

## The Role of Community Treatment Orders in Sustaining Recovery in Recurrent Psychosis: A Case Report

Dr. Musa Absi\*, Dr. Jonathan Iliff and Dr. Rayhan Ghanchi

South London and Maudsley NHS Trust, London, United Kingdom

### \*Correspondence to:

Dr. Musa Absi  
South London and Maudsley NHS Trust,  
London, United Kingdom.  
E-mail: [musa.absi@slam.nhs.uk](mailto:musa.absi@slam.nhs.uk)

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### Abstract

Community treatment orders (CTOs) remain one of the most contested instruments in contemporary mental health law, sitting at the intersection of relapse prevention, constrained resources, and rights-based practice. Recent work from 2020 continues to show mixed population level outcomes but also suggests that CTOs may offer benefits for selecting high-risk subgroups when embedded in comprehensive community care. This case report describes a 22-year-old man with a three-year history of recurrent psychosis (unspecified psychotic disorder code, International classification of diseases (ICD)-10 F29) characterized by repeated relapses following antipsychotic discontinuation, daily cannabis use, limited insight, and severe self-neglect including profound weight loss due to food-related paranoid beliefs. After admission under section 3 of the Mental Health Act 1983 for self-neglect and psychosis, he stabilized with paliperidone long-acting injectable (LAI) and discharged on a CTO to support adherence and continuity of care. Following case report (CARE) guidelines, we present the patient's trajectory, clinical findings, timeline of deterioration and recovery, diagnostic reasoning, and detailed therapeutic course including extrapyramidal side effects (EPSEs) that were resolved after LAI dose reduction and anticholinergic treatment. We then situate the case within post-2020 evidence on CTO effectiveness, LAI antipsychotics, cannabis-related relapse in early psychosis, and evolving human rights frameworks. The case illustrates how a CTO, in combination with LAI treatment, assertive early intervention follow-up, and family work, supported sustained recovery after multiple previous failures of voluntary care. At the same time, it highlights ethical tensions around autonomy, person-centered care, and service-level constraints, particularly in the context of persistent cannabis use and finite community resources. We argue that CTOs should be framed as time-limited, rights-conscious tools of last resort for carefully selected individuals, rather than a substitute for adequately resourced voluntary services.

### Keywords

Community treatment order, Psychosis, Relapse prevention, Long-acting injectable antipsychotic, Cannabis, Autonomy, CARE guidelines

### Introduction

CTOs were introduced in England via the Mental Health Act 2007 with the intention of enabling people suffering from severe mental illness to live in the community while receiving mandated treatment and retaining a legal "safety net" of recall if they deteriorated. Since 2020 registry studies, systematic reviews and umbrella reviews have consistently found that CTOs, at the population level, have limited or no impact on readmission rates or inpatient bed-days, and that their use varies widely between services [1-5].

More recent work has focused less on the general utility of CTOs and rather on who they work for, under what conditions and at what ethical cost. Meta-analytic

and narrative reviews have suggested that potential benefits (for example, reduced aggression or improved engagement) may be confined to specific high-risk subgroups, and that these potential gains must be weighed against concerns about coercion, stigma, and over-reliance on legal mechanisms in the context of under-resourced community services [3, 6-9].

In parallel, international human rights frameworks, particularly the United Nations convention on the rights of persons with disabilities (UNCPRD), have intensified scrutiny of potentially coercive psychiatric practices and emphasized proportionality, least restrictive alternatives, and the primacy of supported decision-making. Recent United Kingdom and European policy documents have called for the alignment of mental health law with rights-based, person-centered approaches that minimize compulsory treatment [5, 7, 8].

This case report contributes to the contemporary debate by presenting a young adult with recurrent psychosis and severe self-neglect in whom a CTO appeared to support recovery after repeated failures of voluntary care. We situate the case within contemporary evidence on CTOs, real world LAI effectiveness, and cannabis related relapse in early psychosis, and explicitly engage with human rights and service level critiques that question whether CTOs sometimes compensate for service paucity rather than representing a genuinely least restrictive option [3, 7-15].

## Methods

This is a single descriptive case report prepared in accordance with the CARE guidelines for clinical case reporting. Clinical data were obtained retrospectively from the electronic health record, multidisciplinary meeting minutes, and contemporaneous correspondence between the early intervention in psychosis (EIP) service, inpatient team, and family. Identifiable details have been removed or altered to protect anonymity.

We focused on the index deterioration leading to admission under section 3, the inpatient treatment episode, and the first three months after discharge on a CTO. Particular attention was paid to the timeline of symptom change, medication adjustments, side effect emergence and resolution, and patterns of engagement with community services.

The literature informing the discussion was identified manually through targeted searches of PubMed and major journal websites, restricted to publications from 2020 onwards, focusing on CTO outcomes, LAI antipsychotics, cannabis use in early psychosis, and rights-based mental health law. Only sources after 2020 were included.

## Case Presentation

### Patient information

The patient is a 22-year-old male living with his parents and three younger siblings in an inner-city area of South London. He has a three-year history of psychotic illness with a working diagnosis of unspecified psychotic disorder (ICD-10 F29), characterized by relapsing-remitting episodes in the context of antipsychotic non-adherence and heavy cannabis

use. There is no recorded family history of psychotic or major mood disorders.

He has asthma and multiple severe allergies (nuts, eggs, dairy, seafood, and latex) requiring an adrenaline auto-injector during admissions. There is no known history of head injury, epilepsy, or intellectual disability.

Over the previous three years he had four compulsory admissions, each triggered by self-neglect, and psychotic symptoms including persecutory ideas such as suspiciousness about food, beliefs about “black magic”, and misidentification of his parents. He had previously achieved nearly a year of relative stability on a long-acting aripiprazole injection with EIP support and family intervention but chose to stop the depot and disengaged from follow-up, describing himself as “fine” and resuming daily cannabis use.

### Clinical findings

In the months preceding the index admission his family noted progressive withdrawal, with the patient spending almost all day in his bedroom. A marked reduction in oral intake was observed, with the patient increasingly refusing food prepared at home, expressing unelaborated concerns that it was “not safe” or “contaminated”, and relying mainly on selected takeaway outlets that he considered “trustworthy”. Weight loss became visibly apparent. He declined offers of home treatment team review and refuted the suggestion that he needed to restart antipsychotic medication.

At Mental Health Act assessment, he was guarded, offered minimal information, and repeatedly stated that he did not have a mental health problem. Collateral information and prior records suggested active psychosis with food related paranoia and likely auditory hallucinations, alongside severe self-neglect. He was detained under section 3 and admitted to an acute psychiatric ward.

On admission he appeared pale and underweight with a body weight of 44.4 kg (Body mass index 16.5). He was tachycardic (100 - 120 bpm) but afebrile and normotensive. Systemic and neurological examinations were otherwise unremarkable. Dietetic assessment confirmed low weight but no immediate biochemical evidence of refeeding syndrome.

Early mental state examinations documented reduced spontaneity of speech, restricted affect, guardedness, and limited insight. He minimized symptoms and mostly denied hallucinations or delusional beliefs, while staff and relatives continued to report suspiciousness about food and intermittent responses to unseen stimuli. There was no current suicidal ideation reported, although previous documentation described command auditory hallucinations telling him to kill himself.

### Diagnostic assessment

Investigations included full blood count, renal and liver function, thyroid function, vitamin levels, C-reactive protein, and refeeding blood panels. Results were largely normal apart from folate deficiency and a raised prolactin level while on oral risperidone. Electrocardiography showed sinus tachycardia with normal corrected QT. There was no evidence of systemic infection, endocrine disorder, or acute substance intoxication.

The recurrent pattern of psychotic symptoms, functional decline, and relapse following medication discontinuation supported a diagnosis of unspecified psychotic disorder (F29) within the schizophrenia spectrum. Cannabis use disorder was considered a key comorbidity given daily use, difficulty cutting down, and temporal association between heavy use, disengagement and relapse.

Alternative possibilities, including mood disorder with psychotic features and purely substance-induced psychosis, were considered less likely given psychotic phenomena had persisted beyond acute intoxication and were accompanied by negative symptoms, as well as enduring functional impairment across several episodes.

### Therapeutic intervention

During admission the patient received oral risperidone, titrated according to clinical response. In light of his history of non-adherence and previous success with LAI, the team transitioned him to paliperidone palmitate using standard loading doses with a planned maintenance dose of 150 mg every four weeks. Folic acid supplementation was prescribed. Nursing staff and dietitians supported gradual re-establishment of regular meals.

A multidisciplinary decision was made to discharge him on a CTO, justified by his repeated relapses following voluntary disengagement, severe self-neglect, and ongoing cannabis use. Conditions focused on adherence to depot treatment, engagement with community reviews, and allowing access to the family home for visits.

Within the first post-discharge week he developed prominent tremor of the hands, head, and tongue, with mild hypomimia but preserved gait and strength. An urgent community review resulted in initiation of procyclidine 2.5 mg three times daily (TDS). When only partial improvement was observed, the paliperidone dose was reduced from 150 mg to 100 mg monthly and procyclidine increased to 5 mg TDS.

### EPSEs then resolved fully

Non-pharmacological interventions included ongoing family work (psychoeducation, communication skills, and re-

lapse-prevention planning), vocational support to explore a return to warehousing work, and signposting to specialist cannabis services. Smoking-cessation advice was offered, although he preferred to continue vaping nicotine.

### Follow-up and outcomes

By the end of the inpatient stay, his weight had increased to 49.5 kg, oral intake had normalized, and he denied current hallucinations or delusions. Affect was more reactive: he was engaging with staff, and basic self-care had improved. He remained ambivalent about long-term medication but agreed to accept depot treatment on discharge.

In the community, the emergence of EPSEs risked undermining this fragile engagement. Rapid recognition, dose adjustment, and symptomatic treatment allowed side effects to be resolved while maintaining an effective LAI dose. He continued to attend depot clinics and adhered to procyclidine, reporting feeling “back to normal” physically.

At a consultant review approximately one month after discharge he described feeling “much better” and, for the first time, disclosed prior command auditory hallucinations telling patient to kill himself. He linked their resolution to being on depot medication and acknowledged that “stopping (medication) before made things worse”. Clinician-rated outcomes included absence of positive psychotic symptoms, normal sleep and appetite, improved insight, and active consideration of a return to work.

He continued to smoke cannabis, typically in the evenings, and did not yet accept that it significantly worsened his mental health. This aligns with recent longitudinal evidence that ongoing cannabis use after early psychosis is associated with higher relapse rates, more admissions and poorer functional outcomes [16-19]. The team therefore framed the CTO as a time-limited scaffold to maintain stability while gradually working on substance use and internal motivation for continued treatment (Table 1).

### Discussion

Large observational studies and meta-analyses published

Table 1: Timeline.

Date/Period	Event and key features
2023 - early 2024	Stable in community on aripiprazole LAI with EIP and family work; working part-time
Mid-late 2024	Stops depot, disengages from EIP, resumes daily cannabis use; gradual functional decline
Early mid 2025	Increasing isolation at home, refusal of most home-cooked food, visible weight loss
August 2025	Mental Health Act assessment: first medical recommendation for section 3 completed
September 08, 2025	Admitted under section 3 with severe self-neglect, body mass index 16.5, food-related paranoia and suspected psychosis
September 2025	Started oral risperidone; transitioned to paliperidone LAI with loading doses; weight increased to 49.5 kg
Late September 2025	Mental state and oral intake improve; unescorted leave tolerated
October 06, 2025	Section 3 converted to CTO; discharged on paliperidone LAI 150 mg monthly and folic acid
October 07 - 08, 2025	Community reviews identify bilateral hand, head and tongue tremor; started procyclidine 2.5 mg TDS
October 13, 2025	Paliperidone reduced from 150 mg to 100 mg monthly; procyclidine increased to 5 mg TDS
Late October 2025	EPSEs resolve fully; stable mental state; patients acknowledge benefit of medication
November 2025	Continues paliperidone 100 mg monthly under CTO; no psychotic symptoms; exploring return to work; transfer to locality community mental health team (CMHT) initiated

since 2020 continue to show that, at the system level, CTOs have limited impact on rates of readmission or inpatient days and are frequently used in ways that reflect local practice variation rather than clearly defined clinical criteria [1-4, 19]. Nonetheless, these same reviews note that CTOs are often applied to individuals with repeated relapses, poor adherence and complex social risks - the very group represented by this patient [3, 7, 8].

This case does not challenge the overall conclusion that CTOs are not panacea. Instead, it exemplifies the argument for maintaining narrow indications that have emerged from recent narrative reviews: CTOs may be justifiable as a last resort tool for a small subgroup with severe, recurrent illness, known life-threatening self-neglect, and clear evidence that multiple voluntary approaches have failed, provided they are embedded within a robust, recovery-oriented service offer [7-9].

In this case, prior episodes had followed a consistent pattern: recovery on depot with EIP support, gradual disengagement, cannabis escalation, medication cessation, and relapse with self-neglect and psychosis. The CTO, together with LAI treatment and family involvement, appears to have interrupted this cycle at a critical point by ensuring post-discharge adherence long enough for insight to consolidate.

### LAI, EPSEs, and adherence

Recent evidence reinforces that LAI antipsychotics, compared with oral formulations, reduce relapses and rehospitalization in real-world settings, particularly in people with poor adherence [12-15]. Choosing a LAI in this context is therefore consistent with current best practice.

However, LAIs introduce their own risks, especially when side effects are not promptly addressed. EPSEs are a major driver of non-adherence and negative attitudes to antipsychotics. The rapid recognition and management of EPSEs hereby way of dose reduction plus anticholinergic treatment, was crucial not just clinically but ethically. It demonstrated responsiveness to the patient's embodied experience and likely prevented the side effects from becoming a justification for refusing further treatment or viewing the CTO as punitive.

### Cannabis, relapse and person-centered care

Recent longitudinal and mechanistic studies strengthen the link between cannabis use and psychosis onset, relapse, and symptom persistence, especially in daily users of high-potency products [16-19]. For this patient, cannabis use played multiple roles: a source of pleasure; a self-medication attempt; and a precipitant of disengagement and relapse.

One limitation of the approach in this case is that cannabis work remained largely at the level of psychoeducation and signposting. More intensive, evidence informed dual-diagnosis interventions might have better addressed his ambivalence and offered alternative ways to achieve the perceived benefits of cannabis. At the same time, his continued use despite clear information about risks underlines that person-centered care must respect the reality of constrained choices and competing

values, rather than assuming simple, rational decision-making once insight improves.

### Human rights, autonomy and service level factors

Recent policy documents and human rights analyses emphasize that compulsory treatment, including CTOs, should be used only as a last resort, for the shortest possible time, and within legal frameworks that align with the UNCRPD and broader disability-rights standards [10, 11]. Contemporary critiques warn that CTOs can drift into routine practice, sometimes compensating for under-resourced community mental health services rather than reflecting truly exceptional need [7-9, 19].

This case raises this tension. On one hand, the threshold for CTO use was high: multiple relapses, clear life-threatening self-neglect, and repeated failure of intensive voluntary engagement. On the other, clinicians were aware that community resources were finite and that, without a CTO, follow-up might become more fragmented as he transitioned from EIP to a local CMHT. The CTO therefore functioned not only as a clinical tool to secure adherence, but also as a mechanism to guarantee access and a structured framework for shared care. These features would, in an ideal system, be achievable without it.

With regard to person-centered care, the case trajectory suggests a shift over time. Early decisions were largely made for the patient on a best-interest basis, justified by impaired insight and acute risk. As stability returned, there was more explicit discussion of options, risks, and preferences, and his evolving perspective was incorporated into care planning. This progression from substituted to increasingly supported decision-making aligns well with rights-based practice where rights are qualified by risks posed. It also reveals how a CTO can initially limit, then later potentially support person-centered care within a case, a contradiction that recent commentaries highlight [7-9].

### Strengths and limitations of this approach

Clinically, strengths included: The use of a LAI tailored to a known pattern of non-adherence, rapid response to side effects, sustained family involvement, and continuity between inpatient, EIP and community teams. With regards to methods this report adheres closely to CARE, includes a detailed timeline and explicit medication changes, and engages with post-2020 literature whilst considering human rights debates.

Limitations include: The reliance on routinely collected clinical data rather than prospectively planned measures, the absence of formal symptom scales, and limited direct exploration, in the notes, of the patient's own reasons for disengagement and his experience of coercion. It is also not possible to disentangle the specific contribution of the CTO from that of LAI treatment, EIP input, and family support. As a single case, it cannot resolve wider debates on CTO utility but instead uses an individual case to support an open, pragmatic and evidence-based approach to CTOs going forward.

## Conclusion

This case suggests that, for a small subgroup of young adults with recurrent psychosis, severe self-neglect, persistent cannabis use and repeated failures of voluntary care, a time-limited CTO combined with LAI antipsychotic treatment, rapid side-effect management, and strong family and community support can provide a stabilizing scaffold that sustains recovery long enough for insight and shared decision-making to develop. At the same time, it reinforces that CTOs must remain exceptional, rights-conscious measures of last resort, used alongside and not instead of adequately resourced, person-centered early intervention and dual-diagnosis services.

## Ethics, Consent, and Governance

This case report describes anonymized information from routine clinical care within a National Health Service, EIP service, and associated inpatient unit. No experimental procedures were undertaken and no changes to treatment were made for the purposes of research. Formal research ethics committee review was not sought for this single anonymized case report. The patient received a written and verbal explanation that his clinical story might be used for teaching and publication. Written informed consent for publication was obtained from the patient.

## Learning Points

The main learning points from this case are that CTOs should be framed as time-limited, rights-conscious measures of last resort for a small subgroup of people with severe, recurrent psychosis, life-threatening self-neglect, and multiple failed attempts at voluntary care, rather than as routine community management.

In young adults with repeated relapses linked to medication non-adherence, using a LAI antipsychotic within a CTO framework can help to maintain stability long enough for insight and shared decision-making to develop, provided that side effects such as extrapyramidal symptoms are recognized early and actively managed through dose adjustment and adjunctive medication.

Persistent cannabis use after first-episode or early psychosis remains a major driver of relapse and poorer functional outcome; CTO-supported adherence alone is not sufficient, and structured, evidence-based dual-diagnosis interventions are required if long-term risk is to be reduced.

The ethical justifiability of a CTO in any individual case depends not only on clinical risk but also on whether less restrictive alternatives and assertive voluntary outreach have been genuinely exhausted, and on the quality of the therapeutic relationship and supported decision-making during and after the order.

Embedding the patient's voice and family perspective, through collaborative relapse prevention planning, family work, and explicit opportunities for the patient to reflect on coercion and benefit, can mitigate some of the relational

harms of compulsory treatment and align CTO practice more closely with the rights of the individuals in question.

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## Conflict of Interest

None.

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