

Supervised community treatment

One of the most controversial proposals in the government's Mental Health Bill (currently before parliament) is the introduction of supervised community treatment (SCT). Under SCT, some patients who have been compulsorily detained in hospital for treatment will, on discharge, become subject to a community treatment order (CTO) requiring them to comply with certain conditions, including taking their medication. SCT can only be imposed on patients directly following a period of compulsory detention for treatment in hospital – it cannot be imposed on patients who are living in the community at the time.

A CTO will be made by a patient's responsible clinician with the agreement of an Approved Mental Health Professional, and will initially apply for six months. If it is considered necessary, it can then be renewed by the responsible clinician for a further six months and then annually. However, the responsible clinician can discharge the patient from SCT at any time, and the patient has a right to apply to the hospital managers and the Mental Health Review Tribunal for a discharge.

The proposal for SCT has met with significant opposition from some patient groups and some professionals. This briefing explores some of the surrounding issues and the available evidence on the likely effect of SCT, including evidence from abroad, where compulsory community treatment has been used for some time.

Why does the government want to introduce SCT?

At present some patients with mental health disorders do not continue with their treatment (in particular, their medication) when they are discharged from hospital. As a result, their health deteriorates to a stage at which they become a danger either to themselves or to other people, and eventually have to be compulsorily re-admitted to hospital. The aim of supervised community treatment (SCT) is to ensure that such 'revolving door' patients continue to accept their treatment after discharge (whether or not they want to, or have the capacity to make decisions about their treatment) thus maintaining their mental health and breaking the 'revolving door' cycle (Department of Health 2007). This is intended to reduce risk – both to the patient and to the public.

What will SCT add to existing powers of compulsion in the community?

The current Mental Health Act 1983 already contains powers to impose conditions on some patients living in the community. These include 'guardianship' (sections 7 and 37), 'supervised aftercare' (section 25) and 'leave of absence' (section 17).

The purpose of guardianship is to enable patients to receive care in the community where it cannot be provided by the use of compulsory powers. The guardian may be a local authority or a named private individual, who may require a patient to live at a specified place, to attend a specified place for medical treatment and to allow health professionals access to their home. However, if the patient refuses to comply with these conditions, the guardian has no power to use force to secure attendance for treatment, impose that treatment (without the patient's consent) or secure entry to the patient's home.

Supervised aftercare was introduced in 1995 as a response to high-profile acts of violence committed by patients with a mental disorder in the community (Eastman 1995) and was aimed at precisely the 'revolving door' patient that the current SCT proposals also target (Johnston 1997). Supervised aftercare allows conditions to be imposed on patients in the community (such as the person must reside at a particular place) and gives the power to recall a non-compliant patient to hospital (as does SCT), but it does *not* give professionals the power to treat a patient who has been returned to hospital without that patient's consent unless they go through a formal compulsory re-admission. Supervised aftercare has not been widely used (640 patients were discharged under supervised aftercare powers in England in 2004/5) and, despite some consultant psychiatrists viewing it as helpful, it is considered by many professionals to be ineffective when faced with patient non-compliance (Franklin *et al* 2000).

What the new SCT adds to current guardianship and supervised aftercare powers is a power to require a patient to accept treatment, in effect, as an outpatient, without needing formally to re-admit them to hospital.

Leave of absence powers allow a patient compulsorily detained under the Mental Health Act to leave hospital and live in the community (for months or even years) while still being subject to the powers of the Act. Under section 17, a patient can be recalled (by notice in writing) at any time that his Responsible Medical Officer considers it necessary, without the need for formal re-admission procedures under the Act, and compulsory treatment can be imposed when the patient is back in hospital as an inpatient.

The government believes that section 17 leave of absence and SCT will serve complementary but different purposes. Leave can be used for a wide range of purposes – from allowing a patient a short period of absence once a week to visit local shops, through to a substantial period of trial leave in the community. Essentially, leave is for patients who are not yet ready to be discharged from detention. SCT patients, on the other hand, will not be subject to detention but rather to being recalled to hospital, which is not the same thing.

Section 17 was originally intended to give only short-term leave of absence, so the government intends that SCT will replace the use of section 17 for managing the longer-term ongoing treatment of patients in the community. The government argues that SCT provides the right structure to manage patients in this way, providing a clear legal framework with unambiguous processes for practitioners to follow and patients to understand.

What do clinicians and patient groups say about SCT?

Clinicians are divided over the introduction of SCT. In one study involving more than 1,000 consultant psychiatrists in England and Wales, 46 per cent favoured compulsory treatment in the community while 34 per cent were opposed to it (Crawford *et al* 2000).

Some psychiatrists have concerns about the ethics of forcibly treating people who have the capacity to make their own decisions about their treatment (especially in view of the potentially serious adverse side-effects of medication), and argue that introducing compulsion in the community is likely to lead to a significant increase in the use of compulsory powers. They also point out the difficulty of making an accurate risk assessment of the potential danger posed by any individual patient, and that many

thousands of people may have to be placed under compulsion in the community to prevent one homicide (Crawford 2000; Szmukler 2000).

On the other hand, some clinicians believe that SCTs can offer real benefits to patients and their families. This group tends to highlight the frustration of seeing an individual's mental health deteriorate because of a failure to take medication, sometimes because the patient deliberately refuses, sometimes because they simply stop taking it as a result of a loss of insight. Under the current arrangements, clinicians can do little until such time as the patient becomes so ill that they have to be compulsorily re-admitted into hospital.

Where CTO arrangements have been in place for some years, there tends to be majority support for them among health professionals. In New Zealand around 80 per cent of psychiatrists and other mental health professionals preferred having the option of using CTOs to not having it (Romans *et al* 2004). A clear majority of professionals surveyed in Canada found CTOs useful (O'Reilly *et al* 2000).

Patient groups have generally opposed the introduction of SCT. Many have strong reservations and believe the answer lies in offering better community services to people, not extending compulsion into the community (Mental Health Alliance 2006a). They question why mental health patients living in the community should be forced to take medication (which often has distressing side-effects) when other patients do not. If a person is unwell enough to need compulsory powers, then, they argue, they should be treated in a safe hospital setting. They fear that an extension of compulsory powers will deter some people from seeking help from mental health services. They also claim that there is a risk they will be imposed on a disproportionately high number of patients from black communities. Currently, this group is significantly more likely to be detained under the Mental Health Act 1983 when compared to the average for all inpatients (Mental Health Alliance 2006b).

When surveyed, patients who have been subject to CTOs around the world have mixed views. Some patients accept that SCT may at times be appropriate as a genuinely less restrictive (and more therapeutic) alternative to an individual being detained longer than necessary in hospital, as long as proper safeguards against abuse are in place. A survey of patients who had been placed under a CTO in New Zealand (Gibbs *et al* 2005) found that most were generally supportive of the CTO, especially if the alternative was hospital, and valued the access to services it provided. A minority were strongly opposed to the order given that it reduced choice about medication and imposed restrictions on residence and travel. An audit of patients in New York (New York State Office of Mental Health 2005) reported high levels of unhappiness at being placed under compulsion, but in time a majority of the patients accepted that it had done them good, with clear benefits arising from the intensive services that they received.

How widely is compulsory community treatment used internationally?

Compulsory community treatment is not a new idea. Similar laws enabling CTOs have been in place for some years in many parts of the developed world, especially the United States, Canada, Australia and New Zealand. Most recently, they were introduced into Scotland in October 2005.

A King's Fund report of September 2005 on the use of CTOs across various international jurisdictions (Lawton-Smith 2005) found a wide range of use of between 2 and 60 per 100,000 population, with higher use where CTO powers had been embedded for longer and had lower legal thresholds for compulsion. The report also found that, in general (although not in every case), the use of CTOs grew over time.

The report estimated that over a period of 10–15 years, the number of people subjected to CTOs in England and Wales might rise to between 7,800 and 13,000 at any one time. This does not necessarily imply an increase in the total numbers of people under compulsion as these could be patients who would otherwise need to be compulsorily detained in hospital.

In the debate on the Bill of 28 November 2006, the Minister for Health, Lord Warner, indicated that the government expected the number of patients subject to SCT would rise to between 3,000 and 4,000 over a five-year period.

What is the early evidence from Scotland's community-based treatment orders?

A King's Fund report (Lawton-Smith 2006) looked at the first six months' use of community-based compulsory treatment orders in Scotland under the Mental Health (Care and Treatment) (Scotland) Act 2003, which came into effect on 5 October 2005.

The report found that the new system of CTOs had, by and large, been introduced successfully in Scotland and there were no 'horror stories' about abuses of the new powers. There had, however, been a number of teething problems. The legislation was criticised as difficult to understand; there was much criticism (especially from psychiatrists) that the arrangements were very burdensome – in particular the extra time it took to complete application forms and provide reports to the Mental Health Review Tribunal; many professionals were still learning about the Act some months after its implementation; and patients, families and carers had a limited understanding of the CTO powers, unless directly affected themselves.

Before the new Act was passed, the Scottish Executive estimated that the numbers of people under CTOs would be approximately 200 at any one time (orders can be authorised for six months, then, if necessary, renewed for a further six months, then renewed annually and, potentially, indefinitely). The build-up of people under CTOs has been gradual (as the evidence from international trends suggested it would be): 65 by January 2006; 131 by April 2006; and 192 by July 2006. By the end of September 2006, the number of CTOs authorised had risen to 344 and, allowing for some discharges from these orders or re-admissions to hospital, the King's Fund estimates that there were around 240 people at that time under such an order.

That rate of use of CTOs is around 5 per 100,000 of Scotland's population. If that rate was replicated in England and Wales, it would suggest around 2,500 people under SCT after one year. However, in considering the lessons that could be learnt from Scotland, it should be noted that the criteria for compulsion under a CTO in the Scottish Act are different to those proposed in the Bill for England and Wales. For example, the Bill – as tabled before amendments were made in the Lords – requires that medical treatment must simply be 'appropriate', while in Scotland it must be 'likely to prevent a disorder worsening or likely to alleviate the symptoms or effects of that disorder'. In addition, the Bill's criteria do not include a patient's capacity to make decisions about their medical treatment. The Scottish Act requires that, for compulsion to be imposed, the patient's ability to make decisions about the provision of medical treatment must be 'significantly impaired' because of their mental disorder.

Whether these safeguards make a great deal of difference in practice is not clear but they have helped to create a widespread consensus in Scotland that the Act is fair to patients and will restrict inappropriate use of the compulsory powers. In England and Wales no such consensus has been reached.

Are CTOs effective?

There has been a number of reviews of the effectiveness of CTO systems across the world, although research is limited and patchy and many reviews subject to methodological limitations (Atkinson *et al* 2005; Churchill *et al* 2007).

One international comparative study (Dawson 2005) suggests that almost all reviews revealed significant therapeutic benefits for patients, greater compliance with treatment, especially medication,

and reduced rates of hospital admissions. Some also revealed enhanced social contacts and reduced levels of violence and self-harm.

However, a Cochrane Review (Kisely *et al* 2005) of two randomised control trials in the USA found little evidence to indicate that compulsory community treatment was effective in any of the main outcome indices: health service use, re-admission to hospital, social functioning, arrests, mental state, quality of life, homelessness or satisfaction with care. The Review concluded that:

...community treatment orders may not be an effective alternative to standard care. It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. There is currently no evidence of cost effectiveness. People receiving compulsory community treatment were, however, less likely to be victim of violent or non-violent crime.

A comprehensive review of all the published evidence on international experiences of using community treatment orders (Churchill *et al* 2007) found that it was not possible to state whether CTOs are beneficial or harmful to patients. The perceptions of different stakeholders (clinicians, patients, family and carers) were mixed, with both positive and negative views expressed by all groups. The review found no robust evidence about either the positive or negative effect of CTOs on key outcomes such as hospital re-admissions, length of hospital stay, improved medication compliance or patients' quality of life. It concluded that:

Whilst we have no firm evidence that, in general, CTOs result in any beneficial health service or patient level outcomes, there is some evidence that CTOs may have a beneficial effect under certain circumstances and with certain groups of patients. Intensive mental health treatment and enhanced monitoring for a sustained period of time may be associated with reduced recidivism and improved outcomes. However it is not clear from the available evidence whether CTOs are necessary to improve services, or whether they play any role in improving services.

Will SCT lead to an increase in compulsion?

It is likely that the introduction of SCT will lead to some increase in the use of compulsion on patients, although the rate of increase is unknown.

First, the threshold for compulsion in the Bill is lower than that in the Mental Health Act 1983. This is deliberate, so that some people to whom the current Act cannot be applied because they are considered to be 'untreatable', can be detained and compelled to accept 'appropriate' treatment. It is possible that some of these 'new' compulsory patients may in due course be discharged from hospital under SCT. The numbers are unknown but are likely to be relatively small, based on estimates of how many people fit into this category.

Second, the government estimates (Department of Health 2006) that the length of time that any individual patient is expected to spend on SCT (nine months) is significantly longer than the length of time the average patient is treated in hospital (109 days, around three and a half months). This will mean that at any one time there may be more patients subject to SCT and detention in hospital than are currently subject just to detention in hospital – the Bill extends compulsory treatment into the community so it will no longer be limited by bed numbers. However, as all SCT patients must have first been compulsorily detained for treatment in hospital under the Act they will not be 'new' compulsory patients, although they may be subject to compulsion for longer periods (potentially, in some cases, for life).

Concerns have been expressed that the introduction of SCT with insufficiently tight criteria for its use might mean that many more people over time get 'dragged into the net' of compulsory powers under the Mental Health Act 1983 who would not previously have been subject to the Act's powers. A recent

study in Massachusetts (Geller *et al* 2006) tested the net-widening belief in that state and ‘found that net-widening did not occur, despite an environment strongly conducive to that expansion. At this time, whatever the arguments against Involuntary Outpatient Treatment might be, net-widening should not be one of them’. However, it may not be possible to generalise from this study given the differences in mental health law and service provision across the range of jurisdictions that currently use CTOs and in England and Wales.

What impact will SCT have on homicides by people with a mental illness?

Protecting the public is an explicit policy objective of the Mental Health Bill. One of the conditions for the imposition of SCT is that it must be considered necessary for the individual’s health and safety or for the protection of other persons.

Evidence from a recent national inquiry (The University of Manchester 2006) suggests that there are about 50 homicides per year committed by patients with a mental disorder living in the community. The inquiry accepted that there was no reliable way of calculating exactly how many homicides might be prevented by a CTO. It did, however, indicate the potential for prevention, in theory at least. In its sample it found 40 previously detained patients who committed a homicide following non-compliance with medication or loss of contact with services – 16 per cent of homicide cases sampled, or eight per year. Of course, this does not include the larger number of people, many of them relatives, who are victims of violent incidents that fall short of death.

Homicides by people with a mental illness are unusual and relatively few in number. Many are committed by people who have not previously been in contact with services or have last been assessed as at low risk (The University of Manchester 2006). It should therefore not be expected that SCT will significantly impact on the total number of these incidents. There has been no discernable reduction in the overall rates of homicides by people with a mental illness in Canada, Australia or New Zealand as a result of CTOs having been in place in those countries for some years.

Independent inquiries in England into cases of homicide committed by those who have been in contact with the psychiatric services (mandatory since 1994) have commonly cited non-compliance with medication as one factor leading to the incident (Zito Trust 1997; The University of Manchester 2006). In such cases it is possible that had the individual been under SCT they may have complied with their treatment regime, which may have been a factor in averting a homicide.

What are the cost implications of SCT?

The government has estimated that the cost of introducing SCT in England and Wales will be £3.4 million in the first year (NHS £1.8 million; local authority £1.6 million) rising to a ‘steady state’ cost of £21.2 million in 2014/15 (NHS £11.2 million; local authority £10 million) (Department of Health 2006).

However, it also estimates a potential saving to the NHS – in terms of saved hospital bed days through some patients being discharged early under SCT – of £8.7 million in the first year, rising to £47.7 million in 2014/15. The weekly cost of care (2005 data) for a psychiatric inpatient is £1,264, but in the community it is estimated to be £360 (for a residential care home SCT patient) or £110 (for a home-based SCT patient).

How is SCT likely to work in practice?

The use of similar community-based treatment systems in other countries has varied. In some, use has built up gradually over time to a point where CTOs are commonly imposed, and accepted as part of the range of options available to clinicians; in others, they are hardly used at all. Factors affecting the rate of use in each system include clinicians’ understanding of the powers that they have; the bureaucratic burden of applying for and processing a CTO; the ease of monitoring patient compliance and whether the law allows effective sanctions to be imposed in cases of non-compliance; the availability of

appropriate community services; pressure on psychiatric bed numbers; and whether clinicians see them as having a benefit for the patient and/or the public.

These factors will no doubt apply equally to the use of SCT in England and Wales. A rigorous evidence base may take three or four years to evolve. If initial findings from studies of the effectiveness of SCT show positive clinical and social outcomes for patients, a reduced risk to the public and net cost savings, then it is likely to become an accepted part of the range of options for the treatment of mental illness in England and Wales.

However, if these benefits do not become evident (and bearing in mind the potential bureaucratic burden of applying for SCT), then it is possible that SCT will be used no more often than existing powers of supervised aftercare.

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