



Mental Health Alliance

Briefing Paper 2

Supervised Community Treatment

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The Mental Health Act 2007 made important changes to the mental health and mental capacity legislation in England and Wales. The Mental Health Alliance, which came together in 1999 to work for humane and effective mental health legislation, is currently assessing the impact of these changes. This paper presents the available evidence on the implementation and impact of the Supervised Community Treatment (SCT) arrangements some 21 months after their introduction in England and Wales on 3 November 2008.

Key messages

- The use of supervised community treatment (SCT) in its first year was significantly higher than the Government expected. An estimated four to five thousand people are currently on community treatment orders (CTOs).
- In a consultation with over 9,000 psychiatrists, most of the 533 who responded thought that SCT was a useful option.
- There is very little information about its impact on people's quality of life. Some people report having a better quality of life being supported in the community while others find CTOs unhelpful.
- Serious concerns include the overall increase of people under compulsory treatment, disproportionate use of CTOs for people from black and minority ethnic communities, possible use of SCT to discharge people earlier than they should be, shortcomings in community support, and delays in obtaining second opinions to authorise treatment.

Summary

Under SCT powers, certain patients subject to detention for treatment in hospital under the Mental Health Act 1983 may be given a Community Treatment Order (CTO) upon discharge. CTOs contain conditions that patients have to comply with, including taking their medication.

The Government significantly underestimated CTO use in the first year. Rather than around 400 to 600 instances, data indicate that 4,000 CTOs were issued across England and Wales in the first year, and over 6,000 by 31 March 2010. The number is likely to have risen to over 7,000 by the end of July 2010, with some 4,000 to 5,000 patients under a CTO at that date.

The ratio of men to women on CTOs is 2:1.

The number of CTOs issued has caused significant problems in obtaining timely Second Opinion Appointed Doctor certifications (SOAD approval is required in order to continue medication treatment after one month under a CTO).

The evidence suggests that the rate of CTO use in England has flattened out (at some 300 to 350 a month), but, as it appears that at present fewer people are being discharged from CTOs than are being placed under CTOs, the overall number of people under a CTO will be rising.

In a survey sent to over 9,000 psychiatrists, most of the 533 who responded thought that SCT was a useful option (325 thought that SCT powers were useful against 74 who thought they had not been useful). Some clinicians are using the SCT powers more than others.

SCT is allowing some patients to be discharged earlier, freeing up beds. However the number of temporary or more permanent recalls of patients to hospital has led to extra pressure on beds, as beds are not being kept free for that eventuality but may be being closed or filled by new patients who were not previously admitted to hospital. Many psychiatrists do not think SCT has had an impact on overall bed occupation or bed numbers, although

clearly SCT (and especially the requirement for patients to take their medication) is helping to reduce readmissions in individual cases, often significantly. In sum, it is not possible at this stage to unpack with any certainty the impact of SCT on bed use.

The initial evidence suggests that most people placed under a CTO are taking their medication, and as a result appear to be living more stable lives. However, there is very little information about the impact they are having on the quality of care and treatment being provided to people, and their impact on the overall quality of people's lives.

What evidence is available highlights a number of serious concerns:

- the introduction of SCT appears to be a significant factor in the increase in the overall number of people under compulsory treatment at any one time
- CTOs are being disproportionately given to people from BME communities
- CTOs do not work for all patients in terms of keeping them well in the community; they need to be backed up with intensive community support, and this appears not always to be provided – having a CTO is not a guarantee of comprehensive community support, whereas in fact one would expect it to be
- the delays in obtaining SOAD approval to treatment after one month of a CTO creates the potential for SCT patients to be treated illegally, or to be treated under emergency powers in non-emergency situations
- some patients may be being discharged earlier than they should be under SCT as a way of freeing up beds
- there is a very clear need for close consultation between hospital and community staff when drawing up patients' CTO conditions and care plans.

The Alliance recommends that the Care Quality Commission specifically monitors these aspects of the SCT provisions and makes public its findings on a regular basis.

Introduction

This paper sets out

- the background to SCT
- use of SCT, based on available evidence from the NHS Information Centre, the Care Quality Commission and the Welsh Assembly Government
- evidence from a Mental Health Alliance survey of psychiatrists; audits in three Mental Health Trusts; and Mental Health Alliance questionnaires
- our conclusions.

There is still an active debate about whether there should be a power of SCT at all. However this paper does not seek to enter that debate, other than to provide the best possible current evidence about the implementation and impact of SCT.

At present both formal data and informal or anecdotal evidence on this issue are in short supply (for example, the NHS Information Centre points out that “only about 45 per cent of eligible trusts returned information about SCT in this first year of the collection” (NHS Information Centre, 2009a). There is, in particular, a shortage of evidence of how SCT is affecting people’s overall quality of life. The findings set out in this paper therefore need to be treated as preliminary. However, we believe there is sufficient evidence to reach some valid conclusions.

A formal Department of Health-funded evaluation of SCT is being undertaken by a research team based in Oxford. This OCTET (Oxford Community Treatment Order Evaluation Trial) project is at the stage of recruiting a full patient sample and has not yet published any findings, although its newsletters do include some findings from local experience of SCT. More information may be obtained from www.psychiatry.ox.ac.uk/research/researchunits/socpsych/research/OCTET/octet

Quotes referenced in the report as ‘Alliance survey of psychiatrists’ refer to responses received to a Mental Health Alliance survey on SCT circulated via the Royal College of Psychiatrists, and running from 10 to 31 March 2010.

The background to SCT

As far back as 1998, the New Labour Government made it clear that it intended to pass legislation to allow for the compulsory treatment of certain mental health patients living in the community:

“Care in the community has failed because, while it improved the treatment of many people who were mentally ill, it left far too many walking the streets, often at risk to themselves and a nuisance to others...”

We are going to bring the laws on mental health up-to-date. In particular to ensure that patients who might otherwise be a danger to themselves and others are no longer allowed to refuse to comply with the treatment they need.”

Department of Health (1998) *Modernising Mental Health Services*

After much debate both outside and within parliament, the SCT powers of the Mental Health Act 2007 (incorporated in Section 17A *et seq.* of the Mental Health Act 1983) came into effect on 3 November 2008. Under these powers, certain patients in England and Wales subject to detention for treatment in hospital under the Mental Health Act 1983 may be placed under SCT upon discharge, through being given a Community Treatment Order (CTO).

To be liable to be placed under SCT, the patient must, in their Responsible Clinician’s view, be suffering from mental disorder of a nature or degree which makes it appropriate for him or her to receive medical treatment. It must be necessary for the patient’s health or safety or the protection of other people that such treatment should be received; such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment; and appropriate medical treatment is available to the patient. An Approved Mental Health Professional (AMHP), generally a social worker, must agree the patient meets these criteria.

Supporters of SCT point out that it is intended to ensure compliance with medication, thereby helping to control or decrease symptoms of serious

disorders; lower risk of self-harm and reduce incidents of aggression and contact with the criminal justice system; allow early discharge from hospital and reduce readmissions; and maintain people's mental health in the community so that they can better retain social contacts, housing, jobs etc.

Those with concerns about SCT argue that it is unnecessarily restrictive and stigmatising; may contravene human rights; lacks a good evidence base; could make people reluctant to engage with services for fear of being placed on a CTO; and that the side-effects of medication people have to take under a CTO may lead to significant harm to their physical health.

The international evidence for the positive effects of CTOs is limited. A 2007 review concluded that "there is very little evidence to suggest that CTOs are associated with any positive outcomes and there is justification for further research in this area." (Churchill et al., 2007). They may be helpful for a particular group of patients with multiple hospital admissions, but it is unclear how far it is the provision of intensive help and sustained monitoring that determines positive outcomes, and whether it is necessary to have a compulsory community order to achieve that.

Use of SCT

Before the Act came into effect, Department of Health Minister of State Lord Warner suggested a gradually increasing proportion of discharged Mental Health Act patients might be placed under SCT (year one, 2%; year two, 4%; year three, 6%; year four, 8%; and year five, a 'steady state' of 10%) and the expected number of people with a CTO would rise to the order of 3,000 to 4,000 per year over a five-year period (Warner, 2006). This would suggest that in year one, some 400 to 600 people might be placed under SCT.

A King's Fund report (Lawton-Smith, 2005) suggested that this was likely to be an underestimate, and that over a period of 10 to 15 years, the number of mental health patients living in the community subject to a CTO could rise to between 7,800 and 13,000 across England and Wales.

Counting CTOs

It needs to be kept in mind that the number of CTOs issued does not necessarily equate to the number of people subject to a CTO. CTOs are issued originally for six months; then, if considered necessary, they are renewed for another six months; thereafter for 12-month periods. Guidance from the NHS Information Centre in terms of data collection on SCT states that "each record should represent the overall period of SCT for a patient and not a separate record for each renewal of the SCT" (Mental Health Minimum Data set Specification and Guidance, table 21a – SCT). In other words, when a CTO is renewed for a further period, it does not get recorded as a new CTO. However, if a patient is discharged from a CTO, or it is revoked, and they later get placed under SCT again, that counts as a new CTO. As a result, two, three or more orders may be made for a single person.

NHS Information Centre data

The first official published data from the NHS Information Centre, which collects returns from English mental health trusts on SCT use, showed that in the first five months of SCT (3 November 2008 to 31 March 2009) 2,109 CTOs had been

issued – an average of roughly 100 mental health patients per week (NHS Information Centre, 2009b).

As at 31 March 2009, data indicated that 1,755 people (1,178 men and 577 women) were subject to a CTO in England. Given the data cut-off at 31 March 2009, all these CTOs would very likely be the patients' first CTO, of up to six months' duration.

Uses of Supervised Community Treatment (under section 17A)

Total number of SCTs 2,109

Section 3 to SCT 1,581

Section 37 to SCT 52

Section 47 to SCT 2

Section 48 to SCT 0

Other sections to SCT 474 (most, if not all, of these would be patients who were transferred onto SCT from after-care under supervision (supervised discharged) under transitional arrangements associated with the introduction of SCT)

Number of SCT recalls to hospital 206

Number of Revocations of SCT 142

Number of discharges from SCT 32

Notes: *Source: KH16 and KP90*

(NHS Information Centre, 2009b)

The number of recalls to hospital and revocations of SCT suggests that for a significant minority of patients being placed on SCT was over-optimistic in terms of being able to stay well in the community. One carer made this point in responding to an Alliance questionnaire:

“My cared-for person simply did not comply with the CTO – the police were called frequently to carry out the necessary steps to treatment usually involving removal to hospital and at least one MHA Section was imposed. The CTO was eventually withdrawn because it could not be effectively sustained.”

The small number of discharges (all of which, due to the date of data collection, would have been within the first six months of a CTO being imposed) suggests that, in clinicians' views, CTOs are both necessary and effective, in terms of maintaining patients' mental health while living in the community, for a period of at least five or six months. NHS Information

Centre data on how many CTOs are renewed for a second six-month period – and after that, annually – are not yet published. The next publication of formal CTO data from the NHS Information Centre is expected in October 2010.

As at 31 March 2009, the NHS Information Centre data suggest there were 2,255 more patients under either hospital or community compulsory treatment than under just hospital compulsory treatment a year earlier, reflecting an overall increase in the numbers of patients under compulsion involving treatment since SCT came into effect. Of course the introduction of SCT may not be the only factor in this increase, but it is likely to be a significant one.

In Wales, the equivalent data covering November 2008 to March 2009 indicated that by 31 March 2009 there were 165 patients subject to SCT. Of this total, 117 were male and 48 were female. Of the 165 uses of SCT during the year there were 11 recalls to hospital, 8 revocations and 7 discharges (Welsh Assembly Government, 2010). At the time of writing, no data on use of SCT in Wales for 2009/2010 are available, but if the first five months' rate of issuing CTOs (around 30 per month) has remained stable, it would suggest that a total of some 500 CTOs may have been issued in Wales by 31 March 2010.

Care Quality Commission data

The Care Quality Commission (CQC) has responsibilities to monitor the use of the Mental Health Act 1983 in England.

In its annual *Count Me In* census, the CQC found that on census day (31 March 2009) 1,371 patients were on a CTO across both England and Wales, 1,253 of whom were outpatients (CQC 2009) – a lower figure than that cited above by the NHS Information Centre figure for England only, suggesting that data collection on SCT is at this early stage not precise.

Current numbers

A recent Freedom of Information request to the CQC revealed that 3,658 CTOs were recorded as made under S17A of the Mental Health Act 1983 between 4 April 2009 and 31 March 2010 in England (CQC 2010a). If we add the NHS Information Centre figures for 3 November 2008 to 31 March 2009

(2,109) and our estimate for Wales (500) that makes a total of over 6,000 CTOs issued in the first 17 months of use, around 350 a month. If that rate is stable – as suggested by SOAD data below – then it suggests that at least 7,000 CTOs have been issued across England and Wales between 3 November 2008 and the end of July 2010.

SOAD requests

The CQC also has responsibilities to appoint independent doctors known as Second Opinion Appointed Doctors (SOADs) when required by that Act, and is therefore reliant on an effective supply of SOADs. SOADs are required to review SCT patients' medication within one month of the CTO being made and certify the appropriateness of continued treatment. SOADs can decide only to certify part of the treatment plan or not to certify treatment at all. Without such certification, treatment with medication under the CTO is no longer lawful apart from in urgent circumstances.

The CQC has received 7,465 second opinion requests for CTO patients in England up to 30 July 2010. The total number is running at just under 1,000 per quarter. This may act as a proxy for how many CTOs have been issued (see 7,000 estimate for England and Wales above). However there is no direct read-across as there may be more than one SOAD application per CTO (for example, there may have been more than one request for an individual CTO patient if there is a change of medication requiring a further SOAD certificate).

In February 2010 the CQC estimated that over 4,000 patients had been placed on SCT in the first year:

“The Department of Health’s forecast for the number of CTOs in the first year was 450. The actual numbers have far outweighed the forecast with over 4,000 patients having been placed on a CTO within the first year. This has created an unplanned pressure on the SOAD service which we have been actively working to manage...”
(CQC, 2010b)

There have been some well publicised delays in obtaining SOAD opinions for people under SCT, and this featured in some of the responses from psychiatrists that we obtained from our survey. Of

the 5,742 requests for second opinion received by the Care Quality Commission (CQC) between 3 November 2008 and 8 March 2010, only 3,423 (60%) were received within the first 28 days, the target set by the CQC in order to meet the legal requirements of SOAD certification within one month (Hansard report, 11 March 2010, Col 471W).

This suggests that in at least 40% of cases, there were no certificates in place to continue treating the patient under a CTO, a point raised by one carer in response to an Alliance questionnaire:

“I was under the impression that a second opinion doctor was meant to be involved with the CTO within the first few weeks of the order being applied. The mental health services said that this was not possible as too many CTOs were being used and not enough second opinion doctors to go round. I wonder whether a CTO is then legal?”

There does not appear to be any definitive evidence at present as to whether treatment with medication does always cease after one month, as is required by the law, if no SOAD opinion is received in that time, or whether urgent treatment powers are being evoked. It remains at least a hypothetical risk that some patients have inadvertently continued to receive medication under the SCT regime despite it no longer being technically legal to do so.

Anecdotally, in other cases, doctors have used an emergency power to treat (Section 64B of the Act for a consenting CTO patient and 64G for those lacking capacity):

“Unavailability of SOAD for compulsory treatment for several weeks leaving lengthy period of needing to use emergency powers in non-consenting patient.”

Alliance survey of psychiatrists, 2010

The Care Quality Commission wrote in February 2010 to all mental health providers in England to ask that SOAD requests be submitted within 48 hours of the start of a CTO, and to reaffirm responsibilities for the arrangements for SOAD visits including dealing with patient 'no-shows'. The CQC is also looking to optimise SOADs' time by working with service providers to establish effective arrangements for SOADs to cover a number of CTO certifications in a single day.

Representation of BME groups in SCT

The Care Quality Commission analysed a set of 726 SCT patients who were referred to a second opinion between 3 November 2008 and 30 January 2009 (Mental Health Act Commission, 2009). It found that the rate of SCT use was higher than average among some minority ethnic groups, although this should be read in conjunction with the Care Quality Commission's 2009 *Count Me In* census which pointed out that "these results are subject to

caution because information about ethnicity was "not stated" for 8% of patients on section 17A." (Care Quality Commission, 2009)

NHS Information Centre data (NHS Information Centre 2009a) confirms this higher use of SCT among certain BME groups of patients. Black or Black British patients make up 12% of those compulsorily detained in hospital, but 18% of those who had a spell of mental healthcare including SCT. If you add to that group the data for mixed race, Asian or Asian British patients, the figures are 20% (detained in hospital) compared to 29% (care has included SCT).

Variations in use of SCT

Data from an Alliance survey of psychiatrists and an audit from South West London and St George's NHS Trust (see following sections) indicate that the use of CTOs varies from clinician to clinician.

Data released by the Care Quality Commission on CTO use in London Mental Health Trusts (CQC, 2010a) also suggest a certain amount of variation in use (see table below). The reasons for these variations may well be down to the particular demographics within each Trust and the range and type of services available (eg, numbers of psychiatric inpatient beds), although clinician preference is likely to be playing some part.

NHS Trust	No. of patients on S17A within one month	Estimated Trust population	CTOs per 100,000 population
Barnet, Enfield and Haringey	124	800,000	15.5
Camden and Islington	90	420,000	21.4
Central and North West London	176	1,800,000	9.8
East London	124	710,000	17.5
North East London	74	1,000,000	7.4
Oxleas	71	750,000	9.5
South London and Maudsley	155	1,100,000	14.1
South West London and St George's	108	1,000,000	10.8
West London	50	700,000	7.1

Alliance survey of psychiatrists

An email invitation to participate in a Mental Health Alliance survey was sent to 9,297 Royal College of Psychiatrists members (active and retired) with registered email addresses who belonged to any of the eight English Divisions, or the Welsh Division. The survey ran from 10 to 31 March 2010. We received 533 responses. The majority (298) of respondents worked in general adult psychiatry, with 64 working in old age psychiatry and 38 in forensic psychiatry.

In setting out the findings below, it should be noted that not all respondents answered every question.

- 325 (61%) respondents thought that SCT powers were useful; only 74 (13.9%) thought they had not been useful (25% didn't know).
- 311 (58%) had authorised SCT, but 131 (25%) said they had not. Of those who had 228 (73%) had between one and five patients under SCT, 49 (16%) between six and 10, and 18 (5.8%) 11 or more. The most common experience appears therefore to be for psychiatrists to have a small number of patients under SCT – though some have none, and others have quite significant numbers.
- 304 respondents (57%) had experienced no significant problems drawing up adequate care plans for SCT patients prior to discharge, with only 66 (12.4%) saying they had. What difficulties there were appeared to reflect the kind of problems that exist in arranging good community support regardless of whether a person is discharged under SCT:

“Accommodation issues are always a problem.”

“Related to accommodation, but also related to the statutory responsible individuals working in different services or teams or offices, making teamwork much more difficult. Trying to plan something feasible.”

“Availability of services late and in weekends.”

“No care co-ordinators, arguments about responsible teams.”

“Lack of clarity about what to include in the Order. Different community teams and practitioners have different ideas.”

However, many accompanying comments made the point that there could be difficulties arising from the fact that conditions in a CTO were drawn up by an inpatient Responsible Clinician, while a community-based Responsible Clinician had to take them on and impose them:

“The split between ‘inpatient’ and ‘community’ consultants has led to a difference of views on occasions. Inpatient consultants tend to take a snapshot view as they rarely have the longitudinal knowledge which comes from community involvement.”

“It is difficult to draw up a care plan for another consultant (community) especially when the consultant does not know the patient.”

“The functional split model causes obstacles as two clinicians may not agree on a treatment regime.”

“Our service is split between inpatient and outpatient so if the inpatient consultant devises the CTO, and although there is consultation on a few occasions, if they have not agreed with the suggested management from the community psychiatrist, they will not include in CTO.”

“While by law my team and I are responsible for writing the SCT plan for a forensic patient who is about to be discharged to the community, it is implemented by a different team who are not always available to contribute to the plan.”

“Different views between inpatient team and community team that would be responsible for aftercare (including, but not limited to, the issue of a CTO).”

“Inpatient Responsible Clinician puts patient on SCT, community consultant does not want this – who takes responsibility for which bit?”

“The SCT is seen by inpatient teams as a way of keeping people out of hospital, the conditions often are unrealistic and community services would be unable to meet them. Negotiations with inpatient teams can be difficult.”

“The consultants in my sector have sometimes

been quite difficult about taking over some of the CTO patients after discharge from the ward, as they say they have enough work already."

- 184 respondents (34.5%) indicated they had been able to discharge patients from hospital earlier under SCT:
 - One to two days 44 (8.3%)
 - Three to seven days 29 (5.4%)
 - One to two weeks 46 (8.6%)
 - Three weeks or longer 65 (12.2%)

"Bed occupation levels are reducing as it is possible to discharge patients earlier."

"SCT has been useful in facilitating early discharge with detailed community care package."

"It has helped to move on revolving-door patients quicker."

Earlier discharge from hospital is one of the aims of SCT, and this suggests a certain amount of success. However, one respondent stated that "preparations for a CTO often delay discharges because of the extra meetings and paperwork involved", and there were comments suggesting that patients may have been discharged with a CTO earlier than advisable:

"My perspective as a member of the Mental Health Tribunal [is that] it seems to be the case that patients are being discharged prematurely to clear beds before they have recovered sufficiently to be able to comply with and adhere to the conditions of discharge."

"In my opinion clearly leads to discharge before impact of medication adequately assessed and reviewed resulting in the assessment of this particular issue being left to a member of the community team rather than the responsible clinician."

"There will be even more pressure to reduce length of stay, which is (on average) too short already."

On the question of the impact of SCT on bed use and occupation levels, bed numbers and rates of readmissions, the data collected via the survey presented a complex and sometimes contradictory picture.

- Twice as many respondents (180; 33.8%) felt there had been no impact on bed-occupation levels or bed numbers that those who thought there had been an impact (80; 15.6%). Some respondents felt that bed usage had in fact increased:

"Bed use has gone up due to high number of recalls."

"There has been no reduction in length of stay but bed usage has gone up due to extra powers of recall."

"It has helped to free up beds but also has created a need for recall beds. In net effect it has increased turnover."

However the majority of respondents' comments reflected experience of lower bed occupancy:

"You can free up a bed more quickly."

"Reduced bed use in Assertive Outreach by over 30% since the introduction of SCT."

"Reduced bed occupancy."

"Decreased need of beds in some cases."

"Marked reduction in beds for Assertive Outreach Team patients."

"Shorter inpatient admission. In my experience, 10 of my patients over the past 12 months, discharged onto a CTO, would probably still be in hospital due to a reluctance to take medication."

"It has been possible to discharge patients with a robust package of care in the community – this would not have been possible in many cases prior to the introduction of SCT, and they would still be treated in hospital, which would have a direct impact on bed occupancy."

Two respondents offered a basic audit of their SCT patients suggesting significant reductions in bed use by patients under SCT:

"I have audited the first 10 patients I placed on SCT. These patients were placed on CTO between 7/11/2008 and 13/1/2009. In the 12 months before being placed on CTO the average bed use was 270 days (range 66 to 365). In the 12 months after being placed on CTO the average bed use was 39 days (range

0 to 246). However seven patients had no readmissions.”

“We did an audit of 19 of my patients on CTOs during an equal period before compared with after CTOs and found that the bed occupancy reduced by more than half.”

- Although more respondents felt there had been no overall impact on bed use and occupation than those who did, nearly twice as many respondents (166; 31.1%) thought SCT had been effective in reducing readmissions than did not (91; 17.1%). Further to the comments on readmissions above, respondents suggested:

“Longer remissions leading to fewer inpatient admissions.”

“Reduction in revolving door.”

“A ‘revolving door’ person who had had several prolonged admissions to hospital over the past five years has now been settled in the community for over six months.”

“There are two patients who have avoided lengthy admissions which were a regular feature of their care in the two years prior to SCT being applied. It has had a very significant impact for one woman in particular.”

“I work with Assertive Outreach Team and client group, who prefer to avoid medication but who respond well to it, with repeated admissions. Once stable and discharged with medication condition in CTO, can work very well.”

“Some patients relapse less frequently if they are made to take their depot injection.”

One respondent pointed out that SCT could reduce the length of readmission:

“It appears to reduce the risk of further long admissions. Have used the powers of recall to re-establish people on medication in situations which would probably have led to Mental Health assessment later in relapse with a consequent longer admission.”

Other respondents felt that the recall powers meant some patients were being readmitted more often:

“Increased admissions by recall for patients that would not have otherwise been deemed ill enough to require inpatient admission.”

“More readmissions have occurred due to recall!”

There are clearly significant variations in psychiatrists’ experience of SCT across the country in terms of its impact on bed use, occupation and readmissions. What appears to be happening is that SCT is allowing some patients to be discharged earlier, freeing up beds. However, the number of temporary recalls of patients / revocations of SCT has led to extra pressure on beds, as beds are not being kept free for that eventuality but are either being closed or filled by new patients who were not previously admitted to hospital.

Many psychiatrists do not think SCT has had an impact on overall bed occupation or bed numbers, although clearly SCT (and especially the requirement for patients to take their medication) is helping to reduce readmissions in individual cases, often significantly. In sum, it is not possible at this stage to unpack with any certainty the impact of SCT on psychiatric bed use (bed numbers have, in total, been reducing year on year for the past 50 or so years), nor separate SCT out from other factors such as improvements to crisis resolution and home treatment services, and local reconfigurations of services.

- 283 (53.1%) of respondents felt their patients had on the whole been compliant with their CTOs, with only 61 (11.4%) suggesting they had not been.

This suggests that most patients, even if reluctantly, do comply with the treatment conditions set out in their CTO. One respondent pointed out that “consent may be wavering but the patient accepts that a SCT is better for them than the alternative – remaining in hospital”.

- Questioned about whether SCT had a significant impact on community mental health services, views were almost equally divided – 143 (26.8%) thought yes, 140 (26.3%) thought no.
- Slightly more respondents felt that the administrative process of applying for SCT worked well (186; 34.9%) than respondents who did not (160; 30%).

Local mental health trust audits

Below is a short summary of CTO audits undertaken in three Mental Health Trusts – South West London and St George’s NHS Trust, Oxleas NHS Trust and Birmingham and Solihull NHS Trust.

Oxleas NHS Trust

Oxleas NHS Trust has undertaken an audit of 132 CTOs (24 in the London Borough of Bexley, 35 in LB Bromley and 73 in LB Greenwich) issued between 3 November 2008 and 31 March 2010 (Cupitt and Inglis, 2010).

Of the 132 CTOs, 77 were current as at 31 March 2010, 32 were discharged (the majority by Responsible Clinicians), 21 were revoked (some of these were then placed again on a further CTO), and two lapsed.

A summary of the main problems encountered and perceived benefits is below. Further details are available from the website of the National Forum for Assertive Outreach (www.nfao.org).

Oxleas NHS Trust audit, 2010

CTOs – the problems

- patients need to accept the conditions and consent to treatment in the Community
- recall is problematic – may be three to four weeks, depends on local arrangements with the police
- delays in obtaining SOAD. Use of S64G often prolonged
- significant paperwork and extra responsibility for the team
- dramatic rise in the number of Tribunals (Automatic Referral)
- On return to hospital – consent to treatment can be problematic; little training; delays with SOAD; use of S62A(6)
- patients need more resources in the community – OT / Psychology to continue meaningful treatment
- SCT more likely to work with intensive community support – treatment has to be more than medication.

CTOs – the benefits

- a real alternative to prolonged hospital admission
- preventing revolving door scenario of non-compliance
- decreased hospital admissions / length of stay (bed occupancy <5%)
- basis for meaningful community rehabilitation
- welcomed by family / carers
- patients get better in the ‘real world’ – re-establishing their lives in the community
- CTOs appeared to have improved therapeutic relationships over time.

Contact for further information: Gary Inglis, email: gary.inglis@oxleas.nhs.uk

South West London and St George’s NHS Trust

This Trust has a population of around one million people, mixed urban and suburban. Its total Community Mental Health Team (CMHT) caseload is 6,300 people, and total Assertive Outreach caseload is 466 people.

- As at November 2009 (some 12 months after the introduction of SCT) there were 68 patients under CTOs, including 34 under the AO teams, 28 from CMHTs and four from early intervention services. With regard to patient ethnicity, relative to the proportion of white and black patients under the care of the AO team, a higher proportion of patients from black groups were under SCT. Black clients made up 38.8% of CTOs although representing 26.8% of the caseload. A correspondingly smaller proportion of people from white and Asian groups were on a CTO relative to the ethnicity of the caseload.
- It was considered that there was neither overuse nor underuse of SCT overall, but variation between teams was based on clinician values and behaviour rather than morbidity.
- At the earlier time point of June 2009 (eight months post introduction) the Trust analysed process outcomes of CTOs. Of a total of 83 SCTs authorised there had been 11 extensions of CTOs beyond the original six-month period of the first Order; nine patients had been discharged from

CTOs, or not had their Orders renewed when they expired; 11 patients had been recalled to hospital, leading to five revocations of Orders, two patients staying in hospital informally and four returning to the community under their CTO within 72 hours.

- In terms of the conditions set out in patients' CTOs, there was an emphasis on patients allowing visits by their support teams and continuing to take their medication as prescribed.
- Delays in SOAD approvals were common due to the CQC being unable to meet demand.

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Birmingham and Solihull NHS Trust

An audit of the first 100 or so CTOs in Birmingham and Solihull NHS Trust, reported in the *OCTET Newsletter* of May 2010 (OCTET 2010), found:

- a higher number than expected of alcohol/substance misuse problems in addition to severe mental illness diagnosis among those on CTOs
- 92% of those on CTOs had a history of violence; 83%, self-neglect; and 45%, self-harm
- the number of black service users on a CTO was higher than in other ethnic groups
- more CTO patients than expected were looked after by CMHTs (as opposed to AOTs)
- those looked after by AOTs were much more likely to receive frequent contact with services
- being on a CTO places patients towards the top of the priority list for hospital beds.

CTOs and Mental Health Tribunals

People may appeal to a first-tier (Mental Health) Tribunal against the decision to place them under SCT in the same way that they can appeal against a decision to detain and treat them in hospital under the Mental Health Act. The patient can apply once during each period of the CTO (during the first six months, the second six months, then subsequently annually). Whether an application is made to a Tribunal by a patient or not, a Tribunal will automatically sit and consider the cases of CTO patients where the CTO has been revoked and the patient is back in hospital as a detained patient (this is in addition to the patient's right to apply to a Tribunal); where six months has passed since they were originally detained (on a Section) and there has been no Tribunal in the intervening period; and in long-term CTO cases, where three years has elapsed since any Tribunal hearing (Butler & Co, 2010).

Data on first-tier (Mental Health) Tribunal hearings between November 2008 and March 2010 are set out in the tables below (The Tribunals Service, 2010). The data include only appeals to the first tier Tribunal and do not include applications for leave to appeal to the Upper Tribunal.

These data show that 3,579 appeals were made in respect of some 6,000 CTOs up to March 2010, indicating that well over half of all CTOs are the

subject of appeals (in some cases there may have been more than one appeal against a single CTO which has been renewed for a further period).

They also show that 4.6% of 1,861 heard appeals against SCT were successful, compared to 14% of 4,599 heard appeals against inpatient detention and treatment. This might suggest that patients have generally been placed, and are being treated, under SCT appropriately, although in a small minority of cases the Tribunal has found it to be inappropriate.

A Mental Health Tribunal perspective was reported in the *OCTET Newsletter* of May 2010 (OCTET, 2010), based on a presentation given by a lawyer and part-time Tribunal judge:

“... from a Tribunal perspective CTOs, when used appropriately, appear to be working. For the typical ‘revolving door’ patient a CTO appears to prolong time in the community. Meanwhile, few CTOs are being discharged by Tribunals but when a CTO is discharged it highlights the importance of ensuring the criteria are met.... [CTOs] should only be used where necessary. ‘Necessary’ is distinguished from ‘desirable’ and the necessity is related to risk. The Code of Practice (25.13) states that a risk of deterioration does not necessarily mean CTO is required: ‘The responsible clinician must be satisfied that the risk of harm arising from the patients’ disorder is sufficiently serious to justify the power to recall the patient to hospital for treatment’.”

Table 1: Appeals against the imposition of Supervised Community Treatment with outcomes and appeals outstanding

November 2008 – March 2010						
Appeals received	Appeals upheld	Appeals rejected	Withdrawn	Invalid	Other*	Appeals outstanding at 4 August
3579	86	1775	696	26	257	172

* Other includes death of patient, patient absconded, discharged by the RMO

Table 2: Appeals against the imposition of inpatient detention and treatment with outcomes and appeals outstanding

November 2008 – March 2010						
Appeals received	Appeals upheld	Appeals rejected	Withdrawn	Invalid	Other*	Appeals outstanding at 4 August
8619	645	3954	545	171	2853	190

* Other includes death of patient, patient absconded, discharged by the RMO

One comment, via our survey of psychiatrists, from a member of the Mental Health Tribunal suggested that post-discharge care for patients on CTOs could be less than ideal, impacting on the effectiveness of Tribunal hearings:

“In poorly staffed community teams, follow-up is often inadequate, in particular social care provision is especially badly thought through often with too little involvement with familial carers in particular. More often than not patients are reluctant to attend tribunal reviews as they have a poor understanding of and fear of readmission risk to themselves and often refuse legal representation and often refuse to meet the medical member of the tribunal prior to the hearing. This means that the case is heard in the absence of the patient and often a legal representative and the medical member is unable to challenge the evidence of the detaining authority as he has no direct clinical knowledge of the patient’s mental state on the day of the tribunal.”

(Alliance survey of psychiatrists, 2010)

Mental Health Alliance questionnaires

A small number of people (62, up to 27 July 2010) have responded to a question about SCT included in a questionnaire about various provisions on the 2007 Act on the Mental Health Alliance website.

Asked about their experience with CTOs, people responded as below.

Helpful	14
Neither helpful nor harmful	12
Harmful	17
Don’t know or N/A	15
Not answered	4

Clearly the small numbers of respondents make any general conclusions unsafe. However it is worth noting that there is broadly a balance between those who think the CTO helpful and those who think it harmful – and that this balance applies within the cohort of respondents with personal experience of detention under the Act, 10 of whom found it helpful and eight harmful.

A number of associated comments from respondents challenged whether there should be a power of SCT at all. However, as indicated earlier, this paper does not seek to reopen that debate, but rather to comment on the implementation and impact.

Comments from those who thought CTOs could bring benefits included:

“[helpful] as being discharged from hospital into a residential care home. I feel the benefit of living more independently, also what it has to offer myself and others, there is always staff available to help and support clients who live in care homes.”

“[You] inevitably want to get the hell out of the bin and get on with your life. The CTOs enable you to get out and receive treatment they think necessary, however... I hate it when the community mental health team (outreach) bring what you have experienced and put it in the home. My care workers used to knock on my door without telling me they were coming, which I feel to be... invasive.”

Responses to Mental Health Alliance questionnaire

	Helpful	Neither	Harmful	Don't know or no answer
Person with experience of detention	10	3	8	10
Nearest relative	1	1	2	1
Other – mental health service user			2	2
Other – friend / relative / carer		1	1	2
Independent Mental Health Advocate	1	3		3
Approved Mental Health Professional			2	
Professional, other statutory role	2	2		1
Professional, not statutory		2		
Other		1		
Not stated			1	

“It is good if it is suitable for the client, but can be abused to stop ‘bed blocking’.”

“I work in a medium secure unit, and a CTO is one option being discussed for a patient as part of discharge planning discussions. The patient likes the idea of this option and says he would comply with treatment. His clinical team may have a different view.”

The majority of comments, however, came from those who did not believe that CTOs were helpful, and focused mainly on the lack of support available:

“I am on a community treatment order. I find it deeply stigmatising and unhelpful.”

“My husband was discharged from hospital on a CTO and we received minimal support and information from services. The CTO achieved nothing and certainly did nothing for my husband’s mental health. In fact it was a cause of great stress to us both as his treatment whilst in hospital was so appalling we were afraid of the consequences of a compulsory readmission. My husband also felt the CTO was a very negative label and felt very stigmatised due to this. Whilst on the CTO my husband received the standard mix of ‘medication and monitoring’ with no help or support to look at his coping strategies, triggers or to develop an effective crisis plan to prevent future relapse.”

“You would think that people would prefer to be subject to community treatment, rather than being detained in hospital. However, those subject to CTOs are finding them very intrusive and interfering with their privacy, according to my experience as an IMHA.”

“Not enough support was given to me when I came out of hospital. My family didn’t know what to ask and what not to ask and I felt very vulnerable as I didn’t then have any contact with the mental health team for a fortnight.”

“My mother... was placed on a community treatment order, no facilities in place to back it up.”

“Both the medication and CTO often blanket covers the underlying trauma and does not deal effectively with the real issues such as poor housing, breakdown of relationships etc.”

Carers’ experiences

A further questionnaire circulated in July 2010 to carer organisations has received to date 17 responses. Again, this small number precludes any generalised conclusions, but the question “Do you think the CTO has helped the person you are caring for?” led to a broadly even split, eight agreeing and nine disagreeing. To the question, “Do you think the CTO has helped you?” nine agreed and eight disagreed.

A number of comments cited a lack of support to carers of people with CTOs from local teams:

“As a carer, I would have liked to have been consulted about the care plan. The contents, and thus my caring work load, were decided by the care team, without involving me in any way. I had to give up a part time job, to care for my relative under the CTO. I feel this is outrageous... I am not trained nor supported to provide 24/7 mental healthcare. There is nothing available locally to support carers of people on CTOs or with profound mental health illness. I also would have liked someone in the CMHT to help me with how to deal with psychosis, with his symptoms. This would have helped him too.”

“My loved one knows he is on a CTO. He feels it’s controlling him at home, and is obtrusive, whereas in the old days, after his Sections, he says he was at least free then. The team turn up for five minutes, but there is no help with activities, physical health issues nor social life. Unless I take him out, he sits in our home 24/7. The care team who visit don’t speak to me, his 24/7 carer, but make decisions about his welfare and care which deeply affect me in my own home. I love my husband dearly, but I feel invisible and like an unpaid for invisible employee, with no say in my caring load. No input, silenced. Not a good recipe for good mental health.”

However, others found the CTO helpful, and agreed that the CTO could help to ensure the person they cared for took their medication, with beneficial results:

“It has helped, as a carer, to graduate the time spent between the hospital having responsibility and us, as parents, taking over and adjusting to both our and our daughter’s new responsibilities. It helped getting to know the Assertive Outreach Team members.”

“Made him take his medication.”

“We *know* that he is taking his medication regularly and as prescribed. As a result his mood is more stable. Risk of becoming psychotic due to not taking medication is apparently removed.”

“Because of the medication my son has been prescribed, he is more stable which has empowered him to be more self-reliant, which has led to less strain on me.”

“It provides evidence that he can avoid hospitalisation if he takes his medication (that is not to say he accepts that evidence as proof of need to take medication).”

“Before he was on the CTO he was non-compliant with medication.”

Conclusions

It is clear that the Government significantly underestimated CTO use in the first year and the number of CTOs issued has caused a certain amount of difficulty, particularly in respect of meeting SOAD requests.

Data suggest that over 6,000 CTOs were issued by 31 March 2010, and the number is likely to have risen to around 7,000 by the end of July 2010.

Allowing for a proportion of patients to have had their CTO revoked, or been discharged from the CTO, or died, there may currently be between 4,000 and 5,000 patients under SCT across England and Wales as of July 2010.

As far as it is possible to tell from the evidence of SOAD requests, the rate of CTO use has flattened out (at some 300 to 350 a month), but, as it appears that at present fewer people are being discharged than are being placed under CTOs, the overall number of people under a CTO will be rising. This would mean England and Wales are following the usual trend when CTOs are introduced in any country (Lawton-Smith, 2005).

While there is a certain amount of data on the numbers of CTOs, there is very little information about the impact they are having on the quality of care and treatment being provided to people, and their impact on the overall quality of people's lives. Bed occupancy rates and readmission rates are not particularly good proxies to measure the value of an intervention such as SCT, and such evidence is in any case only anecdotal at present. It may be reasonable to assume that people's quality of life is better when they are supported in the community under a CTO rather than being detained in hospital. There is anecdotal evidence to that effect, but this sits alongside evidence that for some people CTOs are not working and are not felt to be helpful. There are clearly problems in some cases getting good local support to people under a CTO, and more needs to be done to capture patient, family and carer views.

We have not come across any evidence of 'horror stories' about misapplication of CTOs. The fact that only a relatively small number of people are being discharged from CTOs on appeal to Mental Health Tribunals (4.6% of appeals heard – see The Tribunals

Service data above) suggests that Responsible Clinicians and AMHPs are applying the rules diligently, but also that it may be hard for patients to demonstrate that they need not be on a CTO. (In correspondence, one psychiatrist stated "My own experience is CTOs are lasting much longer than nine months. It can be difficult to know when to remove the order often, given significant progress and improvement in quality of life but lack of insight particularly with regard to medication.") Responsible Clinicians and AMHPs need to be diligent about ensuring that legal thresholds are being met and that there are strong clinical reasons for imposing and maintaining SCT in every case.

Most, though not all, psychiatrists appear to think that SCT is a useful option. Many of the 533 who responded to our survey suggested that it has helped people stay well when back in the community, which is the fundamental purpose of SCT. The initial evidence suggests that most people placed under a CTO are taking their medication, and as a result appear to be living more stable lives, although more research is needed to be sure about this. There appear to be variations in use of SCT between individual clinicians and also between Mental Health Trusts. This is to be expected, and while worth further investigation, does not necessarily imply better or worse practice.

There remain many unanswered questions, however, especially around patient, family and carer experience of SCT, and the impact of SCT on community services. What evidence is available also highlights a number of serious concerns:

- the introduction of SCT appears to be a significant factor in the increase in the overall number of people under compulsory treatment at any one time
- CTOs are being given to people from BME communities disproportionately
- CTOs do not work for all patients in terms of keeping them well in the community; they need to be backed up with intensive community support, and this appears not always to be provided – having a CTO is not a guarantee of comprehensive community support, whereas in fact one would expect it to be
- the delays in obtaining SOAD approval to treatment after one month of a CTO creates the

potential for SCT patients to be treated illegally, or to be treated under emergency powers in non-emergency situations

- some patients may be being discharged earlier than they should be under SCT as a way of freeing up beds
- there is a very clear need for close consultation between hospital and community staff when drawing up patients' CTO conditions and care plans.

On this basis, the Alliance recommends:

- that the Care Quality Commission specifically monitors these aspects of the SCT provisions and makes public its findings on a regular basis
- that relevant service providers in statutory, independent and voluntary sectors actively seek the views of people subject to a CTO, their families and carers and ensure that they are taken into account when delivering support
- that the NHS Information Centre and Welsh Assembly Government publishes data on CTOs quarterly rather than annually.

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Suggested further reading

Advances in Psychiatric Treatment (2010), 16, 245-71 includes four articles on different aspects of SCT, including guidance for clinicians and human rights issues. Royal College of Psychiatrists doi.10.1192/apt.bp.108.006585

Care Quality Commission (2010), 'How we protect the rights and interests of people on community treatment orders', <http://its-services.org.uk/silo/files/how-we-protect-the-rights-and-interests-of-people-on-community--treatment-orders.pdf>

Lawton-Smith S, Dawson J, Burns T (2008), 'Community treatment orders are not a good thing', *The British Journal of Psychiatry* 193: 96-100, doi: 10.1192/bjp.bp.107.049072

Mental Health Act Code of Practice, Chapter 25, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

Mental Health Alliance, *Alliance policies: Supervised Community Treatment*, www.mentalhealthalliance.org.uk/policy/nros.html

Mental Health Alliance members

Afiya Trust; Black Mental Health UK; British Association for Counselling and Psychotherapy; British Association of Social Workers; Caritas Social Action; Ethnic Health Forum North West; Hafal; Institute of Mental Health Act Practitioners; King's Fund; Manic Depression Fellowship; Mental Health Foundation; Mind; National Autistic Society; NUS; Witness; Rethink severe mental illness; Revolving Doors Agency; Richmond Fellowship; Royal College of Psychiatrists; SANE; The Sainsbury Centre for Mental Health; SIRI; Together; Turning Point; UK Federation of Smaller Mental Health Agencies; UKAN; UNISON; United Response; Voices Forum; YoungMinds; The 1990 Trust; African Caribbean Community Initiatives; Age Concern England; Alcohol Concern; Association of Directors of Social Services; AWAAZ (Manchester); AWETU; British Medical Association; BME Mental Health Network; Carers UK; Church of England Mission and Public Affairs Council; Confederation of Indian Organisations; Democratic Health Network; Depression Alliance; Drugscope; East Dorset Mental Health Carers Forum; Family Action; Footprints (UK); General Medical Council; Haldane Society of Socialist Lawyers; Having a Voice; Homeless Link; Imagine; JAMI; Justice; Law Society; Liberty; Local Government Association; Manchester Race and Health Forum; Mencap; Nacro, NHS Confederation; Race on the Agenda; RADAR; Refugee Action; Royal College of General Practitioners; Sign; Social Action for Health; Social Perspectives Network; Somali Mental Health Project; Supporting Carers Better Network; UK Council for Psychotherapy; West Dorset Mental Health User Forum; WISH.

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Mental Health Alliance

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For general enquiries about SCT contact:

Mind

Mind*info*Line is able to provide information on a range of topics including types of mental distress, where to get help, drug and alternative treatments and advocacy. We are able to provide details of help and support for people in their own area.

0845 766 0163 (local call rate)

Monday to Friday, 9.00am–5.00pm

e: info@mind.org.uk

Mind*info*Line

PO Box 277

Manchester

M60 3XN

Rethink

The Rethink Advice and Information Service is a source of detailed advice covering a wide range of mental health problems. We can provide advice and information on a wide range of mental health issues including treatment, second opinions, money and debt, the law and rights, criminal justice issues, information for carers and help with court hearings.

T: 0845 456 0455

Monday–Friday 10.00am–2.00pm

e: advice@rethink.org

SANE

SANE provides practical and specialist support and information for people with mental health problems, their carers and families and the general public through its services:

- Telephone support via SANEline: 0845 767 8000 Every day 6pm-11pm
- Email support via SANEmail: sanemail@sane.org.uk



Mental Health Alliance