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Supervised community treatment: guidance for clinicians†

ARTICLE

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SUMMARY

This article describes the background to the introduction of supervised community treatment (SCT) in the 2007 amendments to the Mental Health Act 1983 for England and Wales. The evidence base for the use of SCT in the UK and in other countries to date is considered, and guidance from the literature regarding the decision to impose it is reviewed. Early local experience of SCT is described, in part through a number of fictitious vignettes. Finally, we present a set of guidelines which may be used by clinicians when considering SCT.

DECLARATION OF INTEREST

None.

Community treatment orders (CTOs) were introduced in England and Wales in 2007 as part of the substantially amended Mental Health Act 1983, ostensibly to enable services to provide support and treatment to those in need who would otherwise refuse it, deteriorate and return to hospital as a result. These people are often referred to as 'revolving-door' patients. Provisions for compulsion in the community are enabling and there are no situations where the use of a CTO is obligatory. Previous powers of guardianship (Section 7 of the Mental Health Act) and leave of absence (leave from hospital under Section 17 with ongoing liability to be detained under Section 3) continue to be available. Discretion as to which to use (if indeed any) rests with the clinical team and especially the responsible clinician. In theory, a CTO can be used to compel adherence with medication administered by any route; in practice, its use is mostly with intramuscular antipsychotic medication.

There was significant opposition to the introduction of CTOs among professional and patient groups (Crawford 2000; Mental Health Alliance 2006). Concerns were wide-ranging but often focused on issues of choice and autonomy, and the possible extension of coercive measures. Also of concern were the need for adequate community services in tandem with such orders (or instead of them) and possible disproportionate effects on people from minority ethnic backgrounds.

However, a large survey suggested that more English and Welsh psychiatrists were in favour of such powers than were against them (Crawford 2000). Surveys of professionals in New Zealand (Romans 2004) and Canada (O'Reilly 2000), where CTOs are well established, also found generally positive attitudes among staff. The evidence from the initial use of such orders in Scotland (since 2005) shows substantial geographical variations in usage along with a gradual increase in use. Estimates of future use are approximately 5 per 100 000 population (Churchill 2007). A report of the early experience of using supervised community treatment (SCT) in Scotland (Lawton-Smith 2006) indicated burdensome administration and limited understanding among professionals, patients and carers, but did not uncover major problems in implementation.

Evidence base for CTOs

For understandable reasons there has been no relevant research in England and Wales, and limited evidence from Scotland, where powers of compulsion in the community came into effect in October 2005. Provisions for compulsory community treatment have been available for a number of years in much of the USA and throughout Canada, Australia and New Zealand. Research relating to them tends to focus either on their effectiveness, consumer and staff views and attitudes, or the ethical and legal implications of their availability. A discussion of the last is beyond the scope of this article, but the first two will be considered here briefly.

Effectiveness

There have been two randomised controlled trials of CTOs, both conducted nearly 10 years ago and both in the USA (Swartz 1999; Steadman 2001). The Steadman study, based in New York, recruited relatively small numbers and there were some methodological issues; it reported no significant findings.

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†See also pp. 245–252, 260–262 and 263–271, this issue.

The Swartz study is generally felt to be more robust, having recruited larger numbers (n=264) and achieved good levels of follow-up. Initial analysis showed no overall difference between those on a CTO and those not, but an increasingly influential *post hoc* analysis found that those kept on orders for over 6 months and offered reasonably high levels of support (contact at least three times per month) were significantly less likely to be admitted to a psychiatric hospital. The authors found that this combination of compulsion and support led to 57% fewer admissions and 20 days less in hospital on average in 1 year. The results were even more pronounced for those with schizophrenia, the admission rate being reduced by 73% and days in hospital by 28. Despite valid criticism of the *post hoc* analysis and potential biases that could have been introduced, these findings remain intriguing and potentially important. Swartz *et al* concluded that CTOs could be effective when they represented 'a reciprocal commitment by community programs to provide sustained and intensive treatment to patients under court orders' (Swartz 1999).

A Cochrane review (Kisely 2005) concluded that 'there is no strong evidence to support the claims made for compulsory community treatment that make it so attractive to legislators'. Although calling for further research, the authors acknowledged the inherent difficulties involved in conducting studies, especially randomised controlled trials, in this area. However, such trials remain arguably the best way to obtain robust evidence of efficacy, and the American experience has shown that they are possible, although hard to conduct. There is one such trial ongoing in England and Wales (Burns 2008).

Attitudes and views of key stakeholders

It may be presumed that patients subject to CTOs would oppose the use of such powers, and a report of focus groups in Australia attended by 30 service users on CTOs and interviews with 18 clinicians (Brophy 2004) found that 'consumers were generally dissatisfied'. Both groups tended to view CTOs as stigmatising and disempowering. However, a survey in New Zealand found that individuals reported advantages and disadvantages, and many did not oppose their treatment (Gibbs 2005).

A report from the US (Pataki, 2005) found that high levels of unhappiness among services users initially, but that a majority ultimately acknowledged the clear benefits of the intensive services they received resulting from CTOs. A report released recently in the same jurisdiction found that service users perceived high levels of coercion in their care, whether or not they were subject to orders (Swartz 2009).

In Canada, O'Reilly *et al* (2006) found that service users reported that they experienced coercion under CTOs, but also that the orders provided 'necessary structure'. Their family members viewed the orders as necessary to control the chaos caused by the individuals' limited insight. In New Zealand, Mullen *et al* (2006a) found in qualitative interviews with relatives that (although they were aware of the ethical dilemmas) they reported benefits for the service user and themselves, and better family relationships and relations with the clinical team.

An international study by Lawton-Smith (2005) showed marked variation in the use of CTOs, from 2 to 60 per 100 000 population in eight jurisdictions across the USA, Australia, New Zealand and Canada. Romans *et al* (2004) surveyed all New Zealand psychiatrists and a regional group of non-psychiatrist community mental health professionals in an attempt to ascertain what factors were important for those deciding on the use of CTOs. Ensuring contact with professionals, providing authority to treat and rapid identification of relapse were found to be very important, whereas ensuring police assistance and reducing substance misuse were reported less often. Respondents felt that the impact of using a CTO on the therapeutic relationship was potentially important, with 42% feeling that it was helpful and 31% reporting it as hindering the relationship.

Evidence from the international use of CTOs

Descriptions of CTOs in the international literature indicate that their use in most countries (as in the UK) is enabling and discretionary, decisions about implementation being based on clinical judgement. There are differing methods of introducing such orders across jurisdictions. For example, in Scotland they can be introduced de novo rather than following a hospital order (as is necessary in England and Wales). It will be interesting to see whether such differences in implementation lead to varying patterns of uptake and effectiveness. Dawson (2005) described four main factors drawn from the international literature which have been found to determine use of CTOs: the legal status of the order (the exact powers available under the order); the extent of mental health services available to support possible informal treatment approaches or to implement a CTO; clinicians' views regarding coercion; and the expectations of third parties (including carers and other agencies such as the criminal justice system).

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Factors influencing the decision to impose a CTO

Mullen *et al* (2006b) described six dilemmas that face clinicians considering the use of CTOs:

- uncertain efficacy
- uncertain balance of advantages
- impact on therapeutic relationships
- resource constraints
- the dilemma of discharge (i.e. does success indicate that discharge is appropriate: 'the more successful, the more unnecessary the order appears to be')
- administrative burden.

Interestingly, regarding the impact on therapeutic relationships, the authors cited the potentially damaging effects of the requirement, as part of the order, that the patient attends tribunals and hearings where they may be confronted with the clinical 'evidence' used to determine the need for a CTO, relating to psychopathology, risk and capacity for self-care in a public setting. This was considered to be potentially alienating, although it was noted that enforced honesty and openness about such matters could be regarded as an aspect of good therapeutic relationships. It was felt that in some cases coercion may subvert the therapeutic alliance. The authors made the six recommendations shown in Box 1.

Dawson & Mullen (2008) studied the reasons for using CTOs in 42 cases in New Zealand, concluding that lack of insight was an important indicator, and that 'potential for treatment compliance' appeared to be the primary focus of the decision. Interestingly, recovering insight appeared not to be an indicator for discharge of the order if there were ongoing risks or a severe or rapidly relapsing illness profile.

BOX 1 Recommendations regarding the use of CTOs

1 Community treatment orders should be tailored to individual needs, taking account of the patient's history
2 The powers available under the CTO should be used with great discretion, and clinicians should try to obtain consent in all cases before using them
3 Clinicians should consider carefully the ethics of using the CTO to help carers/family – this could be viewed as indirect support to the patient and may be vital for survival outside hospital
4 Care should be exercised in the imposition of any additional powers (i.e. beyond enforced treatment with medication), for example if specifying the type of accommodation, avoid stating exact placement, leaving some freedom for the individual to make choices
5 Establishing a good therapeutic relationship with the patient in a reasonable time 'may be an essential condition for the success of a CTO'; if this is not established, or if the patient does not recognise the order as valid, the clinician should consider discharge to voluntary status sooner rather than later
6 Where possible, the power to discharge should be used actively, with a strategy to reinstate commitment in the event of further problems at a later time.

(After Mullen 2006b)

Early experience of the use of CTOs in England and Wales

We were involved in a 1-day training session about 6 months before the implementation of the 2007 amendments to the Mental Health Act 1983. We had access to the Mental Health Act 1983 Code of Practice (Department of Health 2008), which is helpful in describing the process to follow when implementing a community treatment order but not in guiding clinical judgement about the decision to impose an order, or the clinical management of potential cases.

A guide for practitioners produced by the National Institute of Mental Health in England (NIMHE; 2008) was of great value in defining the roles of the responsible clinician and the approved mental health professional (Box 2), establishing agreement and setting up procedures. The guide provides helpful 'good practice questions' to help to decide whether a CTO is right for a particular patient and describes it as 'a kind of contract between patient and the clinical team'. The question of patient agreement is clearly complex, and the Code of Practice (Department of Health 2008) states that although patients do not formally have to consent to a CTO, they 'will need ... to be prepared to co-operate with the proposed treatment'.

The NIMHE has produced a useful workbook (King 2008) to support training in the amended Mental Health Act. This includes clinical scenarios, activities and self-assessment. It is unclear how far this has actually been used in helping the majority of clinicians to learn about CTOs. The

BOX 2 Professional roles under the Mental Health Act 1983

Approved mental health professional	Replacing the approved social worker role, these individuals are drawn from: social workers; first-level mental health or learning disability nurses; occupational therapists; and chartered psychologists. They receive specific training relating to the application of coercive elements of the Mental Health Act. In conjunction with medical practitioners, they assess and decide whether there are grounds to detain, without that person's consent, mentally disordered people who meet the statutory criteria.
Responsible clinician	A mental health professional approved to carry out certain duties under the Mental Health Act who has the power to make decisions about a detained person's treatment and has overall responsibility for their care and treatment in hospital or on a CTO in the community.
Second opinion appointed doctor	An independent doctor called on to assess a responsible clinician's decision regarding treatment under the Mental Health Act.

BOX 3 Factors in favour of Section 17 leave and CTOs

In favour of long Section 17 leave

- Discharge is a 'trial' of leave
- Where the patient is felt likely to need further in-patient treatment without consent
- Where the risk of discharge arrangements breaking down is high

In favour of CTO

- Confidence that leave is more than a trial
- Reason to expect the patient will not need further detention in hospital
- Consent or adhere to the treatment plan
- Overall risks of further recall or discharge arrangements breaking down sufficiently to justify CTO 'but not so high that it is very likely'

workbook sets out the roles of key professionals and considers specifically the relationship between Section 17 leave and CTOs. It recommends factors that may favour the use of either long leave or a CTO (Box 3).

Our experience was that (as so often is the case) we learned about CTOs mostly by experience and empirical trial. We found the use of frequent, in-depth case discussions as part of our regular multi-disciplinary team meeting an important means to engage with the complexity of issues presented and navigate a way through these. A useful backdrop to these considerations were the five guiding principles of the Mental Health Act 1983 (Box 4).

BOX 4 Guiding principles of the Mental Health Act 1983

1 Decisions must be taken to minimise the undesirable effects of mental disorder, maximise patient safety and well-being, promote recovery, and protect other people from harm.

2 Clinicians should aim to practise in the least restrictive manner when considering taking actions without the individual's consent.

3 Respect for diversity and avoid unlawful discrimination.

4 Give the individual opportunities to be involved as far as possible in planning and reviewing their own treatment and care. Involve carers (unless there are particular reasons for not doing so) and take their views seriously.

5 Use resources in the most effective, efficient and equitable way to meet the needs of patients.

(Department of Health 2008)

Case vignettes

The following three fictitious vignettes are designed to demonstrate some of the dilemmas and questions raised for clinical teams when dealing with CTOs.

Case 1: Eddie

Eddie was a 28-year-old man with a long history of disengagement from services. His diagnosis was relapsing paranoid schizophrenia, complicated by polysubstance misuse, which had led to formal admissions roughly yearly for the past 7 years.

On discharge from hospital he was placed on a CTO and, although he did not seem to fully understand the process, he agreed to it, apparently as a means of leaving hospital. The conditions were that he should consent to treatment with intramuscular antipsychotics, meet with the community mental health team and agree to urine testing for illicit substances.

He accepted his intramuscular treatment twice but from this point it became difficult to establish any contact with him. After 10 days of attempted contact beyond the due date of his intramuscular treatment, he was readmitted by compulsion using the police to bring him to hospital. Once in hospital he agreed to have his treatment and was reasonably well. He was discharged within 2 days, still on the CTO. He again refused contact and treatment shortly after discharge, and the next three intramuscular treatments were given by compulsion, late, requiring formal readmission. The team persisted with this, as it seemed the least restrictive means to give treatment, although Eddie was showing signs of deteriorating mental state. It had been impossible to enforce the drug-testing condition as he refused to give a sample, even following readmission.

Subsequently, he was picked up by the police under Section 136 of the Mental Health Act when he was found shouting at a group of children in the city centre. At this point he was readmitted to hospital for a longer term and the CTO was allowed to lapse.

Which CTO conditions can realistically be imposed in practice? At what point should non-adherence to a CTO be seen as a sign of the order failing?

Case 2: Jeanette

Jeanette was a 47-year-old single woman who had been in hospital for 5 years under Section 3 of the Mental Health Act. She had chronic paranoid schizophrenia and continued to suffer severe thought disorder and active paranoid delusions about staff involvement in a religious cult, which led her into frequent conflict over many issues, including treatment. She accepted long-term intramuscular treatment in hospital on the basis that she had to under Section 3.

The assertive outreach team became involved and arranged supported accommodation. At a discharge planning meeting there was an attempt to discuss the possibility of a CTO, but Jeanette refused even to discuss this and became agitated and hostile when subsequent attempts were made to broach the subject outside the meeting.

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Guidelines for clinicians considering the use of a community treatment order (CTO)

Throughout the following process, it may be helpful to bear in mind the use of team-based reflective practice as a way to consider differing professional views on an individual's progress and the use of CTOs in the team more generally. Consultation with the nearest relative (as defined in the Mental Health Act 1983) with the patient's consent is good practice, but also reflects the role of the nearest relative, who has powers to discharge or request a mental health review tribunal hearing.

Stage 1 Assessment

Review the following factors within the multidisciplinary team (clinicians to include the approved mental health professional and responsible clinician in the community team and the in-patient team, when these are different individuals)

History

- Illness history, relapsing/chronic nature of illness. Level of disability. Early warning signs/indicators of relapse.
- Strengths, interests, hobbies, positive aspects from history (i.e. periods of stability/health).
- Response to different treatments, including oral and intramuscular medication. Evidence of progress, with and without treatment. History of engagement/disengagement with services and links to outcome.
- Previous attempts to treat in the community under Section 25/17. General response to 'authority' and previous formal treatment approaches.
- Personality factors, impact on illness/relapse. Motivation for change and stage of preparedness for change.
- Substance misuse, evidence of impact on illness/relapse and readiness to change.

Social circumstances

- Housing and finance.
- Possible vulnerability to exploitation.
- Evidence of impact of social stressors on illness/relapse.

Risk (consider from patient and professional perspective)

- Assessment of risk to self, to others and of neglect. Previous effects of relapse on risks.
- Consider the value of positive risk-taking.
- Consider whether formal risk management processes such as MAPPA or MARMAP are indicated.

Professional views

- Consider the quality of therapeutic relationships generally and the possible impact of formal coercion on the therapeutic relationship.
- Consider the impact of the CTO process (including tribunal and review meetings) on therapeutic relationships.
- Consider the potential for the CTO to increase the experience of stigma.

Stage 2 Agreement within the team to recommend a CTO – establish the conditions of the order

- Conditions will include: adherence to medication; being available to be seen by a second opinion appointed doctor as needed to assess consent and the appropriateness of the responsible clinician's treatment plan; regular contact with the team.
- Consider additional conditions (caution advised: consider how far additional conditions will be beneficial and enforceable).

Stage 3 Recommended process to establish the CTO

Interview the patient, involving responsible clinician and approved mental health professional (may require several meetings)

- Assess current level of symptoms, beliefs about illness, insight. Also interests and strengths.
- Assess capacity to make decisions, consider cognitive ability.
- Consider attitudes to receiving services and support in hospital and the community, and to receiving informal treatment; also attitudes to alternative formal approaches, including CTO and Section 17 leave. Give full explanation of the order, including conditions, recall powers, right to tribunal, proposed review date of the order. Establish level of consent to the proposed order.

Interview with key others (consent needed for this, following standard guidelines on confidentiality)

- Consultation with the nearest relative if practicable. Discussion with accommodation/support team, other agencies.

Further review within multidisciplinary team (Section 117 discharge planning meeting, involving approved mental health professional)

- Review readiness for discharge: are community services available, is community treatment feasible?
- Consider the expectations of third parties (MAPPA, MARMAP, other formal processes, carer/family issues).
- Discuss professional views regarding the impact of the order on therapeutic relationships.
- Agree that a CTO is the most appropriate, least restrictive option.
- Decision made to impose CTO.

Further explanation to patient: review date to be agreed (maximum 6 months)

Stage 4 Review of the CTO

Community treatment order reviewed with patient at regular intervals, and to be reviewed in the event of clinical deterioration, major stress or evidence of new risk issues. Review to consider:

- the overall benefits of the order
- the impact of the order on the therapeutic relationship
- the patient's perspective on the order
- consultation with the nearest relative
- if the patient is stable, consider active use of powers to discharge, with possibility of future reinstatement of formal powers (with a planned strategy for this).

FIG 1 Guidelines for clinicians considering the use of a community treatment order (CTO). MAPPA, multi-agency public protection arrangements; MARMAP, multi-agency risk management and assessment process.

MCQ answers
1 a 2 a 3 c 4 d 5 d

The team concluded that a CTO could not be implemented and a decision was made to discharge Jeanette on long Section 17 leave arrangements.

What level of agreement is needed in order for a CTO to be made?

Case 3: Peter

Peter was a 37-year-old single man living with elderly parents. His diagnosis was delusional disorder and he had chronic paranoid delusions about persecution by MI5 operatives in the local area, which resulted in him leading an extremely isolated existence. He had been admitted formally to hospital five times and on each occasion had defaulted from treatment shortly after discharge.

On his latest admission he agreed at the point of discharge to accept a CTO, which required regular contact with the assertive outreach team and treatment with intramuscular antipsychotics.

Six months later he continues to take treatment and has weekly contact with the team. Peter continues to lead an isolated existence, his only social contact being with the team and his family. He continues to have fears about MI5 operatives, but these seem less fixed and to trouble him less. He wants to come off the CTO and stop treatment. His parents want him to stay on the CTO and keep in regular contact with the team.

What is a 'successful' CTO? When successful, at what stage should a CTO be terminated? What roles do key others, such as family carers, have to play in decisions about CTOs?

Development of guidelines

A group of staff within the Gloucester assertive outreach team (including the consultant (R.M.), advanced trainee (A.U.), associate specialist psychiatrist (R.F.) and two allied mental health professionals, D.B. and A.J.) agreed to meet outside the team meetings to discuss issues regarding CTOs, to try to develop a greater understanding of the background literature and to consider how to develop our team's practice in this area. As part of this process, it was agreed to develop written guidelines focusing particularly on the clinical processes involved in assessing a patient for a CTO and, where appropriate, imposing an order. Subsequently, these have been developed further and we hope they will help clinicians faced with some of the dilemmas and uncertainties this process involves (Fig. 1).

Conclusions

The CTO is a new and untested form of legislation in England and Wales, but it is hoped that careful, judicious use of this form of restricted treatment will enable improved outcomes and greater access to care for a small and particularly disadvantaged group of individuals. Nevertheless, concerns remain in professional and service user groups about the lack of evidence in favour of the CTO, ethical concerns and the risks of increasing use of compulsion at the expense of the development of less coercive forms of service provision (Lawton-Smith 2008).

We agree that we should constantly challenge the use of the CTO, both in individual cases and in healthcare systems. We are hopeful that the ambivalence of British psychiatrists in this area of practice will ensure that its use will be within a well-defined and appropriate group. We hope that these clinical guidelines may be of help in making decisions about whether a CTO is appropriate and in describing a process to follow in order to consider all the necessary factors when implementing an order. We would be pleased to hear from clinicians (by correspondence to the first named author) whether these guidelines are useful in practice.

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MCQs

Select the single best option for each question stem

1 In the UK, supervised community treatment:

a was intended to help patients caught in the 'revolving-door' cycle of readmission to hospital
b is a 'disabling' power
c was made available in England and Wales before Scotland
d levels are projected to remain stable for a number of years following its introduction
e has been unanimously welcomed by professionals and service user groups.

2 The evidence base for the effectiveness of supervised community treatment:

a includes research from the USA, Canada, Australia and New Zealand
b includes only quantitative research such as randomised controlled trials
c suggests that there is always a major impact on hospital admission rate
d shows that the use of supervised community treatment is generally not at the discretion of the clinical team
e includes no studies in which patients subjected to supervised community treatment report benefits.

3 Internationally, where it is available, use of supervised community treatment:

a varies from 100 to 600 per 1000 population
b appears to be unaffected by the quality of available mental health services
c differs according to the legal powers it confers
d is generally seen as more harmful than beneficial by psychiatrists who have been surveyed
e appears to be determined entirely by clinicians' views regarding coercion.

4 The following do not need to be assessed when considering whether it is appropriate to impose a CTO:

a the likely overall benefits
b the impact on the therapeutic relationship with the professional team
c clinical risks
d detailed medical history looking for evidence of organic pathology
e previous treatment under Section 17 leave arrangements or Section 25.

5 The following are included in the five guiding principles set out in the Mental Health Act 1983 Code of Practice:

a discrimination on grounds of race or gender is acceptable
b supervised community treatment should be used in all cases where patients have disengaged from services
c clinicians should practise in the most restrictive manner when considering acting without the individual's consent
d effective, efficient, equitable use of resources to meet patients' needs
e exclusively team-based decision-making, not involving patients.