Authors Should Have Gotten the Facts Right on Community Treatment Orders

Dear Editor: I wish to correct just 2 of the factual errors in O’Brien and Farrell’s recently published article on community treatment orders (CTOs) (1). The authors refer (twice) to Australian studies: in the first reference, they describe the paper by Preston and others (2) as a small-sample retrospective study of hospital bed-day use; in the second (1), they state that Australian studies demonstrated reduced hospital use by patients on CTOs.

As one of the authors of the paper by Preston and others, I can assure readers that it was neither a small-sample retrospective study of hospital bed-day use nor a vindication of the effectiveness of CTOs (2). We used contemporaneously collected routine administrative data from all community-based and inpatient psychiatric services in Western Australia, covering a population of 1.7 million. We undertook an epidemiologic study with a before-and-after, 2-stage design of matching and multivariate analysis, controlling for sociodemographic variables, clinical features, and psychiatric history. We had a sample size of 456 subjects and control subjects. Our results showed no difference in hospital admissions or time spent in hospital between subjects on CTOs and control subjects. These results were confirmed in a later paper where we were able to adjust for forensic history (3).

Our paper’s methodology is consistent with the criteria that the Effective Practice and Organisation of Care (EPOC) group of the Cochrane Collaboration use for inclusion in Cochrane reviews (4). These include contemporaneous data collection (n = 456) and the use of appropriate control groups. I rather suspect that the data from O’Brien and Farrell’s sample (n = 25), collected retrospectively and without blinding or control subjects, would not be consistent with these criteria. Given these methodological problems, their results cannot support their sweeping claims that CTOs are effective tools for allowing patients to live in the least restrictive setting or that CTOs reduce rates and lengths of readmission.

I am aware of only one other Australian study that compared patients on CTOs with control subjects (5). In it, the authors were clearly more circumspect than O’Brien and Farrell in the interpretation of their findings. In the light of problems with matching their CTO groups and control subjects, Vaughan and others state that “Evidence of lower severity of illness in the comparison patients prevented meaningful evaluation of the readmission rates of the 2 groups” (5, p 801).

If O’Brien and Farrell wish to incorrectly interpret their own results to favour a particular viewpoint, they should at least have the courtesy to report others’ results accurately. In this case, evidence appears to be in the eye of the beholder.

References


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Reply: Ann-Marie O’Brien Responds

Dear Editor: We wish to thank Dr Kisely for his interest in our study. We sincerely apologize for including Dr Kisely’s study in the group with others described as “small sample.” As Dr Kisely has pointed out, his study included 456 patients (1). We must clarify that we did not refer to Australian studies twice, as Dr Kisely stated: we referenced 3 Australian papers (1-3).

We did not say that Australian studies demonstrated reduced hospital use in patients on community treatment orders (CTOs), as Dr Kisely suggests. Rather, we stated “Our study findings are consistent with studies in the US and Australia that demonstrate reduced hospital use and increased use of other supportive services” (4, p 29). We stand by this statement and remind Dr Kisely that his own study demonstrated a significant increase in follow-up in the patients who were on CTOs (1). Conclusions based on our study are for subjects in our study. We do not presuppose increased generalizability. There is no incorrect interpretation of our results; instead, we provide a thematic review of others.

CTOs occur within distinct cultural contexts that have largely been ignored in the scientific literature. In Canada, clinicians and policy makers have made decisions about the usefulness of CTOs, based on outcome studies conducted within cultural contexts significantly different from our own. The value of this study is that it is the first published outcome study using Canadian data.

References


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