Community Treatment Orders - Submission to the Mental Health Task Force

Proposal

The Critical Psychiatry Network consists of UK psychiatrists concerned about coercion in mental health care. We believe there should now be a review of Community Treatment Orders and ask for your support or views on the issue.

Summary

Community Treatment Orders were introduced in 2008 with the aim of keeping patients mentally well and out of hospital. They involve the extension of compulsory powers into the community, thus representing a curtailment of liberty. Research has failed to show any benefit and difficulties in accessing hospital beds remain.

Background

Community Treatment Orders (CTOs) were introduced in November 2008, by new sections 17A-G being inserted into the Mental Health Act 1983 by the Mental Health Act 2007. In the Act those subject to CTOs are called community patients.

The 2007 amendment to the 1983 MHA allows for Supervised Community Treatment (application of a CTO) whereby community patients are obliged by law to comply with specified conditions. The powers only apply to patients who have detained in hospital under the MHA and are applied at the point of discharge. The main condition is usually to comply with neuroleptic medication with a view to preventing relapse.

Research

Several randomised trials of CTOs and similar measures have now been conducted worldwide.

The first UK based trial, the OCTET study, was published in the Lancet in 2013. The OCTET study was set up to test whether being on a CTO really does what it is intended to do; that is whether it keeps people mentally well and out of hospital (Burns et al, 2013). The lead researcher psychiatrist Professor Tom Burns has been a long-term advocate of CTOs. The study involved 333 participants who were all considered suitable for a CTO. All participants

were patients who were admitted to hospital under section 3 of the MHA. They were randomised either to be placed on a CTO, or to be managed without one and discharged after a short period of 'leave'. After one year the two groups showed no difference in terms of the rate of readmission to hospital, which was 36% per cent in both groups. There was also no difference in the total number of days people spent in hospital during follow up, the number of readmissions people had, the number of people having multiple readmissions, the severity of symptoms that people showed or in people's level of functioning. People in the CTO arm were subjected to an average of 183 days of compulsory outpatient treatment, whereas people in the non-CTO arm spent an average of 8 days in the community under Section 17 leave restrictions before being fully released from sanctions.

The study report concluded that there is no evidence that CTOs have any benefits and that they do not 'justify the significant curtailment of patients personal liberty' (Burns et al, 2014).

Two other randomised trials conducted in USA also found that compulsory community treatment did not reduce hospital admissions (Swartz 1999. Steadman 2001)

Practice

The government predicted that CTOs would be used for 200 to 400 patients a year but there were over 2000 CTOs in the first year and since then around 4000 per year. Pressure can be exerted on psychiatrists to place patients on CTOs by other team members, and by MHA Tribunals. CTOs are mainly used to ensure compliance with depot neuroleptic medication. As there is no guidance on when to remove CTOs they tend remain in place long term.

Concerns and Recommendations

Two areas of concern were raised at the CPN meeting in September 2014:

a. Research has failed to demonstrate effectiveness. This significant curtailment of liberty has not led to reduced hospital use or improved functioning.

b. Lack of clarity and recommendation about the duration of CTOs.

c. A concern that application of CTOs may be being used to speed up discharge from hospital and reduce pressure on beds

The CPN feel there should be a review of the law relating to CTOs

References

Burns T, Rugkasa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montez M, Voysey M, Sinclair J, Priebe S (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* **381**:1627-33.

Swartz M, Swanson JD, Wagner H, Burns B, Hiday V, Borum R (1999) Can involuntary outpatient commitment reduce hospital recidivism? *Am J Psychiatry* **156**: 1968-75

Steadman HJ, Gounis K, Dennis D, Hopper K, Roche B, Swartz M *et al* Assessing the New York involuntary outpatient involuntary commitment pilot programme. *Psychiatric Services* **52**: 330-6

Contacts

Dr Joanna Moncrieff, FRCPsych. Co-chair UK Critical Psychiatry Network.
j.moncrieff@ucl.ac.uk

Dr Hugh Middleton, MD, MRCP, FRCPsych. Co-chair UK Critical Psychiatry Network.
hugh.middleton@nottingham.ac.uk

Dr Rhodri Huws, FRCPsych. Secretary Critical Psychiatry Network
r.huws@sheffield.ac.uk