

Table 3. Summary of Findings

Population: Patients with mental illness; Intervention: Community treatment order; Comparator: Voluntary treatment.

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Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the evidence (Quality of evidence)	Conclusions
		Voluntary treatment	Community treatment order		
Adverse effects (crucial)					
Physical and psychological adverse events (patient/carer)	-	-		No GRADE (no evidence was found)	No evidence was found regarding the effect of community treatment order on physical and psychological events when compared with voluntary treatment in patients with mental illness.
Death/suicide	Based on data from 641 participants in 2 studies	Parker (2021) reported that five individuals died. Burns (2015) reported a risk difference of 0.04 (95%CI -0.01 to 0.09) between CTO and no CTO.		Very low Due to serious imprecision ¹	The evidence is very uncertain about the effect of community treatment order on death/suicide when compared with voluntary treatment in patients with mental illness. (Parker, 2021; Burns, 2015)
Objective effectiveness (crucial)					
Symptom intensity	Overactive/aggressive behaviour Relative risk: 0.87 (CI 95% 0.65 – 1.15) Based on data from 206 participants in 1 study	528 per 1000	459 per 1000 Difference: 69 fewer per 1000 (95%CI 185 fewer – 79 more)	Very low Due to serious risk of bias, due to serious imprecision ²	The evidence is very uncertain about the effect of community treatment order on symptom severity (overactive/aggressive behaviour, physical impairment, psychotic symptoms) when compared with voluntary treatment in patients with mental illness. (Parker, 2021)
	Physical impairment Relative risk: 1.60 (CI 95% 0.80 – 3.23) Based on data from 206 participants in 1 study	528 per 1000	845 per 1000 Difference: 317 more per 1000 (95%CI 106 fewer – 1177 more)		
	Psychotic symptoms Relative risk: 0.93 (CI 95% 0.75 – 1.15) Based on data from 206 participants in 1 study	528 per 1000	491 per 1000 Difference: 37 fewer per 1000 (95%CI 132 fewer – 79 more)		
Medication use	-	-		No GRADE (no evidence was found)	No evidence was found regarding the effect of community treatment order on medication use when compared with voluntary treatment in patients with mental illness.
Quality of life (important)					
Quality of life	Based on data from 138 participants in 1 study	Patients under CTO had a score of 68.85 as compared to 70.15 for patients who were not under CTO (p=0.845).		Very low Due to serious risk of bias, due to very serious imprecision ³	The evidence is very uncertain about the effect of community treatment order on quality of life when compared with voluntary treatment in patients with mental illness.

				(Nakhost, 2018)
<i>Satisfaction (important)</i>				
Participant/ carer/professionals' satisfaction	-	-	No GRADE (no evidence was found)	No evidence was found regarding the effect of community treatment order on participant/carer/professionals' satisfaction when compared with voluntary treatment in patients with mental illness.
Perceived coercion	Based on data from 138 participants in 1 study	Patients under CTO had a mean Perceived Coercion Scale of 13.8 (SD=5.14) as compared to 10.8 (SD=4.26) for patients who were not under CTO (MD=3.00, 95%CI 1.42 to 4.58).	Very low Due to serious risk of bias, due to very serious imprecision ³	The evidence is very uncertain about the effect of community treatment order on perceived coercion when compared with voluntary treatment in patients with mental illness. (Nakhost, 2018)
<i>Health service contact and utilization (important)</i>				
(re)admission to hospital	<i>Number of readmissions</i> Based on data from 17 studies	Barnett (2018) reported a SMD of -0.14 (95%CI -0.41 to 0.14). Burns (2015) reported a SMD of 0.12 (95%CI -0.15 to 0.39).	Very low Due to serious risk of bias, due to serious inconsistency ⁴	The evidence is very uncertain about the effect of community treatment order on the number of (re)admission to the hospital when compared with voluntary treatment in patients with mental illness. (Barnett, 2018; Burns, 2015)
	<i>Readmission: yes or no</i> Based on data from 5 studies	A pooled RR of 1.58 (95%CI 0.63 to 3.97) was found based on Burns (2015), Dey (2022) and Segal (2022) Barnett (2018) reported a pooled RR of 1.98 (95%CI 0.78 to 5.01).	Very low Due to very serious imprecision ⁵	The evidence is very uncertain about the effect of community treatment order on (re)admission to the hospital when compared with voluntary treatment in patients with mental illness. (Barnett, 2018; Burns, 2015; Dey, 2022; Segal, 2022)
Bed-days spend in hospital	Based on data from 14 studies	Barnett (2018) reported a SMD of 0.13 (95%CI 0.19 to 0.58). Burns (2015) reported a SMD of -0.05 (-0.32 to 0.22). Dey (2022) reported that CTO patients had a higher amount of rehospitalization bed nights of 29-90 days and >90 days than no CTO patients. Parker (2022) reported a SMD of 0.68 (95%CI 0.40 to 0.69).	Very low Due to serious risk of bias, due to serious inconsistency ⁶	The evidence is very uncertain about the effect of community treatment order on bed-days in hospital when compared with voluntary treatment in patients with mental illness. (Barnett, 2018; Burns, 2015; Dey, 2022; Parker, 2022)
Compliance with medication	Based on data from 2 studies	Barnett (2018) reported a SMD of 0.91 (95%CI -0.70 to 2.51).	Very low Due to serious risk of bias, due to serious indirectness ⁷	The evidence is very uncertain about the effect of community treatment order on bed-days in hospital when compared with voluntary treatment in patients with mental illness. (Barnett, 2018)

Use of community services	Based on data from 10 studies	Barnett (2018) reported a SMD of 0.38 (95%CI 0.19 to 0.58). Dey (2022) reported a risk difference of 0.04 (95%CI -0.07 to 0.14)	Very low Due to serious risk of bias ⁸	The evidence is very uncertain about the effect of community treatment order on bed-days in hospital when compared with voluntary treatment in patients with mental illness. (Barnett, 2018; Dey, 2022)
<i>Social functioning (important)</i>				
Imprisonment	Relative risk: 1.00 (CI 95% 0.06 – 15.85) Based on data from 330 participants in 1 study	6 per 1000 6 per 1000 Difference: 0 fewer per 1000 (95%CI 6 fewer – 89 more)	Very low Due to very serious imprecision ⁹	The evidence is very uncertain about the effect of community treatment order on imprisonment when compared with voluntary treatment in patients with mental illness. (Burns, 2015)
Police contact and arrest	-	-	No GRADE (no evidence was found)	No evidence was found regarding the effect of community treatment order on police contact and arrest when compared with voluntary treatment in patients with mental illness.
Employment	-	-	No GRADE (no evidence was found)	No evidence was found regarding the effect of community treatment order on employment and arrest when compared with voluntary treatment in patients with mental illness.
Accommodation status	-	-	No GRADE (no evidence was found)	No evidence was found regarding the effect of community treatment order on accommodation status when compared with voluntary treatment in patients with mental illness.
General social functioning	Based on data from 311 participants in 1 study	Patients who remained on a CTO at the time of discharge had a HoNOS total Score of 13.59 (SD=8.93) as compared to 10.93 (SD=9.68) for patients when involuntary treatment was discontinued on or before discharge (MD=2.66, 95%CI 0.02 to 5.30).	Very low Due to serious risk of bias, due to very serious imprecision ¹⁰	The evidence is very uncertain about the effect of community treatment order on general social functioning when compared with voluntary treatment in patients with mental illness. (Parker, 2021)
Restoration of contact with carer(s)	-	-	No GRADE (no evidence was found)	No evidence was found regarding the effect of community treatment order on restoration of contact with carer(s) when compared with voluntary treatment in patients with mental illness.

1. Serious imprecision: due to low number of events and overlap of both the lower and upper limit of the 95% confidence interval with the minimal clinically important difference.
2. Serious risk of bias: due to missing data.
Serious imprecision: due to overlap of either the lower or upper limit of the 95% confidence interval with the minimal clinically important difference.
3. Serious risk of bias: due to selection bias.
Very serious imprecision: due to the optimal information size which was not achieved.
4. Serious risk of bias: due to studies included in the review of Barnett (2018) with high risk of bias.
Serious inconsistency: due to conflicting results and high level of heterogeneity.

5. Very serious imprecision: due to overlap of either the lower or upper limit of the 95% confidence interval with the minimal clinically important difference.
6. Serious risk of bias: due to studies included in the review of Barnett (2018) with high risk of bias.
Serious inconsistency: due to conflicting results.
7. Serious risk of bias: due to studies included in the review of Barnett (2018) with high risk of bias.
Indirectness: difference in outcome (treatment adherence instead of compliance with medication).
8. Serious risk of bias: due to studies included in the review of Barnett (2018) with high risk of bias.
9. Very serious imprecision: due to low number of events.
10. Serious risk of bias: due to missing data.
Very serious imprecision: due to the optimal information size which was not achieved.