Community Treatment Orders in England:

The state of the evidence
And a recent RCT
Community treatment orders

- Exist in over 70 jurisdictions
- Legal regimes and terms vary,
- Obliged to adhere to treatment. Rapid recall
- Patients very similar
CTO studies

RCTs 2

Controlled 9

Descriptive 61
RCT evidence

New York (2001) 144 pts 50% fu

N Carolina (1999) 264 pts 100% fu

No difference in readmission in either
Do CTOs reduce the readmission rate in psychosis patients discharged from section 3 over the subsequent 12 months?

Need to utilise the window of opportunity while clinical equipoise existed

Catastrophe strikes
Ethics committee refused approval
What to do?
Take a plane and run away
As far away as possible - New Zealand
Go deep into the bush in search of rare creatures..
The shy, reclusive International Mental Health Lawyer
Randomisation to section 17 leave legal
Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial

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Summary

Background Compulsory supervision outside hospital has been developed internationally for the treatment of mentally ill people following widespread deinstitutionalisation but its efficacy has not yet been proven. Community treatment orders (CTOs) for psychiatric patients became available in England and Wales in 2008. We tested whether CTOs reduce admissions compared with use of Section 17 leave when patients in both groups receive equivalent levels of clinical contact but different lengths of compulsory supervision.

Methods OCTET is a non-blinded, parallel-arm randomised controlled trial. We postulated that patients with a diagnosis of psychosis discharged from hospital on CTOs would have a lower rate of readmission over 12 months than those discharged on the pre-existing Section 17 leave of absence. Eligible patients were those involuntarily admitted to hospital with a diagnosis of psychosis, aged 18–65 years, who were deemed suitable for supervised outpatient care by their clinicians. Consenting patients were randomly assigned (1:1 ratio) to be discharged from hospital either on CTO or Section 17 leave. Randomisation used random permuted blocks with lengths of two, four, and six, and stratified for sex, schizophrenic diagnosis, and duration of illness. Research assistants, treating clinicians, and patients were aware of assignment to randomisation group. The primary outcome measure was whether or not the patient was admitted to hospital during the 12-month follow-up period, analysed with a log-binomial regression model adjusted for stratification factors. We did all analyses by intention to treat. This trial is registered, number ISRCTN73110773.
OCTET

• 32 Trusts, multisite clinical effectiveness pragmatic trial,
• 333 psychosis patients
• On sec 3 considered suitable for CTO
• Primary outcome readmission rate
  – Secondary outcome time to readmission
• Broadly equivalent treatments
• Randomisation worked
• 100% follow up at 12 months
Results
Proportion readmitted: (primary outcome)
100% of data collected

36% (59 out of 166) for CTO
36% (60 out of 167) for Section 17
Time to readmission
median CTO 295 days vs 292 days

HR 1.00 (95%CI 0.70-1.43), p=0.983
All three RCTs show no benefit

‘In well functioning mental health services CTOs do not reduce the readmission rate, time to readmission or time in hospital for psychosis patients in the 12 months from discharge’.

The results are clear and strong: CTOs do not work. Can we ignore these results?
Final thoughts

- We over-attribute causality
- We ignore regression to mean
- We are hopeless at grasping probabilities
Insulin Coma treatment

1934 - 1954

Acker and Osner RCT, Lancet 1954
Don’t shoot the messenger!