The case for abandoning the OCTET, and not community treatment orders

In the nearly two years since the negative findings of the OCTET trial were first published online, Community Treatment Orders (CTOs) have remained heavily utilised in England, with at least a quarter of patients who were subject to the Mental Health Act (1983) being on a CTO at any given time (www.hscic.gov.uk). The apparent high usage of CTOs in England probably reflects their perceived benefits, which have also manifested in a number of English naturalistic observational studies that reported significant reduction in hospitalisation following the implementation of CTOs.\(^2\)\(^-\)\(^4\)

Several authors have now demonstrated the fundamental flaws in the OCTET study, rendering its results unusable.\(^5\)\(^-\)\(^10\) Thus, the persistent claims that the OCTET is a rigorous trial are unsustainable.\(^11\)\(^-\)\(^13\)

In 2011, after the OCTET had commenced, we were assured that patients who were viewed as clear candidates for a CTO should be excluded from the trial: ‘the protocol states patients should not be included in the study who are viewed as clear candidates for either leave or a CTO, or considered suitable, when leaving hospital, for immediate discharge to voluntary care’.\(^14\) The same paper reiterated: ‘there is exclusion of patients who are considered by their RCs to be clear candidates for a CTO (and not candidates for leave)’.\(^14\)

However, after the publication of the OCTET results, the authors contradicted their previous statements regarding the study protocol: ‘Dr Mustafa suggests that being a clear candidate for a community treatment order (CTO) was an exclusion criterion, limiting external validity. This is not correct. Rather, the criterion was that clinicians had to be willing for patients’ treatment to be randomised, that is, they would need to be in equipoise to recruit to the trial’.\(^11\) This perplexity regarding the selection criteria only casts further doubt over the methodological integrity of the OCTET, particularly undermining its external validity (generalisability to ‘real world’ CTO patients).

Furthermore, there was an obvious reluctance among clinicians to recruit patients with a higher-risk profile or more severe conditions. This had probably introduced a selection bias towards patients who were less suitable for CTO, resulting in an underestimation of the impact of intervention.

Nonetheless, the OCTET is not in a better position as far as internal validity is concerned.\(^8\) Burns and Molodynski firmly reject the proposition that clinicians could, at least in some cases, directly observe benefits from CTOs, even when their implementation is associated with a dramatic and significant improvement in treatment adherence, which could not be plausibly explained by other factors.\(^12\)\(^,\)\(^13\) Yet, clinicians’ judgement was the main tool that the OCTET relied on, to fully and independently deliver and modify the intervention, in order to arrive at the intended outcome, and without any experimental restrictions. What has gone wrong here? The OCTET utilises what it considers a false premise, in order to reach what it claims to be a true conclusion, hence obliterating the logical basis of the study.

I have argued elsewhere using a hypothetical – albeit realistic – clinical scenario that mechanistic reasoning (which is epistemically superior to a flawed RCT\(^15\)) could be used in individual patients to evaluate the effectiveness of CTOs.\(^10\)

References


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