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An Analysis of *Community Treatment Orders in Ontario: The Emerging Data*

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Abstract

This paper will analyze the article, *Community Treatment Orders in Ontario: The Emerging Data* (Hunt, da Silva, Lurie, & Goldbloom, 2007). It will discuss the pros and cons of community treatment orders (CTO) as well as ethical issues regarding CTOs. CTOs are an important topic for psychiatric nurses to understand as there is a measure of coercion involved with CTO use. Anytime a client loses rights or must comply with a treatment in a mandatory manner, psychiatric nurses must seriously look at the ethical implications. This article will address numerous gaps in research methodology and statistics as well as look at human factors with regard to CTOs. The author of this paper will argue that CTOs are a helpful tool in spite of some of the flaws in the research.

Keywords: Community Treatment Orders, Ethics, methodology, Pros, Cons, argument

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An Analysis of *Community Treatment Orders in Ontario: The Emerging Data*

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The author chose to analyze the article, *Community Treatment Orders in Ontario: The Emerging Data* (Hunt, da Silva, Lurie, & Goldbloom, 2007), because community treatment orders (CTO) are a controversial subject. CTOs ensure treatment and support for people who have severe mental illness. If a person with a CTO fails to comply with a treatment, the police can take that person in for treatment. Some researchers say CTOs are valuable tools for treating people with mental illness while other researchers say there is not enough empirical evidence to conclude that CTOs are helpful. Some say CTOs infringe on the client's rights (Lawton-Smith, Dawson, & Burns, 2008). As advocates for clients' rights, psychiatric nurses should understand the research on this topic so they can better advocate for their clients.

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Hunt et al. (2007)'s article presents original research into the field of CTOs. Specifically, they compared people on a CTO ($n = 224$) to people not on a CTO ($n = 92$) to determine whether there was a difference in hospital stays and continued utilization of health services after discharge from hospital. The researchers were trying to determine whether or not CTOs were effective at increasing mental health service utilization and reducing hospitalization. The researchers hypothesized that there would be no significant differences between CTO and non-CTO groups in terms of hospital usage and that people in the CTO group would be more likely to discontinue treatment once the CTO was expired or cancelled.

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In order to determine whether there was a difference between the CTO and non-CTO groups, Hunt et al. (2007) used a cohort study design. There was a pretest and posttest phase. To ensure both the CTO and non-CTO groups were similar in makeup, the researchers compared a number of sociodemographic and clinical variables. This was to reduce the amount of variance that could be attributed to different sociodemographic and clinical variables. Both groups were

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similar in makeup in terms of sex, age, race, native language, education, and diagnosis. Most of the participants had schizophrenia or a mood disorder. One difference between the two groups was that there were a higher percentage of CTO clients that lived with family in a private residence. After examining medical records (pretest) and following up with all of the participants (post-test), Hunt et al. (2007) found that the number of hospital admissions decreased six to twelve months after the CTO was implemented. Interestingly, this effect lasted after the CTO expired if proper supports were in place. CTO implementation also decreased the cumulative days spent in hospital per admission. When proper supports were implemented, participants in the non-CTO group also saw reduced hospitalization. Therefore, it was inconclusive as to whether the CTO was responsible for reduced hospitalization (Hunt et al., 2007). However, Hunt et al. (2007) felt that clinical experience suggested that CTOs help to engage clients with case management. Overall, CTO clients had a bigger reduction in days in hospital compared to non-CTO clients. Unfortunately, less CTO clients remained in case management after the CTO expired compared to non-CTO clients. Upon further statistical testing, there was a small subgroup of CTO clients that discontinued treatment. Overall, 72% of CTO clients remained in treatment voluntarily. Hunt et al. (2007) used these results to conclude that CTOs were useful for engaging clients who would have refused treatment to stay voluntarily in treatment.

Using the evidence from the study, Hunt et al. (2007) concluded that CTOs are useful for engaging clients who would otherwise refuse treatment. Because 72% of CTO clients voluntarily stayed in treatment, the researchers concluded that CTOs are useful for maintaining health service utilization. Finally, the researchers concluded that CTO usage was associated with decreased numbers of hospital admissions and overall hospital stay time.

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If these conclusions are accepted as fact, it can be concluded that CTOs are effective tools for promoting mental health. Only 28% of CTO clients discontinued treatment after the CTO expired. Another implication, if the conclusions are accepted as fact, is that CTOs can save money by reducing the number of and duration of hospital stays. If the conclusions are discredited, there is still ambiguity as to whether CTOs are effective tools for treatment.

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Some of the researchers' assumptions could be troublesome. One of these assumptions regarded the severity of mental illness as there was no measure in place that identified the illness severity. The researchers assumed the illness was severe. This may not have been the case. Perhaps some of the non-CTO client's illnesses were not as severe. This would affect their hospitalization comparisons. Another assumption relates to the type of treatment the clients where getting. The type of treatment is not discussed. This may be an important variable. Another factor the researchers might have looked into was the difference in living conditions between the CTO and non-CTO groups. The CTO group participants tended to live in a private home with family while non-CTO participants tended to live in non-family homes (i.e. boarding homes). Perhaps living with family members is the difference between continuing treatment voluntarily and discontinuing treatment. Perhaps living with a supporting family helps the client cope. The researchers did not follow up with the people who discontinued treatment. Perhaps those who discontinued treatment could manage independently. Interestingly, the researchers point out that a non-randomized cohort study is not as experimentally rigorous as a randomized controlled trial. This is not necessarily true. The two experimental designs yield different types of information. One is not better than the other. A final assumption by the researchers involves statistics. The researchers used Chi square analyses which are appropriate as long as each subgroups they were analyzing had more than five members (Gravetter & Wallnau, 2007; Pallant,

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2007). Some of the subgroups that Hunt et al. (2007) applied this analyses to had fewer than five members. This means the test for significance will be distorted. The researchers' hypotheses showed that they did not think CTOs were useful tools.

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Other research supports Hunt et al. (2007)'s conclusions. For example, Segal and Burgess (2008) studied 8879 hospital records and found that those who were hospitalized because of community-based CTOs (i.e. CTOs issued by the community; not the hospital) had significantly less inpatient care compared to a comparison group of people with hospital issued CTOs. Further, Muirhead, Harvey, and Ingram (2006) did another study which found that CTOs were associated with an increased number of service contacts, decreased number of hospital admissions, and a decreased length of inpatient stay for clients with schizophrenia. They also found a decreased relapse rate and a trend towards fewer crisis team referrals when CTOs were used. Burgess, Bindman, Leese, Henderson, and Szmukler (2006) found that CTOs issued on discharge from a hospital were associated with increased risk for readmission but CTOs after this second admission reduced risk of further admission. Some studies used different outcome measures for

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CTOs. For example, Ingram, Muirhead, and Harvey (2009) examined whether episodes of aggression, homelessness, and self-harming behaviour decreased when a CTO was used. They also looked at whether participants visited family more and if employment increased. They found that aggressive episodes were cut in half from the year before CTO implementation to the year of CTO implementation. There were also decreases in homelessness. Ingram et al. (2009) concluded CTOs could help increase quality of life for those with schizophrenia. O'Brien, Farrell and Faulkner (2009) found that clients who were issued a CTO had increased likelihood of utilizing community services and an increased likelihood of going to a supportive housing environment. Finally, O'Reilly, Keegan, Corring, Shrikhande, and Natarajan (2006) interviewed

clients and their relatives about CTOs. O'Reilly et al. found that most clients who were interviewed experienced coercion while under the CTO. However, many thought that the CTO provided much needed organization for their lives. Family members of the clients viewed CTOs in a positive light. They thought that CTOs were useful for helping their family member.

It is true that a lot of the research on CTOs has design flaws. Some of the major flaws involve a lack of randomization, no true control group, small sample sizes, and possible extraneous variables. That said, the author of this paper would argue that there is a significant body of work that shows there are many benefits to CTOs. These benefits include: reduced number and duration of hospital stays, decreased risk of homelessness, decreased aggressive behaviour, and increased compliance for treatment after the CTO has expired. The author is not saying CTOs should be used lightly. Efforts have to be made to get a client to seek treatment on his/her own before a CTO is used. However, CTOs can be a very useful tool if all else fails.

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