Exploring experiences with compulsory psychiatric community treatment: A qualitative multi-perspective pilot study in an urban Canadian context

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Abstract

As medical, ethical and clinical effectiveness debates about the use of compulsory psychiatric treatment continues, it is important to further explore the actual experiences and perspectives of all relevant stakeholders in community treatment orders (CTOs). This qualitative pilot study engaged a total of twenty-seven clients, their family members, and care providers in Toronto, Canada. Semi-structured, one-on-one interviews were conducted between February and July 2013 and analyzed using thematic analysis. Top key themes from all the participants identified include, among others: 1) clients’ experiences of coercion while treated under CTO, but a preference for CTOs compared to involuntary hospitalization, nevertheless; 2) limited real opportunities for collaboration in treatment decisions expressed by clients and family members; 3) acceptance of the potential for clinical recovery on CTOs while debating the role of CTO in a broader recovery journey by all stakeholders; 4) general preservation of therapeutic relationships between clients and care providers, while acknowledging the tension of taking on an “enforcer” role by providers; and 5) existence of different avenues for asserting agency by clients. The findings of this research illuminate the nuanced, complex, and adaptive perspectives held by different stakeholders, point to the importance of preserving and enhancing procedural justice in their use, and alert the field to incorporate recovery-based approaches in this controversial practice that is a widely and commonly used clinical tool across many jurisdictions.

1. Introduction

Over the last three decades, many countries have adopted various forms of compulsory Community Treatment Orders, or CTOs. These orders are similar in that they mandate individuals with established history of serious mental illness (SMI) and poor adherence to treatment to accept treatment in the community – failure of which could result in involuntary hospitalization. CTOs have been the subject of on-going debates. Proponents present CTOs as a less restrictive alternative to involuntary hospitalization, and as a pathway leading towards better treatment outcome, contributing to recovery (Geller, 2012; O’Reilly, Brooks, Chaimowitz, et al., 2009); while opponents argue that CTOs violate personal rights, and that coercive treatment is contradictory to self-determination and recovery (Kisely & Campbell, 2006; Snow & Austin, 2009).

There are numerous quantitative CTO studies, including randomized control trials (Burns, 2014; Steadman et al., 2001; Swartz, Swanson, Wagner, Burns, et al., 1999), notable pre-post and cohort studies (Kisely et al., 2013; Van Dorn et al., 2010), and Canadian specific studies (Frank, Perry, Kean, Sigman, & Geagea, 2005; Hunt, Silva, Lurie, & Goldbloom, 2007; Nakhost, Perry, & Frank, 2012; O’Brien & Farrell, 2005) have found variable, at times contradictory, but generally positive results of CTO in reducing length of psychiatric hospitalizations and improving treatment adherence (Geller, 2013; Kisely, 2016; Kisely, Campbell, & Preston, 2011; Nakhost, Perry, & Simpson, 2013; Swanson & Swartz, 2014). While it is recognized that local differences in legislation and enforcement of CTOs, as well as variable health care systems and availability of social services in each jurisdiction limit the generalizability of the quantitative findings (Churchill et al., 2007; Francombe Pridham et al., 2016; Kisely, Cambell, Scott, Preston, & Xiao, 2007;...
1.1. Experiencing compulsory community care: what do we know so far?

A recent review, focusing on experiences of compulsory community care found that clients on CTOs felt more coerced into treatment when compared to voluntary clients, though the levels of coercion varied considerably by study and jurisdiction (Francombe Pridham et al., 2016). The review indicated that the interventions someone is exposed to in addition to the CTO contextualize that person's CTO experience. These may include past involuntary hospitalization, involvement in the criminal justice system, and controlled access to finances and housing (Francombe Pridham et al., 2016). In some qualitative studies, people with SMI described CTOs as coercive, but less so than the perceived alternative of involuntary psychiatric hospitalization (Gibbs, Dawson, Ansley, & Mullen, 2005; O'Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006). Clients in some studies saw the additional community supports included in compulsory community care as a positive aspect of treatment orders (Canvin, Bartlett, & Pinfold, 2002; Ridley & Hunter, 2013). Other clients felt more coerced when they were first placed on the orders, but felt less coerced over time (O'Reilly et al., 2006).

Research findings also suggest that client perceptions of procedural justice - that the process of CTO placement has been respectful, just, and fair - and positive relationships with care providers may mitigate or lower feelings of coercion (Galon & Wineman, 2011; McKenna, Simpson, & Coverdale, 2006; Swartz, Wagner, Swanson, Hiday, & Burns, 2002). In New Zealand, a large qualitative study also found that clients perceived less coercion when there was space to discuss the negative aspects of the order with their providers, suggesting that positive provider-client relationships may also mitigate coercive initiatives (Gibbs et al., 2005; Gibbs, Dawson, & Mullen, 2006).

Additional research on providers’ and family members’ experiences with CTOs from diverse regions, including New Zealand, Australia, England, the United States, Israel, Scotland and Canada (Brophy & Ring, 2004; Canvin, Rugkasa, Sinclair, & Burns, 2014; Gibbs et al., 2005; Gjesfjeld & Kennedy, 2011; Greenberg, Mazar, Brom, & Barer, 2005; O’Reilly et al., 2006; Ridley & Hunter, 2013; Stensrud, Hoyer, Granerud, & Landheim, 2015; Sullivan, Carpenter, & Floyd, 2014) have highlighted a strong theme, in that clinicians feel a professional tension in the enactment of the experiences, incorporating quality of life, self-worth and agency of those receiving the services (Collier, 2010).

This pilot study aims to contribute to the field by exploring the general experiences of CTO from multiple perspectives of clients, their families, and treatment providers.

2. Methods

This pilot study was conducted with three community mental health teams serving an inner-city population in Toronto, Ontario, Canada. The teams provide services in the forms of Assertive Community Treatment, Intensive Case Management, or Early Intervention for Psychosis. Guided by Participatory Action Research (PAR) principles (Swantz, 2008), an interdisciplinary research team, and a diverse Research Advisory Committee composed of psychiatrists, social workers, peer-support specialist, people with lived experience of psychiatric treatment, and a qualitative researcher with a background in social work - together they designed and oversaw the research process. This study was approved by the Research Ethics Board at St. Michael’s Hospital, Toronto.

2.1. Study design

Eligible participants for this study were those who had been involved in at least one CTO over the past three years as a client (C), provider (P) or SDM (S) connected to one of the three community mental health teams (see Table 1). Three years was chosen as the maximum length of time since the last CTO in order to balance optimal memory of experiences and ensuring adequate pool of potential participants.

Table 1: Participant spread across teams.

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<thead>
<tr>
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<th>Early intervention(^a)</th>
<th>ICM(^b)</th>
<th>ACT(^c)</th>
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<tbody>
<tr>
<td>Clients</td>
<td>3</td>
<td>1</td>
<td>5</td>
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<tr>
<td>Clinicians</td>
<td>4</td>
<td>3</td>
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<tr>
<td>SDMs</td>
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\(^a\) Early intervention for psychosis (“First Episode”) service for early psychosis.

\(^b\) ICM = intensive case management.

\(^c\) ACT = assertive community treatment.
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