



## Exploring experiences with compulsory psychiatric community treatment: A qualitative multi-perspective pilot study in an urban Canadian context

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### ABSTRACT

As medical, ethical and clinical effectiveness debates about the use of compulsory psychiatric treatment continues, it is important to further explore the actual experiences and perspectives of all relevant stakeholders in community treatment orders (CTOs). This qualitative pilot study engaged a total of twenty-seven clients, their family members, and care providers in Toronto, Canada. Semi-structured, one-on-one interviews were conducted between February and July 2013 and analyzed using thematic analysis. Top key themes from all the participants identified include, among others: 1) clients' experiences of coercion while treated under CTO, but a preference for CTOs compared to involuntary hospitalization, nevertheless; 2) limited real opportunities for collaboration in treatment decisions expressed by clients and family members; 3) acceptance of the potential for clinical recovery on CTOs while debating the role of CTO in a broader recovery journey by all stakeholders; 4) general preservation of therapeutic relationships between clients and care providers, while acknowledging the tension of taking on an "enforcer" role by providers; and 5) existence of different avenues for asserting agency by clients. The findings of this research illuminate the nuanced, complex, and adaptive perspectives held by different stakeholders, point to the importance of preserving and enhancing procedural justice in their use, and alert the field to incorporate recovery-based approaches in this controversial practice that is a widely and commonly used clinical tool across many jurisdictions.

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### 1. Introduction

Over the last three decades, many countries have adopted various forms of compulsory Community Treatment Orders, or CTOs. These orders are similar in that they mandate individuals with established history of serious mental illness (SMI) and poor adherence to treatment to accept treatment in the community - failure of which could result in involuntary hospitalization. CTOs have been the subject of on-going debates. Proponents present CTOs as a less restrictive alternative to involuntary hospitalization, and as a pathway leading towards better treatment outcome, contributing to recovery (Geller, 2012; O'Reilly, Brooks, Chaimowitz, et al., 2009); while opponents argue that CTOs

violate personal rights, and that coercive treatment is contradictory to self-determination and recovery (Kisely & Campbell, 2006; Snow & Austin, 2009).

There are numerous quantitative CTO studies, including randomized control trials (Burns, 2014; Steadman et al., 2001; Swartz, Swanson, Wagner, Burns, et al., 1999), notable pre-post and cohort studies (Kisely et al., 2013; Van Dorn et al., 2010), and Canadian specific studies (Frank, Perry, Kean, Sigman, & Geagea, 2005; Hunt, Silva, Lurie, & Goldbloom, 2007; Nakhost, Perry, & Frank, 2012; O'Brian & Farrell, 2005) have found variable, at times contradictory, but generally positive results of CTO in reducing length of psychiatric hospitalizations and improving treatment adherence (Geller, 2013; Kisely, 2016; Kisely, Campbell, & Preston, 2011; Nakhost, Perry, & Simpson, 2013; Swanson & Swartz, 2014). While it is recognized that local differences in legislation and enforcement of CTOs, as well as variable health care systems and availability of social services in each jurisdiction limit the generalizability of the quantitative findings (Churchill et al., 2007; Francombe Pridham et al., 2016; Kisely, Cambell, Scott, Preston, & Xiao, 2007;

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Ridgely, Borum, & Petrila, 2001), qualitative understanding of the actual, contextualized experiences of those who under-go and provide the services will help to inform an unsettled field. Furthermore, research on mental health rehabilitation and recovery points to the importance of measuring treatment success in terms of a more holistic understanding of the experiences, incorporating quality of life, self-worth and agency of those receiving the services (Collier, 2010).

This pilot study aims to contribute to the field by exploring the general experiences of CTO from multiple perspectives of clients, their families, and treatment providers.

### 1.1. Experiencing compulsory community care: what do we know so far?

A recent review, focusing on experiences of compulsory community care found that clients on CTOs felt more coerced into treatment when compared to voluntary clients, though the levels of coercion varied considerably by study and jurisdiction (Francombe Pridham et al., 2016). The review indicated that the interventions someone is exposed to in addition to the CTO contextualize that person's CTO experience. These may include past involuntary hospitalization, involvement in the criminal justice system, and controlled access to finances and housing (Francombe Pridham et al., 2016). In some qualitative studies, people with SMI described CTOs as coercive, but less so than the perceived alternative of involuntary psychiatric hospitalization (Gibbs, Dawson, Ansley, & Mullen, 2005; O'Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006). Clients in some studies saw the additional community supports included in compulsory community care as a positive aspect of treatment orders (Canvin, Bartlett, & Pinfold, 2002; Ridley & Hunter, 2013). Other clients felt more coerced when they were first placed on the orders, but felt less coerced over time (O'Reilly et al., 2006).

Research findings also suggest that client perceptions of procedural justice – that the process of CTO placement has been respectful, just, and fair – and positive relationships with care providers may mitigate or lower feelings of coercion (Galon & Wineman, 2011; McKenna, Simpson, & Coverdale, 2006; Swartz, Wagner, Swanson, Hiday, & Burns, 2002). In New Zealand, a large qualitative study also found that clients perceived less coercion when there was space to discuss the negative aspects of the order with their providers, suggesting that positive provider-client relationships may also mitigate coercive initiatives (Gibbs et al., 2005; Gibbs, Dawson, & Mullen, 2006).

Additional research on providers' and family members' experiences with CTOs from diverse regions, including New Zealand, Australia, England, the United States, Israel, Scotland and Canada (Brophy & Ring, 2004; Canvin, Rugkasa, Sinclair, & Burns, 2014; Gibbs et al., 2005; Gjesfjeld & Kennedy, 2011; Greenberg, Mazar, Brom, & Barer, 2005; O'Reilly et al., 2006; Ridley & Hunter, 2013; Stensrud, Hoyer, Granerud, & Landheim, 2015; Sullivan, Carpenter, & Floyd, 2014) have highlighted a strong theme, in that clinicians feel a professional tension in the enactment of the orders, as both supporters and disciplinarians. One of these studies exemplified the concerns of community case managers who felt their participation in compulsory orders would negatively influence their ability to be "cheerleaders" for their clients (Sullivan et al., 2014). Other studies illustrated the limbo that family members are placed in when CTOs are invoked, relieving them of some care-taking responsibilities, but also sidelining them as primary decision-makers (Canvin et al., 2014; Stensrud et al., 2015).

In summary, the current body of qualitative research has revealed nuanced aspects of experiences with CTOs, and a need for further exploration in this important field.

### 1.2. The Ontario, Canada CTO context

CTO legislation was introduced in Ontario, Canada's most populous province, in 2000 with the objective of ensuring public safety as well as providing care to individuals with SMI who have frequent, "revolving

door" service utilization (Dreezer, Bay, & Hoff, 2007). In operation, the Ontario CTOs are valid for up to 6 months at a time and are initiated by a physician (Ontario, 2010). Explicit criteria must be met before a CTO can be initiated, including the number and length of admissions over the past three years (minimum of 2 psychiatric admissions or a psychiatric admission lasting for at least 30 days), and the creation of a feasible treatment plan (Ontario, 2010). Additionally, CTOs can be issued for anyone who has been on a CTO in the last 3 years. CTOs are invoked when the physician believes that the person will decompensate physically or mentally, may be at risk of harming themselves or someone else, or be unable to care for themselves without treatment. Furthermore, there must be evidence that the community treatment plan outlined in the CTO will be helpful to the client (Ontario, 2010). The treatment plan is typically focused on medication and attending appointments with psychiatrists and mental health workers. If a client fails to follow the treatment plan, the police can bring the client to hospital for a psychiatric assessment.

A key element of the Ontario CTO legislation is consent. A physician cannot impose a CTO unilaterally: the individual or the designated substitute decision maker (SDM) must provide informed, capable, and voluntary consent. Though some individuals sign their own CTO, most CTOs are agreed to by SDMs as the individuals themselves are very often deemed incapable to consent to their own treatment. Safe guards are in place to ensure the rights of people who have been subjected to a CTO are respected. These includes the right of clients to request a Review Board hearing to revoke their finding of incapacity (and subsequently their CTO) once every six months, the right to have free legal representations, and automatic, mandatory reviews on the second renewal of any CTO. Another procedural safeguard is having a rights advisor to speak with individuals or their SDMs every time a CTO is issued or renewed in order to ensure that they understand their rights and know how to access the contestation process.

## 2. Methods

This pilot study was conducted with three community mental health teams serving an inner-city population in Toronto, Ontario, Canada. The teams provide services in the forms of Assertive Community Treatment, Intensive Case Management, or Early Intervention for Psychosis. Guided by Participatory Action Research (PAR) principles (Swantz, 2008), an interdisciplinary research team, and a diverse Research Advisory Committee composed of psychiatrists, social workers, peer-support specialist, people with lived experience of psychiatric treatment, and a qualitative researcher with a background in social work – together they designed and oversaw the research process. This study was approved by the Research Ethics Board at St. Michael's Hospital, Toronto.

### 2.1. Study design

Eligible participants for this study were those who had been involved in at least one CTO over the past three years as a client (C), provider (P) or SDM (S) connected to one of the three community mental health teams (see Table 1). Three years was chosen as the maximum length of time since the last CTO in order to balance optimal memory of experiences and ensuring adequate pool of potential

**Table 1**  
Participant spread across teams.

	Early intervention <sup>a</sup>	ICM <sup>b</sup>	ACT <sup>c</sup>
Clients	3	1	5
Clinicians	4	3	5
SDMs	3	1	2

<sup>a</sup> Early intervention for psychosis ("First Episode") service for early psychosis.

<sup>b</sup> ICM = intensive case management.

<sup>c</sup> ACT = assertive community treatment.

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