Oxfordshire and Buckinghamshire Mental Health NHS
NHS Foundation Trust

OCTET

Oxford Community Treatment Order Evaluation Trial

The International Evidence

There have been a number of studies of the implementation and effects of CTOs, particularly in Australia, New Zealand, the US, and Canada. This research has been reviewed in detail by Dawson (2005) and Churchill and colleagues (2007). The majority of this research was observational, non-randomised studies, explorative studies of stakeholder views, evaluations of initiatives etc. It is therefore, as both reviewers warn, problematic to generalise from findings. Generalisability may also be problematic because of differences between the contexts into which CTOs have been introduced.

Dawson (2005) points out that after an initial "bedding in" period, the use of CTOs often increases, particularly where there is a reduction in hospital beds and build-up of community teams. Therapeutic benefits for patients are reported such as greater compliance with outpatient treatment (particularly medication), and reduced rates of hospital admissions. Some studies show better relationships between patients and their families, enhanced social contact, reduced levels of violence or self-harm, and earlier identification of relapse. Dawson's review also identifies potentially negative effects of CTOs, such as a strong focus on medication (particularly depot medication) as opposed to other treatments, that they were often used for the maximum time allowed and possibly over-used.

Churchill and colleagues (2007) report similar findings. They also found that various stakeholder groups hold very different views about CTOs. However, avoiding involuntary hospitalisation was the shared top priority for patients, family members, clinicians and members of the general public alike. They found that where CTOs are implemented, they are consistently directed towards 'revolving door' patients: mainly men around 40 years of age, in the middle phase of their illness with a diagnosis of schizophrenia, with several prior hospital admissions and a history of non-compliance with outpatient care. Many had problems with substance misuse and had experienced imprisonment or forensic care. Most were single, living in rented accommodation alone or, less often, with their family.

Only two randomised controlled trials (the 'gold standard' for evidence of effectiveness of treatments or interventions) have been conducted on CTOs. The New York trial (Steadman et al 2001) has been criticised for being poorly controlled and unrepresentative of routine care, and with a high attrition rate. No significant differences were found. The North Carolina trial (Swartz et al 1999) was more rigorously conducted and has been highly influential. Although this trial also found no significant differences overall, there were significant differences in subsamples. Those who received sustained CTOs (more than 180 days) and regular (weekly) clinical contact had 57% fewer readmissions and 20 fewer hospital days overall compared with the control group. This increased to 73% and 28 fewer days among those with schizophrenia. These findings may reflect selective prolonging of CTOs when it seemed to benefit a patient, so do not constitute proof of overall effectiveness. Similar findings have, however, been reported in an epidemiological study by Kisely and colleagues (2006). Swartz concludes that CTOs may be of benefit when they represent "a reciprocal commitment by community programs to provide sustained and intensive treatment to patients under court orders" (Swartz et al 1999). Kisley's Cochrane review of the two CTO RCTs (Kisely et al 2005) concluded that there is an urgent need for good quality RCTs in this field, particularly to establish whether it is the intensity of treatment or the compulsion in itself that affects outcomes of CTOs.

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