

COMMENTARY

Community treatment orders and their use in the UK[†]

Mark Taylor

COMMENTARY ON... COMPULSION IN THE COMMUNITY?
and SUPERVISED COMMUNITY TREATMENT

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[†]See pp. 245–252 and 253–259, this issue.

SUMMARY

Despite the lack of supportive scientific evidence, the uptake of community treatment orders (CTOs) in England and Wales since their introduction in late 2008 has been higher than expected, although there has been a relative dearth of second opinion appointed doctors. In Scotland, CTOs now constitute about 30% of all long-term civil detentions, with lack of insight and lack of treatment adherence given as the major reasons for CTO use. Ethical considerations such as balancing autonomy against health needs will continue to be weighed by clinicians considering compulsory treatment in the community.

DECLARATION OF INTEREST

None.

The community treatment order (CTO) (Box 1) is primarily used to address treatment non-adherence – usually in people with serious mental illness who lack insight into their predicament – by compulsory treatment in the least restrictive environment (i.e. compared with in-patient care). Community treatment orders were first introduced in the USA in the mid-1970s and they now are also used in several other countries, including Australia and New Zealand. In Australia, Lambert *et al* (2009) found that individuals subject to a CTO were more than twice as likely to be receiving long-acting

injections of antipsychotic medication as opposed to an oral antipsychotic – another common strategy to address treatment non-adherence.

There has been lengthy debate regarding the introduction of the CTO in the UK, particularly in relation to managing risk (Sensky 1991). A Cochrane review (Kisely 2003) examining the efficacy of CTOs pooled data from the only two relevant trials and estimated that 85 people would need to receive a CTO in order to avoid one psychiatric admission, and that 238 people would need to receive a CTO in order to avoid one arrest. These numbers are substantially greater than one might expect. However, these two ‘non-efficacious’ randomised trials concerning CTOs (Swartz 1999; Steadman 2001) had methodological problems (Szmukler 2001; Swartz 2004), and the Cochrane review also excluded the larger body of relevant qualitative data.

A systematic review (Churchill 2007) of over 70 studies concluded that CTOs lacked consistent evidence of benefit and that findings from naturalistic CTO studies were likely to be unreliable. Nevertheless, there are qualitative data available demonstrating some benefits of CTOs: for example, O’Reilly *et al* (2006) concluded that patients found that CTOs provided structure in their lives (Box 2); families found CTOs necessary when patient insight was limited; and clinicians ‘were more consistently positive’ than either patients or families (Box 3).

BOX 1 How might a CTO work?

Directly through the enforcement of care and treatment, and indirectly through the therapeutic relationship. Structurally, a CTO:

- binds into place a ‘structure for care’
- commits service providers to the care of the patient
- gives the patient priority for care
- supports the family’s insistence on treatment
- gives housing providers the confidence to care.

CTOs in England and Wales

Supervised CTOs have been used in England and Wales since November 2008. In this issue of *Advances*, Macpherson *et al* (pp. 253–259) provide helpful practical guidance for clinicians who are considering the use of a CTO, with accompanying illustrative case vignettes. Briefly, CTOs can only be applied after an initial period of detention in hospital, and the requirements or ‘conditions’ specified in the CTO application may focus on aspects of treatment and risk management,

BOX 2 Patients' favourable views regarding CTOs

- Patients felt that CTOs allowed them more freedom and control over their lives than hospital care
- They valued the sense of security and enhanced access to services
- They valued the ongoing support of mental health professionals and accommodation providers
- They viewed a CTO as a transitional step from a chaotic to a more stable style of life
- They assessed their CTO in light of their prior patient career and negative experience of institutions.

(O'Reilly 2006)

including restrictions regarding place of residence. A further statutory condition is that the patient must meet with a second opinion appointed doctor (SOAD) for authorisation of medication treatment within a given time (usually 1 month). If the patient fails to comply with the conditions of the CTO, they can be 'recalled' to hospital for up to 72h. If the patient continues to refuse treatment, the CTO is 'revoked' and the patient is once more detained in hospital under a hospital treatment order.

Also in this issue, Brookes & Brindle (pp. 245–252) consider how supervised community treatment under a CTO fits into the existing legislative framework, and anticipate possible consequences for clinical practice. Although the Department of Health in Westminster forecast that 450 people in England and Wales would be subject to a CTO in the first year of legislation (Gould 2009), the actual figure was about 4000 people, which resulted in a shortage of SOADs (Care Quality Commission 2010), with consequent delays in the authorisation of medical treatment. Other problems with the use of CTOs in England

and Wales include the fact that the patient may appeal only against the imposition of an order, not against the individual conditions attached; that they are not automatically subject to independent review by a mental health tribunal; and that CTOs can be imposed only on those leaving hospital, rather than *de novo* on people already living in the community. All three of these issues do not apply to the use of CTOs in Scotland.

CTOs in Scotland

Scotland has had community-based compulsory treatment orders (CCTOs) since October 2005. These can be applied either after detention in hospital or *de novo*, usually as an alternative to a hospital order, but can be instigated only by the Mental Health Tribunal for Scotland. The Mental Health (Care and Treatment) (Scotland) Act 2003 lists the measures that can be granted as part of a CCTO. The Tribunal grants and can, on application, vary these measures. Despite the attendant bureaucracy, CCTOs are increasingly being used (Mental Welfare Commission for Scotland 2009) and they now constitute about 30% of all long-term civil (treatment) orders.

In a review of the characteristics of the 499 individuals subject to a CCTO in Scotland in 2009 (further details available on request), colleagues and I found that 81% had a schizophrenia-related illness and 10% had a bipolar disorder; 57% of the total were prescribed a long-acting injection of antipsychotic medication. Furthermore, 63% of the CCTO cohort were men, 63% lived alone and 65% were viewed as posing a risk to the safety of others as a consequence of their mental disorder. This raises the question of whether clinicians are disproportionately using CCTOs defensively for individuals whose risk to others remains a concern.

Conclusions

The rapidly increasing uptake of CTOs in England and Wales mirrors the experience of their use in Scotland. If the Scottish experience were to be replicated in England, the number of people on CTOs would rise to around 5000 after 4 years, making the Care Quality Commission's estimate well short of the mark. The increase illustrates the paradox concerning CTO use – namely, the (rather weak) scientific evidence militates against CTO effectiveness, whereas experienced clinicians in the UK have embraced the CTO provision, particularly for the more challenging clinical populations. This suggests that clinicians find them helpful, perhaps by 'persuading the persuadable' (Pinfold 2001), if only because the patient wishes to be law abiding and is aware that they are subject to potential

BOX 3 Clinicians' favourable views regarding CTOs

- A CTO ensures contact with the patient, so negotiations can continue about care
- CTOs help ensure adherence with medication
- They enhance patients' insight into their illness
- They can prevent or identify relapse
- They facilitate the provision of accommodation and social support
- They create a stable situation, so other forms of therapy, activity and psychological change may occur.

(O'Reilly 2006)

enforced treatment (although not in the home environment, importantly).

Evidence is accumulating regarding the characteristics of a 'typical' patient who is subject to a CTO, with the stereotype being an isolated man with a psychotic illness who is ambivalent about medical treatment. When considering the need for a CTO, clinicians will routinely be balancing the right to autonomy with the equally important human right of access to effective treatment that improves quality of life.[‡] Moreover, clinicians will need to be mindful of the 'lobster pot' effect – that it is potentially much easier to get put onto a CTO than off one. Ethical considerations also mean that useful scientific research on the effectiveness of CTOs is hard to undertake, although a randomised controlled trial dubbed the Oxford Community Treatment Order Evaluation Trial (OCTET) is now underway (www.psychiatry.ox.ac.uk/research/researchunits/socpsych/research/octet). However, health policy is not determined solely by randomised evidence, and the emerging qualitative data from UK complements the evident 'market forces' popularity of CTOs.

References

Brookes G, Brindle N (2010) Compulsion in the community? The introduction of supervised community treatment. *Advances in Psychiatric Treatment* **16**: 245–52.

Care Quality Commission (2010) *Mental Health Act 1983 and Mental Capacity Act 2005*. CQC (http://www.cqc.org.uk/_db/_documents/20100211_CM100104_MHA_and_MCA_Cover_paper_Final.doc).

Churchill R, Owen D, Singh S, et al (2007) *International Experiences of Using Community Treatment Orders*. Department of Health.

Gould M (2009) Hazards of a health safeguard. *The Guardian*, 13 May (<http://www.guardian.co.uk/society/2009/may/13/supervised-community-treatment-order>).

Kisely S, Campbell LA, Preston N (2003) Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews* issue 3: D004408.

Lambert TJ, Singh BS, Patel MX (2009) Community treatment orders and antipsychotic long-acting injections. *British Journal of Psychiatry* **195**: s57–62.

Macpherson R, Molodynski A, Freeth R, et al (2010) Supervised community treatment: guidance for clinicians. *Advances in Psychiatric Treatment* **16**: 253–9.

Mental Welfare Commission for Scotland (2009) Annual reports: total number of 2003 Act orders in existence. MWCS (http://reports.mwscot.org.uk/annual_monitoring/overview2008-2009/annualreport2008-2009.aspx).

O'Reilly R, Keegan DL, Corring D, et al (2006) A qualitative analysis of the use of community treatment orders in Saskatchewan. *International Journal of Law and Psychiatry* **29**: 516–24.

Pinfold V, Bindman J, Thornicroft G, et al (2001) Persuading the persuadable: evaluating compulsory treatment in England using Supervised Discharge Orders. *Social Psychiatry and Psychiatric Epidemiology* **36**: 260–6.

Sensky T, Hughes T, Hirsch S (1991) Compulsory psychiatric treatment in the community. II. A controlled study of patients whom psychiatrists would recommend for compulsory treatment in the community. *British Journal of Psychiatry* **158**: 799–804.

Steadman HJ, Gounis K, Dennis D, et al (2001) Assessing the New York City involuntary outpatient commitment pilot program. *Psychiatric Services* **52**: 330–6.

Swartz MS, Swanson JW, Wagner HR, et al (1999) Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *American Journal of Psychiatry* **156**: 1968–75.

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

Szmukler G, Hotopf M (2001) Effectiveness of involuntary outpatient commitment. *American Journal of Psychiatry* **158**: 653–4.

[‡]For a discussion of supervised community treatment and the Human Rights Act, see pp. 263–271, this issue. Ed.