In Debate

Clearing Away the Smoke and Mirrors: Response to Dr O'Reilly

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The arguments made by Dr O'Reilly are largely smoke and mirrors, with facts taken out of context to buttress his position. We are told that studies of CTOs have exceeded 4000 subjects, but Dr O'Reilly does not mention that only 416 subjects have completed RCTs. Dr O'Reilly also fails to mention that the benefits of CTOs largely disappear when people are compared with randomly or appropriately matched control subjects. This finding includes preliminary results from Ontario comparing patients on ACT and CTOs with patients on ACT alone—results showing no additional benefit from CTOs (1). Regarding the assertion that CTOs improve compliance with follow-up, our initial argument also dealt with the fallacy of relying on outpatient contacts to evaluate CTOs. The NNT is useful in summarizing the effects of RCTs. Depending on how the NNT is calculated, it would take up to 100 CTOs to avoid a single admission and 500 to avoid an arrest, although these figures are lower, but still unacceptable, with intention-to-treat analyses (2).

Dr O'Reilly also chides us for overreliance on RCTs. On the contrary, we endorse the use of interrupted time series and controlled before-and-after designs that meet the Cochrane Collaboration's criteria for inclusion in their increasing number of reviews that extend beyond RCTs. We would hardly dismiss a methodology that has formed the basis of our own quasi-experimental studies (3,4). However, any study design has to meet minimum criteria, and when we tried to extend our original Cochrane Review (2) to other designs, we could only include another 3 studies—and even with 1108 subjects, results remained inconclusive (5).

Clinical experience, as well as research evidence, informs our skepticism about CTOs. We are skeptics but not opponents of CTOs—our view would change were appropriate evidence to appear. One of us worked for several years in Western Australia, where CTOs were introduced in 1998, and observed that compulsory treatment does not translate well into the community. The level of clinical observation and supervision can never reach the level that is possible with inpatients. Patients with florid psychosis simply refused any treatment and still had to be admitted compulsorily when they became too ill. Those with encapsulated delusions simply bided their time, finished their order, and then openly refused the medication that we were never sure they had been taking in the first place. Dr O'Reilly's more positive experiences may be influenced by the requirement for patients or substitute decision makers in Ontario to consent to a CTO—a sort of advance directive with attitude. Such cases will always have a better prognosis, which cannot be said of patients who refuse to comply with any intervention in the community. In current practice in Halifax's North End, a socially deprived area where patients often have multiple comorbidities, limited insight, and few social supports, CTOs would do little to help.

Here are the key questions:

- Would any other intervention be introduced with so little evidence? Proponents may mix and match designs to fit their opinions, but the fact remains that CTOs do not produce the desired results when recipients are compared with randomly or appropriately matched control subjects.
- Why is this measure so popular with legislators? It is popular because passing legislation is easier than addressing inadequate funding for psychiatric services.
- Why are families so keen on this measure? They like it because, given current funding levels, they are desperate for anything that promises assistance, however illusory. If you are drowning, you will gladly climb aboard a lifeboat, however leaky—but this enthusiasm is not

Abbreviations used in this article

CTO	community treatment order
ACT	assertive community treatment
RCT	randomized controlled trial
NNT	number needed to treat

shared by patients. One has likened CTOs to "house arrest in home-based institutions."

- Why are clinicians joining the CTO bandwagon and letting politicians off the hook when we should be uniting with families and patients to achieve decent funding levels for psychiatric services? Ask them, not us.

References

1. Freeland A, O'Brien A, Farrell S. The impact of community treatment orders on patients with assertive community treatment and without. Proceedings of the 29th International Congress on Law and Mental Health; 2005 July 2– 8; Paris FR). Available: www.ialmh.org/Paris2005/Abstract_Final.pdf. Accessed 2006 Jul 4.
2. Kisely S, Campbell LA, Preston N. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Systematic Review 2005 Jul 20;3:CD004408.
3. Preston NJ, Kisely S, Xiao J. Assessing the outcome of compulsory psychiatry treatment in the community: epidemiological study in Western Australia. BMJ 2002;324:1244–6.
4. Kisely SR, Xiao J, Preston NJ. Impact of compulsory community treatment on admission rates: survival analysis using linked mental health and offender databases. Br J Psychiatry 2004;84:432–8.
5. Kisely S, Campbell LA, Scott A, Preston NJ, Xiao J. Randomized and non-randomized evidence for the effect of compulsory community and involuntary outpatient treatment on health service use: systematic review and meta-analysis. Psychol Med 2006. Forthcoming.

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