Community treatment orders for patients with psychosis

Tom Burns and colleagues (May 11, p 1627)[1] randomised patients being discharged from hospital with a diagnosis of psychosis to either a community treatment order (CTO) or Section 17 leave of absence. They concluded that CTOs do not reduce the readmission rate of patients with psychosis. We have several concerns regarding this Article.

First, the investigators compared two forms of coercive compulsory community treatments and did not find a difference between them. The control group (Section 17) received a mean of 134·6 days of treatment compared with 241·4 days for the CTO group. Other studies, which have shown a beneficial effect for CTOs, used control groups in which patients did not undergo compulsory community treatment.[2,3] Hence, we are concerned with the broad interpretation of the data in this study.

Second, in many jurisdictions the criteria for qualifying for a CTO are more stringent than what was described by Burns and colleagues. In most Canadian provinces using CTOs, patients must meet the criteria for inpatient committal and have spent a specified amount of time as psychiatric inpatients in the previous 2–3 years.[4] Many jurisdictions require a court hearing before a CTO is issued.[4,5] In the Canadian province of Quebec, where CTOs allow forced treatment in the community, the court makes its final decision for issuing a CTO on the basis of the patient's incapacity to consent to or refuse treatment.[5] Thus, studies in some other jurisdictions include largely the very patients excluded by Burns and colleagues, since they required that patients be capable of giving informed consent. These issues limit the external generalisability of this work.

Third, although restrictions such as place of residence might be included in CTOs, the frequency of the use of such restrictions, and the findings for this potentially more impaired subgroup were not presented.

We declare that we have no conflicts of interest.

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1 Burns T, Rugkåsa J, Molodynski A, et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* 2013; **381:** 1627–33.
2 Swartz MS, Swanson JW, Wagner HR, et al. Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *Am J Psychiatry* 1999; **156:** 1968–75.
3 Hunt AM, Da Silva A, Lurie S, et al. Community treatment orders in Toronto: the emerging data. *Can J Psychiatry* 2007; **52:** 647–56.
4 O'Reilly RL, Brooks SA, Chaimowitz GA, et al. Mandatory outpatient treatment. Canadian Psychiatric Association position paper. http://publications.cpa-apc.org/browse/documents/69 (accessed July 21, 2013).
5 Nakhost A, Perry JC, Frank D. Assessing the outcome of compulsory treatment orders on management of psychiatric patients at 2 McGill University-associated hospitals. *Can J Psychiatry* 2012; **57:** 359–65.

The report by Burns and colleagues[1] of a rigorous examination of community treatment orders (CTOs) is an impressive achievement. Their OCTET study answered the question: "Are CTOs superior to extended Section 17 leave in reducing readmission?" with a firm "no". However, this finding comes as less of a surprise when one considers that the level of coercion at point of randomisation will be much the same whether a patient is assigned to CTO or Section 17 leave. In practice, when faced with a patient needing repeated admissions a clinician asks themselves: "Will a CTO be better than unconditional discharge from section in reducing readmission?". There is a distinction between these two questions and unfortunately we are still without an answer to the latter.

Although OCTET has not proved that CTOs are ineffective, the investigators are correct in stating that there is no good evidence to support their use. A major sociolegal intervention has been introduced that might have a greater effect on patients' lives than any drug treatment. Yet this intervention has been introduced without any of the stringent testing that is needed for approval of a new pharmacological agent. I expect that the challenges of obtaining ethical approval might have been one of the reasons that participants in the control group were initially given leave rather than discharged outright, yet we have to ask ourselves what are the ethics of treating patients with an intervention that they will often not desire when we have no evidence of its benefit?

I declare that I have no conflicts of interest.

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1 Burns T, Rugkåsa J, Molodynski A, et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* 2013; **381:** 1627–33.

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Psychiatric care is often organised on a legal framework that is not validated from a scientific perspective. To overcome this problem, Burns and colleagues[1] tested whether community treatment orders (CTOs) reduced admissions compared with use of Section 17 leave and identified no support in terms of any reduction in overall hospital admission.

However, despite the absence of significant evidence of superiority, the two interventions are not necessarily equivalent. For ethical, practical, and legal reasons, 21% of the patients in the CTO group and 24% of the patients in the Section 17 leave group were switched to the other intervention. When such protocol violations are the rule rather than the exception, intention-to-treat (ITT) analysis is much too conservative to claim