

A QUESTION OF NUMBERS

**The potential impact of community-based
treatment orders in England and Wales**

Simon Lawton-Smith

mental
health

A QUESTION OF NUMBERS

The potential impact of community-based
treatment orders in England and Wales

Simon Lawton-Smith

Compulsory community-based treatment orders require patients at risk of harming themselves or others to comply with a set of conditions, such as taking their medication, while living in the community. The draft Mental Health Bill 2004 incorporates plans to introduce compulsory orders in England and Wales, but it is not clear how many people could be drawn into compulsory community treatment as a result. This report sheds some light on how many people in England and Wales could become subject to such orders if the Bill becomes law, drawing on examples from countries around the world with similar systems already in place.

Published by:

King's Fund
11–13 Cavendish Square
London W1G 0AN
www.kingsfund.org.uk

© King's Fund 2005

Charity registration number: 207401

First published 2005

All rights reserved, including the right of reproduction in whole or in part in any form.

A catalogue record for this publication is available from the British Library.

ISBN 1 85717 531 x

Available from:

King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
Email: publications@kingsfund.org.uk
www.kingsfund.org.uk/publications

Edited by Eleanor Stanley
Typeset by Grasshopper Design Company
Printed in Great Britain by the King's Fund

Contents

About the author	v
Acknowledgements	vi
Summary	1
Introduction	8
Aims and objectives	9
Methodology	9
Terminology	10
Background	12
Current levels of compulsion in England and Wales	12
The draft Mental Health Bill 2004	14
What drives compulsory community-based treatment?	14
Types of compulsory community-based treatment systems	18
Are compulsory community-based orders effective?	19
International data	21
European data	21
Data from outside Europe	21
Increasing use of community-based orders over time	25
Reported underuse of community-based orders	26
Summary	28
Estimates based on patient groups	29
‘Revolving door’ patients	29
Guardianship, supervised discharge and ‘restricted’ patients	31
Supervision registers	31
Assertive outreach team clients	31
Mentally disordered offenders	32
Summary	32
Discussion	33
Discussion point 1: Factors leading to use of orders	33
Discussion point 2: Legislative conditions for compulsion	40
Summary	41

Conclusions	42
Postscript: Future changes to the draft Bill	44
References	45
Appendix 1: List of personal communication sources	50
Appendix 2: List of interviewees	52
Appendix 3: Further reading – effectiveness	53
Linked publications	54

About the author

Simon Lawton-Smith is a Senior Policy Advisor in mental health. He joined the King's Fund in 2003. He is responsible for following up the King's Fund's Mental Health Inquiry (November 2003), aimed at finding solutions to the problems facing London's mental health services, and for the King's Fund's mental health programme. Simon's background is in public service policy development and implementation. He worked in Whitehall between 1979 and 1996, primarily in the Department of Health, but with stints at the Northern Ireland Office and the Cabinet Office. From 1997–2003 Simon was Head of Public Affairs at national service-provider mental health charity Maca, where he was responsible for policy development, media relations and public relations.

Acknowledgements

I would like to thank all those studying or working in mental health services in England and Wales, and around the world, who responded to my regular requests for information during the research stage and provided much data and many insights.

Special thanks are due to Professor John Dawson (Faculty of Law, University of Otago, New Zealand), Dr Rowena Daw (until recently, Head of Policy at UK mental health charity Mind, now Human Rights Legal Adviser, Human Rights Office, Australia) and Professor George Szmulker (Dean of the Institute of Psychiatry, London, UK) for agreeing to act as an external reader of the report at draft stage. Their suggestions were most valuable. The final report, of course, remains my sole responsibility.

I would particularly like to thank Judy Robertson of the University of Essex, who was attached to the King's Fund as a researcher for some months during the course of the work, and who undertook a number of the research interviews.

Simon Lawton-Smith
September 2005

Summary

In countries around the world, legislation allows for people to be compulsorily detained in hospital, under certain circumstances, if their mental health deteriorates to such an extent that they are at risk of harm to themselves or others. Today, a growing number of jurisdictions also allow for people to be placed under a compulsory community-based treatment order.

A compulsory community-based treatment order requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community, as a less restrictive alternative to hospital. These orders are particularly targeted at people who tend to have difficulty engaging with mental health services or taking their medication, leading to an exacerbation of their mental health problems, which can end up with a hospital admission. They are intended to increase compliance with medication and patient engagement with outpatient services, while reducing hospital admissions and lowering the risk of harm to themselves or others.

Through the draft Mental Health Bill 2004, the government is currently planning to introduce community-based treatment orders in England and Wales. The draft Bill would allow tribunals to authorise treatment through an order, which would specify whether the patient should be 'resident' (treated in hospital, the equivalent of the sectioning powers in the current Mental Health Act 1983) or 'non-resident' (treated in the community).

The government's primary concern is that the 1983 Act does not allow sufficient flexibility for care and treatment under compulsion to be provided in the least restrictive environment. Its proposals are designed to provide greater flexibility by using non-residential orders to break the automatic link between compulsory care and treatment, and detention in hospital. The new community treatment powers will be focused on patients who are well known to services, and who are prone to cycles of discharge, relapse and readmission to hospital – so-called 'revolving door' patients.

How many people will this affect? The Department of Health has said that its intention is not to increase the overall use of compulsion. Its planning assumption is that about 10 per cent of those currently detained in hospital (around 1,450 people) will be placed on non-residential orders over time. However, opponents of the proposals have expressed strong concerns about the potential for non-residential orders to draw many more people into compulsory treatment. They believe the orders to be primarily a response to high-profile acts of violence committed by a small number of people with mental health problems living in the community. One analysis points out that estimated figures range from an extra 300–600 people to as many as 50,000 (Rankin 2004).

Given this lack of certainty, in 2004 the King's Fund decided to undertake a study to shed some light on the number of people in England and Wales who may become subject to non-residential orders if the Bill becomes law as it stands.

The primary purpose of the work was twofold:

- to assist the Department of Health and mental health service planners and commissioners in estimating future patient needs in the community, and ensuring adequate resources are allocated to meet those needs
- to contribute to the debate around the impact of non-residential orders on mental health services and workforce.

In brief, we found that the government's estimate of how many people may be placed on non-residential orders is likely to be an underestimate of the true figure, and that over time (say, 10–15 years) health services need to plan for several thousand people living in the community under such orders, rather than several hundred.

Background

In discussing the question of non-residential orders, it is important to note the following.

- The Bill is not suggesting a wholly new system of treatment: community-based treatment orders have been in place for many years – most notably in Australia, New Zealand, Canada, the United States and Israel.
- In England and Wales, a number of people living in the community are already subject to compulsory powers under the Mental Health Act 1983. These powers include:
 - guardianship (sections 7 and 37)
 - detained patients who are granted leave of absence (section 17)
 - those who are subject to supervised discharge (section 25 as amended).
- There is considerable debate about whether compulsory community-based treatment is effective. The research evidence is mixed. Many studies demonstrate benefits, but others disagree. Improved outcomes for some patients are only achieved where intensive community support is provided. This raises the question of whether community-based orders are necessary if patients have access to good community services.

Methodology

Our study drew on questionnaires, interviews and a review of published literature on the international use of community-based treatment systems. These systems are best established, and best documented, in Australia, New Zealand, Canada and the United States. We sent questionnaires to selected mental health administrators and academics from these countries, asking for data on the number of people subject to compulsory community-based treatment in their jurisdictions, and followed these up with email and phone conversations.

We interviewed 15 individuals from England and Wales, including Department of Health officials, mental health managers, clinicians, and service users, asking them for their views on non-residential orders and whether they thought the draft Bill would lead to an increase in compulsion.

We reviewed many hundreds of pages of published journal articles and websites on international community-based treatment systems, and followed this up with personal contact with a number of authors.

Based on the government's intention that non-residential orders should be used for 'revolving door' patients, we looked at the numbers within existing groups of mental health patients exhibiting similar characteristics to this group.

Once all the available data and expert opinion had been collected, we discussed the findings in two ways:

- by analysing how some of the factors that dictate the level of use of orders internationally might influence the level of use in England and Wales
- by looking at three conditions for community-based orders as set out in international legislation against the level of use of such orders in those jurisdictions, comparing the results with the conditions set out in the draft Mental Health Bill 2004.

Findings

The international picture

Community-based treatment orders have been used in a number of international jurisdictions for many years. By measuring how many people were placed on such orders in each jurisdiction, we hoped to shed light on how many people might be placed on non-residential orders in England and Wales.

There is little published international data on the number of people placed on community-based orders. In addition, we found the following limitations:

- jurisdictions have different pieces of legislation authorising use of community-based treatment
- each has a different data-collection system
- some data is from published records, but other data is based simply on an individual's estimate
- some public records are incomplete
- the timescales over which data was collected ranges from a number of years to a single-day snapshot.

As a result of these factors, comparisons across jurisdictions need to be treated with caution. However, we were able to build up a broad picture from available data, which demonstrated significant variations in the levels of use of community-based treatment orders across the world.

The rate of people under a community-based order ranged between around 2 per 100,000 population (Ontario and Saskatchewan in Canada, and New York State in the United States) to some 40–60 per 100,000 population (the Australian states of Queensland and Victoria, and the District of Columbia in the United States, and New Zealand). The general pattern was of low numbers of people being placed on community-based orders in Canada, high numbers in Australasia, and a very mixed picture in the United States.

Whatever the jurisdiction, the number of people placed on community-based orders almost universally increased year on year. For example:

- in Victoria state, Australia, between 1993 and 2000, the number of patients on community treatment orders rose from 1,255 to 2,260
- across New Zealand, the number rose from an estimated 1,207 in 1998 to 1,769 in 2003
- in Tennessee, United States, the number rose tenfold from around 50 per year in the early 1980s to over 500 in 2005.

We also found that, mainly in US jurisdictions, community treatment orders were imposed less regularly than anticipated, with some jurisdictions hardly using the powers at all.

This was attributed to a range of factors, including opposition to such orders in principle, resource constraints on community services, the bureaucracy involved and a ‘lack of teeth’ to enforce community treatment if a patient refuses.

On their own, the international figures did not allow an estimate to be reached on the number of people who may be placed on non-residential orders in England and Wales. However, they did set out the parameters of likely numbers, and demonstrated that numbers were likely to increase year on year.

EXISTING GROUPS OF PATIENTS

The government says that non-residential orders are aimed at ‘revolving door’ patients. To arrive at an estimate of how many people might be placed on such orders, we therefore sought to establish the number of ‘revolving door’ patients in England and Wales. We also looked at the numbers of people within existing patient groups who exhibit the same characteristics as ‘revolving door’ patients, such as non-compliance with medication, risk to others, and frequent hospital admissions.

‘REVOLVING DOOR’ PATIENTS

We asked three individual mental health practitioners to provide estimates of the number of ‘revolving door’ patients in England. One estimated 1,500, the second 2,500, and the third between 2,000 and 4,500. A higher estimate of some 23,000 came from the Revolving Doors Agency, a voluntary sector agency supporting people in contact with the criminal justice system. This was based on the agency estimating that number of potential clients across England with a formal diagnosis of a mental disorder, typically with a history of self-harm or harm to others, and non-compliance with medication.

PEOPLE SUBJECT TO GUARDIANSHIP AND SUPERVISED DISCHARGE, AND ‘RESTRICTED’ PATIENTS

The proposed Mental Health Bill is expected to replace existing guardianship and supervised discharge arrangements. It seems reasonable to assume that many people in England and Wales who at the time are subject to guardianship, and most if not all of those who are subject to supervised discharge, will be transferred to non-residential orders – around 1,600 people.

In addition, there are currently around 1,300 conditionally discharged ‘restricted’ patients (mentally disordered offenders) living in the community. It is likely that they will be transferred to non-residential orders under the new legislation, in a similar fashion to many of those under guardianship and supervised discharge.

If so, this means that, in all, up to 2,900 people currently under some form of community compulsion may be transferred to non-residential orders as soon as the necessary arrangements are in place.

CLIENTS OF ASSERTIVE OUTREACH TEAMS

As at July 2005, 17,500 people were being looked after by assertive outreach teams (AOTs). Based on studies looking at AOT patients and incidents of violence, hospitalisation and compliance with medication, we surmised that up to one-third might fit not only the description of a revolving door patient, but also the conditions set out in the draft Mental Health Bill – in other words, up to 5,000 people.

SUPERVISION REGISTERS

When supervision registers were introduced in 1994, authorities were expected to place on the register people who, because of their mental health problems, were hard to engage and presented a high risk of harm to themselves or others – characteristics of ‘revolving door’ patients. At the time, the Department of Health estimated that around 15 people per 100,000 total population might be registered, leading to a figure of about 7,800 people at today’s population level in England and Wales. However, by 1997, only some 4,100 people had been placed on registers and by 2001, the requirement to maintain them ended.

Although it was not possible to estimate with any accuracy the number of ‘revolving door’ patients in England and Wales, the comparison of ‘revolving door’ patient characteristics with assertive outreach clients and people placed on supervision registers gave us useful pointers to a possible number around the 4–5,000 mark.

The discussion

To judge more accurately where England and Wales might sit in the international range of use of community-based orders (between about 2 and 50 per 100,000 population), we undertook two discussions:

- a discussion of some of the key factors that led to a higher or lower use of orders in other jurisdictions and how these might apply in England and Wales
- a discussion of three conditions in international legislation for the imposition of community-based treatment orders, and how these compare with the draft Mental Health Bill 2004.

DISCUSSION POINT 1: FACTORS THAT INFLUENCE THE USE OF COMMUNITY-BASED TREATMENT

A number of factors indicate the potential for relatively high use of non-residential orders in England and Wales if the draft Mental Health Bill becomes law. They include:

- professional support for orders and fears about liability for patients in the community
- media and public support for orders
- pressure on acute psychiatric beds
- the likely beneficial outcomes for some patients including increased compliance with medication.

However, the following factors indicate the potential for relatively low use:

- reluctance of professionals on the grounds of ethics and/or efficacy
- too few resources available for tribunals and appropriate community services
- broadly stable numbers of psychiatric beds
- bureaucratic complexity and the difficulty of monitoring compliance
- no greater powers, over and above current measures, to impose medication in the community if a patient refuses.

On balance, given widespread concerns about available resources to implement the legislation, this suggests a moderate use of non-residential orders, placing England and Wales in the lower to mid-range of the use of orders demonstrated in the international data. Taking this to be around 15 people per 100,000 population, over time, the resulting number of people under an order in England and Wales would be some 7,800.

DISCUSSION POINT 2: LEGISLATIVE CONDITIONS FOR IMPOSING COMMUNITY-BASED ORDERS

The conditions that have to be met before a person can be placed on a community-based order are set out in each jurisdiction's legislation. Though broadly similar across jurisdictions, these conditions vary in detail. We looked at whether the presence or absence of three key conditions – none of which appear to be in the draft Mental Health Bill 2004 – could be associated with higher or lower numbers of people being placed on community-based orders in international jurisdictions, and whether, as a result, we could gauge the likely level of use in England and Wales.

The three specific conditions were:

- that the patient has a specifically defined previous history of hospitalisation set out in legislation
- that the patient poses a specific significant or substantial risk of serious harm to others, as opposed to just an unspecified level of harm
- that treatment is specifically likely to be of therapeutic benefit.

We found that the jurisdictions that contained none, or only one, of these conditions lay at the highest end of the range of use of community-based treatment orders, in terms of prevalence per 100,000 population. These tended to be in Australia and New Zealand. Meanwhile, the jurisdictions that included two or three conditions in their legislation lay at the lowest end of the range, namely Ontario, Saskatchewan and New York State.

The precise interpretation of the legislation in each jurisdiction may be open to debate, and, as we have seen, a range of factors influence the level of use of community-based orders, over and above the conditions set out in legislation. The government plans to draft regulations to define clearly the group of patients initially eligible for assessment and treatment in the community. Nevertheless, given that the draft Mental Health Bill 2004 does not include any of the three conditions set out above, in time, England and Wales may have a relatively high use of non-residential orders. While future changes to the Bill and regulations could lead to a lower figure, on the basis of what we know now, such a relatively high use would mean about 25 people per 100,000 population, resulting in around 13,000 people under an order in England and Wales.

The sum of our two discussion points suggests that, based on international comparisons, the numbers of people who may in time be placed on non-residential orders in England and Wales might lie somewhere between 7,800 and 13,000 people.

Conclusions

Comparisons across international jurisdictions must be made very cautiously, because of the variations in legislative powers and data collection systems. In addition, many different factors influence the level of use of community-based treatment orders, and there is a great deal of uncertainty about how one might count the number of 'revolving door' patients at whom non-residential orders are targeted.

We concluded that the draft Mental Health Bill 2004 could have the following impact on England and Wales, should it become law as it stands.

- The use of non-residential orders in England and Wales will lie within the parameters of use from around the world – in other words about 2–50 per 100,000 population (leading to a total of between around 1,000 and 26,000 people in England and Wales).
- The government estimates that in the first years of the new Act, about 10 per cent of the total number of patients currently detained in hospital (in other words, about 1,450 people) will be placed on non-residential orders. This figure is not unreasonable, but it is lower than our own expectation, and we believe it underestimates the number of people who will be placed on non-residential orders in the longer term (10–15 years).
- Assuming that most of those who are currently subject to guardianship and supervised discharge, and all ‘restricted’ patients, are transferred to non-residential orders, up to 2,900 people currently under some form of community compulsion may be placed on orders once arrangements are in place.
- In addition, some 200–300 mentally disordered offenders will be placed on community-based orders from within the criminal justice system relatively soon after the new law comes into effect.
- In the first years of a new Act, up to 5,000 people currently not under any form of compulsion in the community (most likely clients of assertive outreach services) may be placed on a non-residential order.
- The use of non-residential orders in England and Wales is likely to build over a period of some 10–15 years to around 15–25 per 100,000 population – in other words, 7,800–13,000 people in total. The build-up will be gradual, with relatively small numbers to start with.
- There will probably be a year-on-year increase in the number of people on non-residential orders as orders become an accepted part of the mental health system and their effectiveness for some patients demonstrated. However, pressures on tribunals and community services, along with concerns about the ethics and efficacy of non-residential orders, will act as a brake on uncontrolled use.
- There will be significant regional variations in the use of non-residential orders, mirroring the current experience of guardianship, supervised discharge and leave-of-absence arrangements, and current detentions under the Mental Health Act 1983.

In summary, on the basis of the draft Mental Health Bill 2004 as it stands, we concluded that the government’s estimate of the numbers of people who may be placed on non-residential orders is likely to be an underestimate of the true numbers, and that health services should plan, over time, for several thousand people living in the community under such orders, rather than the figure of less than 2,000 estimated by the Department of Health.

However, both the passage of the Bill through parliament and subsequent regulations may lead to a tightening of the conditions for compulsion and thus greater restrictions on who may be placed on non-residential orders.

Introduction

The story of mental health care in developed countries over the past 20 or 30 years has been one of deinstitutionalisation: the closure of long-stay psychiatric hospitals (the ‘asylums’) and the development of community services for people with a mental disorder. This has allowed tens of thousands of people to live less restrictive and more fulfilling lives in their communities. It also means that some people with severe and enduring mental disorders are now cared for in the community rather than in hospitals.

In countries around the world, legislation allows for people to be compulsorily detained in hospital, under certain circumstances, if their mental health deteriorates to such an extent that they are at risk of harm to themselves or others. Today, a growing number of jurisdictions also allow for people to be placed under a compulsory community-based treatment order.

A compulsory community-based treatment order requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community, as a less restrictive alternative to hospital. These orders are particularly targeted at people who tend to have difficulty engaging with mental health services or taking their medication, leading to an exacerbation of their mental health problems, which can end up with a hospital admission. They are intended to increase compliance with medication and patient engagement with outpatient services, while reducing hospital admissions and lowering the risk of harm to themselves or others.

Through the draft Mental Health Bill 2004 (Department of Health 2004a), the government is planning to introduce community-based orders in England and Wales. The draft Bill would allow tribunals to authorise treatment through an order, which would specify whether the patient should be ‘resident’ (treated in hospital, the equivalent of the sectioning powers in the current Mental Health Act 1983) or ‘non-resident’ (treated in the community).

The government’s primary concern is that the 1983 Act does not allow sufficient flexibility for care and treatment under compulsion to be provided in the least restricted environment. Its proposals are designed to provide greater flexibility by using non-residential orders to break the automatic link between compulsory care and treatment, and detention in hospital. The new powers will be focused on patients who are well known to services, and who are prone to cycles of discharge, relapse and readmission to hospital – so-called ‘revolving door’ patients.

How many people will this affect? The Department of Health has said that its intention is not to increase the overall use of compulsion. Its planning assumption is that around 10 per cent of those currently detained in hospital (some 1,450 people) will be placed on

non-residential orders over time (Department of Health 2005a) However, opponents of the proposals have expressed strong concerns about the potential for non-residential orders to draw many more people into compulsory treatment. They believe the orders to be primarily a response to high-profile acts of violence committed by a small number of people with mental health problems living in the community. One analysis (Rankin 2004) points out that estimated figures range from an extra 300–600 people to as many as 50,000.

It seemed to us unhelpful that no proper assessment had been made of the likely number of people with a mental disorder who might be placed on non-residential orders, given:

- the need for parliamentarians to debate the likely impact of the draft Mental Health Bill with the best evidence available to it
- the need for community services to allocate resources to meeting these patients' care plans
- the levels of concern expressed by service users who believed they might become subject to compulsory treatment in the community
- a widespread belief that the proposed legislation is a public safety measure aimed at reducing levels of violence (and sometimes homicide) by people with a mental disorder.

Given this lack of certainty, in 2004 the King's Fund decided to undertake a study to look at the question of how many people living in the community might be affected by the Bill.

Aims and objectives

The aim of this project was to shed light on the possible number of people in England and Wales who may become subject to non-residential orders, should the draft Mental Health Bill 2004 become law.

The purpose of the work was:

- to assist mental health service planners and commissioners to estimate future patient needs in the community and ensure adequate resources are allocated to meet those needs
- to contribute to the debate around the impact of the introduction of non-residential orders on the mental health workforce and services, particularly in view of concerns expressed about their possible excessive use
- to encourage more detailed research into the factors that affect the number of people subject to compulsion under a system allowing compulsory hospital- and community-based treatment, and the impact on services in England and Wales.

Methodology

The research used quantitative and qualitative methods, including:

- **Questionnaires to international contacts** Compulsory community-based treatment systems are best established and documented in Australia, New Zealand, Canada and the United States. We emailed 48 questionnaires to selected overseas mental health administrators, academics and statisticians from these countries. We asked for data on the number of people subject to compulsory mental health treatment and related

homicides and suicides over a period of time, both before and after community-based systems were introduced.

Nine questionnaires were returned (19 per cent), but none of the respondents was able to even partly complete the data tables. Follow-up phone conversations with many of those to whom we had sent questionnaires confirmed that the figures we had asked for were either not gathered, or gathered only at local level that was not easily accessible. We did, however, collect much valuable opinion, and many suggestions for locating data, from subsequent personal correspondence via email and telephone.

- **Desk research** We carried out a review of the available literature by looking at organisational websites and published research in the field. This was not only to collect relevant data on the use of community-based treatment orders, but also to provide background information about the policy and effectiveness of such orders around the world. Personal correspondence with some authors of this material enabled us to gain further insights into the reasons for levels of use of orders in different jurisdictions.
- **Semi-structured interviews** We interviewed 15 individuals from England and Wales to gather a range of expert opinion. These included mental health managers, clinicians and service users (for a list of interviewees, *see* Appendix 2, p 52). Some interviews were based on the draft Mental Health Bill 2002, before the publication of the revised draft Mental Health Bill 2004 in September 2004. However, there were no significant changes to the provisions for non-residential orders in the second version of the Bill.
- **Discussion** Once all the available data and expert opinion had been collected, we discussed the findings in two ways:
 - by analysing how some of the factors that dictate the level of use of orders internationally might influence the level of use in England and Wales
 - by looking at three conditions for community-based orders, as set out in international legislation, against the level of use of such orders in those countries, comparing the results with the conditions set out in the draft Mental Health Bill 2004.

From this, we were able to reach a number of conclusions about the likely number of people with a mental disorder who would be placed on a non-residential order in England and Wales.

Terminology

Compulsory community-based treatment

The terminology used in the field of compulsory community-based treatment varies. In the United States, it is generally referred to as ‘involuntary outpatient treatment’ (IOT) or ‘involuntary outpatient commitment’ (IOC), though in New York State it is referred to as ‘assisted outpatient treatment’, or AOT. In Canada, it can be called ‘mandatory outpatient treatment’ (MOT). In Ontario and New Zealand, it is called a ‘community treatment order’ (CTO), sometimes referred to a ‘CommTO’, while in Scotland the term is ‘compulsory treatment order’. In Israel, references are made to ‘outpatients in compulsory ambulatory treatment’.

For England and Wales, the draft Mental Health Bill 2004 refers to orders either for ‘residents’ (people in hospital) or ‘non-residents’ (people living in the community). For the purposes of this paper, we refer to ‘non-residential orders’ when referring to the specific proposals in the draft Mental Health Bill 2004, and to ‘community-based orders’ when referring to the totality of such systems across the world.

People with a mental disorder

There is no universally accepted term for someone with a mental health problem. People can variously be described as having a mental health problem or disorder, or a mental illness – or as being a mental health service user. If they have been convicted of a crime, and are in contact with criminal justice services, they can be referred to as mentally disordered offenders (MDOs). For the purposes of this paper, we have generally used the term ‘mental disorder’, as this is the term used in the draft Mental Health Bill in its conditions for the imposition of an order.

Geographical areas of study

We talk about the various ‘jurisdictions’ we have looked at around the world. This is intended to describe an area (for example, a country, state, province, or city) where a particular community-based treatment order system applies for which figures are available.

Background

Current levels of compulsion in England and Wales

The current Mental Health Act 1983 contains powers not only to detain people in hospital and compulsorily treat them there, but also to impose certain requirements on some people living in the community – primarily under guardianship, leave of absence from hospital, or supervised discharge powers.

The Bill's proposals for non-residential orders, imposing obligations on people living in the community, do not therefore represent a wholly new departure. The number of people who are currently under such community-based powers might give us an idea of how many people may be placed under non-residential orders.

In hospital

Most people who are subject to compulsory treatment for a mental disorder are detained in hospital under the Mental Health Act 1983. In England, there were 45,700 detentions under the Act in 2003/04, including 26,200 formal admissions and 18,200 detentions after informal admission to hospital (Department of Health 2005b).

Levels of detention were nearly twice as high in London as in any other part of England, at around 140 per 100,000 population, compared with about 80 per 100,000 outside London. As at 31 March 2004, there were some 14,000 detained patients in NHS facilities and independent hospitals in England.

In Wales, in 2003/04 there were 1,387 formal admissions under the Mental Health Act 1983. As of 31 March 2004, 498 patients were detained under legislation (National Assembly for Wales 2004).

In the community

A number of people living in the community in England and Wales are already subject to compulsory powers under the Mental Health Act 1983. These primarily cover guardianship (sections 7 and 37), detained patients who are granted leave of absence (section 17), and those who are subject to supervised discharge (section 25, as amended by the Mental Health (Patients in the Community) Act 1995).

Guardianship

The Department of Health (then known as the Department of Health and Social Security) redefined guardianship powers in the Mental Health Act 1983 because it felt that some patients who did not need hospital care did nevertheless require supervision and control

in the community (Fennell 1992). This is precisely the issue being debated today, more than 20 years on.

In England, 932 people were subject to guardianship in England on 31 March 2004 (Department of Health 2004b). Ten per cent of all local authorities accounted for 43 per cent of cases open, suggesting significant variations in use across the country. By 2004, the number of new guardianship cases had decreased for the fourth successive year.

In Wales, in the year ending 31 March 2004, 117 people were under guardianship under the Mental Health Act 1983 (Wales Local Government Data Unit 2005), making a total of around 1,000 for England and Wales.

Leave of absence

Section 17 (1) of the Mental Health Act 1983 states that patients may be granted leave to be absent from hospital 'subject to such conditions (if any) as [the responsible medical officer] considers necessary in the interests of the patient or for the protection of other persons'.

The Department of Health does not collect data centrally on the number of patients on leave of absence at any given time. The enquiries that we made of a number of mental health trusts in England suggested that the number of patients on leave of absence varied from day to day, along with the length of time that leave of absence was granted. Across England, significant numbers – in the hundreds – of detained patients are granted day leave, a lesser number overnight leave, and a yet smaller number extended leave.

Supervised discharge

Supervised discharge allows for certain people with a mental disorder who have been detained under the 1983 Mental Health Act to receive care, under formal supervision, after leaving hospital, if there would otherwise be a substantial risk of harm to the patient or to others.

When supervised discharge was introduced in 1995, it was regarded as a political response to high-profile homicides committed by people with a mental disorder in the community (Eastman 1995). One concern raised at the time was that the approach would draw in more people than was intended – the same concern that is raised in relation to non-residential orders today. However, supervised discharge has not been widely used as a way of monitoring compliance with medication, and what usage there is varies considerably between health trusts (Davies 2002).

Reflecting this, in 2003/04, only 608 patients were recorded as discharged to supervised discharge in England (Department of Health 2005b) and 26 in Wales (National Assembly for Wales 2005).

Mentally disordered offenders

Sections 42 and 73 of the Mental Health Act 1983 give the Home Secretary and a Mental Health Tribunal respectively the powers to conditionally discharge into the community certain mentally disordered offenders (MDOs) detained in hospital under a restriction

order. (A restriction order is imposed on a patient at high risk of reoffending and causing serious harm to the public, which means that they can only be discharged from hospital on the authority of the Home Secretary or a Mental Health Review Tribunal.)

As at August 2005, the Home Office estimated that there were around 1,300 conditionally discharged ‘restricted’ patients under active supervision in the community (Nigel Shackleford, personal communication 8 August 2005). Although transitional arrangements for this group have yet to be determined, they are likely to be transferred, in effect, to non-residential orders under the new legislation.

Powers in the Criminal Justice Act 2003 provide for community sentences with attached conditions for mental health treatment, intended to allow certain people to live in the community rather than be imprisoned. The provision is explicitly aimed at people who do not meet the criteria for hospital admission under the Mental Health Act 1983. It was used 215 times in 2001 (Nigel Shackleford, personal communication 7 July 2005).

In summary, there already exist a variety of powers to provide community treatment to certain people with a mental disorder, but these powers are relatively little used. This raises the question: will non-residential orders be used to any significantly greater extent?

The draft Mental Health Bill 2004

The draft Mental Health Bill 2004 is the culmination of six years’ consideration of how to update the Mental Health Act 1983 to reflect changes in mental health services and practice over the past 20 years – especially the move towards care in the community. In particular, the government is keen to introduce legislation that allows compulsory compliance with treatment, where deemed necessary, for patients living in the community.

In 1998, the government established an expert committee chaired by Professor Geneva Richardson to advise on how best to achieve this. The committee submitted its report to ministers in July 1999 (Richardson 1999). It was published alongside a government consultation paper in November 1999 (Department of Health 1999). Following consultation, the government published a White Paper in 2000 (Department of Health 2000a), an initial draft Mental Health Bill in June 2002 (Department of Health 2002), and its present draft Mental Health Bill in September 2004 (Department of Health 2004a).

The provisions in the draft Bill concerning the authorising of a non-residential order are provided in the box opposite.

What drives compulsory community-based treatment?

An analysis of the driving forces behind the introduction of community-based treatment orders internationally, sheds some light on who might be the target patient group for such orders, and therefore the numbers of people who may be affected.

Public safety

Much of the literature suggests that the impetus for introducing legislation allowing compulsory community-based treatment is homicides or other significant acts of violence committed by people with mental disorders (Rolfe 2001, Appelbaum 2001). One example

AUTHORISING ORDERS IN THE DRAFT MENTAL HEALTH BILL 2004

Conditions for making an order for a patient to be treated either in hospital (as a resident) or in the community (as a non-resident).

Part 2, Chapter 1, Clause 9

The relevant conditions:

1. In this Part, references to the relevant conditions are to the following conditions (subject to subsection 7).
2. The first condition is that the patient is suffering from mental disorder.
3. The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.
4. The third condition is that it is necessary –
 - a. for the protection of the patient from –
 - i. suicide or serious self-harm, or
 - ii. serious neglect by him of his health or safety, or
 - b. for the protection of other persons, that medical treatment be provided to the patient.
5. The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.
6. The fifth condition is that medical treatment is available which is appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.
7. The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.
8. For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

Part 2, Chapter 6, Clause 46

4. The order must state whether the patient is to be provided with medical treatment –
 - a. as a resident patient for the period until the order ceases to be in force
 - b. as a non-resident patient for that period, or
 - c. as a resident patient for the period specified in the order then as a non-resident patient for the period until the order ceases to be in force.
6. If the order states that the patient is to be provided with medical treatment as a non-resident patient for any period, the order must –
 - a. specify the conditions imposed on him to –
 - i. secure that the treatment may be provided to him, or
 - ii. protect his health or safety or other persons against the risk by reference to which the Tribunal determined that the third of the relevant conditions is met in his case,
 - b. make a recommendation to the clinical supervisor as to the action which might be taken by him if the patient fails to comply with the conditions or there is a material change in the patient's circumstances, and

continued overleaf

AUTHORISING ORDERS IN THE DRAFT MENTAL HEALTH BILL 2004 *continued*

- c. state that the clinical supervisor is authorised by the Tribunal to determine whether the conditions should be suspended in accordance with section 62 [in other words, leave of absence arrangements].

- 7. The conditions may include –
 - a. a condition that the patient –
 - i. attends at a specified place at specified times,
 - ii. resides at a specified place,
 - iii. makes himself available for treatment during specified periods,
 - b. a condition that the patient does not engage in specified conduct.
- Note: In this subsection, ‘specified’ means specified in the order

It should be noted that in clause 15, the Bill also contains powers of compulsory assessment in the community (prior to any possible treatment), including similar requirements to clause 46(7) above.

is Nebraska’s Mental Health Commitment Act, which introduced powers to treat people involuntarily in the community from 1 July 2004. Its stated purpose is to provide for the treatment of people who have a mental disorder and are dangerous.

This purpose can also be seen in Ontario, Canada, where the legislation is referred to as ‘Brian’s Law’, after Brian Smith, an Ottawa broadcaster who was shot dead in 1997. In New York, it is known as ‘Kendra’s Law’, named after Kendra Webdale, a woman pushed to her death in a subway station. California has ‘Laura’s Law’, named after Laura Wilcox, a student shot and killed in January 2001. More recently, community-based orders were introduced in Florida in June 2004. Here, a major factor was the murder in 1998 of a law officer by a man who was himself killed in the subsequent shoot-out. In each of these cases, the person who committed the homicide was diagnosed with schizophrenia and was not taking any medication.

Widespread coverage of such incidents in the media has led to increasing public concern and pressure for legislative action to protect public safety. Before the introduction of community-based treatment in Ontario, it was noted that:

Recently, as a result of media attention to violent incidents involving persons with mental illness, and several high profile Coroner’s inquests, there have been renewed calls to amend the provincial Mental Health Act to permit coercive treatment of individuals with mental illness living in the community.

(Canadian Mental Health Association 1998, p i)

In England and Wales, ministers have made it clear that the purpose of mental health law is to protect patients and others from harm that can arise from mental disorder (Department of Health 2004c).

In England, some 40–50 homicides occur each year in which the perpetrator has a diagnosis of schizophrenia (Taylor and Gunn 1999). Inquiries into these homicides have consistently cited patients' poor compliance with treatment and medication, alongside poor communication between local services and lack of care planning (Mackay 2004).

Government research (Office of National Statistics 2000) suggests that around 80 per cent of those diagnosed as having a psychotic disorder receive one or more psychoactive medications. Of these, almost a third (32 per cent) said they sometimes did not take it. This proportion rose to almost half (48 per cent) among those aged up to 45.

Suicide

Another purpose of community-based treatment is to reduce the number of people with mental disorders who commit suicide – which is far greater than the number of homicides. In England and Wales, there were 4,796 adult suicides in 2003 (Office of National Statistics 2005).

The government has set itself the target of reducing the number of suicides by 20 per cent between 1999 and 2010. In its response to the Joint Parliamentary Scrutiny Committee of July 2005, the Department of Health emphasised that 'The government's and society's concern is to protect very vulnerable people from harming themselves or, much more occasionally, others' (Department of Health 2005c, p 4).

Evolution of inpatient leave arrangements

In New Zealand, and the Australian states of Victoria and New South Wales, community-based treatment arose as a procedural evolution of, and eventually replaced, the 'long leave' systems – where patients were granted leave from hospital – rather than as a political response to homicides or suicides (John Dawson, personal communication 26 May 2005).

Who are non-residential orders in England and Wales aimed at?

The Department of Health has stated that powers to treat people under compulsion in the community will be focused on 'revolving door' patients. In giving evidence to the Joint Committee on the draft Mental Health Bill, the National Director for Mental Health, Professor Louis Appleby, described this group of patients:

We have an unacceptable situation at the moment where people with quite severe illnesses who have a history of frequent relapse and frequent admissions associated with high risk resulting from lack of treatment are allowed to continue that pattern because there is no power to ensure that treatment is delivered. I think this is putting patients unnecessarily at risk and it is putting clinicians and the patients' families in a very difficult position. Therefore, this measure is to target that group of people, the revolving door group.

(Joint Committee 2005, vol 2, p 522)

Types of compulsory community-based treatment systems

Looking at different jurisdictions around the world, there are generally three circumstances in which compulsory community-based treatment orders can be made (Swartz *et al* 1995):

- for a person being discharged from hospital into the community
- for a person who meets criteria for admission to hospital but, it is judged, does not need to be detained in hospital
- for a person who does not meet these criteria but does meet a lower threshold of criteria for treatment as an outpatient.

Another way of looking at community-based orders is to categorise them as diversionary and preventive (O'Reilly *et al* 2003). The diversionary order is imposed as an alternative for someone who would otherwise need to be hospitalised. The preventive order allows a patient to be subject to compulsion in the community based on a judgement that if they are not placed under compulsion, their mental and/or physical health will deteriorate until they require hospital admission.

Around the world, community-based orders tend to be imposed as a condition of discharge from hospital. For example, in Western Australia, 15 per cent of patients placed on a community-based order had the order imposed while living in the community, but 85 per cent had it imposed on discharge from hospital (Kisely *et al* 2004).

Particularly in more established systems, the number of people on community-based orders can easily outweigh the number of patients detained in hospital. For example, in New Zealand, on any one day in 2002, there were estimated to be about 1,400 people on a community-based order, 600 on an inpatient order in hospital, and 300 on inpatient short-term leave (Dawson 2002). In the District of Columbia, United States, of approximately 400 committed patients, 100 are inpatients and 300 are outpatients (Anne Sturtz, personal communication 3 March 2005).

Systems do vary considerably from one jurisdiction to the next, and no single best practice model exists. For example, most – though not all – states in the United States have compulsory community-based treatment powers, but they vary considerably (Swartz *et al* 1995, Ridgely *et al* 2001). The same applies to states and territories in Australia (Rolfe 2001, Main 2005).

What this means is that:

- thresholds for compulsion set out in legislation vary
- some systems have identical criteria for inpatient and outpatient treatment (as is proposed for England and Wales) while others have different thresholds
- sometimes an order is authorised by a judge; sometimes by a psychiatrist
- the length of time that orders may be imposed varies
- some orders combine inpatient and outpatient treatment.

This does mean that comparisons across jurisdictions need to be made cautiously.

Are compulsory community-based orders effective?

This is a crucial question to ask in relation to the rate of use of community-based orders, and one that has generated thousands of pages of research and opinion without producing a definitive answer. Although our paper does not consider this in detail, whether or not clinicians and others consider community-based orders to be effective will clearly have an impact on how often people are placed on them.

Though some of the evidence has been contested (Swartz and Swanson 2004), the general consensus is that community-based orders can be effective in improving outcomes:

Although there are limitations in all studies that evaluate [community-based order] regimes, their results usually reveal: significant therapeutic benefits for patients; greater compliance with outpatient treatment, especially medication; and reduced rates of hospital admissions. Some also reveal: better relations between patients and families, or enhanced social contacts; reduced levels of violence and self-harm; and earlier identification of patients' relapse.

(Dawson 2005, p 4)

A recent report from New York (New York State Office of Mental Health 2005), looked at the first five years of 'Kendra's Law', under which 3,908 individuals had been placed under community-based treatment. Among those with severe psychiatric disorders, the report found significant reductions in hospitalisation, homelessness, substance abuse, threat of harm to others, arrest, and imprisonment. The number of patients exhibiting good adherence to medication rose from 41 per cent to 62 per cent. Of a cohort of 76 patients interviewed, 75 per cent said that the treatment had helped them gain control over their lives and 81 per cent said that it had helped them to get well and stay well. A recent study in New Zealand (Gibbs *et al* 2005) suggests that the usefulness of community treatment orders is accepted by most, though not all, patients under them in New Zealand, as well as by most psychiatrists.

Some research suggests that community-based orders do not reduce the overall risk of hospital admission (Preston *et al* 2002, Lurie 2005), although admissions are likely to be of shorter length (Kisely *et al* 2004). A recent Cochrane Review suggests that compulsory community treatment in fact results in no significant difference in service use, social functioning or quality of life compared with standard care (Kisely *et al* 2005).

Improved outcomes for some patients are only achieved where intensive community support is provided, suggesting that they will be effective for some patients in England and Wales so long as they operate in conjunction with frequent contacts with effective community services (Davies 2002).

This begs the question of whether community-based orders are necessary at all, if there are good community services that patients wish to engage with (Rolfe 2001, Swartz *et al* 2001). As McIvor points out in a paper on community psychiatric treatment:

In a field dogged by methodological difficulties, findings have been conflicting and, regarding efficacy, the jury is still out.... There is not yet enough evidence to demonstrate that involuntary outpatient treatment is significantly and consistently

better at ensuring adherence to community treatment and reducing hospital usage than a fully functioning and well-resourced community service.

(McIvor 2001, p 370)

However, better-resourced community services may not negate the need for compulsory community treatment (Geller 2005). Most clinicians who work within community-based treatment systems are of the view that, even with good community services, some patients will not engage voluntarily owing to their mental disorder and lack of insight (John Dawson, personal communication 26 May 2005).

In England, the efficacy of existing community rehabilitation orders with additional requirements of psychiatric treatment (issued under criminal justice legislation) has been queried, with the suggestion that coercive mental health practice (such as supervision registers, supervised discharge orders and the proposals for non-residential orders) has been driven not by the results of research but by political expediency (Bartlett 2002).

For further reading on the effectiveness of community-based orders, see Appendix 3, p 53.

International data

Community-based treatment orders have been used in a number of international jurisdictions for many years. By measuring how many people were, and are, placed on such orders in each jurisdiction, we hoped to shed light on how many people might be placed on non-residential orders in England and Wales.

However, accessible international data on the numbers of people subject to community-based orders appear to be very limited. Relatively few jurisdictions collect these data centrally, and many have no easy access to any data that may be recorded locally.

European data

A European study looking at different countries' use of community-based treatment (Salize and Dressing 2002) reported difficulties in collecting data in many countries and wide variations in the availability of good data. Four European countries (Belgium, Luxembourg, Portugal and Sweden) were reported as having compulsory community-based treatment systems, but the lack of information about the nature and scope of such arrangements meant that we were unable to use the Salize data.

Furthermore, delays in introducing the Mental Health (Care and Treatment) (Scotland) Act 2003 (to come into effect in October 2005) meant we were unable to use initial data from Scotland on levels of use of community-based orders.

Data from outside Europe

We therefore looked at the community-based order systems outside Europe that most closely matched the proposals set out in the draft Bill – namely Australia, New Zealand, Canada, the United States and Israel. These are the jurisdictions where community-based treatment systems are best established, and are the subject of most of the available published data and literature.

When collecting and comparing data, it is important to note that jurisdictions vary considerably in the legal conditions that need to be met before a person can be placed under a community-based order. In addition, every jurisdiction contains a variety of social and cultural factors that can influence the level of use of community-based orders, such as:

- the attitude of medical professionals
- the availability (or otherwise) of good community services
- the rate at which institutionalised care is being replaced by community-based care
- the number of available inpatient psychiatric beds
- the overall prevalence of mental disorder among the population.

Further issues compound the difficulty:

- the figures are not collected on a consistent basis
- the information does not take the varying lengths of orders into account
- some figures go back to the 1980s
- some relate to periods of longer than one year, some to a single year, and some are snapshots taken at a particular date
- some refer to individual cities, some to states or provinces, and some to whole countries
- the populations of jurisdictions, used to calculate prevalence, are constantly shifting.

As a result, comparisons between different jurisdictions need to be treated with caution.

Bearing in mind the above limitations, we were able to collect the data set out in Tables 1a and 1b, showing the number of people subject to community-based orders per 100,000 across a number of international jurisdictions.

Table 1a sets out data based on a collection period of one year or more. Table 1b sets out data collected on a snapshot (census) basis. As a rule, a snapshot figure will be less than a whole-year figure for the same jurisdiction. In any given year, some people are likely to be discharged from orders before a census date but will still be counted in the year's figures. Additionally, others will be placed on orders later in the year, after the census date.

TABLE 1A: NUMBER SUBJECT TO CBOs PER 100,000 (BASED ON DATA COLLECTION PERIOD OF ONE YEAR OR MORE)

Jurisdiction	Total population	No of people under orders (actual or estimates)	People under orders per 100,000 population	Period of data collection
New Zealand				
Otago ¹	180,000 (1996)	259 (average 48 per year)	26.6	1 Nov 1992 – 24 April 1998
Australia				
Victoria ²	4,645,000 (2001)	7,500 (average 577 per year)	12.4	Nov 1990 – 2003
Victoria ³	4,600,000 (2000)	2,260	49.1	2000
Victoria ⁴	4,911,000 (2003)	2,700	55	2003
Western Australia ⁵	1,780,000 (1998)	313	17.6	13 Nov 1997 – 31 Nov 1998
New South Wales ⁶	6,682,000 (2003)	2,500	37.4	2003
Canada				
Toronto, Ontario ⁷	2,400,000 (2004)	480 (average 144 per year)	6	Dec 2000 – 31 March 2004

TABLE 1A *continued*

Jurisdiction	Total population	No of people under orders (actual or estimates)	People under orders per 100,000 population	Period of data collection
Canada <i>continued</i>				
Ontario ⁸	12,260,000 (2003)	635 (average 206 per year)	1.7	1 Dec 2000 – 31 Dec 2003
Saskatchewan ⁹	990,200 (1996)	59 (average 17 per year)	1.7	July 1995 – Dec 1998
United States				
New York State ¹⁰	18,976,000 (2001)	more than 400	2.1 plus	Jan 2000 – Jan 2001
New York State ¹¹	18,976,000 (2001)	3,908 (average 748 per year)	3.9	8 Nov 1999 – 1 Feb 2005
Tennessee ¹²	4,660,000 (1983)	78 (average 47 per year)	1	1 July 1981 – 1 March 1983
North Carolina ¹³	6,413,000 (1987)	4,179 (average 1,393 per year)	21.7	1 July 1985 – 30 June 1988
Nebraska ¹⁴	1,747,000 (2004)	450	25.7	1 July 2003 – 30 June 2004
Israel				
Israel, Jerusalem and South Districts ¹⁵	1,380,900 (1999)	208 (average 52 per year)	3.8	1991–94
Israel ¹⁶	6,867,000 (2004)	1,101	16	2004

¹ Dawson and Romans (2001)² Mental Health Research Institute of Victoria (2003)³ King's College London (2004)⁴ Victoria Department of Human Services (2003)⁵ Preston *et al* (2002)⁶ Dawson (2005)⁷ Canadian Mental Health Association (2004)⁸ Stephen Dreezer, personal communications 20 and 28 January 2005⁹ Dave Nelson, personal communication 7 March 2005¹⁰ New York State Office of Mental Health (2001)¹¹ New York State Office of Mental Health (2005)¹² Bursten (1986)¹³ Fernandez and Nygard (1990)¹⁴ Bob Bussard, personal communication 16 July 2005¹⁵ Durst *et al* (1999)¹⁶ Daniella Nahon, personal communication 17 March 2005

TABLE 1B: NUMBER SUBJECT TO CBOs PER 100,000 (BASED ON DATA COLLECTED ON A SNAPSHOT (CENSUS) BASIS)

Jurisdiction	Total population	No of people under orders (actual or estimates)	People under orders per 100,000 population	Date of data collection
New Zealand				
New Zealand ¹	3,939,000 (2002)	1,400	35.5	Any one day in 2002
New Zealand ²	4,000,000 (2003)	1,769	44.2	Average of month-end counts during 2003
Australia				
Victoria ³	5,000,000 (2005)	more than 3,000	60 plus	Any one day in 2005
Western Australia ⁴	2,000,000 (2004)	200	10	Any one day in 2004
Queensland ⁵	3,877,000 (2004)	1,663	42.9	22 March 2005
United States				
Maricopa County, Arizona ⁶	3,389,260 (2004)	1,050	31	Count from December 2004
Tennessee ⁷	5,777,000 (2004)	567	9.8	1 June 2005
District of Columbia ⁸	553,500 (2004)	300	54.2	As at March 2005

¹ Dawson (2002)

² Chris Windsor, personal communication 9 February 2005

³ Brophy (2005)

⁴ Tim Rolfe, personal communication 24 November 2004

⁵ Julia Carter, personal communication 30 March 2005

⁶ Scott Tiffany, personal communication 28 January 2005

⁷ John Gerdes, personal communication 6 June 2005

⁸ Anne Sturtz, personal communication 3 March 2005

As indicated, comparisons across jurisdictions must be treated with caution, given the different legislative frameworks and data collection systems. However, the figures do demonstrate that internationally, there is extreme variation in the use of community-based orders. This is particularly true between states within the United States. Elsewhere, Canada

appears to reflect relatively low use, while Australia and New Zealand appear to reflect relatively high use.

The figures suggest parameters of between approximately 2 to 50 people per 100,000 population being subject to community-based orders. If we transpose this to England and Wales, this would suggest that approximately 1,000 to 26,000 people would become subject to non-residential orders if the draft Mental Health Bill becomes law.

Increasing use of community-based orders over time

Whatever the jurisdiction, the pattern is almost universally one of an increasing number of people becoming subject to community-based orders as they become established (Dawson 2005). Some examples of this are shown below:

- **In Victoria State, Australia**, between 1993 and 2000, the number of patients treated on community treatment orders rose from 1,255 to 2,260 – an 80 per cent increase (King's College London 2004).
- **In Toronto, Canada**, overall numbers of referrals have risen substantially since the programme's inception in December 2000 (Canadian Mental Health Association 2004). In 2002/03, 249 people were referred to Toronto's Community Treatment Order (CTO) Project. This rose to 332 people in 2003/04 – an increase of 33 per cent. About 70 per cent of referrals result in a community-based order being issued.
- **In New Zealand**, the number of people receiving community-based orders rose from an estimated 1,207 to 1,769 between 1998 and 2003 (Chris Windsor, personal communication 9 February 2005).
- **In Tennessee, United States**, the number of people on community-based orders has risen tenfold from around 50 per year in the early 1980s to more than 500 in 2005 (John Gerdes, personal communication 6 June 2005).
- **In Israel**, the number of people on community-based orders has risen from 690 in 2000 to 1,101 in 2004 (Daniella Nahon, personal communication 17 March 2005).

Although this rising pattern is common, it is not universal, as the following examples show:

- **In Saskatchewan, Canada**, the relatively low level of use of community treatment orders is stable year on year (Dave Nelson, personal communication 2005), although many psychiatrists originally believed that their use would increase (O'Reilly *et al* 2000).
- **In Nebraska, United States**, the recorded numbers of outpatient commitment orders issued rose from 350 in 2001/02 to 448 in 2002/03, but fell to 398 in 2003/04. These figures, however, come from incomplete returns and should be treated with caution (Bob Bussard, personal communication 1 March 2005).
- **In Tasmania**, numbers fell rather than rose (Sharyn Eastaugh, personal communications 18 December 2003 and 6 June 2005). After its Mental Health Act commenced in 1999, community treatment orders totalled 15.5 per cent of the total orders made. This reduced to 10 per cent in 2000/01 (33 orders), 5 per cent for 2001/02 (19 orders) and only 2 per cent for 2002/03 (9 orders). They now constitute only 1 per cent of all orders. The decline is accounted for by the fact that community orders cannot be enforced if they are breached – something the Tasmanian legislature is in the process of amending.

Reported under-use of community-based orders

Despite the general increase in the number of people subject to community-based orders year on year, there is evidence, especially from the United States, that orders are not used as much as they might be, or as much as anticipated.

Examples in the United States

In the United States, a number of studies point out that usage of community-based orders varies widely from state to state, with some using the powers frequently and others hardly at all (Torrey and Kaplan 1995, Swartz and Monahan 2001).

One review involving eight states in the United States (Ridgeley *et al* 2001) indicates that outpatient commitment laws are seldom used. It cites New York State officials initially estimating that 7,000 individuals would be placed on community-based orders under 'Kendra's Law', passed in August 1999, but that by September 2000 only 235 involuntary outpatient petitions had been filed. The most recent report of Kendra's Law notes that the early 2005 figure of 3,908 people under outpatient commitment is noticeably lower than the 10,000 people per year that Kendra's Law opponents predicted would be caught in the 'dragnet' of the law (New York State Office of Mental Health 2005).

Another US study (Allen and Smith 2001) pointed out that in the United States, not all administrations use their powers with any regularity: of the 40 or so states having such laws on their book at the time, more than half seldom invoked them.

Torrey and Kaplan (1995) suggest the following reasons for underuse of orders in the United States:

- concerns about civil liberties
- reluctance of professionals to act as 'police'
- the possibility of liability for crimes committed by patients
- extra financial burdens on community services
- overly tight commitment criteria
- a lack of 'teeth' should a patient cease to become compliant with their treatment
- poor understanding of outpatient commitment powers.

To give some specific examples, in Tennessee, in the 20 months after mandatory outpatient treatment was introduced in 1981, it was found that outpatients clinics were not rigorously enforcing the law, and that of a population of 4.6 million, only 78 people had been placed on an order (Bursten 1986). This was partly because of the reluctance of the mental health centres to accept and coercively treat severely mentally disordered and dangerous patients, and partly because the legislation had not been backed up with adequate funding to provide services to this client group.

In Illinois (Patrick Knepler, personal communication 25 February 2005) the involuntary community treatment powers are used 'very seldom', for 'probably fewer than 50 people a year', out of a population of some 12.6 million people. This is ascribed to:

- financial pressures on community services and the cost of outpatient commitment
- the issue of liability of professionals should a patient on outpatient commitment commit an act of violence

- the fact that the court order for outpatient commitment incorporating provisions from the person's treatment plan is much more labour intensive than the order for hospital commitment.

In Florida, the powers allowing community-based orders ('involuntary outpatient placement') came into effect on 1 January 2005. By August 2005 it appeared that only six or seven orders for community-based orders had been made (Annette Christy, personal communication 9 August 2005).

A condition for community-based compulsion of 'immediate dangerousness' has led to some community-based systems being seldom used. Jon Stanley of the Treatment Advocacy Centre, Virginia, described the situation in about half of the 42 states of the United States that have community-based orders:

The laws were tacked on to existing involuntary inpatient criteria requiring that a person be an immediate danger to self/others or some similarly stringent standard. That requires a judge to, in the same hearing, find someone presently dangerous and safe to live in the community. Not surprisingly, states with such a legal configuration for CTOs [compulsory treatment orders] almost never make use of the mechanism. Virtually every state that makes liberal use of CTOs permits their use for reasons other than solely imminent dangerousness.

(Jon Stanley, personal communication 25 October 2004)

Examples from elsewhere

In Saskatchewan, there was relatively low use of community-based orders during their first three years of use, in 1995–98 (O'Reilly *et al* 2000). Factors contributing to this included:

- some psychiatrists not having patients suitable for treatment under such an order
- a lack of information about orders
- a view that orders' powers were insufficient to deal with treatment non-compliance.

In Toronto, factors deterring the use of community-based orders by professionals included the infringement of clients' rights, a lack of knowledge about and experience with the orders, a lack of demonstrated efficacy and the time it required to issue an order (Canadian Mental Health Association 2005).

An Australian study (Rolfe 2001) identifies an increase in work for clinicians as a deterrent to use orders and cites an example of a local service that restricted orders to 20 at one time because of resource constraints.

In Israel (Ajzenstadt *et al* 2001) some psychiatrists have refused to carry out what they see as a police function, and a lack of community treatment facilities means psychiatrists rarely impose orders on people in some regions of Israel. Also compulsory community-based treatment has been criticised for the weakness of the enforcement procedure, the detrimental effect on civil liberty of the individual and its lack of therapeutic efficiency (Mester and Barel 2005).

Summary

The available international data must be treated with caution. However, the figures suggest significant variations in levels of use of community-based orders around the world. This information provides us with parameters (between about 2 and 50 per 100,000 population) within which the numbers of people placed on non-residential orders in England and Wales would be likely to fall. They also point almost universally to an increase over time in the numbers of people who are placed on orders – something that services in England and Wales will need to take into account.

Despite the ever-increasing number of people on community-based orders, the accompanying literature, and evidence gained from our international contacts, suggest that orders are often used patchily (especially in the United States), for a variety of reasons, including lack of community resources and a lack of powers to force treatment on people in the community if they fail to comply with an order.

Estimates based on patient groups

The international figures provide one pointer to the likely level of use of non-residential orders in England and Wales. For another perspective, we looked at the number and types of patients in certain groups, to see which might fit the descriptive characteristics of the government's target group for non-residential orders, as well as the conditions set out in the draft Mental Health Bill 2004:

- 'revolving door' patients
- guardianship, supervised discharge and 'restricted' patients
- patients on supervision registers (1994)
- assertive outreach team clients
- mentally disordered offenders.

These are described in detail below.

'Revolving door' patients

The Department of Health has cited 'revolving door' patients as the target group for community-based orders. Its assumption for modelling the effects of the Bill (for example, to assess its impact on tribunals) is that in the first years when the new Act comes into force, about 10 per cent of the total number of patients who are currently detained in hospital will be on non-residential orders (Department of Health 2005a). Given that at any one time there are around 14,500 patients detained in hospital in England and Wales, this would suggest a figure of some 1,450 people.

In passing, it is worth noting that in many jurisdictions, the number of people on community-based orders is significantly higher than the number in hospital. For example, in New Zealand around 65 per cent of all patients under compulsion are on community-based orders, in the District of Columbia, United States, the figure is around 75 per cent, and in Maricopa County, Arizona, United States, the figure is around 87 per cent.

We approached a number of mental health practitioners for a view on the number of 'revolving door' patients in England and Wales. Three felt able to make an estimate as follows:

- no more than 15 people per trust providing mental health services, producing a total of some 1,500 people in England and Wales (Len Bowers, personal communication 21 December 2004)
- a build-up over five years to around 25 people in each of 100 local mental health services in England (in other words, the old health districts), giving 2,500 after five years (Philip Sugarman, personal communication 27 January 2005)

- an estimate of 25 to 50 in the borough/primary care trust (PCT) of Lambeth, London (Stuart Bell, personal communication 10 January 2005). This works out at between 9 and 18 per 100,000 population. If an equivalent total were to be estimated for England and Wales, this would be between 4,770 and 9,540 people. However, as an inner-city London borough, Lambeth has a very different socio-demographic make-up from most other PCTs across England and Wales. Furthermore, in London as a whole, current levels of hospital detention under the 1983 Mental Health Act are about twice as high as those in any other part of the country. Taking this into consideration, a truer national figure based on the Lambeth estimate may be between 2,000 and 4,500 people.

We also approached the Revolving Doors Agency, a charity that works with people with mental health problems who come into contact with the criminal justice system. The agency estimates that there are some 50,000 people across England who fit the agency's client profile. Of these, some 23,000 have a formal diagnosis of a mental disorder, typically with a history of self-harm, or harm to others, and non-compliance with medication. Its view was that these 23,000 clients could fit the conditions set out in the draft Mental Health Bill for the imposition of a non-residential order (Nick O'Shea, personal communication 12 April 2005) – a significantly higher estimate than the estimates obtained from individual mental health practitioners.

Dr Stephen Hunter, Chair of the Adult Psychiatry Faculty, Welsh Division, Royal College of Psychiatrists, suggested an estimate of 223 patients in Gwent, using ten or more admissions as the threshold for 'revolving door' status, based on five years' admissions to all adult wards (Stephen Hunter, personal communication 25 April 2005). If the situation in Gwent were typical, this would equate to approximately 1,100 'revolving door' patients across Wales.

Using the same criteria for England (patients who have had ten or more admissions in the last five years, most recently 2003/04), an analysis of Hospital Episode Statistics (HES) data indicated that 4,181 patients fell into this group.

However, the data can be cut in various different ways, depending on how a 'revolving door' patient is classified in terms of readmissions to hospital. If the category was redefined as referring to two or more admissions, or 30 or more days in the last three years (as in Ontario), then 123,296 patients fall into the group. If the definition was three or more admissions or 60 or more days in the last two years (as in Saskatchewan), 49,593 patients fall into the group.

While these figures accurately reflect the numbers of people who 'revolve' between the community and hospital (depending on how many admissions they have over what period of time), they do not provide a very helpful basis for estimating numbers of people who may become subject to non-residential orders. The figures are based on all patients with a mental disorder admitted to hospital, but not necessarily detained under any section of the Mental Health Act. Many of them would be unlikely to fit all the other conditions that are required for the use of compulsory treatment in the draft Bill. We therefore discounted estimates based on the HES data.

Guardianship, supervised discharge and ‘restricted’ patients

The new legislation is expected to replace existing guardianship and supervised discharge arrangements. It seems reasonable to assume that many of those in England and Wales who are subject to guardianship at the time of the legislation (around 1,000) and most if not all of those who are subject to supervised discharge (around 600) will be transferred to non-residential orders – though it should be noted that the latter figure is based on the number of patients granted supervised discharge in 2003/04, which may be different from the number of people under supervised discharge at any one time.

In addition, there are currently around 1,300 conditionally discharged ‘restricted’ patients (mentally disordered offenders) living in the community. It is likely that they will be transferred to non-residential orders under the new legislation, in a similar fashion to many of those under guardianship and supervised discharge.

If so, this means that, in all, up to 2,900 people currently under some form of community compulsion may be transferred to non-residential orders as soon as the necessary arrangements are in place.

Supervision registers

Supervision registers were introduced in 1994 and the requirement to maintain them ended in 2001. They were aimed at patients with a severe mental disorder who needed to be engaged by outpatient services, and who were, or might be, at risk of serious self-neglect, or committing suicide or a serious act of violence (NHS Executive 1994).

Estimates of the number of patients likely to be registered ranged from 40 to 300 per 100,000 total population, although at the time, the Department of Health suggested that if local mental health services used a narrow criterion (in other words, a tight definition of risk), the figure might be around 15 per 100,000 total population (Bindman *et al* 2000). At today’s population level in England and Wales (52.1 million), that would lead to a figure of 7,815 people.

However, in 1997, a research study showed the actual total number of patients on supervision registers in England to be 4,136 (8.6 per 100,000 total population) – just over half the Department of Health’s estimated amount (Bindman *et al* 1998). There were wide local variations in numbers across different trusts.

Given the similarities in the patient characteristics of those placed on supervision registers and those intended to be placed on non-residential orders, the figure of 4,136 may provide a clue to how many people may be placed on non-residential orders, if the draft Mental Health Bill 2004 becomes law, in the first few years of a new Act.

Assertive outreach team clients

Assertive outreach teams (AOTs) began to be formally set up in the late 1990s, and were picked up by the Department of Health as a good practice model that should be widely implemented (Department of Health 2000b). They are intended to establish and maintain contact in community settings with hard-to-engage people on a seven-day-a-week, long-term basis. AOTs have small caseloads, and use a team approach and generic

working to meet the majority of people's needs, including practical help and social care, medication and psychological interventions (Firn and Burns 2004). Clients typically do not engage with services, have complex needs (including substance misuse), are non-compliant with medication, and have high levels of unplanned admissions to hospital. There is clearly a strong descriptive similarity between the 'revolving door' patients described on p 30 and AOT clients.

The government originally cited a figure of 20,000 people as due to receive AOT support by December 2003 (Department of Health 2000b). By July 2005, a lower number of 17,500 people were in fact being supported by AOTs (Department of Health 2005d).

One interpretation might be that all AOT patients would fit the 'revolving door' description and the conditions set out in the draft Mental Health Bill 2004, and would therefore become subject to non-residential orders. However, the AOT client group is a heterogeneous one, and individual characteristics can vary considerably. It is likely that many AOT patients would not, at any given time, in practice fit all the conditions for a non-residential order in the Bill.

To estimate how many might fit the conditions, we looked at two studies of AOT clients. The first, based on clients within 24 London AOTs (Wright *et al* 2003) showed that the two-year incidence of physical violence was 35 per cent and that more than 30 per cent could expect to be hospitalised within a nine-month period. The second study suggested that around one-third of AOT patients only partially comply or totally refuse to take their medication (McPherson 2004).

We surmised from this data that up to one-third of AOT patients might present a high risk of not taking their medication, and/or rehospitalisation, and/or acts of violence, so might fit not only the description of a 'revolving door' patient, but also, at some point, the conditions set out in the draft Mental Health Bill. As there are currently 17,500 or so patients under AOT, this produces an estimate of up to some 5,000 current AOT clients who might over time be placed on non-residential orders under the proposed new legislation.

Mentally disordered offenders

In giving evidence to the Joint Committee on the draft Mental Health Bill (Joint Committee 2005), Home Office Minister Paul Goggins stated that the Home Office wished to provide the widest possible range of disposals for the criminal courts, including non-residential orders, so that a greater number of mentally disordered offenders (people with a mental disorder convicted of a crime) can be dealt with in the community in the future. It has estimated that there may be 200 or 300 people in England and Wales who might at any one time be liable to such an order, who would otherwise either be in prison or in hospital.

Summary

It is not possible to accurately estimate the number of 'revolving door' patients. However, it is clear that there are some thousands of patients already receiving some form of community support (especially assertive outreach services) who would fit the characteristics of this group. It is therefore likely that many of these patients will be placed on non-residential orders over time.

Discussion

To judge more accurately where England and Wales might sit in the international range of use of community-based treatment orders (between around 2 and 50 per 100,000 population), we looked at the available evidence in two ways:

- a discussion of some of the key factors that led to a higher or lower use of orders in other jurisdictions and how these might apply in England and Wales, and
- a discussion of three conditions in international legislation for the imposition of community-based treatment orders, and how these compare with the draft Mental Health Bill 2004.

Through these discussions, we aimed to gauge whether England and Wales would be more likely to follow the low-use path of Canada and New York or the high-use path of Australia and New Zealand.

Discussion point 1: Factors leading to use of orders

A number of factors influence the greater or lesser use of orders. We chose to look at six of these in the context of England and Wales, chosen because of their prominence in the published literature on community-based orders:

- civil liberties and public opinion
- attitudes of professionals
- the possibility of liability for crimes committed by patients
- the adequacy of resources to implement the new arrangements
- psychiatric bed numbers
- the likely effectiveness of orders.

These factors are discussed below.

Civil liberties and public opinion

In some parts of the United States, a strong civil libertarian movement has slowed or even halted proposals to introduce community-based treatment, and the debate on the ethics of such treatment remains active. In contrast, in Australia and New Zealand such measures have on the whole become an accepted 'part of the furniture' of mental health care.

In England and Wales, the trend in recent years has been to impose greater levels of control on certain individuals living in the community who are considered a threat to public order and public safety. Witness, for example, the creation of anti-social behaviour orders (ASBOs), drug testing and treatment orders (DTTOs), and electronic tagging of criminal offenders. These measures are all designed to impose some sort of requirement on individuals, or a restriction on their activity, to reduce public risk and offending behaviour.

The DTTO, for example, includes a requirement for a person to undergo treatment at a specified place, just as the mental health non-residential order would.

There has been little or no demonstration of public opinion against these measures. Nor has there been any general public outcry against the idea of non-residential orders. Media coverage of mental health issues has tended to fuel public perceptions linking people with a mental disorder with acts of violence, which makes it likely that the general public will welcome the introduction of non-residential orders as a public safety measure.

Civil libertarians have two powerful tools in the European Convention on Human Rights (ECHR) and the Human Rights Act 2000, but the Department of Health has made it clear that it has drafted the Bill so as not to fall foul of this legislation. It may not be until some time after the introduction of a new mental health act before a definitive ruling on whether the actual use of non-residential orders contravenes any aspects of that legislation.

Overall, it seems unlikely that civil liberty issues in England and Wales will lead to a groundswell of public opinion to oppose or restrict the use of non-residential orders.

Attitudes of professionals

Health professionals in England and Wales have demonstrated relatively little overt support for non-residential orders, although many consider the idea acceptable in principle, so long as there are strict conditions imposed on their use and adequate safeguards for patients.

Regarding the principle of non-residential orders, the Mental Health Alliance (which includes professional bodies such as the British Association of Social Workers, the British Psychological Society, the Mental Health Nurses Association and the Royal Colleges of Nursing and of Psychiatrists) has stated, in its memorandum to the Joint Committee on the draft Mental Health Bill:

Some members of the Alliance – including all service user groups – are opposed to NROs [non-residential orders] in any circumstance. The Alliance, however, recognises that, given the government's commitment to introducing them, it is necessary to consider how they could be introduced in a constructive manner and with appropriate safeguards.... Overseas research gives some credence to the view that there may be a small group of patients for whom repeated access to hospital may not be necessary although compulsion might be beneficial.... We recognise that in this small number of cases an NRO may be appropriate as a less restrictive alternative than a long hospital admission.

(Joint Committee 2005, vol 2, p 134)

With respect to existing compulsory community-based arrangements, consultant psychiatrists appear not to object to current supervised discharge or guardianship powers in principle, and one study suggests that 62 per cent would like additional legal powers to enforce medication compliance (Bindman *et al* 2001). In another 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).

A third study, this time of 259 health care professionals in New Zealand, where community-based orders have been available for some years, found that 73 per cent preferred to work

in a mental health system with community treatment orders. Only 8 per cent said they would prefer not to have them (Romans *et al* 2004).

Faced with the daily dilemma of what to do about non-compliant patients with a history of violence during relapse, individual psychiatrists in England and Wales may welcome non-residential orders (Tony Maden, personal communication 9 March 2005). In addition, some professionals may see them as a way of getting individual patients at the end of a long waiting list to the front of the queue (Paul Corry, interview 9 August 2004). In the view of Dr Mark Cross, 'As with anything, it takes a while for people to get used to something, but if it [a non-residential order] becomes law and it is available, then it will be used' (interview 7 December 2004).

Others believe there may be a general reluctance by some psychiatrists to use non-residential orders as discriminatory (Michael Howlett, personal communication 18 January 2005).

The ease with which orders can be processed and monitored will also affect their levels of use. If the orders are regarded as bureaucratically complex and time consuming, and there are difficulties in monitoring patient compliance with the conditions of the order, professionals may be reluctant to go through the process for what they see as little benefit. Bob Lepper of the South London and Maudsley NHS Trust suggested that difficulty of use was one reason why supervised discharge procedures were relatively little used:

Have you seen a supervised discharge application? It's bigger than the other Section papers... Consultants looking at those bits of paper just somehow don't want to know, and I feel that's going to be the same with community treatment orders.

(Bob Lepper, interview 24 January 2005)

Evidence does suggest that in some jurisdictions, professionals do not use community-based orders much as they are simply unaware of them or do not understand them (Torrey and Kaplan 1995). This should be less of a problem in England and Wales where there has been widespread and ongoing professional debate about the introduction of non-residential orders. In addition, the UK government intends to ensure that training takes place in the use of the new legislation before it comes into effect (Adrian Sieff, interview 21 January 2005).

The possibility of professional liability for crimes committed by patients

In the United States, professionals have become concerned about their liability should one of their patients commit an act of violence in the community. This has been one factor in limiting the use of orders (Torrey and Kaplan 1995).

In England and Wales, the argument has been somewhat different. As bed numbers have reduced, mental health practitioners have become more safety conscious (Lelliott and Audini 2003). If patients are to be discharged in any case, given pressure on beds, then placing someone on a non-residential order could be seen as a way of diluting any blame for an act of violence ('We did what we could.'). Overly defensive use of non-residential orders might arise in response to sensationalist media reporting of the small number of

homicides committed by a mentally ill person. As Paul Corry of the national mental health charity Rethink put it:

If you are a professional and you are faced with the new opportunity of the community treatment order, you may well think, 'What it will do is protect me as a professional from any accusations that I may have acted inappropriately.'

(Paul Corry, interview 9 August 2004)

The adequacy of resources to implement the new arrangements

The government has estimated that 830 new staff will be required to operate the new legislation. The scheme will entail £11 million in training and development costs during the year before implementation, and an extra annual running cost of £70 million per year, mainly to establish the Mental Health Review Tribunal system (Department of Health 2004d). A number of organisations that submitted evidence to the Joint Parliamentary Scrutiny Committee, and individuals who we interviewed, suggested these estimates were too low. The government is to revise its resource estimates (Department of Health 2005c).

At present, there are significant difficulties in fulfilling the legal requirements to provide patients with mental health tribunal hearings under the Mental Health Act 1983. The number of hearings is expected to rise under the new legislation. An inadequate tribunal system would clearly restrict the number of non-residential orders (and, indeed, residential orders) that could be made, even to the point that there may be fewer people placed on non-residential orders than are currently placed under supervised discharge (that is, fewer than 600 a year) (Jonathan Bindman, personal communication 22 April 2005).

A brake on orders may also occur through a lack of appropriate and available community services. Before a non-residential order is imposed by a mental health tribunal, it has to be satisfied that 'medical treatment is available which is appropriate in the patient's case' (Draft Mental Health Bill 2004, Clause 9(6)). If appropriate services are not available, then an order cannot be made even if a person fulfils all the other conditions.

Many community mental health services in England and Wales are at present very stretched. Significant numbers of patients do not receive an adequate level of service, or find that the requirements of their care plans are not met (Sainsbury Centre for Mental Health and Mental Health Act Commission 2005).

Furthermore, referring in particular to Wales, the Joint Committee on the draft Mental Health Bill reported that it seemed very unlikely that Wales could successfully implement the provisions of the draft Bill with the resources currently available, and that the standard of mental health services in Wales would have to be at least as good as it is now in England before the provisions in the draft Bill could be implemented (Joint Committee 2005).

Confirming doubts about the introduction of non-residential orders in Wales, Richard Timm, a client of Welsh mental health charity Hafal, has stated:

This law could be a disaster for Wales. We don't have the resources to support it here. Our services are way behind those in England. In fact it could mean that services get worse in Wales because so many doctors will be tied up with delivering the new law.

(Hafal 2005)

John Dawson of the University of Otago, New Zealand, echoes this concern. He takes the view that the limitations of community services in England and Wales may restrict the number of people placed on non-residential orders. His research (Dawson and Romans 2001), based on data from New Zealand, New South Wales and Victoria, suggested that the use of community-based orders may be between 33 and 50 per 100,000 population, and that these figures might provide some foundation for service planning in England. His figures would suggest between some 17,200 and 26,000 people across England and Wales might be placed on non-residential orders. However, he has argued that the actual figures would turn out to be substantially lower in the UK owing to lower levels of support for them among community mental health professionals, longer inpatient stays and less-well-developed community facilities (John Dawson, personal communication 22 December 2003).

Recognising the problems faced by community mental health services, the Department of Health has stated that new investment in this area is aimed at reducing the number of people with mental disorders who become so ill that compulsory treatment becomes necessary (Department of Health 2004e). There is some evidence that the development of assertive outreach teams and crisis resolution teams may reduce hospital admissions (Sainsbury Centre for Mental Health 1998, 2001), but the overall number of compulsory admissions has remained broadly constant over the past few years. The increasing number of people in England and Wales presenting with complex needs (mental health and drug and/or alcohol use) suggests greater numbers of admissions in the future for this group.

Overall, it seems likely that limitations in the capacity of the new tribunal system and the availability of appropriate community mental health services will act as a considerable brake on the use of non-residential orders.

Bed numbers

In the 1950s, there were approximately 150,000 psychiatric beds in England. But, with the move from institutional to community care, that number has now dropped to around 32,000, for a population of some 49 million. This figure has been broadly stable for the past few years. In Wales (which has a population of about 3 million) there were around 2,600 psychiatric beds in 2003/04 – a slight reduction from 2,800 in 2000/01 (National Assembly for Wales 2005).

John Dawson of the University of Otago has pointed out that the degree of deinstitutionalisation, and declining psychiatric bed numbers, affects the use of community-based treatment orders in many ways:

As bed numbers decline, the extent of the community services available tends to go up. This then expands the use of CTOs, because CTOs will only be widely used by clinicians if there is a credible community service available. Further, if bed numbers decline dramatically, so will average lengths of hospital stays. This, in turn, means that some patients will be discharged when still very unwell (for example after about two weeks, or less). In those circumstances, use of CTOs tends to go up steeply, if allowed, to permit continuing intensive community treatment of such patients, following their early discharge. These factors largely explain, in my view, why use of CTOs increased so rapidly in Australasia during the 1990s: this was a period of rapid hospital bed closures.

(John Dawson, personal communication 26 May 2005)

The question is, therefore, will inpatient psychiatric bed numbers in England and Wales decline over the coming years alongside the introduction of non-residential orders? Increasing efforts to treat people in the community (such as the introduction of assertive outreach and crisis resolution teams) have led to some authorities closing some psychiatric beds. However, there has been no significant reduction in the number of psychiatric beds across the board, and the pressure on beds remains high. In many parts of the NHS, occupancy levels are above 100 per cent, meaning that patients have to be allocated beds elsewhere – generally in the private sector – or are granted leave from hospital under section 17 of the Mental Health Act 1983. In England, the number of overall psychiatric bed days (the number of days a patient was accommodated in a designated psychiatric unit) has risen from some 5,348,000 in 1998/99 to 5,582,000 in 2003/04.

Clinicians may feel under pressure to place patients on non-residential orders in order to reduce pressures on acute psychiatric wards. However, as Dr George Szukler, Dean of the Institute of Psychiatry, has pointed out, one cannot assume that as non-residential orders go up, formal admissions will go down (George Szukler, personal communication 18 May 2005).

On balance, there appears to be little evidence that psychiatric bed numbers will decline significantly over the next five years, and therefore any impact from this quarter on the level of use of non-residential orders will be minimal.

Will non-residential orders be effective?

Non-residential orders are intended to do the following:

- improve patient compliance with medication
- maintain patients' social relationships
- reduce hospitalisations
- increase patient and public safety by reducing incidences of self-harm, suicide and homicide.

If non-residential orders demonstrably meet these aims, they are likely to become popular with professionals and others, including patients' carers and families, and may become widely used. As we have seen ('Are compulsory community-based orders effective?' p 19), international figures suggest that they can have a beneficial outcome for some patients, though perhaps no more so than providing good-quality community services with which patients wish to engage.

However, previous attempts to impose some sort of control or monitoring regime over difficult-to-engage and potentially dangerous patients living in the community have had mixed success. Supervision registers, introduced in 1994, showed large variations in use between areas (Bindman *et al* 2000). The fact that the requirement to maintain them ended in 2001 suggests that they failed to meet their two key aims: patient engagement and increased public safety. Supervised discharge powers have been shown to have positive outcomes for patients (Davies 2000), and supervised discharge and guardianship orders alike are regarded by clinicians as effective in most of the cases in which they have been used (Bindman *et al* 2001). However, they have been used for relatively small numbers of people and, in proposing new non-residential orders, the government clearly considers the current powers inadequate for its purposes.

The low use of the existing community-based measures of supervised discharge and guardianship may partly relate to the fact that these powers do not allow treatment to be compulsorily imposed in the community, and are therefore considered ineffective in certain circumstances. A similar ‘lack of teeth’ argument has been used to explain the low use of community-based orders in some other jurisdictions (Torrey and Kaplan 1995, Mester and Barel 2005).

However, the non-residential order, as outlined in the draft Mental Health Bill, has no greater powers of forced treatment in the community than these existing measures. If a patient chooses not to comply with their care plan and agreed conditions, then they would need to be ‘taken into custody and conveyed to the relevant hospital or place’ (Clause 80). The extra advantage for clinicians of a non-residential order is that medical staff would immediately be able to compulsorily medicate a person once they had been conveyed to hospital, without any additional legislative or administrative process in order to effect admission to hospital, and then return them to the community (in effect, compulsory treatment on an outpatient basis).

It remains to be seen whether clinicians are more tempted by non-residential orders than by existing measures. It may be that they will inspire no more confidence in professionals and will lead to a not significantly greater number of people being placed on them than the number already under existing measures.

In terms of enhancing public safety, Dr George Szmukler, Dean of the Institute of Psychiatry told us that he believed that non-residential orders would have a small impact on the admission rates, and virtually no impact on violence, and that in fact substance abuse had a much bigger impact on violence than whether a patient was taking their medication (interview 27 September 2004). This view was echoed by Paul Corry, who pointed out that the violence that is associated with particularly severe mental disorder is usually triggered by outside factors, like drink and drugs, and it was difficult to see how CTOs were going to deal with these issues (interview 9 August 2004).

Discussion point 1: Summary

A number of factors indicate the potential for relatively high use of non-residential orders in England and Wales if the draft Mental Health Bill becomes law. They include:

- professional support for orders and fears around liability for patients in the community
- media and public support for orders
- pressure on acute psychiatric beds
- the likely beneficial outcomes for some patients, including increased compliance with medication.

However, the following factors indicate the potential for relatively low use:

- reluctance of professionals on the grounds of ethics and/or efficacy
- too few resources available for tribunals and appropriate community services
- broadly stable numbers of psychiatric beds
- bureaucratic complexity and the difficulty of monitoring compliance
- no greater powers, over and above current measures, to impose medication in the community if a patient refuses.

Given widespread concerns about available resources to implement the legislation, on balance this suggests a moderate use of non-residential orders, placing England and Wales in the lower to mid-range of the use of orders demonstrated in the international data. If we take this to be around 15 people per 100,000 population, the resulting number of people under an order in England and Wales, over time, would be around 7,800.

Discussion point 2: Legislative conditions for compulsion

The conditions that have to be met before a person can be placed on a community-based order are set out in each jurisdiction's legislation. Though broadly similar across jurisdictions, these conditions vary in detail.

For our second measure to help us to estimate how frequently non-residential orders might be used in England and Wales, we looked at whether the presence or absence of three key conditions – none of which is in the draft Mental Health Bill 2004 – could be associated with higher or lower numbers of people being placed on community-based orders in international jurisdictions, and whether, as a result, we could gauge the likely level of use in England and Wales.

The three specific conditions were:

- that the patient has a specifically defined previous history of hospitalisation set out in legislation
- that the patient poses a specific significant or substantial risk of serious harm to others, as opposed to just an unspecified level of harm
- that treatment is specifically likely to be of therapeutic benefit.

Table 2 sets out how these conditions are included in the primary legislation of 13 jurisdictions for which we have recent data or estimates on the use of community-based orders (see Tables 1a and b, pp 22–24).

The precise interpretation of the legislation in each jurisdiction may be open to debate. In addition, as we have seen, a range of factors influence the level of use of community-based orders, over and above the conditions set out in legislation, as also happens with inpatient commitment (Engleman *et al* 1998).

Nevertheless, Table 2 does suggest an association between the presence or absence of these three conditions in legislation, and the relative number of people who are placed under community-based orders. Those jurisdictions that do not have the conditions tend to have higher numbers, while those with the conditions tend to have lower numbers. The only three jurisdictions that include the condition of a specific history of previous inpatient care (Ontario, Saskatchewan and New York State) have the three lowest numbers of people per 100,000 population on community-based orders.

We noted that the government plans to draft regulations to define clearly the group of patients initially eligible for assessment and treatment in the community (which could satisfy the first condition set out above). In addition, human rights legislation requires compulsion to be a proportionate response to the harm that might be caused if no action were taken (which could suggest that compulsion would be imposed only if the level of potential harm to others was serious, even though the draft Bill does not specify this).

TABLE 2: LEGISLATIVE CONDITIONS FOR THE USE OF COMMUNITY-BASED ORDERS

Jurisdiction	Rate per 100,000 population	Previous history	Significant risk	Therapeutic treatment
Victoria	>60.0*	no	no	yes
Columbia District	54.2*	no	no	no
New Zealand	44.2*	no	no	no
Queensland	42.9*	no	no	no
New South Wales	37.4	no	no	no
Nebraska	25.7	no	yes	yes
Israel	16.0	no	no	no
Western Australia	10.0*	no	no	no
Tennessee	9.8	no	yes	no
Toronto, Ontario	6.0	yes	yes	yes
New York State	3.9	yes	yes	yes
Ontario	1.7	yes	yes	yes
Saskatchewan	1.7	yes	no	yes

*These figures are taken from census (snapshot) data. Other figures are based on data collected over a period of a year or more – see Tables 1a and 1b, pp 22–24.

However, given that the draft Mental Health Bill 2004 as it stands does not include any of the three conditions set out above, this would suggest that, in time, England and Wales may have a relatively high use of non-residential orders. Taking this to be around 25 people per 100,000 population, the resulting number of people under an order in England and Wales would be around 13,000.

Summary

The conclusion we reach from our two discussion points suggests that, on the basis of international comparisons of factors that influence the use of community-based orders, and conditions set out in the draft Mental Health Bill 2004, the numbers of people who may in time be placed on non-residential orders in England and Wales might lie between some 7,800 to 13,000 people.

Conclusions

We set out to shed light on the possible number of people in England and Wales who may become subject to non-residential orders should the draft Mental Health Bill become law. To help us judge this, we looked for evidence in international data on the numbers of people under community-based orders and the available literature on this subject, and spoke to a number of academics, researchers and mental health professionals both internationally and in England and Wales.

The range of estimates that we reached, based on the different sources of information, are summarised in Table 3. No one estimate can be said to be a definitive one.

TABLE 3: ESTIMATED NUMBER OF PEOPLE WHO MAY BECOME SUBJECT TO NON-RESIDENTIAL ORDERS IN ENGLAND AND WALES

International data range (around 2–50 per 100,000 population)	1,000–26,000
Assuming 15 per 100,000 population (based on discussion of factors influencing use of orders)	7,800
Assuming 25 per 100,000 population (based on three specific legislative conditions not being in the draft Bill)	13,000
Existing patients who might transfer to non-residential orders	
Patients under guardianship	up to 1,000
Patients under supervised discharge	600
‘Restricted’ patients	1,300
Mentally disordered offenders	200–300
‘Revolving door’ patients	
Ten per cent of currently detained patients (Department of Health estimate)	1,450
Individual expert opinion ‘a’ (England only)	1,500
Individual expert opinion ‘b’ (England only)	2,500
Individual expert opinion ‘c’ (England only)	2,000–4,500
Revolving Door Agency opinion (England only)	23,000
Assertive outreach patients (England only)	up to 5,000
Supervision register	
Department of Health estimate (1994)	7,800
Actual figures (1997)	4,136

In reaching conclusions about how many people may become subject to non-residential orders in England and Wales, it is important to remember the following considerations:

- There is relatively little international data on the total number of people subject to community-based orders. Comparisons between data must be made very cautiously due the many variations in legislative powers, socio-demographic factors and data collection systems.
- We do not yet know how the conditions for imposing compulsory treatment, as set out in the draft Mental Health Bill 2004, will be interpreted by professionals – especially as no draft regulations or Code of Practice have as yet been issued by the Department of Health – or how resource constraints may limit use of the new powers.
- It is not possible to reach even a broad consensus on how many ‘revolving door’ patients – the Department of Health’s target group for non-residential orders – there are in England and Wales.

A very wide range of factors influence the level of use of orders, the legislative conditions for compulsion being only one. Many jurisdictions use community-based orders extensively. Almost universally, the numbers of people on community-based orders rise year on year, and in some cases a majority of people under compulsion now live in the community rather than being detained in hospital.

However, for a variety of reasons, other jurisdictions hardly use their community-based treatment powers at all, or use them less than expected. Estimates of how many people may be placed on community-based orders are generally not quickly reached – and existing powers of community treatment in England and Wales are used moderately.

On balance, we concluded that the draft Mental Health Bill could have the following impact on England and Wales, should it become law as it stands:

- The use of non-residential orders in England and Wales will lie within the parameters of use from around the world – in other words around 2–50 per 100,000 population (leading to a total of between approximately 1,000 and 26,000 people in England and Wales).
- The government estimates that in the first years of the new Act, about 10 per cent of the total number of patients currently detained in hospital (in other words, about 1,450 people) will be placed on non-residential orders. This figure is not unreasonable, but it is lower than our own expectation, and we believe it underestimates the number of people who will be placed on non-residential orders in the longer term (10–15 years).
- Assuming that most of those who are currently subject to guardianship and supervised discharge, and all ‘restricted’ patients, are transferred to non-residential orders, up to 2,900 people currently under some form of community compulsion may be placed on orders once arrangements are in place.
- In addition, some 200–300 mentally disordered offenders will be placed on community-based orders from within the criminal justice system relatively soon after the new law comes into effect.
- In the first years of a new Act, up to 5,000 people currently not under any form of compulsion in the community (most likely clients of assertive outreach services) may be placed on a non-residential order.
- The use of non-residential orders in England and Wales is likely to build over a period of some 10–15 years to between around 15–25 per 100,000 population – in other words, 7,800–13,000 people in total. The build-up will be gradual, with relatively small numbers to start with.

- There will be a year-on-year increase in the number of people on non-residential orders as orders become an accepted part of the mental health system and their effectiveness for some patients demonstrated. However, pressures on tribunals and community services, along with concerns about the ethics and efficacy of non-residential orders, will act as a brake on uncontrolled use.
- There will probably be significant regional variations in the use of non-residential orders, mirroring the current experience of guardianship, supervised discharge and leave-of-absence arrangements, and current detentions under the Mental Health Act 1983.

In summary, we concluded that on the basis of the draft Mental Health Bill 2004 as it stands, the government's estimate of the numbers of people who may be placed on non-residential orders is likely to be an underestimate of the true numbers, and that health services should plan, over time, for several thousand people living in the community under such orders, rather than the figure of less than 2,000 estimated by the Department of Health.

Postscript: Future changes to the draft Bill

The government received the recommendations of the Joint Committee on the draft Mental Health Bill in March 2005, and responded to them in July 2005 (Department of Health 2005c). None of the changes to be taken on board by the Department significantly tighten the conditions set out for the imposition of orders, though it has accepted that it needs to recalculate the resources that will be required to meet the needs of the new legislation, and intends to define clearly in the regulations the group of patients initially eligible for assessment and treatment in the community.

It should be noted that both the passage of the Bill through parliament and subsequent regulations may lead to a tightening of the conditions for compulsion and consequently greater restrictions on who may be placed on non-residential orders. However, at this stage it is not possible to assess what impact changes to the Bill may have.

References

- Ajzenstadt M, Aviram U, Kalian M, Kanter A (2001). 'Involuntary outpatient commitment in Israel: Treatment or control?' *International Journal of Law and Psychiatry*, vol 24, pp 637–57.
- Allen M, Fox Smith V (2001). 'Opening Pandora's box: the practical and legal dangers of involuntary outpatient commitment'. *Psychiatric Services*, vol 52, no 3, pp 342–6.
- Appelbaum P (2001). 'Thinking carefully about outpatient commitment'. *Psychiatric Services*, vol 52, no 3, pp 347–50.
- Bartlett A (2002). 'Commentary'. *Advances in Psychiatric Treatment*, vol 8, pp 289–90.
- Bindman J, Beck A, Thornicroft G (1998). *PRISM Evaluation of Supervision Registers*. London: Department of Health.
- Bindman J, Beck A, Thornicroft G, Knapp M, Szmukler G (2000). 'Psychiatric patients at greatest risk and in greatest need'. *British Journal of Psychiatry*, vol 177, pp 33–7.
- Bindman J, Pinfold V, Hatfield B, Canvin K, Bartlett A, Thornicroft G (2001). *National Evaluation of Supervised Discharge and Guardianship*. London: Research and Development Division, Department of Health.
- Brophy L (2005). 'Social and structural dimensions in the implementation of community treatment orders'. Abstract for International Congress on Law and Mental Health conference, Paris, 2–8 July 2005. Montreal: International Academy of Law and Mental Health.
- Bursten B (1986). 'Posthospital mandatory outpatient commitment'. *American Journal of Psychiatry*, vol 143, pp 1255–8.
- Canadian Mental Health Association (1998). *Response to Proposals to Amend Mental Health Act*. Executive summary. Toronto: Canadian Mental Health Association.
- Canadian Mental Health Association (2004). 'Community treatment order project update'. *Annual Report*. Toronto: Canadian Mental Health Association.
- Canadian Mental Health Association (2005). *Report on the Survey of Hospitals' Use of Community Treatment Orders and Case Management Services*. Toronto: Canadian Mental Health Association.
- Crawford M, Hopkins W, Henderson C (2000). 'Concerns over reform of the Mental Health Act'. Letter. *British Journal of Psychiatry*, vol 177, p 563.
- Davies S (2000). 'Involuntary outpatient commitment and supervised discharge'. Letter. *British Journal of Psychiatry*, vol 177, p 183.
- Davies S (2002). 'Compulsory treatment in the community: current legal powers'. *Advances in Psychiatric Treatment*, vol 8, pp 180–88.

Dawson J (2002). 'Attenuated Liberty: Life under a community treatment order'. Law faculty seminar. Dunedin, New Zealand: University of Otago, October 2002.

Dawson J (2005). *Community Treatment Orders: International Comparisons*, University of Otago, New Zealand, May 2005. Available at: www.otago.ac.nz/law/otagoCTO/index.html (accessed on 6 September 2005).

Dawson J, Romans S, (2001). 'Use of community treatment orders in New Zealand: early findings'. *Australian and New Zealand Journal of Psychiatry*, vol 35, pp 190–95.

Department of Health (1999). *Reform of the Mental Health Act 1983: Proposals for consultation*. Green Paper. London: Department of Health.

Department of Health (2000a). *Reforming the Mental Health Act*. White Paper. London: Department of Health.

Department of Health (2000b). *The NHS Plan*. London: Department of Health.

Department of Health (2002). *Draft Mental Health Bill*. London: Department of Health.

Department of Health (2004a). *Draft Mental Health Bill*. London: Department of Health.

Department of Health (2004b). *In-patients Formally Detained in Hospitals Under the Mental Health Act 1983 and Other Legislation, England: 1992/93 to 2002/03*. Statistical report. London: Department of Health.

Department of Health (2004c). *Improving Mental Health Law: Towards a new Mental Health Act*. Summary. London: Department of Health.

Department of Health (2004d). *Draft Mental Health Bill: Explanatory notes*. London: Department of Health.

Department of Health (2004e). *The National Service Framework for Mental Health – Five years on*. London: Department of Health.

Department of Health (2005a). *Mental Health Bill: Implementation advisory group workforce implementation issues*. Paper. London: Department of Health.

Department of Health (2005b). *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and Other Legislation – NHS trusts, care trusts and primary care trusts and independent hospitals: 2003/04*. Statistical report. London: Department of Health.

Department of Health (2005c). *Government response to the report of the Joint Committee on the draft Mental Health Bill 2004*, 13 July 2005. London: Department of Health.

Department of Health (2005d). 'Key targets hit in mental health reform programme'. Press release 11 July 2005, 2005/0242. London: Department of Health.

Durst R, Teitelbaum A, Bar-El Y, Shlafman M, Ginath Y (1999). 'Evaluation of compulsory ambulatory treatment in Israel'. *Psychiatric Services*, vol 50, no 5, pp 698–700.

Eastman N (1995). 'Anti-therapeutic community mental health law.' *British Medical Journal*, vol 310, pp 1081–2.

Engleman N, Jobes D, Berman A, Langbein L (1998). 'Clinicians' decision-making about involuntary commitment.' *Psychiatric Services*, vol 49, no 7, pp 941–5.

Fennell P (1992). 'Balancing care and control'. *International Journal of Law and Psychiatry*, vol 15, pp 205–35.

Fernandez G, Nygard S (1990). 'Impact of involuntary outpatient commitment on the revolving door syndrome in North Carolina'. *Hospital and Community Psychiatry*, vol 41, no 9, pp 1001–04

Firm M, Burns T (2004). 'Assertive outreach'. *Community Psychiatry*, vol 3, issue 9, pp 14–16.

Geller J (2005). 'Involuntary outpatient treatment in the USA: conundrum to quagmire'. Abstract for International Congress on Law and Mental Health conference, Paris, 2–8 July 2005. Montreal: International Academy of Law and Mental Health.

Gibbs A, Dawson J, Ansley C, Mullen R (2005). 'How patients in New Zealand view community treatment orders'. *Journal of Mental Health*, August 2005, vol 14, no 4, pp 357–68.

Hafal (2005). 'Government plans for mental health put pressure on Welsh services'. Press release 13 July 2005. Cardiff: Hafal.

Joint Committee (2005). *Draft Mental Health Bill*. Report of the Joint Committee on the draft Mental Health Bill, session 2004/05. London: House of Lords/House of Commons.

King's College London (2004). Evidence submitted to the Joint Committee on the draft Mental Health Bill, 26 October 2004, published in *Draft Mental Health Bill*. Report of the Joint Committee on the draft Mental Health Bill, session 2004/05, vol III, Ev 779. London: House of Lords/House of Commons.

Kisely S, Campbell LA, Preston N (2005). 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders'. *The Cochrane Database of Systematic Reviews*, 2005, art no CD004408, pub 2, DOI: 10.1002/14651858.

Kisely S, Xiao J, Preston N (2004). 'Impact of compulsory community treatment on admission rates'. *British Journal of Psychiatry*, vol 184, pp 432–38.

Lelliot P, Audini B (2003). 'Trends in the use of Part II of the Mental Health Act 1983 in seven English local authority areas'. *British Journal of Psychiatry*, vol 182, pp 68–70.

Lurie S (2005). 'CTO case management services in Toronto: the hard data – first returns on the efficacy of the Ontario experience'. Presentation from International Congress on Law and Mental Health conference, Paris, 2–8 July 2005. Montreal: International Academy of Law and Mental Health.

McIvor R (2001). 'Care and compulsion in community psychiatric treatment'. *Psychiatric Bulletin*, vol 25, pp 369–70.

McPherson R (2004). 'The role of psychiatrist in assertive outreach'. Talk given at Sainsbury Centre for Mental Health Assertive Outreach conference, Leeds, 24 September 2004. Available at: www.scmh.org.uk/website/SCMH_Conferences (accessed on 6 September 2005).

Mackay J (2004). 'Review of the findings of some homicide mental health inquiries since 1994'. *The Mental Health Review*, vol 9, issue 2, pp 28–30.

Main L (2005). *Review of selected literature relating to international mental health legislation*. Report, 26 January 2005. Adelaide: Mental Health Services and Programs Unit, Department of Health, Government of South Australia.

Mental Health Research Institute of Victoria (2003), Applied Research Division, Community Treatment Orders. Available at: www.mhri.edu.au/pag-2003.html (accessed 16 December 2003).

Mester R, Barel Y (2005). 'Involuntary outpatient treatment in Israel – its evolution and evaluation'. Presentation at International Congress on Law and Mental Health conference, Paris, 2–8 July 2005. Montreal: International Academy of Law and Mental Health.

National Assembly for Wales (2004). 'Admission of patients to mental health facilities in Wales (including patients detained under the Mental Health Act 1983)'. SDR 62/2004. Cardiff: National Assembly for Wales.

National Assembly for Wales (2005). *Statistics for Wales: Health – Mental Health*. Cardiff: National Assembly for Wales. Available at: www.wales.gov.uk/keypubstatisticsforwales/topicindex/topics.htm (accessed on 6 September 2005).

New York State Office of Mental Health (2001). *Progress Report 2001*. New York: State Office of Mental Health.

New York State Office of Mental Health (2005). *Kendra's Law: Final report on the status of assisted outpatient treatment*. New York: State Office of Mental Health.

NHS Executive (1994). 'Introduction of supervision registers for mentally ill people from 1 April 1994'. HSG (94) 5. Leeds: NHS Executive.

Office of National Statistics (2000). *Adults with a Psychotic Disorder Living in Households*. Norwich: The Stationery Office.

Office of National Statistics (2005). *Suicide rates in England and Wales, 2000 to 2003*. Norwich: The Stationery Office.

O'Reilly R, Keegan D, Elias J (2000). 'A Survey of the Use of Community Treatment Orders by Psychiatrists in Saskatchewan'. *Canadian Journal of Psychiatry*, vol 45, pp 79–81.

O'Reilly R, Brooks S, Chaimowitz G, Neilson G, Carr P, Zikos E, and others (2003). *Mandatory outpatient treatment*. CPA Position Paper 2003–43. Ottawa: Canadian Psychiatric Association.

Preston N, Kisely S, Xiao J (2002). 'Assessing the outcome of compulsory psychiatric treatment in the community: epidemiological study in Western Australia'. *British Medical Journal*, vol 324, no 7348, p 1244.

Rankin J (2004). *Developments and Trends in Mental Health Policy*. London: Institute for public policy research.

Richardson G (1999). *Reform of the Mental Health Act 1983*. Report of the Expert Committee. London: Department of Health.

Ridgeley S, Borum R, Petrila J (2001). *The Effectiveness of Involuntary Outpatient Treatment: Empirical evidence and the experience of eight states*. Santa Monica, United States: RAND.

Rolfe T (2001). *Community Treatment Orders – A review*. Office of the Chief Psychiatrist, Western Australia. Perth: Department of Health.

Romans S, Dawson J, Mullen R, Gibbs A (2004). 'How mental health clinicians view community treatment orders: a national New Zealand survey'. *Australian and New Zealand Journal of Psychiatry*, vol 38, pp 836–41.

Sainsbury Centre for Mental Health (1998). *Locality services in mental health: designing local mental health services – Assertive Community Treatment: The evidence base*. London: SCMH.

Sainsbury Centre for Mental Health (2001). *Crisis Resolution*. Mental health topics briefing. London: SCMH.

Sainsbury Centre for Mental Health/Mental Health Act Commission (2005). *Back on Track?* London: SCMH/MHAC.

Salize HJ, Dressing H (2002). 'Compulsory admission and involuntary treatment of mentally ill patients – legislation and practice in EU member states'. Health and Consumer Protection Directorate-General, European Commission. Brussels: European Commission.

Swartz M, Burns B, Hiday V (1995). 'New directions in research in involuntary outpatient commitment'. *Psychiatric Services*, vol 46, 381–5.

Swartz M, Swanson J, Hiday V, Ryan Wagner H, Burns B, Borum R (2001). A randomized controlled trial of outpatient commitment in North Carolina. *Psychiatric Services*, vol 52, pp 325–9.

Swartz M, Monahan J (2001). 'Introduction: Special section on involuntary outpatient commitment'. *Psychiatric Services*, vol 52, pp 323–4.

Swartz M, Swanson J (2004). 'Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: what's in the data?' *Canadian Journal of Psychiatry*, vol 49, pp 585–91.

Taylor PJ, Gunn J (1999). 'Homicides by people with mental illness: myth and reality'. *British Journal of Psychiatry*, vol 174, pp 9–14.

Torrey EF, Kaplan R (1995). 'A national survey of the use of outpatient commitment'. *Psychiatric Services*, vol 46, no 8, pp 778–84.

Victoria Department of Human Services (2003). *Community Treatment Orders: Discussion paper*. Melbourne: Mental Health Branch, Victoria Department of Human Services.

Wales Local Government Data Unit (2005). *Guardianship under the Mental Health Act 1983 during year ending 31 March 2004*. SSDA 702.1. Cardiff: Wales Local Government Data Unit.

Wright C, Billings J, Johnson S, Muijen M, Priebe S, Ryrie I, Watts J, White I (2003). 'Assertive outreach teams in London: models of operation'. *British Journal of Psychiatry*, vol 183, pp 132–8.

Appendix 1: List of personal communication sources

The individuals listed in this section provided information and advice that helped us greatly in our research. Many are quoted in the paper.

Aviram U, Professor, Paul Baerwald School of Social Work and Social Welfare, the Hebrew University of Jerusalem, Israel

Bell S, Chief Executive, South London and Maudsley NHS Trust, London, UK

Bindman J, Clinical Senior Lecturer, Institute of Psychiatry, London, UK

Bowers L, Professor of Psychiatric Nursing and Head of Research, City University, London, UK

Bussard R, Program Specialist, Division of Behavioural Health Services, Department of Health and Human Services, Lincoln, Nebraska, USA

Carter J, Quality and Legislation Team, Mental Health Unit, Queensland Health, Brisbane, Australia

Christy A, Research Associate Professor, Department of Mental Health Law and Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Florida, USA

Dawson J, Professor, Faculty of Law, University of Otago, Dunedin, New Zealand

Dreezer S, President, Dreezer and Dreezer Inc, Toronto, Ontario, Canada

Eastaugh S, Legislation Review Officer Community Support, Department of Health and Human Resources, Hobart, Tasmania, Australia

Emmerson B, Executive Director, Royal Brisbane and Women's Hospital Health Service District, Brisbane, Australia

Gerdes J, Forensic Specialist, Department of Mental Health and Developmental Disabilities, Nashville, Tennessee, USA

Howlett M, Director, the Zito Trust, Hereford, UK

Hunter S, Chair, Faculty of Adult Psychiatry, Welsh Division, Royal College of Psychiatrists, Cardiff, UK

Kielhorn M, Director, Division of Program Development, Consultation and Contract for the Department of Community Health, Michigan, USA

Knepler P, Legal and Legislative Liaison, Division of Mental Health, Illinois Department of Human Services, Springfield, Illinois, USA

Kupfer D, Acting Director, Division of Mental Health, Colorado Department of Human Services, Denver, Colorado, USA

Lurie S, Executive Director, Canadian Mental Health Association Toronto Branch, Toronto, Ontario, Canada

Maden A, Professor of Forensic Psychiatry, Imperial College, and Clinical Director, Dangerous Severe Personality Disorder services, West London Mental Health Trust, London, UK

Melligan G, CTO Co-ordinator, St Joseph's Healthcare Hamilton, Centre for Mountain Health Services, Ontario, Canada

Nahon D, Director, Division of Research, Evaluation and Planning Ministry of Health, Jerusalem, Israel

Nelson D, Executive Director, Canadian Mental Health Association, Saskatchewan Division, Regina, Saskatchewan, Canada

O'Brien A, CTO Co-ordinator, Royal Ottawa Hospital, Ottawa, Canada

O'Shea N, Director of Development, Revolving Doors, London, UK

Rolfe T, Senior Project Officer, Office of the Chief Psychiatrist, Department of Health, Western Australia, Australia

Shackleford N, Deputy Head of the Mental Health Unit, Home Office, London, UK

Shaw R, Systems Analyst, National Association for State Mental Program Directors Research Institute, Alexandria, Virginia, USA

Stanley J, Assistant Director, Treatment Advocacy Centre, Arlington, Virginia, USA

Sturtz A, General Counsel, Department of Mental Health, District of Columbia, Washington DC, USA

Sugarman P, Medical Director and Acting Chief Executive, St Andrew's Group of Hospitals, Northampton, UK

Tiffany S, Program Representative, Arizona Department of Health Services, Phoenix, Arizona, USA

Toulon A, Mental Health Program Administrator, Washington State Department of Social and Health Services, Mental Health Division, Olympia, Washington, USA

Windsor C, Principal Analyst, Mental Health Directorate, New Zealand Ministry of Health, Wellington, New Zealand

Appendix 2: List of interviewees

Those listed below from England and Wales, who kindly agreed to be interviewed during our work, provided us with a wealth of expert opinion on the likely impact of the draft Mental Health Bill 2004, and the context in which non-residential orders will operate.

Barnett S, mental health service user, London

Bell S, Chief Executive, South London and Maudsley NHS Trust, London

Corry P, Head of Campaigns and Communications, national mental health charity Rethink Severe Mental Illness, London

Cross M, Consultant Psychiatrist, Hackney Assertive Outreach Service, London

Daw R, Head of Policy and Parliamentary Unit, national mental health charity Mind, London

Kinton M, Senior Policy Analyst, Mental Health Act Commission, Nottingham

Lepper R, Mental Health Act Policy Development Manager and Adviser, South London and Maudsley NHS Trust, London

Richardson G, Professor of Law, Queen Mary's University, London

Sieff A, Head of Mental Health Legislation, Department of Health, London

Sugarman P, Medical Director and Acting Chief Executive, St Andrew's Group of Hospitals, Northampton

Szmukler G, Dean, Institute of Psychiatry, London and Consultant Psychiatrist at South London and Maudsley NHS Trust

Thomas A, Deputy Chief Executive, national mental health charity Hafal, Cardiff

Westra A, Consultant and mental health service user, London

Wilson M, Deputy Chair, London Health Commission and Chair of Wandsworth Primary Care Trust, London

Zigmond A, Vice-President, Royal College of Psychiatrists, London and Consultant Psychiatrist, Leeds Mental Health Trust

Appendix 3: Further reading – effectiveness

The following selected publications include summaries of evidence about the effectiveness of community-based treatment orders:

Atkinson J, Patterson L (2001). *Review of Literature Relating to Mental Health Legislation*. Edinburgh: Scottish Executive.

Dawson J (2005). *Community Treatment Orders: International comparisons*. Dunedin: University of Otago.

Gerbasi J, Bonnie R, Binder R (2000). 'Resource document on mandatory outpatient commitment'. *Journal of American Academy of Psychiatry and Law*, vol 28, pp 127–44.

Hiday V (2003). 'Outpatient commitment: the state of empirical research on its outcomes'. *Psychology, Public Policy and Law*, vol 9, pp 8–32.

O'Reilly R, Brooks S, Chaimowitz G, Neilson G, Carr P, Zikos E, and others (2003). *Mandatory outpatient treatment*. CPA Position Paper 2003–43. Ottawa: Canadian Psychiatric Association.

Ridgeley S, Borum R, Petrila J (2001). *The Effectiveness of Involuntary Outpatient Treatment: Empirical evidence and the experience of eight states*. Santa Monica, United States: RAND.

Rolfe T (2001). *Community Treatment Orders – A review*. Office of the Chief Psychiatrist, Western Australia. Perth: Department of Health.

Swartz M, Swanson J (2004). 'Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: what's in the data?' *Canadian Journal of Psychiatry*, vol 49, pp 585–91.

Linked publications

London's State of Mind: King's Fund mental health inquiry 2003

Ros Levenson, Angela Greatley, Janice Robinson

In 1997, a King's Fund inquiry expressed serious concerns about mental health services under extreme pressure, including long delays and gaps in key areas such as crisis support. This report presents the findings of a two-year inquiry into how far London's mental health needs and services have come since then. It offers a comprehensive overview of substantial changes to policy and governance structures in London and nationally, and probes the special challenges posed by London's population. Drawing on extensive consultations with mental health service users, carers, staff and policy-makers, it proposes key areas for development, including a London-wide strategy, primary care commissioning, and improved financial and service information.

November 2003 ISBN 1 85717 482 8 178 pages £20.00

Community Renewal and Mental Health: Strengthening the links

Marsali Cameron, Teresa Edmans, Angela Greatley, David Morris

The government's commitment to promoting social inclusion, regeneration and developing sustainable communities presents real opportunities for promoting better mental health. Poverty, depression, stress and relationship problems can exacerbate feelings of being isolated and excluded from mainstream society, particularly for people living in disadvantaged areas. This publication argues that agencies and partnerships need to work together to address the range of factors that can affect people's mental health. A key requirement, alongside funding flows, is an integrated knowledge of mental health issues and an in-depth understanding of local communities. This publication is designed to help individuals and agencies learn about each other's perspectives and find innovative ways to achieve common goals.

September 2003 ISBN 1 85717 478 X 54 pages £10.00

Developing Primary Care for Patients With Long-Term Mental Illness: Your guide to improving services

Richard Byng, Helen Single

Primary and acute care services both aim to provide the best possible care for people with mental health needs, but adopt very different approaches. This publication argues that partnership working is essential if community teams are to provide comprehensive, appropriate services at local level, with the right kind of support from hospital services. It considers the best way for primary and acute care services to work together and provides a framework for joint decision-making.

September 1999 ISBN 1 85717 271 X 124 pages £12.99

To order any of these titles, and to discover our full range of publications on health and social care, visit our online bookshop at www.kingsfund.org.uk/publications, or call Sales and Information on 020 7307 2591.

Compulsory community-based treatment orders require patients at risk of harming themselves or others to comply with a set of conditions, such as taking their medication, while living in the community. The draft Mental Health Bill 2004 incorporates plans to introduce compulsory orders in England and Wales, but it is not clear how many people could be drawn into compulsory community treatment as a result. This report sheds some light on how many people in England and Wales could become subject to such orders if the Bill becomes law, drawing on examples from countries around the world with similar systems already in place.

ISBN 1-85717-531-X



9 781857 175318