Coercion in mental health: a trial of the effectiveness of community treatment orders and an investigation of informal coercion in community mental health care

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Plain English summary

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Coercion outside hospital reflects concern over difficulties in helping individuals with severe mental illness to stay well in community care: ensuring that they take their medication and keep in touch with services. In mental health care, *formal coercion* (*compulsion*) means compulsory treatment. Community treatment orders (CTOs), introduced in 2008, permit mental health teams to treat patients involuntarily at home but recall them if necessary. *Informal coercion* refers to pressures exerted by professionals to induce the patient to stick to treatment. They include *leverage,* where aspects of care (e.g. access to restricted accommodation) are made dependent on patients agreeing to continued treatment.

The Oxford Community Treatment Order Evaluation Trial (OCTET) examined effects of CTOs on 336 patients with psychosis diagnoses discharged from compulsory inpatient care. We conducted a randomised controlled trial (RCT) where half were discharged on a CTO and half to voluntary care. We tested whether or not CTOs reduced the rate of further psychotic episodes (measured by readmission) over 12 months. CTOs neither reduce the number of relapses nor demonstrate improvements in well-being or reductions in costs. Patients, family carers and psychiatrists reported mixed experiences. Our results mirror those in two published RCTs and we concluded that there is no clinical or ethical justification for CTO use.

The OCTET Follow-up Study followed up the same patients for another 24 months. There was still no evidence for CTOs being beneficial. We tested whether or not CTO use leads to improved follow-up or disengagement from mental health services and found no differences.

The Use of Leverage Tools to Improve Adherence in community Mental Health care (ULTIMA) Study investigated lifetime informal coercion, measured primarily by the reported rates of leverage. We asked four distinct clinical groups, totalling 417 people in voluntary community care with mental health and substance misuse services. One-third reported that they had been ‘leveraged’, with housing support being the most common inducement. This mirrors US patterns but with lower rates. Patients and professionals expressed positive and negative views about leverage, and we also identified a wider range of pressures than those previously described. We produced some ethical guidance for the use of informal coercion.

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