clinical knowledge of the patient's mental state on the day of the tribunal" (22).

DISCUSSION

This review of qualitative research shows that clinicians see benefits from CTOs for service users, but they also struggle with the dissonance caused by supporting an imposed treatment regimen while attempting to adhere to the principles of recovery and person-centered care. Clinicians believe that it is necessary to use CTOs in some situations. It is possible that discomfort working with imposed treatment may have led other clinicians to avoid this work and that the voices expressed in the reviewed studies may not reflect those of a wider sample of clinicians.

Clinicians desire to build positive therapeutic relationships with service users because such relationships have been shown to improve health outcomes (30). In a review of the literature on care planning for service users on CTOs, which included quantitative and qualitative research and opinion papers, Dawson and colleagues (31) noted that although clinicians are concerned about the effect of CTOs on

the therapeutic relationship, they still believe that CTOs are needed for some service users. But how can clinicians develop positive relationships with service users when treatment is mandatory? Dawson and colleagues reported that clinicians emphasized the need for empathic communication about the purpose of CTOs, the importance of building trust, and the need to encourage service users' involvement in decision making when possible. Light and colleagues (32) suggested using an approach that focuses on service users' capabilities and that reconceptualizes their strengths, rather than focusing on their deficits, as most consistent with a recovery approach.

The views and experience of clinicians are given limited importance in a hierarchy of evidence that prioritizes randomized controlled trials (RCTs). However, the lack of clear evidence from RCTs regarding the efficacy of CTOs may reflect the complexity of the intervention (33), which varies markedly in the powers conferred on clinicians and requires the cooperation of multiple participants. Failure of one of these groups to effectively fulfill its commitment to the CTO may make the order ineffective. We saw examples of this in our review, such as the following comment by a psychiatrist in the study by Lawton Smith (22): "The split between 'inpatient' and 'community' consultants has led to a difference in views on occasions. . . . It is difficult to draw up a care plan for another consultant. . . . This functional split model causes obstacles."

Clinicians had suggestions about ways to make CTOs more effective. Making procedures for the use of CTOs less burdensome and ensuring that all stakeholders were educated about the powers and responsibilities of various stakeholders and the rights of service users on a CTO were the most frequently heard.

Both psychiatrists and nonmedical clinicians attributed the positive outcomes of CTOs to increased service user adherence to medication prescribed for their mental disorder. This perspective is not unexpected given that a medication requirement is almost universal in CTO schemes (34,35) and that psychiatrists in the United Kingdom rated promoting compliance with medication as second only to ensuring contact with mental health professionals as a reason to place a person on a CTO (7).

It was notable, however, that some clinicians believed that CTOs are excessively focused on medication compliance. The contrasting views of clinicians regarding the importance of medication requirements may reflect different concepts of the "treatment plan." In many jurisdictions, service users are required to follow a formal treatment plan that is part of the CTO. This treatment plan usually specifies only the mandatory elements of treatment, and psychiatrists prefer to mandate only elements of treatment that are absolutely necessary (36).

Perhaps the pertinent question is how often individuals who are placed on CTOs are offered other services that may support recovery? Some jurisdictions place a clause in the CTO legislation that the services necessary to support the CTO must be available in the community. This requirement is usually interpreted as "services necessary to support the mandatory components of the CTO." For some cases, the conditions of the CTO could, at a bare minimum, be supported by a psychiatrist who would monitor the person's condition, prescribe medication, and complete the assessments and paperwork required by the CTO. More typically, service users require a case manager or an assertive community treatment team, and a minority of service users may require an appropriately supervised residential setting. Lack of services in rural areas and a more pervasive lack of suitable supported housing were noted in several studies as limiting the effectiveness of CTOs.

Maximizing opportunity for recovery usually necessitates more than simply ensuring that the person takes medication and stays symptom free. Many individuals on CTOs could benefit from skills training designed to promote independence or to secure competitive employment. Others could benefit from attendance at a clubhouse or other social outlet or from addiction services tailored to their needs. The principle of reciprocity dictates that when the state takes away a right, it must provide a benefit (37). Such a benefit must be more than just reducing system utilization, which is often more of a benefit for the system than for the service user. Some critics suggest that prioritizing service users on CTOs for scarce services, such as assertive community treatment, could result in inappropriate placement on CTOs, a concern shared by some clinicians (20). However, a well-functioning review board system should be able to obviate this risk. One of the authors (ROR) works in a system in which the commitments of clinicians are written into the CTO treatment plans. These commitments often include such things as taking the service user to medical appointments or teaching activities of daily living. This type of reciprocity may reduce concerns that CTOs are "all about medication."

Variation of CTO statutes across jurisdictions results in differences in the powers and the administrative details of the orders. Our review found that even within a single jurisdiction, clinicians reported variations in how the powers of the legislation were being interpreted (21), especially concerns that suitable service users were not being placed on CTOs and, conversely, that services users were being maintained on CTOs for longer than necessary.

In a previous report, we noted that families of persons on CTOs complained about the burdensome legal and administrative process of initiating and maintaining a CTO (11). This review found that clinicians shared these concerns (18,21,27,28). One contribution to the bureaucratic burden is the requirements of CTO renewal. The frequency of renewal has been identified as an important issue (6). In Saskatchewan, the original legislation required renewal every three months. In a study conducted in that province with clinicians and other stakeholders, the three-month renewal requirement was noted as unnecessary and burdensome to case managers and psychiatrists (18). Partly as a result of these findings, the Saskatchewan government lengthened the duration of CTOs to six months (38). Other jurisdictions

authorize the use of a CTO for a much longer period. For example, in Quebec a court may renew a CTO for up to three years (39). A compromise would be for a first CTO to last six months, with renewals lasting up to 12 months.

CONCLUSIONS

Qualitative research has confirmed many findings from quantitative research about clinicians' views on CTOs. Although quantitative studies indicate that most clinicians believe that CTOs are both ethical and necessary, qualitative studies show that clinicians actually tend to have ambivalent views about CTOs and that clinicians struggle to balance perceived benefits with ethical and philosophical concerns. Clinicians have many suggestions about how CTO legislation could be improved and how CTOs could be implemented in ways that ameliorate the potential negative effects for service users. One source of tension for clinicians is the potential detrimental effects on the therapeutic relationship, and this is an area where a focused qualitative inquiry of clinicians' and service users' views would likely add to our knowledge and improve practice.

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REFERENCES

1. Kisely S, O'Reilly R: Reappraising community treatment orders: can there be consensus? Medical Journal of Australia 202:415–416, 2015
2. Little J: Misrepresenting community treatment orders. Australasian Psychiatry 26:38–40, 2018
3. O'Reilly RL, Keegan DL, Elias JW: A survey of the use of community treatment orders by psychiatrists in Saskatchewan. Canadian Journal of Psychiatry 45:79–81, 2000
4. Romans S, Dawson J, Mullen R, et al: How mental health clinicians view community treatment orders: a national New Zealand survey. Australian and New Zealand Journal of Psychiatry 38:836–841, 2004
5. Manning C, Molodynksi A, Rugkåsa J, et al: Community treatment orders in England and Wales: national survey of clinicians' views and use. Psychiatrist 35:1–6, 2011
6. Coyle D, Macpherson R, Foy C, et al: Compulsion in the community: mental health professionals' views and experiences of CTOs. Psychiatrist 37:315–321, 2013
7. DeRidder R, Molodynski A, Manning C, et al: Community treatment orders in the UK 5 years on: a repeat national survey of psychiatrists. British Journal of Psychiatry Bulletin 40:119–123, 2016
8. Grant MJ, Booth A: A typology of reviews: an analysis of 14 review types and associated methodologies. Health Information and Libraries Journal 26:91–108, 2009
9. Noyes J, Popay J, Pearson A, et al: Qualitative research and Cochrane reviews; in Cochrane Handbook for Systematic Reviews of Interventions, Version 5.1.0. Edited by Higgins JPT, Green S. London, Cochrane Collaboration, 2011. http://handbook.cochrane.org
10. Corring D, O'Reilly R, Sommerdyk C: A systematic review of the views and experiences of subjects of community treatment orders. International Journal of Law and Psychiatry 52:74–80, 2017
11. Corring D, O'Reilly R, Sommerdyk C, et al: What families have to say about community treatment orders (CTOs). Canadian Journal of Community Mental Health, in press
12. Light E, Robertson M, Boyce P, et al: The many faces of risk: a qualitative study of risk in outpatient involuntary treatment. Psychiatric Services 66:649–652, 2015
13. Owens N, Brophy L: Revocation of Community Treatment Orders in a mental health service network. Australasian Psychiatry 21: 46–50, 2013
14. Lawn S, Delany T, Pulvirenti M, et al: A qualitative study examining the presence and consequences of moral framings in patients' and mental health workers' experiences of community treatment orders. BMC Psychiatry 15:274, 2015
15. Lawn S, Delany T, Pulvirenti M, et al: Examining the use of metaphors to understand the experience of community treatment orders for patients and mental health workers. BMC Psychiatry 16: 82, 2016
16. Brophy L, Ring D: The efficacy of involuntary treatment in the community: consumer and service provider perspectives. Social Work in Mental Health 2:157–174, 2004
17. Courtney M, Moulding NT: Beyond balancing competing needs: embedding involuntary treatment within a recovery approach to mental health social work. Australian Social Work 67:214–226, 2014
18. O'Reilly RL, Keegan DL, Corring D, et al: A qualitative analysis of the use of community treatment orders in Saskatchewan. International Journal of Law and Psychiatry 29:516–524, 2006
19. Gibbs A, Dawson J, Mullen R: Community treatment orders for people with serious mental illness: a New Zealand study. British Journal of Social Work 36:1085–1100, 2006
20. Stensrud B, Høyer G, Beston G, et al: "Care or control?": a qualitative study of staff experiences with outpatient commitment orders. Social Psychiatry and Psychiatric Epidemiology 51:747–755, 2016
21. Canvin K, Rugkåsa J, Sinclair J, et al: Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study. Social Psychiatry and Psychiatric Epidemiology 49: 1873–1882, 2014
22. Lawton Smith S: Supervised Community Treatment. Briefing paper 2. London, Mental Health Alliance, 2010
23. Rawala M, Gupta S: Use of community treatment orders in an inner-London assertive outreach service. Psychiatric Bulletin 38: 13–18, 2014
24. Stroud J, Banks L, Doughty K: Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24:88–92, 2015
25. Scheid-Cook T: Controllers and controlled: an analysis of participant constructions of outpatient commitment. Sociology of Health and Illness 15:179–194, 1993
26. Sullivan WP, Carpenter J, Floyd DF: Walking a tightrope: case management services and outpatient commitment. Journal of Social Work in Disability and Rehabilitation 13:350–363, 2014
27. Dreezer and Dreezer Inc: Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act for the Ontario Ministry of Health and Long-Term Care. Toronto, Ministry of Health and Long-Term Care, 2005. http://www.ontla.on.ca/library/repository/mon/17000/270414.pdf
28. Malatest and Associates Ltd: The Legislated Review of Community Treatment Orders: Final Report. Toronto, Ministry of Health and Long Term Care, 2012. http://www.health.gov.on.ca/en/public/programs/hepatitis/docs/cto_review_report.pdf

29. Anthony WA: Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal 16:11–23, 1993
30. Kelley JM, Kraft-Todd G, Schapira L, et al: The influence of the patient-clinician relationship on healthcare outcomes: a systematic review and meta-analysis of randomized controlled trials. PLOS One 9:e94207, 2014
31. Dawson S, Lawn S, Simpson A, et al: Care planning for consumers on community treatment orders: an integrative literature review. BMC Psychiatry 16:394, 2016
32. Light E, Robertson M, Kerridge I, et al: Reconceptualizing involuntary outpatient treatment from "capacity" to "capability." Philosophy, Psychiatry, and Psychology 23:33–45, 2016
33. O'Reilly R, Vingilis E: Are randomized controlled trials the best method to assess the effectiveness of community treatment orders? Administration and Policy in Mental Health and Mental Health Services Research (Epub ahead of print, Dec 28, 2017)
34. Smith M, Branton T, Cardno A: Is the bark worse than the bite? Additional conditions used within community treatment orders. Psychiatric Bulletin 38:9–12, 2014
35. Lepping P, Malik M: Community treatment orders: current practice and a framework to aid clinicians. Psychiatrist 37:54–57, 2013
36. O'Reilly R, Dawson J, Burns T: Best practices in the use of involuntary outpatient treatment. Psychiatric Services 63:421–423, 2012
37. Eastman N: Mental health law: civil liberties and the principle of reciprocity. British Medical Journal 308:43–45, 1994
38. Mental Health Services Act: SS 1984-85-86, c M-13.1. Ottawa, Canadian Legal Information Institute. http://canlii.ca/t/52jhk. Accessed on May 3, 2017
39. Nakhost A, Perry JC, Frank D: Assessing the outcome of compulsory treatment orders on management of psychiatric patients at 2 McGill University–associated hospitals. Canadian Journal of Psychiatry 57:359–365, 2012

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