Mental Health Alliance

Community treatment orders: threshold criteria

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Amendment 1 Threshold

Page 19 line 25 leave out subsection (5) and insert

“”(5)the relevant criteria are –

(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
"(b) if the patient is not under Part III of the Act, (a patient concerned in criminal proceedings or under sentence), the patient's ability to make decisions about the provision of medical treatment is significantly impaired because of his mental disorder;

(c) it is necessary for

(i)the protection of others from serious harm, or

(ii) the protection of the patient from suicide or serious harm to himself

that he should receive treatment for his mental disorder;

(d) subject to his being liable to be recalled to hospital for medical treatment such treatment can be provided without his continuing to be detained in a hospital;

(e) the patient has on at least one occasion within 5 years previous to the present admission under section 3 refused to accept medical treatment for mental disorder;

(i) when appropriate medical treatment has been refused there has been a significant relapse in his mental or physical condition justifying compulsory admission to hospital; (whether or not there has been such an admission), AND

(ii) medical treatment was then provided to him which alleviated or prevented a worsening of his condition, its symptoms or its manifestations;

(f) it is necessary for the protection of others from serious harm, or the protection of the patient from suicide or serious harm to himself, that he should be liable to be recalled to hospital for medical treatment; and
(g) appropriate medical treatment is available for him."

Amendment 2

Leave out Clause 30

Purpose of the amendments

The purpose of the amendments is to introduce a restricted regime of community treatment orders and to retain supervised discharge for patients who need continued supervision on discharge from hospital, without the extra coercion imposed under CTOs

Under this amendment extra conditions are imposed before a CTO would be available. These include

(1) that on one previous occasion in the past 5 years the patient has suffered from a mental disorder refused treatment and suffered a decline in his mental or physical health as a result. On subsequent taking medication his condition improved.

(2) that the person needs medical treatment for the protection of others from serious harm or his own protection from suicide or serious harm to self (these underlined words are those added to the current provision)

(3) that if the patient is sectioned under section 3 he has impaired decision making ability

The amendment would usually apply as follows. A person is detained in hospital. After their discharge, they stop treatment against medical advice, relapse as a result, and they are detained again. This person would now be eligible for a CTO.

Summary

1.1 **Revolving door patients** Most Alliance members have no objection in principle to community treatment orders. However, after studying the evidence on CTOs from

overseas jurisdictions, we concluded in 2004 that the case for them had not been made beyond possibly some advantages for so- called 'revolving door' patients. Since then the Institute of Psychiatry Report, 'The International Evidence for Community Treatment Orders' (IOP Report 2007) has reinforced these views.

1.2 Breadth of the regime Furthermore the government proposals are for a very wide regime – wider than that in 51 comparable jurisdictions (see attached paper on this). We do not believe that the government has made the case for such broad powers.

The group of patients subject to a CTO must be considered in conjunction with the conditions for compulsion for all patients which the Bill widens. This includes

- Section 3 criteria which will cover <u>all</u> patients with a mental disorder (any disability or disorder of the mind)
- The removal of some exclusions in the 1983 Act
- The wide definition of appropriate treatment

The result is a larger group of people who may be subject to compulsory powers than under the 1983 Act at present.
The conditions for a CTO are <u>merely</u> that the patient

- requires medical treatment for his health or safety or the protection of others, that appropriate treatment is available
- and that he needs to be subject to recall to hospital.

These are broader than the current supervised discharge criteria under section 25A ('substantial risk of serious harm to the health or safety of the patient, or the safety of other persons, or of the patient being seriously exploited'). They are broader than proposed in the 2004 Bill.

1.3 In considering the design of the CTO provisions in this Bill we believe that the following points are relevant;

- There is support for CTOs especially among professionals but only for a very limited set of patients. Evidence from other jurisdictions demonstrates consistently the type of person for whom practitioners do in fact impose a CTO.
- Overall there is no robust evidence of the effectiveness of CTOs and key issues have not been researched.
- There is a potential for harm to patients and to service provision for voluntary patients which should not be discounted
- CTOs interfere with a person's Article 8(1) rights to private and family life and need to be proportionate under Article 8 (2).
- CTOs increase the numbers of people under compulsion. This brings bureaucratic burdens and adds to public expenditure.
- In the 'blame' culture in which mental health professionals work there is a strong incentive to use extra coercive powers even when they may not be needed or desirable.
- There is no enthusiasm for the government proposals from any professional group and they are feared by service users.
- There are existing powers for compulsion in the community in the 1983 Act.
- Law that is over-inclusive is not good law. It may lead to unintended adverse effects.

1.4 On the positive side we accept that there is evidence that they work for a small group of patients. We obviously support the notion that patients should be cared for in the least restrictive environment and understand fully why people wish at times to be back in their own home. What we question is whether the CTO regime – rather than supervised discharge or complete discharge – is appropriate for them.

1.5 On balance therefore the law should be clearly targeted to fill a gap in the current law for use where there is a demonstrated need and some likelihood of benefit. There are a number of ways of achieving this – as other jurisdictions' laws demonstrate. We consider that this amendment which retains the flexibility of keeping the other regimes (s 17 leave, s 25A supervised discharge and s 37/41conditional discharge) as well as introducing CTOs for a limited group is an excellent approach.

1.6 In urging caution in relation to CTOs we are mindful of the conclusions reached by witnesses to a recent informal committee[1], from experts such as Professor Maden and Professor Thornicroft. While the former concentrated on homicides (see below) the latter stated

> "There are real risks not just of the unamended Bill having neutral effects but causing actual harm. The key such areas of harm, would be increased treatment avoidance by people with mental health problems, perpetuation, at least, of current disparities with respect to people from black and ethnic minorities who, as you know, are much more likely to be detained, and huge transaction costs from the implementation of CTOs. Without the evidence that CTOs work, not only would that money be ill-spent, but the opportunity to invest the relevant funds wisely in effective services would be lost."

1.7 The leading international expert in favour of CTOs, Professor John Dawson, has argued persuasively that CTOs work only when certain conditions apply.[2] His understanding of the situation in England and Wales was that the conditions were not in place here. [3].

The detailed case

Powers in the current 1983 Act

2.1 Under the 83 Act there are powers, through Section 17 leave, Section 25A-J supervised discharge, and Part III conditional discharge orders for professionals to retain a degree of control over patients whom they release into the community.

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[1] Informal Oral Evidence Committee On Mental Health Bill 23 April 2007

[2] Dawson J (2005). *Community Treatment .Orders: International Comparisons* Otago University Print, Dunedin, New Zealand. P,7

[3] Dawson defines these conditions are follows:

"• the regime is well-embedded and has the full support of clinicians

• a reasonably intensive level of community services is provided, by clinicians who visit the patient at their residence and are committed to enforcement of the scheme

• a good range of supported accommodation is available, plus a range of additional health services, including ready access to treatment for substance misuse

• the local inpatient and outpatient services are well-coordinated, permitting rapid access for involuntary outpatients to hospital

• no financial barriers, or problems in reimbursement, discouraging use of the scheme

• good continuity of staff in therapeutic relationships, staff are experienced and assertive, have sound relations with well-trained police, and high degree of cross-cultural capability.

2.2 The power of supervised discharge was introduced in1995 to cover so –called 'revolving door' patients. Although it allows conditions to be imposed on patients in the community and gives the power to return non-compliant patients to hospital (as does a CTO), it does not have a power to then forcibly treat patients against their will unless they are formally re-sectioned. What a CTO adds is the power to forcibly treat a person, in effect, as a hospital outpatient. Its central aim is to force patients to take their medication, either directly or by threat.

2.3 Section 17 leave of absence powers allow a compulsory patient to leave hospital and live back in the community while still being subject to the powers of the Act. A section 17 patient can be recalled at any time that a clinician wishes, without the need for formal re-sectioning, and compulsory treatment imposed. It is widely used. As stated by the Kings Fund

> "This does raise the question of whether a better understanding of section 17 powers might negate the need for SCT" [4].

Research into the use of supervised discharge shows that the absence of the power to enforce medication does not apparently prevent supervised discharge from improving compliance with medication in many cases – and that the reasons why people remain compliant or stop taking their medication are complex.[5] This throws into question the rationale for CTOs.

The existence of these powers at least raises the question – what is the gap that CTOs are needed to fill and how should that best be addressed?

Government proposals – the group subject to a CTO

2.4 The government amendment will restore its original community treatment regime into the Mental Health Bill. This must be considered in conjunction with the conditions for compulsion for all patients which the Bill widens. This includes

- Section 3 criteria which will cover all patients with a mental disorder (any disability or disorder of the mind)
- The removal of some exclusions in the 1983 Act
- The wide definition of appropriate treatment

The result is a larger group of people who may be subject to compulsory powers than under the 1983 Act at present.

2.5 The conditions for a CTO are merely that the patient **requires medical treatment for his health or safety or the protection of others**, that appropriate treatment is available and that he needs to be subject to recall to hospital. These are broader than the current supervised discharge criteria under section 25A ('substantial risk of serious harm to the health or safety of the patient, or the safety of other persons, or of the patient being seriously exploited'). They are broader than proposed in the 2004 Bill.

[4] Kings Fund , Briefing on CTOs , March 2007
[5] ibid

Although this Bill limits the application of CTOs to those who have been admitted to hospital under a section 3 order at the point at which the patient is to be discharged the entry criteria are broader than in the 2004 Bill. The 2004 Draft Bill specified a level of seriousness of harm and significance of risk ('to protect the patient from suicide or serious self harm or from serious neglect of the patient of his/her health').

2.6 The least restrictive option The government asserts that to allow a person to be discharged on to a CTO is to provide them with the least restrictive option. However this is incorrect. The principle is used to describe CTO regimes in which the criteria for compulsion in hospital and compulsion in the community are the same and it dictates that where possible the latter, as less restrictive should be chosen[6]. **Under the 1983 Act patients are discharged when they no longer require treatment in hospital. CTOs can only be applied to people when they no longer require treatment in hospital. Furthermore the patient must be recalled if, once again, they do require treatment in hospital. In other words, patients cannot be on a CTO instead of being detained in hospital.** By definition they are not the same patients as those on a CTO. If the government means rather supervision that is less restrictive because less coercive then the less restrictive option is that under Section 25A.

3. Commentary on the proposals

3.1 An increase in the numbers of people under compulsory powers: The Bill will inevitably lead to an increase in the use of compulsory powers, thus exacerbating a trend that was not anticipated in 1983[7]. By definition those on CTOs cannot be detained in hospital – they are a different group.The Government (Department of Health 2006) assumes that in the first year 2% of detained section 3 patients in England and Wales may be discharged to a CTO. However if the experience of Scotland is replicated - where in the first six months 23% of all hospital-based orders were varied, upon patient discharge, to a CTO - this is a significant underestimate.

3.2 The Government also estimates that the length of time that any individual patient is expected to spend on a CTO (nine months) is significantly longer than the average patient treated in hospital (109 days - around three and a half months). Thus at any one time there are most likely to be more patients subject to SCT and detention in hospital than currently subject just to detention in hospital - compulsory treatment will no longer be limited by bed numbers.

3.3 Comparison with other jurisdictions The CTO regime is broader than any other CTO regime in all 52 jurisdictions in which they are to be found (excluding European

[6] In North America one can distinguish between so-called "least restrictive" CTOs and so-called preventative CTOs. In other jurisdictions, mainly Australasian, that distinction is blurred. The key feature of the former is that the criteria for their use are the same as for detention in hospital. The key feature of preventative CTOs is that the criteria for their use is different from hospitalisation. Examples would be in New York, where CTOs are restricted to patients with revolving door histories, or histories of non-compliance resulting in violence. North Carolina CTOs are restricted to patients with impaired decision making, and Saskatchewan CTOs are restricted to patients with both revolving door histories and impaired decision making.

[7] Numbers of patients detained have already doubled since 1983 and have increased from 2004-5 to 2005-6. It is not clear why this has occurred but defensive practice is likely to be one factor.

countries).[8] In some cases the foreign law limits the use of all compulsory powers to people who are at a serious risk of harm to themselves or others, or to those who have a serious mental illness. In most US jurisdictions the use of compulsory powers has been greatly restricted on civil rights grounds and is confined to people with a mental illness who are at imminent danger to themselves or others[9]. In many cases there is no enforcement mechanism[10]. So they are comparable in many respects to supervised discharge rather than to CTO.

Research evidence to support introduction of CTOs

3.4 There is no clear evidence that CTOs, of themselves, promote better outcomes. The IOP Report, 2007, is the most comprehensive and thorough review ever undertaken of the international research literature on CTOs relating to civil patients. The research reviewed 72 studies from six countries. The report concludes that the empirical evidence indicates that there is no robust evidence that CTOs cause either reduction or increase in a range of outcomes- hospital admission, hospital bed days, compliance with treatment, violence, symptoms, offences resulting in arrest, social functioning, quality of life, care or satisfaction, and perceived coercion.

3.5 The key variable which research needs to address is the use of a court order to enforce provision of services or taking medication. In many studies, this variable is confounded as higher levels of service are provided along with the court order, meaning that it is impossible to know whether it is the higher level of service or the court order which was the key factor in promoting any beneficial outcome. We know that enhanced community based services support better outcomes. If these are available, in most cases, the addition of a court order is likely to make no difference to outcomes, and indeed in some cases may detract from them due to the element of coercion which many service users fear.

3.6 Evidence shows no significant benefit in terms of hospital admissions. Recent research found that community orders in Western Australia did not reduce numbers of hospital admissions or number of days spent in hospital in the year following placement on the order [[11]].It was impossible to tell whether any beneficial effects are due to the compulsory nature of the order or the increased community services made available. This concords

[8] Mental Health (Care and Treatment) Scotland Act 2003; NSW Mental Health Act 1990; Victorian Mental Health Act 1986; Queensland Mental Health Act 2000; ACT Mental Health (Care and Treatment) Act 1986; New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992; Ontario Mental Health Act; Saskatchewan Mental Health Services Act; New York Kendra's Law: North Carolina Mental Health Act, Florida Mental Health Act The Virginia Code Title 37.2. The other US jurisdictions are discussed generally in IOP Report 2007 at p28.

[9] This results from the Lessard decision which stipulated “extreme likelihood that if the person is not confined he will do immediate harm to himself or others”.

[10] The Virginia Code Title 37.2

[11] Preston, Kisely & Xioa, Assessing the outcome of compulsory psychiatric treatment in the community: epidemiological study in Western Australia, 2002.BMJ, 324, 1244-1246

with most other studies which have shown no significant difference in outcome between provision of well developed services and community based orders [12].

3.7 There have only been two Randomised Control Trials of CTOs, both in the USA. The results of these are inconclusive, and one is methodologically flawed as it does not use a true control. In other areas of health care, it would be very unusual to introduce a major health care intervention without a comprehensive evidence base, including RCTs. If CTOs were to be considered as an intervention comparable to other treatments, such that they must empirically demonstrate effectiveness, the available research would be unlikely to gain NICE approval.

The Government has placed great emphasis on the use of community treatment orders in New Zealand. However the CTO arrangements and the system in which they exist are not directly comparable with England and Wales. In particular, in the New Zealand system, criteria for use of compulsion are extremely narrow and explicitly exclude people with a primary diagnosis of personality disorder[13].

4 Ethical issues

4.1 Professor Thornicroft, Chair of the external reference group on the National Service Framework for Mental Health states that the proposals in the Bill conflict with the established, consensually agreed principles in that framework that guide current mental health policy for England. He predicts that the Bill will cause "difficult if not irreconcilable conflicts in policy, which would feed through to confusion in practice"[14].

4.2 CTOs raise civil rights concerns. They refer principally to compliance with medication. Other forms of treatment for mental disorder, such as psychological treatments, cannot be enforced through a sanction of compulsory recall to hospital for medical treatment CTOs therefore give the opportunity for the compulsory treatment of patients for long periods of time when they are no longer sufficiently unwell to require hospital treatment.

4.3 Patients in the community have returned to lead their daily lives. Their decisions may include, as it does for people with physical illnesses, a decision to dispense with the medication doctors prescribe for them. It has been found for instance that only 8% of patients with heart disease that is potentially fatal, take the statins that they have been prescribed[15]. For mental health patients in particular this decision may be because of the side effects which they may understandably find less tolerable than the symptoms of their illness. The IOP Report 2007 states

> "some specific and highly relevant outcomes have been almost completely ignored [by researchers].For example, some medication side-effects may be intolerable

12 Steadman, et al Assessing the New York City involuntary commitment pilot programme, 2001. Psychiatric Services, 52, 330-336.

13 NZ's definition of mental disorder is "an abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition and; this abnormal state of mind means that either: there is a serious danger to the person's health and safety, or the health and safety of another person; or the person's ability to care for him/herself is seriously reduced". Exclusions: political, religious, or cultural beliefs; sexual preferences; or criminal or delinquent behaviour; or substance abuse; or intellectual disability.

14 Evidence to Informal Committee, Monday 23rd April 2007

15 Heart 2002 88 229-33.

(Parkinsonism, weight gain) affecting quality of life, while others might actually be life-threatening in the longer term".

4.4 There is the question of the need for medication. A recent survey has shown[16] that after a first episode of psychosis, 34% suffer by not taking medication, for 27% it makes no difference (because they will relapse anyway) and 39% will be harmed by taking medication because they would not have relapsed **Good practice, from the patients' perspective, would be to discuss the risks and permit the patient to make the decision as to whether or not to continue with the medication. Unfortunately, because of the 'blame culture' and risk aversion, it is likely that most patients will be required, by force authorised by a CTO if necessary, to continue with medication lest they harm themselves or someone else, however unlikely that eventuality.** Psycho-social interventions are most likely to aid people in preventing their relapse. 20% of patients diagnosed as suffering from schizophrenia will not relapse on stopping medication or have a second episode. Unless CTOs are limited, there is a danger this group will be forced to continue with medication unnecessarily. Many others, particularly those with bi-polar disorder will relapse, but not until after many years. Such patients may rather relapse and be admitted to hospital occasionally, than take medication with all its adverse effects, throughout many years. If they do not present a significant risk to others is this unreasonable?

Other problems of CTOs cited in the IOP Report include damage to therapeutic relationships with patients[17] and the delivery of community care[18] and the impact of coercion on patients' quality of life, social functioning, mental state and family life.

4.5 Effects on service provision There is a fear that the introduction of CTOs on a broad basis will focus the provision of services upon those with a CTO, while adding to the bureaucratic burdens and costs of mental health services. The result would be that those without a CTO will be left with inadequate access to more poorly resourced community services. There is some evidence of this having occurred in other countries.

CTOs may conflict with positive approaches to engagement and service user autonomy through new services (such as assertive outreach and intensive home treatment services) for a group of people who have often been unable or unwilling to engage with mental health services. The models upon which the latter are based emphasise a partnership approach with the users of their services. Any element of coercion in that equation will provide a mixed message.

The IOP Report states

> "Despite 20 years of investigation, there is little indication that CTOs per se are effective, but there is good evidence for alternative interventions such as Assertive Community Treatment19.Given the coercive nature of CTOs, there is a need to

[16] Managing the acute psychotic episode Peter Byrne BMJ 2007;334:686-692,Therefore, a) permitting a CTO after a single episode is more likely to lead to patient harm than good, b) if we are really to reduce relapse rates psycho-social interventions (as in NICE guidance) must be available.

17 Dawson, 2002; *Ambivalence about CTOs*, Institute of Psychiatry IJLP 2003, 243-255.

[18] Studies have shown that when benevolent treatment and coercion operate together, coercion tends to become pervasive and treatment remains nominal. If this result is replicated, it is clearly a serious objection. It could impact most on people from black and minority ethnic backgrounds. Hoyer & Fernis: *Out patient Commitment: Some reflections on ideology practice and implications for research,* 2001. Journal of Mental Health Law 1, 56-62

[19] Ridgely et al (2001) analyse 23 reviews of the empirical literature on community-based interventions, including assertive community treatment (ACT) This report concluded that there was strongest evidence of

consider whether any potential therapeutic gains might be better delivered by enhancing the quality and assertiveness of community treatment for high risk patients. Alternative interventions that do just that have not yet been compared with CTOs for clinical and cost effectiveness, but are already available to support seriously mentally ill patients living in the community".

5. 1 Stakeholder views

Service users are on the whole opposed to CTOs20.

Service users fear:

1. that CTOs will increase their chances of being compulsorily detained if they disagree with the treatment recommended by their psychiatrist.

2. they may not be kept safe. Some consider that when they have been very unwell, hospital provided security because it is a contained environment, with regular monitoring of their condition and any medication. CTOs cannot provide this, and consequently give rise to fears that compulsion will be used when people are not severely unwell, or that people who are severely unwell will not be given appropriate and sufficient support to help them through this time.

3.Service users consider the element of control of their home life an infringement of their privacy. They fear the impact on other family members who must have the burden of their care in a situation in which they are opposing treatment. One service user stated that he thought his marriage would break down if his wife had to look after him at such times.

"*treatment when you are ill carries bad memories. I would prefer to associate these with a place that is not my home*". Another added: "*To be treated at home that unwell with lots of people coming in attracting attention. If that were to happen again I don't think I could go home. My home is my castle, my husband, my children. I wouldn't want to ruin that for them again*".

- They fear that it will be difficult to come off a CTO, even if their mental health has improved, because clinical staff will practice defensively and "play safe" by ensuring treatment is continued.
- They fear that once they are placed on a CTO they might never be taken off, as clinicians might see it simply as a way of maintaining the person's "compliance" with medication.
- They fear the damage to their relationship with their community mental health team if there is a coercive power.

There is little research on these issues.

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the effectiveness of ACT, which offers a multidisciplinary, community-based intervention combining the delivery of clinical treatment with intensive case management(Marshall and Lockwood, 2000).

[20] There is evidence of some support in one study undertaken in New Zealand but the findings are equivocal as there was less than 50% response rate (43 patients) and it is likely that was from those who found them most beneficial . Their views were very ambivalent. Dawson J, Romans S, Gibbs A, Ratter N (2003). *Ambivalence about community treatment orders*. International Journal of Law and Psychiatry. 26(3): 243-255.

5.2 Professional groups also have serious reservations about CTOs. The Royal College of Psychiatrists, the Royal College of Nursing, the British Psychological Society, the Mental Health Nurses Association, the British Association of Social Workers, the Law Society and the Council on Tribunals are among the many bodies that have opposed the government plans, albeit that the focus of their concern varies to an extent[21].

5.3 BASW comments on their fear of the misuse of CTOs to relieve pressure on beds and the dangers that may bring

> "The main change compared with 30 years ago is that in most places there are now too few in-patient beds, and that there is pressure to reduce the numbers still further in order to cut costs, resulting in patients being discharged prematurely in order to free beds for others who are even more acutely ill. In this context, there is a high likelihood that CTOs will be used to expedite discharges in circumstances where the patient has not yet fully recovered and where they have not yet regained sufficient insight to be able to co-operate voluntarily with community services, and where they do not have a history of non-co-operation resulting in relapse.
> The danger of misuse is made all the greater due to the lack of any external oversight of the decision to make an order. As things stand, it can be made by the responsible clinician and an AMHP who are close colleagues in the same clinical team, with no requirement to bring in a professional from outside the team as is the case with admissions to hospital".

5.4 The Royal College of Psychiatrists cites a legitimate fear that they will be overused because of the risk averse society's pressures on clinicians. Baroness Meacher, in the Lords Committee stage debate, agreed:

> "The last thing service users need is the new Sections 17A to 17G, which would inevitably put pressure on professionals to impose community treatment orders more than they would necessarily wish, and certainly more rather than less. It will take only one tragic case to drive up the use of CTOs. If one service user is not placed on a CTO and subsequently commits suicide, this will result in the inevitable inquiry and public criticism of the professionals involved for not taking advantage of the legislation. Is it fair to ask professionals to risk this public criticism when the imposition of a CTO will protect their back? That is the crucial point about limiting the application of CTOs—to protect the professionals from the pressure they will be under to impose these CTOs when really it is not justified"

For these reasons we do not see the need for the introduction of CTOs beyond the group outlined in the Lords amendment.

5.5 As the Royal College of Nursing made clear in its response to the consultation on the previous draft Mental Health Bill

> "many mental health patients are cared for successfully in the community. However, if a patient is so unwell as to require legal compulsion that patient almost always also requires in-patient care. We acknowledge that there are some exceptional cases where this is not the case, but would emphasise that these are very rare. A patient who requires legal compulsion is, inevitably, seriously unwell. Existing community resources will rarely permit adequate care of such patients and the burden on family

[21] All these stakeholders gave evidence to the Joint Scrutiny Committee on the 2004 Bill and most to the Commons Committee on the 2006 Bill.

and other carers is likely to be very great. The RCN therefore has serious concerns about assessment and treatment in the community. In the absence of additional safeguards we believe that these proposals might lead to:

— compulsory treatment taking place in the community, due to lack of hospital beds, when the patient ought to receive hospital care; and

— compulsory medication being used as a substitute for adequate mental health care. “

The amendment

The revolving door

6.1 Lord Warner, in the House of Lords Committee Stage debate stated:

> “One thing that has not changed as much as we would like, however, is the continuing number of revolving door patients. They leave hospital, disengage from mental health services, do not continue with their treatment, their health deteriorates and they end up compulsorily detained in hospital. We may have differences in view about the numbers involved, but that is the cycle we are trying to deal with.”

The Secretary of State, stated in the Commons second reading debate that:

> “These provisions, of course, are designed particularly for the so- called ‘revolving door’ patients”.

6.2 However the current Bill is not framed for this group but goes much wider, indeed wider, in most respects, than any other CTO regime in the 52 jurisdictions which have CTOs, including New Zealand which the government has cited in support of its case or North Carolina where there is some positive evidence of their use

6.3 The amendment establishes that only those patients with some history of non compliance are covered by the supervised community treatment provisions, that is: people who have, on one occasion before the current admission under section 3, refused to accept medical treatment for a mental disorder and been admitted to hospital under compulsion (or that this was justified) . Medical treatment following their compulsory admission resulted in an improvement in their condition or prevention of deterioration in their condition. On their discharge from hospital there has been a significant relapse in their condition because of non compliance with medical treatment justifying compulsory admission to hospital (probably the present admission)

This provision links the previous refusal of treatment which results in admission and the proven benefit to the patient from the treatment proposed. It requires a relapse to occur because of the failure to continue with the medication. These provisions are based closely on the New South Wales Mental Health Act. Unlike other foreign laws that use the revolving door model it requires only ONE previous admission.

6.4 The Scottish experience: Evidence collected by the Kings Fund22 indicates that considerable emphasis has been placed on a person having a history of non-engagement and non-compliance, followed by deterioration in health, before a CTO would be authorised:

> "Community orders will not be used in first episodes of illness. There has to be disengagement to prove to a Tribunal that a community order is required. There should be a path of disengagement or lack of engagement pre-existing any such order. [Anyone] applying for a community order must demonstrate a history of non-engagement of services."

The Report concludes that

> it does seem evident from our interviews that the initial cohort of patients under CCTOs are, very largely, the "revolving door" patients with a history of non-compliance and deterioration that the new arrangements are intended to address.

6.5 Previous admissions of voluntary patients

The Secretary of State in the House of Commons second reading debate criticised the House of Lords amendment:

> It would exclude patients whose first compulsory admission has already been preceded by several voluntary admissions and it would deny the potential benefits of supervised community treatment to patients until there had been a further crisis and a further hospitalisation."

This amendment however only requires that the person refused treatment and compulsion was justified as a result. It may be that they were admitted to crisis care and that actual use of the Act was not required – perhaps because the person was treated under the powers in the Mental Capacity Act.

The risk of extending the possibility of CTOs beyond the patient with a previous situation of non compliance is that it will be widely used in speculative anticipation of crises which may never arise, and in the meantime placing significant limitations on a person's freedom to live their life in the way they choose through the imposition of a range of restrictions. A far better option in this type of case, where there is no clear pattern of refusal and relapse is to make every effort to engage a person, voluntarily, with high quality, proactive services in the community, perhaps with supervised discharge.

7 The question of risk

7.1 Protection of others from serious harm

The Government's argument for community treatment orders has focused on cases where a person poses a serious risk to others. This is in part as a result of the work of forensic psychiatrists such as Professor Maden whose recent report[23] has been widely cited. The amendment covers these patients so long as there is some history to their case.

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[22] Simon Lawton-Smith, 'Community-based Compulsory Treatment Orders in Scotland: The early evidence ' The Kings Fund, November 2006

[23] *Review of Homicides by Patients with Severe Mental Illness* Tony Maden, Professor of Forensic Psychiatry, Imperial College London 15th March 2006

As discussed in the IOP Report 2007 [24] there is remarkable consistency in the characteristics of patients on CTOs across jurisdictions. Patients are typically males with a long history of mental illness, previous admissions, poor medication compliance and likely to be suffering from a schizophrenia like or serious affective illness and displaying psychotic symptoms, especially delusions, at the time of the CTO. There is some evidence of a potential for violence.

7.2 Homicide and CTOs: Research by Professor Maden, has cited non-compliance with medication as one factor leading to the incidence of homicide. In such cases it is alleged that had the individual been under a CTO they may have complied with their treatment regime and the homicide may have been averted. He therefore calls for a wider use of CTOs than in the Lords amendment for revolving door patients. However there is no evidence that a CTO can protect from homicide.

7.3 The recent Five year Report of the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness.[25] stated that

> Homicides by people with a mental illness are unusual and relatively few in number. Many are committed by people who had not previously been in contact with services or had last been assessed as at low risk. It should therefore not be expected that SCT will significantly impact on the total number of these incidents. There has been no discernable reduction in the overall rates of homicides by people with a mental illness in Australia and New Zealand[26] as a result of CTOs having been in place in those countries for some years.

7.4 The John Barrett case The tragic case of Denis Finnegan, killed by John Barrett in 2004, has been raised in Parliamentary debates, with the suggestion that CTOs might have reduced the likelihood of this event occurring. However, John Barrett was at the time an inpatient in a medium secure unit and had been granted unescorted leave without having been properly assessed following his admission. He was also, concurrently, on conditional discharge following a restriction order, as he had been for some time. Formal recall to hospital was an option at the time. The issue of CTOs is irrelevant to the circumstances immediately preceding his crime, and in the longer lead up to the circumstances of the murder, CTOs would not have added any significant new powers in his case. The report into his care and treatment[27] clearly states:

> "The remedy for what went wrong in this case lies not in new laws or policy changes… The challenge, both organisational and individual, is to ensure that the care of potentially dangerous psychiatric patients is based on sound clinical practice and the systematic application of principles of risk and organisation management."

7.5 CTOs and suicide rates The Government has stated that introducing CTOs will help to reduce rates of suicide. The Mental Health Alliance and its members have been supportive of the Government's measures to reduce suicide, particularly amongst young men. Some measures have had a degree of success. However, the Government's

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[24] P.109

[25] University of Manchester (2006) Five year report of the national confidential inquiry into suicide and homicide by people with a mental illness. University of Manchester, December 2006

[26] Simpson et al (2004) Homicide and mental illness in New Zealand, 1970-2000. British Journal of Psychiatry 185 (5); 394-398

[27] *Report of the independent inquiry into the care and treatment of John Barrett*, November 2006, NHS London.

statement on the likely impact of CTOs on suicide is based on assertion rather than evidence. In the IOP Report 2007, studies did not include suicide rate as an evaluation measure. If the Government has evidence which shows the use of CTOs (as opposed to the provision of better community services generally) to be linked to decreased suicide rates, we would be keen to examine this.

As quoted in a recent article on the national confidential inquiry, authors including Professor Appleby state:

> "Despite the fact that the majority of people who die by suicide in the general population have a definable mental illness at the time of their death, only a quarter have been in contact with mental health services in the year prior to death" - "Although suicide prevention is an NHS priority, the efficacy of different interventions in reducing the rate of suicide is, as yet, unknown. No interventions to date have reliably been shown to prevent suicide"[28].

Nevertheless it has been decided to include serious harm to self in this amendment because of these concerns that were raised.

8. Impaired decision making ability (IDM) (the main case for this is made in a separate briefing)

With the absence of any form of capacity test in the Bill, an order, once applied, could be too longstanding in its application. Clinicians are likely to face real pressure to continually renew such powers, forcing patients to remain on CTOs almost indefinitely.

Lord Parker in Devon County Council v Hawkins said: “It is said, and said with much force, that so long as it is necessary for a person to be under treatment for a disease or disability, then that person must be held to be suffering from that disease or disability. In my judgement that is in general right”. 1967.

The problem with this is that the only way it can be determined if the person is still suffering from the disease is, usually, to stop the medication and monitor the person’s condition

Given the breadth of the criteria for compulsion, it may be difficult for a patient to oppose the renewal of an order successfully if the clinical view is that the medication is keeping the patient well. The amendment passed by the Lords therefore includes an IDM test, the same as that which has been accepted by the House of Lords for detention under section 3. It is seen as fundamental that patients who retain full decision making powers should take control of their lives whatever their health condition Saskatchewan, Victoria, New South Wales(in part) and Scotland have such a test[29].

9. Part III patients

The concerns of forensic psychiatrists has led the Alliance not to include a condition of impaired decision making ability for those patients who are offenders or defendants under Part III of the Act. They consider that this condition would significantly restrict the

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[28] **Ref National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: new directions, Swinson et al, Psychiatric Bulletin, 2007 31, 161-163**

[29] In New Zealand, Dawson has argued for a test of ‘substantially diminished capacity to consent to treatment for mental disorder’ to be added to the existing legal action for all involuntary treatment, thereby improving theharmony of the rules governing consent to psychiatric treatment with other forms of medical care

possibility of using CTOs for forensic patients who might otherwise remain in secure institutions or receive a criminal justice disposal. This has been a controversial decision within the Alliance as some members consider it discriminates against Part III patients. Considerations of public protection have however swayed the majority of members to recognise that this is the most acceptable approach.

Many proponents of CTOs consider that lack of insight is a regular feature of those patients who constantly relapse, are routinely readmitted under mental health legislation, then inevitably drop out of follow-up care after discharge because they refuse to consider that they are ill or need help. It is certainly true that a frequent feature of severe mental illness is lack of insight, and that many people who lack insight also lack capacity to make treatment decisions. Some studies have even suggested that psychotic patients who do not believe that they are ill can experience symptom improvements with treatment, yet continue to believe that they are not ill (Munetz et al, 2003).

10 Supervised discharge – Section 25A

10.1 The MHA agrees with the House of Lords that the existing provisions of the Mental Health Act 1983 relating to supervised discharge should be retained. This would ensure the patient receives a care plan and that the provision of services to them after discharge from hospital is facilitated.

10.2 According to research, supervised discharge – although little used – is perceived by clinicians to be effective in most of the cases in which they have been used and were regarded as producing improvements to a wide range of clinical and social problems. These include problems of non-compliance with medication, despite the lack of specific powers of enforcement. It concluded that the 'power to convey' under supervised discharge is of minimum importance and rarely used – and conversely the absence of the power to enforce medication does not apparently prevent the measures from improving compliance in many cases. [30]

10.3 The Alliance believes that a positive and practical purpose could be achieved using supervised discharge for those patients who are in hospital under compulsion, whose condition has stabilised to the extent that they do not require close hospital supervision, but who are not sufficiently well to be fully discharged from medical care. **Supervised discharge** would consequently be a part of a supportive process towards disengaging from medical care and therefore could strengthen rather than weaken the therapeutic relationship.

10.4 The community treatment order may potentially be a useful addition to existing 25A powers for patients who no longer need to be in hospital but have impaired decision making ability and who need the extra degree of coercion that a CTO provides because it has been shown by previous history that a failure to take medication can cause them to relapse and be at serious risk

For those who may be a lesser risk to themselves, whether or not their judgment is impaired, S25a and s 17 provides protection.

[30] Bindman J (2002). Evaluation: of Supervised Discharge and Guardianship. *The Research Findings Register*.