Community treatment orders – principles and attitudes

Commentary on . . . Community treatment orders: current practice and a framework to aid clinicians†

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Summary The community treatment order (CTO) was implemented in 2008 as part of the 2007 amendments to the Mental Health Act 1983. Initially, health professionals and patient groups were sceptical about the successful implementation of CTOs. However, as more than the expected number of patients has been subjected to CTOs in the past 3 years in England and Wales, the professionals' views are shifting in favour of CTOs. More needs to be done to improve the approach and attitude of care providers so that CTOs are used in the most appropriate and effective way for the patients.

Declaration of interest None.

The supervised community treatment was one of the important amendments of the Mental Health Act 1983 introduced in 2007. The other was the community treatment order (CTO) under Section 17(A–G) which replaced Section 25 (aftercare under supervision). This allowed some patients who are detained under Section 3 or who are on unrestricted hospital order to be subjected to a CTO under Section 17A, with a provision to recall under Section 17E, mainly to provide treatment close to home and reduce their stays in hospital. The implementation of supervised community treatment and CTOs commenced in November 2008.

The guiding principles of the CTO are to minimise the undesirable effects of mental disorder, maximise the safety and well-being of patients, promote their recovery and protect other people from harm.[1] The *Code of Practice* sets out further principles of least restriction, respecting patients' liberty, diverse needs and their values including race, religion, culture, gender, age, sexual orientation and disability.[2] People taking decisions regarding CTOs must consider patients' wishes and feelings, giving them the opportunity of involvement in planning and reviewing their treatment and involving their family members and carers who have an interest in their welfare. Furthermore, the available resources must be used in the most efficient, effective and equitable way.[2]

CTOs – views and findings

Before the introduction of the CTO in England and Wales, concerns rose from almost all sectors. A third of psychiatrists considered this would be unworkable[3] and patient groups felt that their liberty would be infringed. The general consensus was that CTOs would be used sparingly. On the other hand, views of clinicians from other parts of the world, namely New Zealand[4] and Canada[5] who had experience of implementing CTOs in their services, were more positive. A recent survey in England and Wales reported a distinct positive shift in the views of psychiatrists towards the CTO.[6]

Use of CTOs in England and Wales

The Care Quality Commission's annual report on monitoring the Mental Health Act in 2010/2011 revealed that in 2008/2009, 2134 patients were put on CTOs.[7] This number increased almost twofold to 4103 in 2009/2010, but then dropped to 3834 in 2010/2011. The number of discharges by mental health tribunals remained low at around 5%, but many more cases (nearly half) were discharged from CTOs. In the 3 years from March 2009 to March 2011, the number of patients subjected to a CTO in England and Wales rose from 1755 to 4291. This increase is due to a higher number of new CTOs being applied compared with the number of patients discharged from CTOs. During this time the overall number of patients subjected to the Mental Health Act Section 3 fell sharply by 14%. These data suggest that the CTO has effectively filled an important gap in the range of compulsory treatments available under the Mental Health Act. However, the jury is still out on its effectiveness.

A systematic review of compulsory community treatment in the USA found no difference in service use, social functioning or quality of life of patients on a compulsory

†See also current practice, pp. 54–57 and pp. 60–64, this issue.

CTO compared with patients under standard care.[8] But, one has to bear in mind that the provision of mental health services in the USA is different than in England and Wales.

The Care Quality Commission's report gave some examples of good practice in applying CTOs, but at the same time it found widespread unsatisfactory practices regarding their implementation. Lack of patient involvement in their care planning remained a consistent concern of the Mental Health Act commissioners. Poor communication as well as providing inadequate or no information about patients' rights were other issues raised by the commissioners. Misunderstanding of the legal powers of CTOs by the mental healthcare providers was another area of concern. For example, many practitioners failed to appreciate that a patient on a CTO has the right to refuse treatment while in the community and such refusal in itself does not warrant his recall to hospital.

The main focus of the paper by Lepping & Malik in this issue of *The Psychiatrist* is to examine the conditions put on patients on CTOs and the ways to improve them.[9] They present their audit results on 50 patients on a CTO in North Wales. Their findings point out that in some patients, a CTO was applied following their fist admission. Comorbid substance misuse was found in 40% of patients, yet only 18% were given conditions to refrain from illicit drugs and alcohol. Recall rate was 34%, whereas another 8% had voluntary admissions. The authors question the effectiveness of the CTO as 40% of their patients on a CTO had readmissions. A small audit sample size makes such interpretations of their results questionable.

Lepping & Malik highlight the lack of clarity in some conditions put on the patients and consider other conditions such as 'stop driving', 'restrict family visits', 'attend education' and 'take medication' as authoritarian. They also point out that in some cases CTOs appear to address management of risk rather than non-compliance. The conditions related to risk management are particularly applied to patients who were put on a CTO after their first admission. However, the authors propose a set of guidelines (the SMART framework: Specific, Measurable, Achievable, Realistic and Time framed) on conditions to be placed on patients on a CTO. This is a useful suggestion to be kept in mind while setting conditions for a CTO. The findings of this audit and of the Care Quality Commission report on monitoring the Mental Health Act,[7] however, reflect a need for improving the overall framework of care provision as well as the mindsets of care providers. The SMART framework, with its focus on efficient and effective use of resources, is possibly applicable in planning health and social care for any patient with a mental illness rather than just for setting CTO conditions.

The CTO still remains under scrutiny despite its higher-than-expected use in clinical practice in recent years. A decline in the use of Mental Health Act Section 3 admissions since the introduction of the CTO is possibly a good indicator that CTOs are effective.

Healthcare professionals need to understand the spirit of CTOs. They have to keep patients' health, safety and well-being in mind, along with taking account of patients' wishes, rights and dignity. It is worth noting that the ethics of supervised community treatment have been examined,[10] and it was concluded that a CTO is permissible in patients with severe mental illness who have a history of losing capacity to consent to treatment.

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