CTO Webinar Questions

- Around 'virtual CTOs': Is this really a less restrictive alternative to an actual CTO? It sounds like it has all the same safeguards and requirements for follow-up as an actual CTO, without the possibility of appeal that you would get if you had to go before the Tribunal. Thoughts?

Its Lyn Chiem - in response to your question: Yes the 'virtual CTO' or community care plan as Sarah has just mentioned has similar safeguards. However the care plan is generally more collaborative with really no degree of legal coercion (which the CTO would have when you breach a client). That being said, with a community care plan the MHA can still be used to facilitate an admission if criteria for mentally ill or mentally disordered are met.

- How do you monitor things like water loading to avoid admission?

Its Lyn Chiem - in response to your question. Water loading can be monitored by testing a patient's urine specific gravity on a simple dipstick test taken at the time of the weight. Otherwise sometimes you can see that they might have a low sodium level on their bloods. If you have the equipment, you could do a bladder scan but that is not common practice. It is good to get the client to change into a gown and empty their bladder as part of the routine of weighing wherever possible.

- How do you ensure the client is taking prescribed oral medication? There is no way of monitoring this

Its Lyn Chiem here - in response to your question. You are correct that there is no way to ensure that someone is taking their oral medications. This is probably one of the biggest differences between a CTO for a person with an eating disorder versus the more commonly utilised CTO for someone with schizophrenia who is on depot medication. You will be monitoring for indicators of them taking their medication e.g. behaviours, thoughts, and wherever possible establishing collaboratively with the patient ways of trying to ensure this.
For patients where it is possible to have the medications delivered by depot and it is thought clinically necessary this could be worked into the CTO for a person with an eating disorder also.

- What about psychological or therapy interventions?

The community treatment plan and/or a CTO can assist in getting the client to attend appointments. Severe eating disorders are marked by ambivalence about treatment – this often results in the person being too anxious/avoidant to attend sessions. If sessions are mandated and monitored, and the therapist understands the person is coerced, validates this for them, and works with motivational principles to try make the sessions useful and helpful for them in some way, this can help in developing engagement and therefore facilitate therapy. If the client is not turning up in the first place, then there is no opportunity for therapy, so a very important outcome to monitor under a community treatment plan or CTO if at all possible is attendance at sessions.

- Is there evidence that using a coercive treatment approach improves outcomes in AN in the long term?

To my knowledge there is not a body of literature around the use of CTOs in the treatment of eating disorders. Also with regards to coercive treatment generally it is difficult to evaluate the evidence given coercive treatment is most commonly utilised in delivering life-saving treatment. What we have observed in NSW (and should probably publish a case series on) is that in several cases weight and other parameters deteriorated after the CTO was completed/abandoned.

- For those who are not familiar with all the abbreviations used in this webinar, please could a slide be added to the end of the presentation as a glossary for all the abbreviations used?

CTO - community treatment order
MHA - Mental Health Act
NCAT - NSW Civil and Administrative Tribunal

- Can you please clarify if there was a nutrition plan in the CTO?

Attendance at appointments with the dietitian has been included in both community treatment plans and CTOs, and weight parameters always form part of the CTO/community plan requirements. It is less common to have an actual nutritional plan as part of the requirements as the dietitian will often make adjustments to the plan, and as long as the dietitian is being seen and the weight parameter set, then the required nutrition to maintain that weight point will be implicit.

- Thank you for the presentation. It is clear that this area is a minefield at present. Depending on the Community Health Service that the client attends to what can be offered. Asking a client to don a gown, toilet and then be weighed at a CHC may be difficult. The client may argue that the scales at the GP, Health Service all read differently, how can this distress be alleviated while still trying to work out the correct weight.

Yes it is not always possible to weigh in a gown after urinating, the most important thing is to establish monitoring of the weight on one set of scales in around about the same clothing and circumstances each time. So weighing the person on the community scales, in bare feet with any extra layers off as soon as possible after discharge from hospital/intake into community service to establish a 'baseline' weight on the scales that will be used to monitor progress, and then setting the exact parameters for admission to hospital or intensification of therapy etc. based on that set of scales.
It is best to only have one health professional doing the weighing and distributing this number periodically to any other professional in the team who need it, as you are quite right it is very distressing to the client to have different numbers and multiple weigh ins, and it serves no purpose clinically.

- Should the Care Plan (Virtual CTO) agreement be placed in the CTO Treatment Plan?

Yes the framework of the care plan should form part of the CTO. All clients in the community should have a care plan, the only difference is whether you decide it is clinically appropriate to put that person under a CTO or rather just collaboratively agree to a community treatment plan that essentially has the same elements but is voluntary care. It should be said the Tribunals differ at this point in time in terms of what they want to see/will accept in that care plan. To get around this teams can have a care plan that isn't fully described in the CTO – the CTO covering all the elements the Tribunal requires.

PLEASE NOTE: The Outreach team at RPA is happy to review draft CTO and community plans for teams who refer their clients for Outreach support.