



Review article

Are community treatment orders counterproductive?



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ABSTRACT

Objective: This article briefly reviews the literature pertaining to community treatment orders (CTOs) specifically how and why they are utilised and how effective mandated community treatment really is. This review discusses the use of CTOs in the context of the recovery model.

Conclusions: This article highlights the shortfalls in the current CTO system while also demonstrating the increase in acute coercive care. The literature pertaining to the effectiveness of CTOs is inconsistent with more recent reviews denoting that there is now robust evidence the CTOs are not effective. Further treatment that aligns with the recovery model as oppose to mandated treatment is known to increase treatment compliance.

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1. Background

The principle of patient autonomy is at the heart of modern healthcare; however in contrast to other fields in medicine in psychiatry it is not always possible and feasible for the patient to make autonomous decisions that are in their best interest and the best interest of others. Therefore coercive treatments are relatively commonplace in psychiatric inpatient facilities (Dressing and Salize, 2004) and are increasingly common in the community worldwide (Brookes and Brindle, 2010; Lepping and Malik, 2013). Coercive treatment is justified in psychiatry if it is in the interest of the patient, in the interest of society or related to reasons pertaining to autonomy (Dedman, 1990). The idea that certain people should be treated in order to promote public safety has wide support in national legislations as well as amongst the general public. Coercive measures to protect people from a dangerous person can indeed be justified under certain circumstances (Dedman, 1990). Further psychiatric illness may impair a patient's autonomous capacity; a complicated challenge in

delivering psychiatric care (Prinsen and van Delden, 2009; Sjostrand et al., 2015). Awareness of one's illness is an important parameter in psychiatric examinations and diagnoses. Such insight is necessary for autonomous choice of treatment, and it is also an important feature of mental health (Prinsen and van Delden, 2009). Restoring autonomy (if it is lacking) is therefore an important goal when treating any mentally ill patient. When a patient does not want treatment but cannot be considered capable of autonomous choice, this puts physicians in a situation where coercive care may be motivated for reasons of autonomy (Prinsen and van Delden, 2009; Sjostrand et al., 2015).

2. Community treatment orders

Coercive community based treatment has been growing in the western world since deinstitutionalisation in an effort to bridge the gap between inpatient treatment and treatment in the community for a portion of individuals with severe mental illness [SMI] (McIvor, 1998; Rugkasa and Dawson, 2013). Thus over the past three decades many countries have implemented legal regulations pertaining to coercive psychiatric care in the community, referred to as 'Community Treatment Orders' [CTOs] in Australia (Dedman,

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1990). This form of treatment, in the literature has also been named compulsory community (mental health) treatment or care, (involuntary) outpatient commitment/treatment, supervised community treatment, and involuntary community treatment (Rugkasa and Dawson, 2013; Rugkasa et al., 2014).

Legally sanctioned outpatient treatment generally targets 'revolving door' patients with schizophrenia and bipolar disorder; who are routinely non-adherent to medication and as such have frequent hospital admissions, lack insight into their illness and consequentially are at an elevated risk of relapse (Rugkasa and Dawson, 2013; Burns and Molodynski, 2014). Further Burns and Molodynski (2014) specify that the typical recipient of a CTO is a male with schizophrenia who has numerous prior involuntary hospital admissions and commonly presents as self-neglected and isolated. The fundamental philosophy underlying legally mandated community care is that the patient is allowed to reside in the community as long as they comply with certain conditions of care; most commonly adherence to their medication/s and keeping in regular contact with their mental health care team (Burns and Molodynski, 2014). From an ethical and personal liberty perspective this mode of care is viewed as superior to inpatient hospitalisation as it is the less restrictive option; with the primary aim being to assist patients in maintaining stability while also controlling risk (Rugkasa and Dawson, 2013). If they fail to comply with the ordered conditions of care their ability to reside in the community can be revoked and they may have to return to inpatient psychiatric care. As most CTOs are placed upon patients with SMI and focus upon the adherence to medication; conditions of care commonly mandate the use of long-acting injectable (LAI) anti-psychotics (Lambert et al., 2009; Patel et al., 2011).

Results of studies investigating the efficacy and effectiveness of CTOs upon patient outcomes are mixed. While there are studies reporting positive effects of CTOs, for example Frank et al. (2005) found patients with refractory SMI on CTOs spent a decreased amount of time hospitalised and an increased amount of time living in the community. Similarly Nakhost et al. (2012) found a significant reduction in hospital re-admissions and an increased length of time to readmission under CTOs. Further this effect was found to be sustained beyond the expiration of the CTO (Nakhost et al., 2012).

In contrast an earlier systematic review conducted by Churchill et al. (2007) investigating the use of CTOs internationally found that it could not be determined whether CTOs were advantageous or detrimental to patients. Specifically, the review found that there was no evidence that CTOs reduce length of hospital stays, readmission rates or assist with compliance. More recently the Oxford Community Treatment Order Evaluation Trial a multi-site randomised controlled trial also found that CTOs had no significant impact upon relapse rates (Burns and Molodynski, 2014; Rugkasa and Dawson, 2013; Rugkasa et al., 2014). Further the use of CTOs was questioned due to the results indicating no positive benefit while the CTO significantly impedes the personal liberty of the patient (Burns and Molodnski, 2014).

Similarly two recent reviews also found negligible evidence regarding the effectiveness of CTOs. Firstly a recent Cochrane review found that compulsory community treatment has no significant effect on service use, social functioning, or quality of life compared with standard care (Kisely and Campbell, 2014). Further the only significant positive finding was that patients under compulsory community treatment were less likely to be victims of both non-violent and violent crime (Kisely and Campbell, 2014). Secondly Rugkasa et al. (2014) reviewed the effectiveness of CTOs from an evidence-based medical perspective and concluded that there is no evidence to support the use of CTOs in their current format as they do not reduce relapse, readmission or levels coercion.

Further a recent review conducted by Maughan et al. (2014) aimed at updating the earlier review by Churchill et al. (2007) found little evidence of the effectiveness of CTOs. Specifically, this review indicated that there is now strong evidence from RCTs that CTOs have no effect on hospitalisation and other service use outcomes. While non-randomised studies continue to provide inconsistent results.

How Patient's Experience Coercive Treatment:

The majority of patients experience coercive treatments as negative (Gilbert et al., 2008), although a great proportion also believe there use is, at times, appropriate (Gibbs et al., 2005; Ridley and Hunter, 2013). Some patients perceive coercive treatments as beneficial and as an important component of 'keeping safe' (Gibbs et al., 2005; Ridley and Hunter, 2013). However, use of any form of coercion by staff tends to undermine the development of a trusting relationship with the patient (Gilbert et al., 2008; Sheehan and Burns, 2011) thus negatively impacting the therapeutic alliance between the patient and the treating team. Furthermore a poor therapeutic alliance and a lack of patient involvement in treatment commonly results in poorer treatment compliance and thus treatment outcomes (Fenton et al., 1997; Leamy et al., 2011; Thompson and McCabe, 2012). Although medication compliance is a multi-determined phenomenon one of the best protective factors promoting compliance is an ongoing positive relationship between the patient and physician in which issues affecting compliance can be understood and addressed (Fenton et al., 1997; Thompson and McCabe, 2012). Moreover the use of coercion is contrary to the recovery model of mental illness a model that should be practiced as standard care and the aspired model of care in many countries (Leamy et al., 2011; Noordsy et al., 2002). The recovery model advocates the importance of empowerment, self-control, autonomy, collaboration with professionals and self-responsibility in the recovery process (Leamy et al., 2011; Liberman and Kopelowicz, 2005; Noordsy et al., 2002). Thus the use of coercion and specifically CTOs works against all of these principles and can be counterproductive to the primary aims namely; treatment adherence.

In addition the use of coercive treatments can leave patients feeling traumatised by their experiences (Frueh et al., 2005; Holmes et al., 2004). In a study of patients with schizophrenia who had been treated involuntarily with an injection of antipsychotic medication or by physical restraint, 'fear' and 'powerlessness' were the predominant feelings reported (Naber et al., 1996). Therefore taking patients' preferences into account aligns with the recovery model of mental illness and assists with promoting recovery by fostering a strong and trusting therapeutic alliance. This should result in better patient co-operation, treatment adherence and treatment outcomes, thus increasing patient autonomy and the patient's quality of life (Ambrosini and Crocker, 2007).

3. Conclusion

Worldwide the number of involuntary admissions has increased (Salize et al., 2002; Salize and Dressing 2004; Muller et al., 2006), while at the same time the use of CTOs has also increased (Light et al., 2012; O'Dowd, 2011). This implies that patients with SMI are often progressing to stages where legislated acute coercive treatment is necessary. It is clear that this is an undesirable trend, which not only leads to a very negative experience for the patient as their autonomy is impaired and their personal liberty restricted (Dedman, 1990). It also impacts upon their family and friends as they watch the patient deteriorate (Dedman, 1990). Moreover and most fundamentally it leads to poorer outcomes and prognosis for the patient. As when intervening at a later stage of decompensation, psychotic episodes take longer to remit, and the restoration of premorbid functioning is less optimal in comparison with early

intervention (Dedman, 1990; Heres et al., 2014). Therefore steps need to be taken to attempt to reverse the increasing trend of the need for legislated coercive treatment and the associated costs to the patient and society.

The research indicates a lack of effectiveness of CTOs upon patient outcomes and hospitalisations (Kisely and Campbell, 2014). It should be noted that although the effectiveness of CTOs is lacking there will still be a small subset of the population that require mandated treatment merely for control and risk reduction. However there is a larger portion that would benefit from less coercive care that aspires to providing care in accordance with the recovery model.

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