CHECK THESE OUT...

Mental Illness Policy
Kendra's Law Guide
http://mentalillnesspolicy.org/kendras-law/kendras-law-guide.html

Nursing Times
Article discussing the absent research base to support CTOs
http://www.nursingtimes.net/home/behind-the-headlines/community-treatment-orders-dont-reduce-psychiatric-readmissions/5057725.article

Mental Health Law Online
Information regarding England's laws, policies, and regulations around CTOs.
http://www.mentalhealthlaw.co.uk/Community_Treatment_Order

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TOPIC WATCH

Each month we will feature a different topic; expanding the knowledge, resources, and peer networking in targeted areas. These target areas will include workforce development, transition, supported education, leadership, organizational development, sustainability, and others as they are identified.

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Community Care and In-Patient Care: Benefit Claims on Both Sides

One of the central conflicts in current thinking about how to best meet the needs of individuals with mental health concerns centers on the question of how to serve people while allowing them the sense of freedom and empowerment that comes with living in the community. On the one hand, many advocates assert that a meaningful life in the community is essential to recovery. On the other hand, various professionals and policy makers have argued that individuals with mental health needs are better served in an in-patient setting where they can be closely monitored and treated.

While many users of community-based mental health services proclaim its benefits, especially when those services are provided within the context of a consumer driven approach, some researchers argue that community-based care does not replace, nor is it more effective than, inpatient care. Even within the research field itself, there is disagreement regarding the efficacy of community-based care versus inpatient care, especially as it relates to the mandated treatment of people that may not want to participate in their own care.

The issue of supporting people recovering from mental illness in the community has grown further clouded by the introduction of the "public safety" argument that has been made in favor of compulsory treatment in different settings throughout the nation. This argument rests on the now-debunked assumption that people with mental illness are inherently dangerous and likely to harm others, and that people must therefore be treated against their will for the greater public good.

One of the best-known examples of this controversy is New York “Kendra’s Law” and its supporters’ claim that it has significantly reduced many of the associated negative outcomes of mental illness. Kendra’s Law was initially proposed in 1999, by families of individuals with the most serious mental illnesses as a way to help their loved ones while simultaneously keeping society safer. Kendra's Law does two things:

1. It allows courts - after extensive due process - to order a certain group of narrowly defined individuals with serious mental illness who already have a past history of multiple arrests, incarcerations or needless hospitalizations to accept treatment as a condition for living in the community. Before Kendra's Law, the law required people so ill they refuse treatment to become dangerous before they could be required to accept treatment. Families felt the law should prevent dangerous behavior, rather than require it.
2. Kendra's Law allows judges to order the recalcitrant mental health system to serve people with serious mental illness, rather than cherry picking the easiest to treat for admission.

Researchers behind some studies asserting the positive outcomes of Kendra’s Law are accused of producing claims that mandated treatment orders *by themselves* play a key role in improving outcomes, although scientific head-to-head proof is lacking. There is ample of research to show that people who get more and better services do better. The question at issue is whether “mandated” mental health services can improve outcomes. In comparing treatment given to those with and without court orders, many studies fail to ensure that both groups receive the same level of enhanced care. In practice, Kendra’s Law patients receive priority access to a significantly higher level of services than those not under a court mandate, thus skewing the results to make mandate care seem more effective. Other studies that measured the outcomes of voluntary and mandated groups that received identical level of services found “no statistically significant differences” on “all major outcomes measures” and concluded that “the package of enhanced services” caused the improvements, not the court orders.

The use of these mandated courses of treatment, often known as “Community Treatment Orders” (CTO), are not isolated to NY. They have been used for some time in England, Canada, and Australia, where CTO’s are a legal measure that allows mental health teams to impose compulsory supervision on a patient after they have been discharged from an involuntary stay in hospital. In those settings, they have yet to convince a majority of researchers that they have the capacity to reduce hospitalizations or improve overall mental health. In England, CTO’s were introduced in 2008 as a means of addressing the problem of revolving door inpatients who were detained for treatment for a mental disorder, then released back into the community, often with little support or after-care, who predictably ended up back in the system. It was felt that those patients often refused to cooperate with community mental health teams and would not take their prescribed medication, which could not be enforced outside of the hospital. However, despite the “enforcement” of treatment, a recent study found that CTO’s did not reduce the length of time patients stayed in hospital, the severity of their symptoms, or how they coped in society.

One of the major shortfalls of compulsory care like that codified in Kendra's Law or Community Treatment Orders is that it places the individual with mental health needs in opposition to those providing care, instead of promoting empowerment and cooperation, as the Recovery-Resiliency Model does. A recent comment by Natalie Banner states the obvious; "If anything, this overuse of CTO's is disempowering and disenfranchising: hardly the best route to building much-needed trust between patients and mental health services and enabling people to manage their own lives" (Humanities and Mental Health. 2008. http://humanitiesandhealth.wordpress.com/2010/10/28/community-treatment-orders-and-the-mental-health-act/).

The Recovery Model is an approach to mental health that emphasizes and supports each individual's potential for recovery. Recovery is seen within the model as a personal journey, which may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. Mental health recovery is a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (National Consensus Statement on Mental Health Recovery).

Mental health advocates for a community-based, consumer-driven, recovery model might consider the following while keeping an eye on the national debate regarding CTO's:

- Is there ample research that indicates the efficacy and effectiveness of CTO? What is missing as necessary research?
- Is the CTO practice compatible with the empowerment, resiliency, recovery, and consumer-driven models currently in place?
- Would most individuals requiring community-based mental health services and treatment see improvements if they were offered an expanded array of services?
- Would the current state of CTO's be considered a sound foundation for movement toward it becoming an evidence-based practice?
- Are there situations where a CTO should be considered?
- What assumptions underlie the CTO model? Who does it benefit?

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