

Community Treatment Orders: An Overview

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Background

Most psychiatrists will have faced the dilemma of managing the 'revolving door' patient at some point. These patients typically do well on enforced treatment in hospital whilst detained under the Mental Health Act but remain limited in their insight regarding the need for, and benefit of, treatment; when discharged from their Mental Health Act section, back into their community, they soon stop the medication and eventually suffer a relapse in mental illness, leading to another admission, often under the Mental Health Act once again. This is a source of endless frustration to their families and to all the professionals involved in their care.

Until legislative changes in 2007, there were limited options to deal with this problem. The Mental Health Act 1983 was clearly focussed on hospital inpatient treatment. Various parts of the Act dealing with community matters (e.g. S.7 guardianship, S.25 supervised discharge) did not deal with the issue of treatment in the community. The only option available to clinicians was to send detained patients on extended S.17 leave, thereby making them liable to recall to hospital if problems arose. In effect, this was a de facto community treatment order, with patients attending hospital as little as once a month for depot antipsychotic medication or a ward round and sections being renewed in patients' absence.

This practice has been controversial and challenged in the courts. Indeed, its use has primarily been determined by case law. The practice of renewing detention whilst a patient is on extended leave was deemed unlawful in a 1985 case (1), by the dint of the fact that S.20 of the Act (2), which deals with duration of authority for detention and circumstances around renewal, clearly mentions, in subsection 4, that one of the conditions for detention should be that the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment *in a hospital* (my italics), and the judge in this case stated that patients on extended leave cannot be said appropriately to require treatment in hospital as an inpatient at the time.

Another case fourteen years later appeared to reverse this ruling (3); a patient who was living mainly in the community but subject to random illicit drug testing challenged the renewal of her S.3 on the grounds that she was not receiving sufficient hospital medical treatment to warrant continued detention. S.145(1) of the Mental Health Act 1983 defines medical treatment as including 'nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care' (2); the Court of Appeal, which held that 'continues to be detained' should be interpreted as 'continues to be liable to be detained', determined that regular illicit drug testing satisfied the renewal criteria under S. 145 and that any element of hospital treatment that ensured a holistic care plan's success allowed lawful detention, even if the individual resided mainly in the community (4).

Two further cases strengthened the use of extended S. 17 leave and liberalised the definitions pertaining to the criteria for detention. In 2002 (5), a patient who resided in the community but returned to hospital for once-weekly occupational therapy, once-weekly clinical review and fortnightly antipsychotic administration, was deemed by the court to be receiving a 'significant part' of their treatment plan 'in hospital' and therefore subject to lawful renewal of detention under these circumstances. In 2004 (6), the case was heard of a patient who attended hospital once a week for psychological treatment and once a month for a ward round and whose S.3 was renewed by a Mental Health Review Tribunal whilst she was on extended leave. Her appeal against this was rejected; the judge stated that the rôle of the hospital in the overall treatment plan must be clearly visible, but might be very narrow, and civil detention with extended leave was required to allow recall to hospital, should the patient's condition deteriorate.

There was clearly dissatisfaction at the governmental level with the lack of statutory legislation allowing community treatment under some degree of compulsion, so one of the main changes introduced in the 2007 Amendments to the Mental Health Act (7), alongside the simultaneous repeal of the toothless S.25 supervised discharge order, was the creation of the community treatment order (CTO) as a form of supervised community treatment, which is seen as S.17A of the amended Act, a logical extension of the existing S.17 provisions.

Criteria

The criteria are clearly stated on the CTO1 form itself, which needs to be completed by the responsible clinician (RC) and an Approved Mental Health Professional (AMHP), after which a patient's period under the CTO will have begun. There are the usual criteria for S.3 (or unrestricted Part 3) detention (the presence of a mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment, which is necessary for the patient's health, the patient's safety and/or the protection of other persons), but also criteria specific to the implementation of a CTO. 'Appropriate' treatment (another amendment to the Act in 2007 (7), which replaced the previous 'treatability' test) must be available to the patient in the community and this treatment must be deemed to be able to 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 it should be necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital. The recall issue is crucial – it provides, in theory, for the ability to organise a swift readmission to hospital for assessment for a patient at perhaps a relatively early stage of deterioration, with the aim of preventing a full-blown relapse, without the need for going through the whole process of a fresh Mental Health Act assessment. If the power to recall is unnecessary, a CTO will not be appropriate.

In order to prevent early failure of the CTO, it is extremely helpful to have the agreement of the patient to the CTO. This agreement should be seen as very specific and does not, by any means, mean agreement about diagnosis, treatment or any aspect of the patient's care within mental health services whatsoever. In patients who chronically lack insight, this agreement is usually tantamount to an understanding that this is the quickest way for them to get out, and stay out, of hospital.

Conditions

The two mandatory conditions for all patients on a CTO are that the patient must allow examination by the responsible clinician in order to extend the CTO (under S. 20A of the Mental Health Act (7)) as necessary and also must allow examination by the second opinion appointed doctor (SOAD) at the time necessary to authorise treatment. S. 17B (7) allows for the imposing of other conditions; the most common are to ensure ongoing engagement and compliance with treatment (e.g. to keep all appointments with the care coordinator, to attend all outpatient appointments with the psychiatrist, to continue taking depot antipsychotic injections). These conditions must be necessary to ensure that the patient receives medical treatment, to prevent risk of harm to the patient's health or safety and/or to protect other persons.

Recall

The need for the power of recall when deciding to implement a CTO has already been mentioned. There is some misunderstanding about the circumstances under which a patient can be recalled from their CTO. S. 17E(1) (7) is very clear that the RC can recall a patient if he believes that '(a) the patient requires medical treatment in hospital for his mental disorder; and (b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.' However, the extent of the latitude which might be given to the RC's perception of this risk of harm has not yet been tested in court, in the way that the interpretation of 'hospital treatment' in the case of extended S. 17 leave has. S. 17B also makes clear that the failure to comply with a condition of the CTO may contribute to the RC's decision to recall 'but *nothing...restricts the exercise of that power* (my italics) to cases where there is such a failure'.

The practicalities of the machinery of recall may present considerable problems for the community RC. Only the RC can recall a patient and he or she must do so in writing, outlining the reasons for recall. This written notice may be given to the patient by hand, hand-delivered to the last known address or posted. If given to the patient by hand, recall takes immediate effect. If hand-delivered to the patient's last known address, recall takes effect from the day after it was delivered. If sent by first-class post, recall takes effect from the next working day after that. The timing issue is important as it determines when the recall is in force, and the patient may be considered absent without leave (and an application for a warrant may be made under S. 135) if they do not comply with a recall notice. The RC is responsible both for the delivery of the recall notice and conveyance to hospital (8).

Once in hospital, the treating team have 72 hours to assess the patient to decide if they need further treatment in hospital, and if they might consent to voluntary admission or require revocation of the CTO, or if they can be managed in the community back on the CTO. The patient can also be given treatment during this time; at this point, if the treatment has been authorised by a SOAD to be given in the community, this certification can be used to treat the recalled patient. This is an essential point as it permits the archetypal situation of a patient being recalled to hospital, given a depot antipsychotic injection and then discharged back into the community after a very brief stay, thereby maintaining their 'wellness' without the need for a prolonged admission.

The legal details are important to prevent mishaps in the recall process. The RC for the patient at the time of recall must furnish the recall notice. In most areas, services have now been 'functionalised', with different teams working in inpatient and outpatient settings. Therefore, it must be the community RC who recalls the patient, not the inpatient RC for the ward to which the patient is going. Also, the patient must be recalled to a hospital and, in Trusts with multiple stand-alone units, the particular unit to which the patient is going must be identified in advance. The wrong RC or hospital name on a recall notice would render it legally invalid.

Revocation

If, following recall, the RC feels that further detention in hospital is necessary, the CTO can be revoked and the patient placed back on their original section. The criteria for revocation are similar to those for detention in the first place and, as with initiating the CTO, the RC and the AMHP must both agree. The RC now would be the RC in the hospital and therefore different to the RC who had issued the recall notice.

Duration

CTOs last for 6 months and can then be renewed for a further 6 months and 12-monthly thereafter. Discharge can take place in ways similar to the processes for the sections underlying the CTO; the RC, Mental Health Review Tribunal and Hospital Managers can discharge a patient from a CTO and the patient's nearest relative can also apply for discharge.

Discussion

CTOs were introduced to enable more effective management of 'revolving door' patients in the community. Despite their widespread use in particularly North America and Australia, there was considerable debate prior to their introduction in the 2007 Amendments to the Act. Nevertheless, the uptake of the opportunity to use CTOs by psychiatrists seems to have been sufficient that the SOAD service appears to have been swamped.

However, they are not without their detractors. Apart from the practical difficulties mentioned above, such as the recall process and the need for exemplary communication between community and inpatient services, there has been genuine doubt about the ethics of essentially indicating to patients that the swiftest route out of hospital is via a CTO, and whether or not this amounts to coercion. The very necessity for their existence has also been questioned, given that the use of extended S. 17 leave

had been sanctioned by the courts, although the legislation tries to curtail extended S. 17 leave by suggesting that a CTO should be considered for anyone being granted more than 7 days' consecutive leave from a hospital.

The ultimate test of vindication for CTOs will be if they really do improve the long-term outcome for the difficult-to-manage group of patients for whom they were envisaged. Only time will tell.

GP comment

What have I learned from this paper?

1. Community treatment orders provide a clear legal process to ensure that patients who need it, can receive compulsory treatment without having to remain in hospital.
2. The details of the process, in other words who does what, must be followed carefully for it to be legal.
3. In theory it should be less restrictive, since patients needing treatment do not have to remain in hospital, allowing more of them to maintain good mental health in the community, but whether this will prove to be the case long term remains to be seen.

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References

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