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Community Treatment Orders—A pause for thought

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ABSTRACT

Community Treatment Orders (CTO) have been available for several decades in some countries and are being progressively introduced worldwide, with significant uptake in Asian countries as they move more mental health care into the community. However the evidence for the effectiveness of CTOs is limited. The evidence from local audits and evaluations is conflicted with some studies showing clear benefit and others not. The same is the case for uncontrolled before and after studies. The higher levels of evidence such as randomised controlled trials, systematic reviews, and Cochrane reviews have consistently failed to demonstrate benefits from CTO use on key measures such as symptom levels, functioning, and healthcare use. Despite this they are increasingly available internationally and often greeted enthusiastically by clinicians and families who want to ensure care and follow up for the mentally ill. This article briefly discusses the evidence before describing potential alternatives to the use of compulsion that do have an evidence base, such as multidisciplinary community working, housing initiatives, and employment support.

1. Introduction

Community Treatment Orders (CTOs) provide clinicians with the authority to supervise patients with severe mental illness in the community, while enabling rapid and compulsory recall to a psychiatric inpatient facility if the terms of the order are not adhered to. Such legal mechanisms were introduced in several countries including the United States over 30 years ago (Geller, 2006), and over recent decades have been brought into practice in over 30 countries worldwide (Maughan et al., 2014). Recent years have seen their introduction in several jurisdictions in Asia such as Taiwan, China, and Hong Kong. Their introduction is also being actively considered in African countries, for example Uganda. Although the exact legal mechanisms vary between different jurisdictions, there are striking similarities with regard both to the type of person made subject to an order and the reasons why. Powers to compel outside hospitals have generally been introduced to provide a novel treatment approach for a cohort of mentally ill patients prone to recurrent re-admissions; the so called 'revolving door' patients (Churchill et al., 2007). Such individuals have been characterised by their limited insight, high risk of relapse, and previous compulsory care and admissions.

Psychiatry's 'move into the community' over recent decades has at its heart the principle that care should happen outside institutions wherever possible. The commonly used justification for CTOs is that the inherent reduction in an individual's civil liberties is the price to pay for an improvement in care. It has been argued that this will lead to lower symptom levels, better functioning, and improved quality of life (Swanson and Swartz, 2014). This sacrifice of civil liberties could only be considered to be reasonable, from a service user perspective (Katschnig, 2011), if CTOs did at the least result in a reduction in psychiatric re-admissions, relapse rates, and/or time spent in hospital (Botha et al., 2010). Improvements in other key outcomes, such as the amelioration of symptoms and improved social functioning, might also justify this liberty gap from a paternalistic perspective (Pelto-Piri et al., 2013). One might also hypothesise that a reduction in experienced coercion as a result of less hospital care and better functioning (if indeed these did result) may justify CTOs from a service user perspective (Lay et al., 2015; Newman et al., 2015;

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Molodynski et al., 2014). Some early research on CTOs did suggest a reduction in the rate of hospital admissions, but subsequent studies have not (Churchill et al., 2007; Maughan et al., 2014). Crucially, no randomised controlled trials have provided evidence of their effectiveness despite three now having been completed (Swartz et al., 1999; Steadman et al., 2001; Burns et al., 2013). The overwhelming weight of current evidence is that CTOs are ineffective at reducing relapse rates, readmissions, or time spent in hospital. In an era where health care decisions (and legal ones) should be based on solid evidence, these findings demand that we re-open the debate regarding the appropriate management of a vulnerable cohort of patients. As things stand, many patients are having their liberty reduced with no net gain in care or improvement in outcome.

1.1. Evidence for effectiveness

Prior to the introduction of CTOs in England and Wales in 2008, clinicians relied on Section 17 of the Mental Health Act (United Kingdom Government, 2007) to grant patients a 'leave of absence' from inpatient care and to assess an individual's functioning in the community prior to full discharge from hospital. Section 17 of the Act allows patients admitted to inpatient wards to take leave for a few hours, days, or even weeks whilst still subject to recall. In 2013, a randomised controlled trial was performed in England comparing the effectiveness of CTOs to brief Section 17 leave (Burns et al., 2013). In this study CTOs did not reduce readmission rates, time spent in hospital, or improve clinical outcomes. Both patient groups were very similar at baseline on key measures that are known to affect outcome, such as illness severity and certain demographic and social characteristics. Participants received equivalent levels of clinical contact throughout the 12 month study period. The only difference between the two study arms was a very significant difference in length of compulsion, with a median of 183 days in the CTO arm and 8 days in the 'non CTO' arm of the study. A further evaluation of the same cohort's outcomes after 36 months (Burns et al., 2015) again found no significant differences on key outcome measures. This provided further evidence that CTOs do not lead to reduced admission rates, and crucially it found this over a much longer time period. Both previous randomised controlled trials assessing the effectiveness of CTOs failed to find an overall positive effect (Swartz et al., 1999; Steadman et al., 2001), though the Swartz study did find significant reductions in a sub sample selected out 'post hoc' who had prolonged compulsion and higher levels of input. The same study did demonstrate some reduction in violent behaviour by those subject to CTO (Swanson et al., 2000), though this has failed to be replicated in other studies or meta-analyses.

These three studies are the only randomised controlled trials and bring much needed evidence to the field. Each study had some limitations, with the exclusion of those with a history of violence in the Swartz study, follow up issues in the Steadman study, and some suggesting selection bias and high 'cross over' rates (in which randomised legal status was changed by clinicians) in the Burns study. However, there is no such thing as the 'perfect' study and the agreement of all three represents a demonstration of the ineffectiveness of CTOs that should not be ignored. Evidence from studies using non-randomised samples is contradictory and hard to draw conclusions from. It certainly does not provide sufficient evidence to advocate for CTO use (Kisely and Campbell, 2014; Maughan et al., 2014). While the higher level evidence does not support CTO use, a number of service evaluations, audits, and uncontrolled studies have reported benefits in terms of patient outcome and hospital use. While they are clearly important and may support and improve practice within jurisdictions, their design does not allow for as much weight to be given to them as compared to the 'higher levels' of evidence described above (Morandi et al., 2016).

1.2. Clinician attitudes

This lack of evidence for the effectiveness of CTOs has not however hindered their use. The Health and Social Care Information Centre (HSCIC) (2004) reported a 32% increase in CTOs since they were first introduced in 2008 for England and Wales. The beliefs and opinions of clinicians play a key role in the use of this enabling legislation (legislation that **can** be used in a wide set of circumstances but is **never** mandated). Large scale surveys of psychiatrists and other healthcare professionals in the UK and New Zealand have highlighted almost identical arguments for the use of CTOs in these distinct systems. Clinicians in New Zealand cited a number of reasons to initiate a CTO: providing a structure for treatment, enhancing a patients' priority for care, supporting continuing contact, and producing a period of stability for patients while other therapeutic modalities are implemented (Romans et al., 2004). In England and Wales the rationalisation behind the use of CTOs was as follows: promoting adherence to medication, protecting patients from the consequences of illness/relapse, ensuring contact with health professionals, and providing authority to treat the patient (Manning et al., 2011). Although conditions placed upon patients by clinicians are designed to enhance adherence to treatment and reduce risk (Lepping and Malik, 2013), it is unclear whether these aims can be achieved using CTOs (Sharma, 2013). Lawton-Smith (2005) suggested that the enthusiasm for community orders in England and Wales was in fact driven by factors such as the pressure for acute psychiatric beds and subsequent inability to bring a vulnerable patient into a place of safety, alongside fears about liability for patients in the community.

Other factors may reduce the likelihood of CTO use. Many clinicians are fearful of harm to therapeutic relationships but there has been no evidence of this as a systematic effect of CTOs (Romans et al., 2004). Ethical concerns (Swanson et al., 2006 Seo et al., 2013) regarding deprivations of liberty for an individual remain key in contemporary discussions of the use of community compulsion.

Despite the evidence base not supporting the continued use of CTOs, clinicians continue to resort to them when working with a group of patients who are hard to help and who continue to have poor outcomes. Such gaps between the evidence-base and clinical practices have been repeatedly reported (Gonzalez-Valderrama et al., 2015). This is undoubtedly a complex phenomenon reflecting the clinicians' prevailing attitudes, the system within which they work, and assumptions about effectiveness, however ill placed these appear to be (Raboch et al., 2010; Valenti et al., 2015; O'Reilly et al., 2000, 2006). Our natural desire to reach out and humanely assist those who are unwell and in distress undoubtedly plays a part too. Pressure from families desperate to ensure their loved one receives care can be hard to resist, as can arguments about enhanced access to scant resources. Clinicians may hypothesise that CTOs could help some vulnerable individuals regain autonomy by having effective treatment in the community and regaining or improving their capacity to make decisions. Appealing and intuitive though this seems, there is no evidence to support it currently. Unnecessarily restrictive orders can undoubtedly have a detrimental impact on a patient's human rights and consequently their well-being (Khurmi and Curtice, 2010).

1.3. Alternatives to CTOs

For patients with relapsing psychotic illnesses there are a number of evidence based interventions that improve outcome. Some may not be available or sufficiently accessible in healthcare