

# Community Treatment Orders

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A community treatment order is now a well-established feature of various common law jurisdictions in North America and Australasia, and in other countries. Its introduction into England and Wales was a central part of the government's drawn out reform of the Mental Health Act 1983<sup>2</sup>, and it attracted heated debate as part of the Parliamentary process<sup>3</sup>, both in the exchanges between Parliamentarians and the evidence and briefings filed by interested parties. A CTO provision was introduced with a speedier gestation period in Scotland. But there is no single form of "community treatment order"; and there may also be different policy objectives. What is usually central is the desire to provide a regime for patients who are assessed as being able to function in the community so long as they accept medication but who may disengage from treatment and relapse to the extent that they require in-patient treatment: the description "revolving door" is often attached to such patients and was during the course of the debates<sup>4</sup>.

The first question to be explored is whether what emerged in the Mental Health Act 2007 is much different from what already exists in relation to such patients: if it is and it allows community treatment which was previously not available, the further question is whether that is a good thing in light of the experience of other jurisdictions that have CTO regimes. If it is not, there are two further questions: firstly, why has something called a CTO been introduced if it does not amount to a change of substance; and secondly, is it a missed opportunity in light of the information from other jurisdictions – in other words, would a substantive change provide benefits which England and Wales is now missing?

## A. The New English Law: What Difference Will it Make?

### (i) The Current Law

Until the relevant portions of the Mental Health Act 2007 are brought into effect<sup>5</sup>, the existing provisions in the Mental Health Act 1983 will govern. The courts have interpreted the language of the 1983 Act to allow a patient to live in the community but be subject to compulsory treatment (albeit that if force has to be used, that can occur only in a hospital setting). The extent of the shift towards treatment

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<sup>2</sup> *There was an expert committee which reported in November 1999, a Green Paper in November 1999, a White Paper in December 2000, a Draft Bill in 2002 and a further Draft Bill of 2004, both of which proposed a replacement Mental Health Act and finally a Bill introduced in 2006 to modify the 1983 Act but in a number of significant respects, which became the Mental Health Act 2007.*

<sup>3</sup> *Although there was no real opposition to the introduction*

*of something to be called a CTO, there was a significant difference of views on some of the details of the scheme. Some of this is discussed below.*

<sup>4</sup> *At the risk breaching the obvious requirement that patients should be treated on an individual basis, the use of the "revolving door" motif is accepted as a way of describing a feature which is common to some patients.*

<sup>5</sup> *The changes are apparently due to come into force around October 2008: see the Regulatory Impact Assessment of June 2007, Department of Health.*

with a community basis is made plain by figures as to the number of available beds: a Joint Committee of both Houses of Parliament<sup>6</sup> on mental health law reform noted that there were 154,000 psychiatric beds in 1954, but only 33,000 by 2005.

The civil provisions of the Mental Health Act 1983 authorise detention for assessment and treatment, under sections 2 and 3 respectively; both provide for a patient to be “admitted to hospital and detained there”. However, the power to detain does not mean that there has always to be detention. The Act sometimes uses the phrase “liable to be detained”: perhaps most importantly, powers relating to the imposition of treatment (in Part IV of the Act) arise in relation to those who are “liable to be detained”<sup>7</sup>.

At first sight, the phrase “liable to be detained” is explicable by the existence of the power to grant leave of absence under section 17: however, the power to grant leave of absence applies to a person who is “liable to be detained” and so the granting of leave of absence cannot produce that status<sup>8</sup>. The important point for present purposes is that the treating clinician may allow the patient to be in the community whilst still liable to detention and treatment under the Act. Indeed, the government position is that the granting of leave can be part of the treatment programme: the Code of Practice issued under s118 of the 1983 Act<sup>9</sup> states in paragraph 20.1 that it can be an important part of the treatment plan.

Given that the aim of detention for treatment under the Act must usually be the rehabilitation of the patient and hence their return to liberty, which may entail an element of testing in the community or reintegration, it is sensible to have leave as part of a care plan. Whether leave is treatment is a different question, but one which is important to resolve because in assessing whether liability to detention remains appropriate and necessary (to use the example of a s3 treatment order and its substantive criteria), it has to be for the purposes of treatment. So what amounts to treatment is central to whether liability to detention should remain in place.

The starting point is the language of the statute, under which “medical treatment” is widely defined<sup>10</sup> as including (and so not being limited to) “nursing, and ... care, habilitation and rehabilitation under medical supervision”. The use of leave as a part of the testing of progress is easily categorised as rehabilitation. But what if leave becomes long-term, such that the patient may no longer have a bed assigned? Both sections 2 and 3, plus the provisions for the renewal of the section 3 order in section 20, have as a pre-requisite that the patient’s condition is such that detention in a hospital is required: so the breadth of the definition of what amounts to treatment seems to be qualified by the context that the patient’s condition must be such as to require it on in-patient basis. Extended leave to allow the patient to reside in the community is difficult to square with the need for in-patient treatment to justify the continuation of the section. But there are no specific limits on leave, which can be granted indefinitely<sup>11</sup>, and there is the wide definition of what is treatment.

How this tension has been resolved can be traced through a number of cases, the net effect of which is a judicial endorsement of the view that extended leave is part of a treatment programme and only a very limited amount of in-patient treatment is required, which need not involve any bed being provided at the

6 *Joint Committee on the Mental Health Bill, Session 2004–5, HL Paper 79, HC 95; see ch 5, paras 183ff.*

7 *Though not if that liability arises from various short-term powers; and also not if the patient is a restricted patient granted a conditional discharge. See s56.*

8 *There is also the point that the patient can remain in custody during the leave period, under s17(3), which is*

*not consistent with being other than detained. It is beyond the scope of this article to provide (or determine whether there is) a satisfactory explanation for the statutory language.*

9 *As guidance in relation to the operation of the Act.*

10 *Section 145.*

11 *Section 17(2).*

hospital. The starting point is *R v Hallstrom ex p W*, *R v Gardner ex p L*<sup>12</sup>, in which it was noted that the law did not permit the patient to be detained in order to be released on leave with the status of “liable to detention” and hence subject to treatment even though the patient is in the community: some form of in-patient treatment remains necessary. The next case is *R v Barking, Havering and Brentwood Community Healthcare NHS Trust ex p B*<sup>13</sup>, where a section 3 patient’s detention was renewed at a time when she was allowed to be at home between Thursday and Monday inclusive and to be away from the hospital during the days when she slept in the hospital. She was subject to ongoing monitoring to determine whether she was using illicit drugs. The renewal was challenged on the basis that there was insufficient in-patient treatment: the test for renewal<sup>14</sup> is that medical treatment in hospital “cannot be provided unless he continues to be detained”. The Court of Appeal, in rejecting the challenge, held that the phrase “continues to be detained” should be construed to mean “continues to be liable to be detained” and that the treatment as a whole – including returning from leave and being monitored for drug use – was sufficient to meet the test. It was important, noted the Court, to assess whether or not the treatment plan as a whole required an element of in-patient treatment to ensure its success. If this were the case, then the test for liability to detention would be made out even if the patient spent a considerable part of the time on leave<sup>15</sup>.

More recently, in *R (DR) v Mersey Care NHS Trust*<sup>16</sup> the issue for the Administrative Court was whether it was proper to renew the detention of a patient who lived outside hospital and who returned only for occupational therapy one day a week and to attend the ward round on a different day for monitoring and review by the clinical team. The liability to detention was the only way in which DR would take her prescribed medication, without which there would be a rapid deterioration. The judge held that the renewal was valid, and went further than had the Court of Appeal in the *Barking* case. Wilson J commented that the latter case had involved in-patient treatment, and so it was natural that there would be reference to in-patient treatment: he felt that the requirement was only for there to be treatment at a hospital<sup>17</sup>. On the facts, the judge found that the requirements to attend hospital on two separate days meant that a significant component of treatment plan was provided in hospital and so it was permissible to renew the section and hence subject the patient to treatment without her consent. He also noted that leave of absence may be part of the treatment regime<sup>18</sup>.

Finally, in *R (CS) v MHRT*<sup>19</sup>, the facts before the Tribunal related to a patient on leave with a requirement that she attend ward rounds every four weeks. She had a history of not complying with medication for her diagnosed condition, schizophrenia, leading to a deterioration of her state and

12 [1986] 1 QB 1090.

13 [1999] 1 FLR 106.

14 Section 20(4)(a) and (c).

15 Thorpe LJ described the patient as retaining a “home base” in the hospital despite spending significantly more time away from hospital, and the structure and discipline of having to return to hospital for monitoring to ensure that prescribed medication was taken and illicit drugs were avoided were essential parts of the rehabilitation programme. As it happened, the facts of the case demonstrated that this was so: before the appeal hearing, the patient had moved to permanent leave, ie without any time in hospital to provide the structure, and had relapsed.

16 [2002] Mental Health Law Reports 386.

17 At para 29 he confessed that the “distinction between treatment at hospital and treatment in hospital is too subtle for me” and noted that “When I eat at a restaurant, I eat in a restaurant.” The argument against this as a statement of principle is that the purpose of the civil sections is to secure “admission” to hospital for assessment or treatment, which connotes treatment as an in-patient rather than treatment at a hospital as an out-patient. The analogy should perhaps have been between a restaurant in a hotel which is available to residents only and one which, although at a hotel, is open also to non-residents.

18 At para 30 the judge stated “There is no doubt ... that the proposed leave of absence for the claimant is properly regarded as part of her treatment plan.” He relied expressly on the Code of Practice.

19 [2004] Mental Health Law Reports 355.

readmission to hospital. At the ward rounds, there was discussion of her progress, whether changes in medication were required, and what was described as motivational interviewing to assist in her move to out-patient treatment; she received anti-psychotic medication by injection in hospital because she did not wish to receive it at home and had sessions with the ward psychologist. The Tribunal upheld the section on the basis that her poor insight and history of non-compliance with medication and disengagement with services meant that she would probably refuse medication and deteriorate rapidly if taken off section, so the nature of the illness justified detention.

Five weeks later, her care was transferred to a community psychiatrist and the section was lifted approximately 6 weeks after that. A challenge to the Tribunal decision failed on the basis that there was a significant element of treatment at hospital as part of a transition towards discharge, which was designed to break the historical cycle of relapse and readmission. Although Pitchford J rejected a submission that “the mere existence of the hospital and its capacity to be treated by the patient as a refuge and stability is part of the treatment of the patient at that hospital”, he noted that the treating psychiatrist was planning a staged discharge designed to break the cycle of admission, serious relapse and readmission. He concluded:

*“46. ... It may be that in the closing stages of the treatment in hospital her grasp on the claimant was gossamer thin, but to view that grasp as insignificant is, in my view, to misunderstand the evidence. ...”*

So extended leave of absence is legally acceptable as part of the process of treatment, allowing patients to be treated at hospital even if they are not in-patients: at the outer limits, liability to detention is liability to be recalled from leave so long as there remains a process of moving the patient towards the community (which may be extended).

Once released from liability to detention under section 3 of the Act, a patient has a right to aftercare under s117 of the Act: this is phrased as a duty on the relevant social service and health authorities to provide aftercare<sup>20</sup>. Onto this is grafted the Care Programme Approach process, based in Department of Health guidance to health and social services, which is designed to ensure that there is easy access to care, and provides for a level of intensity in care planning which is suitable for the needs of the patient and so designed to ensure there is ongoing service provision but also monitoring and persuasion where there is limited co-operation<sup>21</sup>.

In addition, there is the power to make the patient subject to an order for aftercare under supervision, under ss25A of the 1983 Act, introduced by the Mental Health (Patients in the Community) Act 1995 as from 1 April 1996. This was designed for patients who do not exercise their right to aftercare services because they do not accept its need (or may be insufficiently organised to co-operate fully). The patient must be 16 or over and liable to detention under section 3 of the 1983 Act when the order is made<sup>22</sup>; it must be determined (but only in the loose sense that the opinion must be formed by the treating

20 There are also general duties as to comprehensive health service and community care provision in various other statutes. The duty also expressly applies to those who have been detained under ss37, 45A, 47 or 48.

21 At the same time as the Mental Health Bill 2006 was passing through its early Parliamentary stages, there was an ongoing consultation on proposals for a modification of the CPA, which was introduced in 1990 and was last revised in 1999: see *Reviewing the Care Programme Approach 2006: a consultation document*, Department of

Health, November 2006. The consultation process ended in February 2007. It does not seem to feature in the Parliamentary debates on the CTO.

22 And so be mentally disordered; this is an express pre-condition to a supervision application – s25A(4)(a). A patient who has been detained under a s.37 hospital order is treated as if detained under s3 for this purpose. See s40(4) of the 1983 Act read with sch.1 part 1, particularly paras 1,2 and 8A.

psychiatrist) that the failure to accept aftercare services would lead to a “substantial risk of serious harm to the health or safety of the patient or the safety of other persons or of the patient being seriously exploited” and the use of the order is “likely to help to secure that he receives the aftercare services”<sup>23</sup>. A risk which is more than remote of the patient relapsing so that the degree of their illness necessitates in-patient treatment would meet the test<sup>24</sup>.

The patient on an aftercare under supervision order may be required to reside at a particular place (such as a hostel or similar setting), to attend for treatment, occupation, education or training (and be taken and conveyed there), and to grant access to medical and social care professionals<sup>25</sup>. The statute sets out a process for the making of an application, and its review<sup>26</sup>: these arrangements, which include a consultation process, are comparable to what is required by the CPA process<sup>27</sup>. A failure by the patient to co-operate means that there should be consideration of whether to assess him or her for a return to liability to detention through the making of a further order for detention<sup>28</sup>. Naturally, this may also apply if the patient co-operates fully but deteriorates.

So the 1983 Act provides for a regime of liability to detention whilst residing in the community on leave (from which recall is a simple matter of a written order of revocation if that is felt “necessary ... in the interests of the patient’s health or safety or for the protection of other persons”<sup>29</sup>), and for ongoing monitoring on release from liability to detention. There is no power to require acceptance of treatment in a community setting: but a patient on s17 leave can be recalled, and in relation to a person receiving aftercare under supervision there is persuasion and the threat of a review which might lead to detention<sup>30</sup>.

## (ii) The New Regime

The Mental Health Act 2007 introduces a Community Treatment Order regime by the addition of ss17A–G to the 1983 Act<sup>31</sup>. At the same time, the aftercare under supervision regime is removed<sup>32</sup>. In addition, s17 is amended by requiring that consideration be given to the use of a CTO instead of using leave which is longer than 7 days<sup>33</sup>. The essential components of the CTO regime are:

- (a) *Preconditions, Criteria and Effect*: A CTO can only be put in place in relation to a patient who is liable to be detained under an application for admission for treatment<sup>34</sup>: it cannot be imposed

23 s25A(4)(b) and (c).

24 See Jones, *Mental Health Act Manual*, (Sweet and Maxwell) 10th ed, para 1–291.

25 s25D; these are similar to the provisions applicable under a guardianship application (see s8 of the Act), with the addition of the power to convey the patient to the place of treatment etc. It is similar to guardianship, but led by health services rather than social services (though the development of partnership trusts in relation to mental health matters meant that there was supposed to be integration between health and social services).

26 Ss25B and E. There are also provisions relating to the renewal of the order, and its ending – ss25G and H; the patient may appeal to the Mental Health Review Tribunal – ss66 and 72(4A).

27 Given the target group, it is almost inevitable that those subject to aftercare under supervision would be subject to more intensive levels of the CPA process; there is an obvious need in all cases to ensure that the relevant services in the community are in place.

28 s25E(2) and (4).

29 s17(4).

30 The initial research suggested that the powers of s25Aff were of assistance where used: see the articles cited by Jones at para 1-329 of the *Mental Health Act Manual*, 10th ed.

31 By s32(2) of the 2007 Act.

32 By s36 of the 2007 Act, which also provides for the right to apply to a Mental Health Review Tribunal by a CTO patient.

33 Section 33 of the 2007 Act, adding s17(2A) and (2B) to the 1983 Act.

34 See ss17A(1) and (2); s40(4) provides that a hospital order under s37 has the effect of an application for admission for treatment, subject to amendments in Schedule 1 to the 1983 Act: the Schedule as amended provides for the application of the CTO regime to a hospital order patient, but not to a patient whose hospital order was combined with a restriction order.

without a period of in-patient treatment (and so mirrors aftercare under supervision in this regard), and is therefore not available in relation to voluntary in-patients or voluntary patients who seem to be disengaging but have not yet reached the stage when their condition justifies in-patient treatment<sup>35</sup>.

The criteria for the use of a CTO are that there be a mental disorder requiring treatment for the protection of the patient or others (and that appropriate treatment be available<sup>36</sup>), but that “such treatment can be provided without his continuing to be *detained* in a hospital” though with the additional point that it is necessary that the power of recall to hospital be available<sup>37</sup>. In assessing whether the latter test is met, the “responsible clinician”<sup>38</sup> must consider the risk of deterioration in the absence of detention in hospital<sup>39</sup>.

The making of a CTO means that the patient is discharged from hospital but is made liable to recall<sup>40</sup>; in addition, conditions can be imposed, provided they are “necessary or appropriate” to ensure that the patient receives treatment or to prevent risk to the patient or protect others<sup>41</sup>.

One of the conditions will invariably be that the patient accept treatment: but there is no way to enforce any condition, ie compulsion will not be available<sup>42</sup>. At the Committee Stage in the House of Commons, the Minister of State said<sup>43</sup>:

*“The way that a community treatment order would work is as follows. The individual would need to accept the conditions on which the CTO was being given and be given a written copy of those. The conditions would have to be agreed by an approved mental health professional, because if an individual did not accept the conditions of the CTO, it would not work so there would be no point giving it in the first place. This is not about saying, “This is what you are going to do”, with the person sitting there saying, “I don’t accept any of that”, because a CTO will not be given if the individual does not accept the conditions.”*

35 At the Second Reading in the House of Commons, the Secretary of State for Health, Ms Hewitt, noting that the proposals envisaged CTOs being available in more limited situations than in Scotland or than had been proposed under the 2004 Draft Bill, stated “under the Bill, supervised community treatment will not be available to a patient who is already being treated in the community or who is a voluntary in-patient”. This was said to be a change which responded to objections made plain in the process of consultation relating to the 2004 proposals. See Hansard 16 April 2007, Vol 459 at col 57. As noted below in the article (part B (ii) (b)), a patient whose condition is liable to relapse may be detained prior to relapse on the basis of the nature of the illness.

36 A new requirement in relation to detention for treatment (inserted into s3 of the 1983 Act by s4(2) of the 2007 Act); but, note, not a pre-requisite for the use of guardianship.

37 Section 17A(5).

38 The replacement for the Responsible Medical Officer, the change in terminology necessitated by the extension of the lead clinical role to those who are not medically qualified: see s9(10) of the 2007 Act; see also paras 47 and 48 of the Explanatory Notes to the 2007 Act, which notes that approved clinicians may be from various professions,

namely medical, nursing, psychology, occupational therapy and social work.

39 Section 17A(6).

40 Section 17A(1). Section 17D(1) is expressed that the application for admission for treatment does not cease to have effect, but s17D(2) provides that the authority to detain under s6 is suspended and so the patient is not liable to detention at that time. There are detailed provisions relating to the duration and renewal of the order; it can be discharged under s23 (by the RC, hospital managers or nearest relative, the latter being subject to a barring certificate by the RC) or through an application to the Mental Health Review Tribunal.

41 Section 17B(2). The conditions can be modified or suspended: ss17B(4) and (5).

42 See Part 4A, which is inserted into the 1983 Act to deal with treatment in the community. Its effect is summarised in the Explanatory Notes issued with the 2007 Act: ‘129. ... Community patients aged 16 or over with capacity to consent to treatment can only be treated in the community if they do consent to their treatment.’ There are also equivalent provisions for children who are competent; but different rules apply to those without capacity.

43 Rosie Winterton MP, 10 May 2007, Hansard Public Bill Committee Session 2006–7 Cols 305–358 at col 334.



So the requirement that the treatment be possible without detention – the substantive test – means that the criteria for a CTO are fairly strict: the RC must form a view that the patient will accept treatment in the community. In turn, this means that the CTO is as much dependent on the co-operation of the patient as is aftercare under supervision if the key component for successful maintenance in the community is medication.

- (b) *Putting a CTO in Place*: there is no application process; instead an order for a CTO may be made by the RC. Before making such an order, there must be consultation with, and agreement by, an Approved Mental Health Professional<sup>44</sup>. The process may appear more streamlined than the requirements in relation to aftercare under supervision, but since this all takes place in the context of the CPA and the need for adequate community-based services to be in place, this is hardly a difference which is fundamental<sup>45</sup>. There may be an assumption that the RC will be the same, whereas aftercare under supervision may well have set a requirement for extensive consultation on the basis of an assumption that there would be a different Responsible Medical Officer in the community: the process is, naturally, much easier if there is in fact only one clinician involved. It should be noted that since the government wishes CTOs to be considered instead of leave lasting more than 7 days, and the process of ordering s17 leave is simpler still than the CTO process, the bureaucratic burden of operating the new regime may be greater overall if patients currently on s17 leave are moved to CTOs.
- (c) *Recall*: although breach of a condition is a relevant factor in determining whether to recall<sup>46</sup>, it does not automatically lead to recall. The criteria for recall are that the patient “requires medical treatment in hospital for his mental disorder” and a failure to recall would present “a risk of harm to the health or safety of the patient or to other persons”<sup>47</sup>. This may be met even if there is no breach of condition<sup>48</sup>. It is also stated in section 17E(2) that “the responsible clinician may also recall a community patient to hospital if the patient fails to comply with a condition...”<sup>49</sup>.

The important point is that there is a power of recall, not a duty. Since its effect is that, at least if accompanied by a revocation of the CTO under s17F, the patient returns to the status of a patient under section 3 of the Act, the recall power can be used properly only if the patient meets the test under that section. Again, to quote the Minister of State in Committee<sup>50</sup>:

*“I should also say... that if an individual did not stick to the conditions, it would not automatically mean that they would be recalled to hospital. It is up to the clinician to decide whether it is appropriate – whether it is because the person has become a risk to themselves or others – for them, at that point, to be recalled to hospital.”*

44 Section 17A(4). The AMHP is the replacement for the Approved Social Worker, reflecting the fact that professionals from other roles may now perform this other role: see ss18–21 of and Schedule 2 to the 2007 Act, which sets out the various amendments to the 1983 Act. Paragraph 64 of the Explanatory Notes to the 2007 Act notes that “a wider group of professionals, such as nurses, occupational therapists and chartered psychologists will be able to carry out the ASW’s functions as long as individuals have the right skills, experience and training, and are approved by an LSSA to do so.” It is also suggested that, whilst they may be NHS employees, their skills and training will ensure that they bring an “independent social perspective”.

45 And if the application process relating to aftercare under supervision was the problem, that could have been amended.

46 Section 17B(6).

47 Section 17E(1).

48 And s17B(7) is clear about this. See also s17E(4) which allows a recall even if the patient is in hospital at the time, as a voluntary patient.

49 There is also a process for revoking the CTO, which requires the written approval of an AMHP: see ss17F and G.

50 See note 43 above.

This in turn ought to mean that the only difference between a CTO and the supervised discharge provisions in terms of returning the patient to hospital is that the latter requires a formal resectioning process before the patient is returned to detention, ie a formal assessment with medical and social work support in favour of detention: but this is consistent with the requirements of ethical good practice, which discourages unilateral decision-making, and should not pose a difficulty if the CPA process is working properly in relation to the patient<sup>51</sup>. Equally importantly, if the recall is to a mental health unit which is operating at full capacity, the need to find a bed for a recalled patient will be of as much significance as filling out the relevant form.

So, the CTO does not represent a major change from the existing powers to make creative use of s17 leave (which will remain but be discouraged in relation to leave of more than 7 days) and the aftercare under supervision powers (which will disappear). It is a shuffling around of the deck of powers rather than the addition of new ones.

## B. The Route Taken to the New Position and the Policy Position

If this is right and there is no real change, one question which arises is why did the government make it such a priority to introduce something which it could describe as a new form of order requiring treatment in the community? Assuming a rational explanation exists, one possibility is that there was simply a momentum towards reform involving the introduction of a CTO, and that in the process of compromise that was involved in the formulation of the policy, no-one took the opportunity to stand back and realise that there was in fact no significant reform. At the less charitable end of the same continuum, the explanation is that there was too great a political momentum towards asserting that there was major change even though the reality was one of semantics.

### (i) The Momentum Towards a CTO Regime

It is certainly the case that the introduction of some form of CTO has featured throughout the extended reform process.

#### (a) The Expert Committee and the Initial Proposals

The Expert Committee<sup>52</sup> proposed a new structure to compulsory orders, requiring authorisation by a Tribunal for anything beyond short-term assessment and more restrictive grounds for the use of compulsion, particularly for those with capacity<sup>53</sup>. But it would be possible for the treatment order to be on an in-patient or community treatment basis, with conditions set out in the order (referring to the obligations of both the patient and the care team). Non-compliance by the patient together with

51 Note that if the RC is not a doctor and acts alone in a situation which is not an emergency, there is an obvious ground for a challenge raising Article 5 of the European Convention and the Winterwerp criteria (see *Winterwerp v Netherlands* (1979–80) 2 EHRR 387) requiring “objective medical expertise” before detention can be “lawful” for the purposes of Article 5(1)(e).

52 The Report of the Expert Committee headed by Professor Geneva Richardson, “Review of the Mental Health Act 1983”; Department of Health, November 1999.

53 The cumulative criteria for compulsion (see para 5.95 of the Report) were to be (i) “... mental disorder ... of such seriousness that the patient requires care and treatment

under the supervision of specialist mental health services”; (ii) the treatment be the least restrictive option; (iii) it be in the patient’s best interests; (iv) (a) for those without capacity, the treatment be necessary for the patient’s health or safety or to protect the patient from serious exploitation, or to protect others from serious harm; and (b) for those with capacity (which the Committee believed would largely be those with personality disorders – see para 5.100), there be a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if s/he remains untreated, together with the availability of positive clinical measures likely to prevent a deterioration or secure an improvement in the patient’s mental condition.



deterioration in health would lead to detention. As to the location of treatment, the Committee indicated that force could only be used to administer medication in a hospital “until safe and adequately staffed non-hospital settings are available”<sup>54</sup>. The Committee did express the view that a community order would not be appropriate in the absence of “a history of failure to accept the proposed care and treatment” to demonstrate the necessity of an order<sup>55</sup>.

The Green Paper issued by the Government following the Expert Committee Report accepted the recommendation relating to the new Tribunal and the power to make CTOs<sup>56</sup>, as did a White Paper issued after consultation on the Green Paper<sup>57</sup>. The Government eventually produced a Draft Bill in 2002<sup>58</sup>, which was designed to replace the Mental Health Act 1983. Its structure for the use of compulsion in the civil context was that an examination would be carried out when requested<sup>59</sup>, which could lead to an assessment section being imposed, on an in-patient or out-patient basis<sup>60</sup>. The main function of the assessment process was the formulation of a care plan on the basis of which an application would be made to the Mental Health Tribunal for a treatment order<sup>61</sup>: this could be as a resident or non-resident patient.

(b) The 2004 Draft Bill

There was a similar structure proposed in the further Draft Bill of 2004<sup>62</sup>, which was subject to pre-legislative scrutiny by a Committee of both Houses of Parliament<sup>63</sup>. The latter examined the issue of CTOs in some depth<sup>64</sup>, having set the context as the move towards treatment in the community. The Mental Health Act Commission gave evidence that of the 13,500 patients detained under the Mental Health Act 1983 at any one time, a relatively significant proportion were in the community under the leave of absence powers of s17 of the Act. The Commission also noted that the proposals in the Draft Bill for non-resident patients (who could be required to attend at specified places, reside, be available for assessment and not engage in specified conduct) was closely approximate to the use of detention and leave and so the effect was to consolidate and clarify the existing legal regime.

Other evidence to the Joint Committee made it clear that there were significantly different views as to the principle behind and efficacy of CTOs. Its conclusion<sup>65</sup> was that the framework suggested in the Draft Bill was too wide: “non-residential compulsion could be applied to a far wider population than is appropriate, and in circumstances which could be unacceptable”. Amendments were therefore recommended to provide a more focussed power: CTOs would normally require previous hospitalisation (albeit only for assessment) and evidence of responsiveness to and co-operation with treatment; and there would be limitations, namely the only permissible conditions would be residence and treatment, force would be permissible only in hospital settings, and there would be time limits, with a maximum of three years on an order in any five.

54 Ch 1, Introduction, paras 21–22; more details are set out at paras 5.105ff.

55 Para 5.104.

56 *Reform of the Mental Health Act 1983: Proposals for Consultation*, November 1999, Cm 4480; see in particular ch 6, paras 10ff.

57 *Reforming the Mental Health Act*, December 2000, Cm 5016 (which was in two parts, one setting out *The New Legal Framework and the other dealing with High Risk Patients*); see in particular ch 3 of Part I.

58 June 2002, Cm 5538.

59 Clause 9ff.

60 Clause 17ff.

61 Under cl 30ff; see in particular cl 38.

62 Cm 6305; see in particular cl 38ff.

63 *Joint Committee on the Mental Health Bill, Session 2004–5*, HL Paper 79, HC 95.

64 Ch 5, paras 183ff. The figures for bed numbers quoted are reported at para 184.

65 Para 197.

The Joint Committee also expressed concern that the CTO regime would be used to manage limited in-patient resources (by discharging people because of bed shortages), and so emphasised the importance of having a significant increase in resources, to be achieved by imposing a duty on health and local authorities to provide adequate care.

(c) Scotland

The Draft Bill of 2004 went no further. In the meantime, the Scottish Parliament had instituted a process of reform of its own legislation. An expert report led to a Bill and then an Act which passed in 2003. The Millan Committee<sup>66</sup> had a number of proposals for reform. One was that the criteria for long-term compulsion involve not only a mental disorder of a nature or degree making treatment appropriate and that it be necessary for the health or safety of the patient or the protection of others (which should be expressed as a significant risk of harm to the health, safety or welfare of the patient, or a significant risk of harm to others), but also that the patient suffer from impaired judgment to the extent that compulsory treatment was appropriate and that the treatment be likely to provide a therapeutic benefit (in alleviating or preventing a deterioration of the patient's condition or symptoms). It further suggested that if the criteria for compulsion were made out, the location of treatment should be either on an in-patient or community basis, depending on what was the least restrictive alternative (but with the proviso that there could be no forced medication in the community, and a Code of Practice should specify treatments that should only be given on an in-patient basis). The Committee also recommended that the decision as to this be made by a Mental Health Tribunal, which would have to sanction compulsion on the basis of a care plan.

The Mental Health (Care and Treatment) (Scotland) Act 2003<sup>67</sup> largely adopted the recommendations of the Millan Committee. The structure it provides is for administratively imposed emergency and short-term detention, but any longer term compulsion must be on the basis of a Compulsory Treatment Order made by the Mental Health Tribunal for Scotland<sup>68</sup>. It provides for community treatment. The criteria for compulsion are set out in s64(5):

- “(a) that the patient has a mental disorder;
- (b) that medical treatment which would be likely to—
  - (i) prevent the mental disorder worsening; or
  - (ii) alleviate any of the symptoms, or effects, of the disorder, is available for the patient;
- (c) that if the patient were not provided with such medical treatment there would be a significant risk—
  - (i) to the health, safety or welfare of the patient; or
  - (ii) to the safety of any other person;
- (d) that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired;
- (e) that the making of a compulsory treatment order in respect of the patient is necessary; and
- (f) where the Tribunal does not consider it necessary for the patient to be detained in hospital, such other conditions as may be specified in regulations.”

66 *New Directions: Report on the Review of the Mental Health Act (Scotland) 1984, January 2001, SE/2001/56; see in particular ch 5, Compulsory Treatment, which deals with the criteria for the use of compulsion, and ch 6,*

*Compulsory Interventions, which deals with the range of interventions.*

67 *In effect from 5 October 2005.*

68 *Under ss57 ff of the Act.*

The measures that may be specified in a Compulsory Treatment Order are set out in s66 of the Act: they include treatment, detention or attendance for treatment or to receive community care services, residence (and also having to seek permission to change address, or to inform the official coordinating the treatment plan of a change of address), and allowing visits by doctors or community care service providers. So the Tribunal has a clear option to determine that anyone who is in need of ongoing treatment can be made the subject of a non-resident order, which seems to have become known as the Community Based Compulsory Treatment Order<sup>69</sup>.

## (ii) The Mental Health Act 2007: The Policy Objectives

### (a) The Bill in the House of Lords

The Mental Health Bill 2006 was introduced into the House of Lords. It was no longer intended as a replacement for the 1983 Act, but rather contained amendments to various key sections. The introduction of the CTO remained central. On the Second Reading, the then Minister of State, Lord Warner, outlined the proposals in the following terms<sup>70</sup>:

*“Supervised community treatment is probably the key change in the Bill ... It is important not just from a patient and public safety angle but because clinical practice itself has changed. At present, most patients treated under the Mental Health Act are detained in hospital. That reflects the fact that, in 1983, most acute mental health services were provided in hospital. However the world has moved on and we now have a wide range of community-based mental health services....”*

These, he noted, were suitable for the needs of some patients, as was the practice in various other countries. The group to be targeted were patients who...

*“... stop taking their medication or treatment once they leave hospital, and so relapse and end up being readmitted. This detrimental cycle is often referred to as the revolving door. Patients on supervised community treatment will benefit from a structure designed to promote safe community living. This will reduce the risk of relapse and re-detention...”*

But there would be the power of recall in case of deterioration, which would be the only situation in which treatment could be forced. As for numbers<sup>71</sup>, he gave the government estimate as rising “to the order of 3,000 to 4,000 per year over a five-year period”<sup>72</sup>.

69 Also involved in a process of reform which overlapped with the English process was the Irish Parliament. It passed a new Act, the Mental Health Act 2001, but did not find it necessary to include community treatment orders to supplement the powers of admission and leave of absence on conditions under ss14 and 26 of the Act.

70 28 November 2006, Hansard Vol 687 Cols 656ff.

71 Col 730.

72 See also the initial Regulatory Impact Assessment (Department of Health, November 2006). It stated that the procedures for managing patients in the community (which it described as guardianship and supervised aftercare: it did not mention the use of leave) “19. ... are limited in terms of providing an effective way for clinicians to treat a patient in the community both in terms of ensuring compliance with treatment and acting quickly when problems occur...” The introduction of the CTO would have three benefits (see para 49), namely it would

“enhance patient and public safety” by enabling swift recall if patient’s mental health “deteriorated to the point that they pose a risk to themselves or others”, provided the community treatment in lieu of detention, minimizing the disruption to patients’ lives and allowing early intervention for ‘revolving door’ patients, and supported the modern community-based provision of mental health services; and there were no real risks (para 50) as the criteria for the use of a CTO and the safeguards in place would prevent the “unjustified extension of the use of compulsion”. An alternative option of encouraging the use of supervised aftercare could not provide the benefits (see para 117) and so there remained the risk that it would not be used; nor would that address the administrative burden of supervised discharge (and the RIA did not contain any suggestions for making the administrative burden less cumbersome). It calculated the cost implications on the basis of 10% of people placed on a s3 detention order would be placed on a CTO.

The House of Lords amended the government's proposals<sup>73</sup> by adding a requirement that the patient have significantly impaired ability to make decisions about treatment by virtue of his or her mental disorder<sup>74</sup>, limiting the CTO to the protection of others, and requiring that the patient had a previous history of refusing treatment leading to relapse which was remedied on further compulsory treatment<sup>75</sup>.

(b) Action in the House of Commons

The government's response to the Lords' action (and some other changes they made) was made plain outside Parliament. The lead Minister on the Bill in the House of Commons, Rosie Winterton MP<sup>76</sup>, on 1 March 2007 noted the need for intervention because of risks posed:

*"6. These risks are real. Every year over 1,300 people in contact with mental health services take their own lives. Every year mental health patients commit around 50 homicides. Often these are preceded by a reluctance to take treatment that would have kept them well. This number is higher than of homicides (46) by shooting last year."*<sup>77</sup>

The changes introduced by the Lords were roundly criticised as producing the risk "either that patients have to stay longer in hospital, or be discharged without proper supervision. The result again may be that they become a danger to themselves and others". She indicated that they had to be overturned.

And overturned they duly were in the Public Bill Committee<sup>78</sup>. Ms Winterton set out government policy in more detail<sup>79</sup>. She noted that the CTO regime was well-established in other jurisdictions and was "a measure to enable patients to receive treatment under formal supervision without always having to be in a hospital setting, which is not necessarily the best place for an individual to make a recovery ... CTOs are seen as the modern workable way to manage mental disorder in a community setting<sup>80</sup>". In relation to the target group, namely 'revolving door patients', the aim was to avoid having to wait until they deteriorated to the extent that they needed to be in hospital: the aftercare under supervision provisions were deficient because it was necessary to allow people to deteriorate to the level when they were sectionable before they could be taken back into hospital<sup>81</sup>.

This does not hold water as a matter of law. Detention under the provisions of the Mental Health Act 1983 turns on the nature or degree of the disorder: so a person who suffers from a relapsing illness and who is relapsing or engaging in conduct which the clinical team can say will lead to relapse can be detained on the basis of the nature of the illness without any need for the degree of the illness to become acute. The additional requirement for detention under section 3 of the Act, namely that it be necessary

73 Which were in round terms similar to those as passed.

74 This reflected changes made by the Lords in relation to all instances of civil compulsion (and did not apply in criminal proceedings); it was overturned in the Commons.

75 See the Report stage, 26 February 2007: Hansard Vol 689 Cols 1406–1418; 1427–28.

76 Minister of State at the Department of Health; the speech was to the conference of the Local Government Association and is available at: [http://www.dh.gov.uk/en/News/Speeches/DH\\_072442](http://www.dh.gov.uk/en/News/Speeches/DH_072442).

77 See also the Secretary of State, Patricia Hewitt MP, who at the Second Reading stage in the House of Commons (Hansard 16 April 2007, Vol 459 Cols 52–132, particularly from col 56); she noted that the CTO provisions would help with revolving door patients, whose pattern "features all too often when someone who has

been in contact with mental health services takes their own life—some 1,300 people a year. The same is also true in many of the far smaller number of cases—about 50 a year—when someone else dies at the hands of a mental health patient. We will probably never be able to prevent every such death, but supervised community treatment is essential to help ensure that patients who have been discharged from hospital continue with their treatment in the community, helping to keep them well and thereby helping to protect them, their families and the wider public."

78 10 May 2007; Hansard Public Bill Committee Session 2006–7 Cols 305–358.

79 Starting at col 329.

80 Cols 330–331.

81 Col 333.

for the health or safety of the patient or the protection of others, is also met by conduct (such as failure to take medication) which will lead to a deterioration in the degree of the illness. If there is a problem in practice because the law is not understood or used properly, that is a different matter, but presumably the first line of response to that should be training on the existing law.

Ms Winterton next prayed in aid the report of the inquiry into the homicide committed by John Barrett, noting that it had said:

*“In our view, the only means of securing John Barrett’s compliance with treatment as an out-patient would have been a community treatment order, which is not available under the Mental Health Act.”*<sup>82</sup>

It is worth putting this comment in context. To explain, the inquiry<sup>83</sup> was into the killing by Mr Barrett of a cyclist in a London park; Mr Barrett suffered from schizophrenia. Prior to the homicide, he had been convicted of serious assaults and made the subject of a hospital order with a restriction order (ss37 and 41 Mental Health Act 1983); he had been granted a conditional discharge by a Mental Health Review Tribunal in October 2003, and his life was subject to conditions, including the standard one that he comply with medication. During the period of his conditional discharge, he had a short informal admission in May 2004 because of his concerns that he was hearing voices. The suggestion of a recurrence of symptoms led to a further informal admission on 1 September 2004 to a medium secure unit: his psychiatrist could not see him that day, and he was allowed to leave the hospital but told that he was expected back after an hour. He did not return, and stayed overnight with a friend; responding to auditory hallucinations, he committed the homicide on 2 September. The Inquiry team found various deficiencies which played a part in the homicide, including the failure to detain Mr Barrett formally on 1 September and the decision to give him permission to leave the ward.

The comment referred to by Ms Winterton as to the need for a CTO to secure the taking of treatment by Mr Barrett relates to the Inquiry team’s review of Mr Barrett’s care and treatment in the period to January 2002<sup>84</sup>, which was before the assaults which led to the imposition of the hospital and restriction orders. At the time of the homicide, he was a conditionally discharged restricted patient, and so he was subject to a regime involving conditions of the sort that will be available under the CTO regime. (Moreover, he could not be made the subject of a CTO as a restricted patient.) It was the failure of the team involved with the care and treatment of Mr Barrett to make use of their existing powers, not the absence of a CTO, which was the problem. Indeed, the Inquiry panel specifically stated<sup>85</sup>:

*“6. The remedy for what went wrong in this case lies not in new laws or policy changes. Nor is there any reason to believe that an insufficiency of resources contributed in any way to the shortcomings we have found. The challenge, both organisational and individual, is to ensure that the care of potentially dangerous psychiatric patients is based on sound clinical practice and the systematic application of established principles of risk and organisational management. ...”*

So, when the Minister emphasised the importance of the “recommendation” of the John Barrett inquiry, there was no recommendation<sup>86</sup>; and Mr Barrett was subject to a regime which the CTO provisions will

<sup>82</sup> Col 334.

<sup>83</sup> *Report of the Independent Inquiry into the Care and Treatment of John Barrett, November 2006, NHS London; commissioned by South West London Strategic Health Authority.*

<sup>84</sup> It can be found at p212 of the Report.

<sup>85</sup> See p9, in the chapter summarising its findings and recommendations.

<sup>86</sup> *The most that can be said is that had Mr Barrett been made the subject of a CTO in the period to January 2002, this might have secured his compliance with medication and so have assisted with his management in the period before the assaults which led to the imposition of hospital and restriction orders: but that is a long way from the implicit suggestion of the Minister that the Panel recommended the introduction of a CTO regime.*

emulate for non-restricted patients.

Moving next to the potential for preventing self harm<sup>87</sup>, the Minister noted that the report of a national inquiry<sup>88</sup> indicated that there were “1,300 suicides a year ... carried out by people who have been in touch with mental health services” and that “56 people in the last year had committed suicide following non-compliance with medication or loss of contact with services” and so that was the potential.

Again, it is worth reviewing the primary source. It involved a survey of 6367 suicides between January 2000 and December 2004 by people who were at the time or had been recently been in contact with mental health services: so the average number is some 1300 per year (and it represents some 27% of all suicides). Clinicians felt that 19% of suicides were preventable<sup>89</sup>: however, the percentages vary according to the status of the patient (and the inquiry commented that its calculations were necessarily somewhat crude). So, of the suicides by in-patients (including those released on leave), some 41% were felt to be preventable. There were also those who committed suicide between discharge and their first follow-up, of which 22% were felt to be preventable. Of the other “community suicides”, some 12% were felt to be preventable. The report specifically addressed the issue of CTOs in the following terms:

*“We have no reliable way of calculating how many suicides would be prevented by a community treatment order. Our figures do, however, indicate the potential for prevention. Our sample contains 264 patients who had been detained in their final admission and who died following non-compliance with medication or loss of contact with services, 4% of cases or 56 per year. Overall, 14% of patient suicides were preceded by non-compliance.”<sup>90</sup>*

The inquiry investigated the factors behind non-compliance. A significant one was lack of insight (which was thought to be a factor in 48% of the cases). It also reviewed responses from professionals to the problems of non-compliance: they were the use of higher levels of service provision under the CPA system (in 46% of the cases) and face to face attempts to encourage use of medication (in 73% of cases and 83% of the patients in the group who suffered from schizophrenia). On the question of whether suicides by those who were not compliant with medication were preventable, the inquiry reported that 24% of those suicides were classed as preventable, but the tools to be used were better compliance and closer supervision: new legal powers were specified by respondents to the survey only in 4% of cases (34 out of the 813 instances). At the risk of stating the obvious a mental disorder of a nature or degree to cause suicide is one which can be used to detain.

Whether the figure the Minister should have used was 56 cases per year or the 34 cases over 5 years, either figure represents a number of tragedies. But the focus should have been on the success in reducing suicides in non-compliance cases without the availability of the CTO regime<sup>91</sup> to assess the factors involved in this and build upon them. Moreover, there remain more significant problems in relation to

87 Col 336.

88 Taken to be a reference to “Avoidable Deaths: five year report of the National Confidential Inquiry into suicide and homicide by people with mental illness”, University of Manchester, December 2006; available at <http://www.medicine.manchester.ac.uk/suicideprevention/nci/>.

89 See part 3.9 of the report, page 91 and following. Note that the real issue is one of risk assessment (to the extent that this is ever possible): the risk of suicide was assessed as low or absent in 86% of cases. The obvious conclusion

is that it was errors in the risk-assessment process that were important, not the lack of legal powers.

90 Moreover, in the period from 1997–2004, the proportion of suicides preceded by non-compliance had fallen from 22% to 14% (ie 71 fewer deaths per year): see part 3.7 of the Report. This non-compliant group (813 of the total of 6337) included 30% diagnosed with schizophrenia (as opposed to 18% of the overall group), and higher proportions who also had alcohol or drug misuse issues or a secondary diagnosis.

91 Namely 71 fewer deaths per year.



in-patient deaths (856 in the survey period). And the real danger period for those discharged into the community is the first three weeks<sup>92</sup>, which is not the crucial period to which the CTO regime is aimed: Ms Winterton was aiming at the patients who were not in the immediate post-discharge period.

What conclusion can be drawn as to the reason for the introduction of the CTO? The policy objectives mentioned by the government had two themes: one was the structure of modern practice and the other was the need to protect both patients and the public. But modern practice has developed under the 1983 Act without anything termed a CTO among the techniques designed to seek to prevent the revolving door cycle, the need to tackle which is hardly controversial. Moreover, the new regime offers no new legal powers to offer protection to patients or the public. When this is added to the use of figures and quotations by government ministers which are at best misleading and emphasise serious self-harm and danger to the public – matters which tend to grab headlines – it does suggest that this was a political imperative.”

### C. Do CTOs Work?

The further question posed is whether CTOs work in any event, and if so in what form? In “*Community Treatment Orders: International Comparisons*”<sup>93</sup>, Professor John Dawson formed a view that the research as to the efficacy of CTO regimes presented a relatively positive picture<sup>94</sup>. However, he noted that success was more likely when there were well-resourced and co-ordinated systems in operation, which include community visits from clinicians who are committed to the system; and that there were risks, including de-facto detention, overuse in relation to some groups where the efficacy of the CTO was less clear (particularly younger males with concurrent substance abuse problems), and issues about the overuse of CTOs to deal with pressure on beds and inadequate reviews of the ongoing use of CTOs on patients who have been on them for an extended period.

Dawson considered the legal regimes in place in New Zealand, Victoria and New South Wales in Australia, Canada (and in particular Ontario), Switzerland and the British jurisdictions, and also the structure of service provision. His aim was to assess the adequacy of the regime in New Zealand, where a CTO was introduced to the statute book in 1992, but in so doing he provides a detailed analysis of the formats available in the jurisdictions he covered. In particular, he was able to identify what he called “the major fault-lines” in CTO legislation, namely the role of capacity<sup>95</sup> and the extent of the powers given to clinicians to enforce treatment<sup>96</sup>: his conclusions were that capacity should play a role and that there should be no power to enforce treatment outside a clinical setting<sup>97</sup>. As to what was features were required for a successful CTO regime, he suggested that they were powers to control residence, to compel accepting visits from relevant professionals, a duty on the patient to attend out-patient appointments and to accept treatment, though with the proviso as to its enforcement without consent only in a clinical

92 Page 78 of the report. 49% of patients who killed themselves had been in contact with services in the previous week and 19% in the previous 24 hours.

93 May 2005; available at [www.otago.ac.nz/law/otagoCTO/publications/index.html](http://www.otago.ac.nz/law/otagoCTO/publications/index.html).

94 Dawson p4-5, he summarised that they were linked with significant therapeutic benefits, greater compliance with medication (often depot), and reduced hospital admission rates.

95 This is a feature in Ontario, other North American

jurisdictions, and also Switzerland: see pp87–8, 125–7, and 142ff. It is also part of the new Scottish regime – see above.

96 Pages 148ff.

97 Pages 2, 146-8 and 150. On the question of whether there should be a power to compel medication in the community, he notes (at p49) “The line that emerges from study of the statutes, and the law reform debates, as the Rubicon that should not be crossed, is the authorisation of forced medication in community settings” because of concerns about privacy, dignity and security.

setting, and also a swift power of recall with police assistance in the process<sup>98</sup>. This is what the new English regime involves; but also what is available in any event.

Indeed, one of the points which emerges from Dawson's review of the change in New Zealand<sup>99</sup> was that the CTO:

*"did not involve a radical break with past practices... [CTOs] simply replaced the well-established prior practice of granting involuntary patients 'trial leave' from hospital care. That kind of leave had been granted for some years on rather similar conditions to those that would later be imposed on patients under the [CTO] regime."*<sup>100</sup>

In other words, the process of deinstitutionalisation was accomplished without a CTO. The statute in Victoria, the Mental Health Act 1986, was one of the first in the World to provide a CTO regime: no surprise to Dawson because "Victorian psychiatrists have been international leaders in the field of community care"<sup>101</sup>. The period following the introduction of the CTO regime<sup>102</sup> has been marked with a significant reduction in the number of in-patient beds in Victoria<sup>103</sup>. Dawson records<sup>104</sup> that:

*"Many people interviewed considered this rapid reduction in psychiatric beds and the associated shift in resources to the community would not have been possible without the introduction of [CTOs]."*

Of course, the experience in New Zealand was to the contrary: there was deinstitutionalisation before a CTO via the use of leave<sup>105</sup>. In other words, both formal CTOs and detention with the use of leave can achieve the same effect in support of the policy aim of moving psychiatric care into the community so far as possible.

Noting that the particular group targeted by CTOs is "revolving door" patients, the idea, comments Dawson, is to provide sufficient benefits in terms of preventing or reducing the severity of relapse to outweigh the sense of coercion the patients may experience. He notes that this also benefits carers and family, who have less stress from dealing with the illness, as well as reducing the risks of harm<sup>106</sup>. The focus is therefore the benefits to be obtained by patients and others who are potentially affected. A recent

98 See Overview, pp1–3.

99 Through the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992, which creates a presumption in favour of a CTO: an in-patient order may only be made (by a judge) if the patient cannot be treated adequately as an out-patient (section 28(2) of the Act), though it is also provided that there must be a finding that there are appropriate facilities available (section 28(4)).

100 Page 19; he gives further figures at p25, to the effect that there were 1700 CTOs in place on an average day in 2003 (amounting to 1 person in 2350 of a population of 4 million), which was similar to the number of patients on leave in the late 1980s (though there has been a slight population growth in the period). There are, he says at p18, more people under CTOs than involuntarily detained in hospital.

101 Page 31.

102 The statutory regime involves a finding that the patient meets the requirements for involuntary treatment, and also a finding that out-patient care is proper, which reflects a "least restrictive environment" approach (p34). Placement on the regime is controlled by senior psychiatrists, though

any extension of an order is subject to review by the Mental Health Review Board (pp 35–7).

103 The figures given (p43) are for 2003, and amount to 2700 people on a CTO out of a population of 5 million and so 1 person in every 1850, so more than in New Zealand; in New South Wales, the figure for 2003 was roughly 1 person in every 2640 (see pp71–3) For further details of figures as to CTO use in different jurisdictions, see A Question of Numbers, Simon Lawton-Smith, Kings Fund, September 2005, particularly at pp21ff. He comments that Australasian use of CTOs is high compared to North America and Israel; he also records that CTO use rose further in Victoria, to a figure of more than 3000 in 2005, and so more than 60 per 100,000 of the population.

104 Page 32.

105 For New South Wales, where the CTO was introduced in 1991 via the Mental Health Act 1990, the use of CTOs is recorded as rising in parallel with the process of deinstitutionalisation (p62ff). However, the number of in-patient beds declined steeply during the 1980s (p63).

106 Pages 11ff.

comprehensive review of studies into the efficacy of CTOs – “*International Experiences of Using Community Treatment Orders*”<sup>107</sup>, prepared by a team based at the Institute of Psychiatry at the Maudsley Hospital in South London<sup>108</sup> – suggests that CTOs originally had a different aim, namely assisting the transition from the use of asylums to the provision of community care, which left a group (including “revolving door” patients) less able to cope and so in need of ongoing intervention. In this context, CTOs were viewed as providing a less restrictive alternative than in-patient treatment and so ethically desirable<sup>109</sup>. But the other conceptualisation which is said to have become more prominent is that CTOs provide health benefits to the patient, usually with a view to preventing a relapse.

In assessing the efficacy of this aim, the Institute of Psychiatry report paints a picture which is less positive than Dawson’s conclusions as to the benefits enjoyed. The researchers – “supported by a Department of Health Grant”<sup>110</sup> – reviewed the 72 research studies which had been carried out into civil CTO regimes in use in various parts of the world<sup>111</sup>. The report notes that there are different forms of CTO, but with three recurring themes, namely (1) whether the criteria are the same as for a hospital treatment order, (2) whether the aim is to treat or to prevent a deterioration, and (3) whether the aim is to provide patient choice for a less restrictive regime than in-patient treatment or to be a tool for involuntary management of patients (such as revolving door patients)<sup>112</sup>. The different aims might well overlap, but the report suggested that it was important to be clear about the reason for the regime because that had implications for how it was to be designed and used in practice, with those based on the least restrictive option having conceptual problems and being difficult to use in practice, whereas those based on preventive aims raise the potential for human rights challenges<sup>113</sup>. However, the different aims did not affect the likely recipients of a CTO, typically people with a long history of schizophrenia-like or serious affective illness<sup>114</sup>. The proposals in what was then the Mental Health Bill 2006 were considered as aiming to prevent deterioration whilst allowing treatment in the least restrictive environment<sup>115</sup>.

As for efficacy, the summary of the report<sup>116</sup> noted:

*“It is not possible to state whether ... CTOs are beneficial or harmful to patients. .... Overall, although some stakeholder views are positive, there is currently no robust evidence about either the positive or*

107 8 March 2007;  
[www.iop.kcl.ac.uk/news/downloads/Final2CTOReport8March07.pdf](http://www.iop.kcl.ac.uk/news/downloads/Final2CTOReport8March07.pdf)

108 Headed by Dr Rachel Churchill.

109 See pp17ff.

110 The report was published after the Lords had finished their debates. As the study was commissioned to assist in the formulation of policy, it is an indicator of poor timing to say the least that it was not made available in time for these debates. The report notes (p17), that the Bill of 2006 was published after the “first submission of this report to the Department of Health”. At the Committee Stage in the House of Commons, (see 10 May 2007, Hansard Public Bill Committee Session 2006–7 Cols 305-358, at col 339) Tim Loughton MP noted “... The report was delivered to the Government last August. The Government were not happy with its conclusions so they told the Institute to go away and think again. The authors did and, not surprisingly, there was little change to the proposals. The Government then decided to sit on the

report.” He then said that the report had only been published “under duress” but on the day after the Lords finished their consideration of the Bill and said that this was “a shameful suppression of key evidence that was absolutely integral to this important piece of legislation.”

111 Defined as regimes for enforceable community treatment with no necessary tie to hospital: Appendix 2, p219; see -- 20.

112 Ch 2, pp28 ff.

113 Ch 6.1, pp176ff.

114 Ch 4.3, pp105ff.

115 Page 27; it was also noted that the provisions for compulsory community treatment were already extensive, with the extended use of s17 leave plus the aftercare under supervision regime: the latter was noted (at p23–4) as being intended for post-hospital management with a view to preventing the risk of harm to self or others – which was one of the themes behind the government’s position in favour of the CTO regime.

116 Page 7. See further details at pp177ff.

*negative effects of CTOs on key outcomes, including hospital readmission, length of hospital stay, improved medication compliance, or patients' quality of life."*

Speaking in favour of restricting the criteria for CTOs at the Report stage in the House of Commons<sup>117</sup>, Tim Loughton MP<sup>118</sup> made the major speech for those opposed to the government's position. He noted "There is no empirical evidence for the efficacy of CTOs where they exist overseas... The Government have been proceeding with a new measure, pioneering new ground affecting new classes of patients, without being able to provide evidence that this arrangement works anywhere in the world where there is an equivalent system"<sup>119</sup>. Turning to the potential for damaging effects, he expressed concern that resource provision for voluntary patients would be lost because of the concentration on CTOs; and he both quoted an expert view as to the risks of increased avoidance of treatment and the continuation of the unequal treatment of people from ethnic minorities, and also noted that there was no proper information as to why the existing powers under ss17 and 25Aff were not working, which should be provided before a new regime was put in place. Despite this, the opposition supported the introduction of the CTO, merely suggesting that the concerns outlined justified a regime with restricted criteria. The proposals from the government were said to be too open-ended and so would cover too many people<sup>120</sup>, particularly in light of tendencies to make use of powers if only to avoid criticism in the event of any problems. The suggestions put forward as to the restrictions to be imposed on the regime<sup>121</sup> were not accepted by the Commons.

In light of the fact that the regime as introduced in the Mental Health Act 2007 is in terms of the legal powers different in form rather than substance, and in the context of the switch to community care which has proceeded whether or not something labelled a CTO was on the statute books, the question arises as to whether the CTO debate was worth the fuss.

#### D. Resources

On one level, the debate during the Westminster proceedings about the structure of community treatment for England and Wales was a complete red herring, given that no new powers were created, rather that existing powers were shifted around. The power that remains absent is one to compel medication in the community: it was never on the table, and international experience suggests that this is no bad thing. Dawson, having set out the consensus position that treatment outside a clinical setting was not appropriate<sup>122</sup>:

117 18 June 2007, Hansard Vol 461 Cols 1088–1210.

118 Con, East Worthing and Shoreham; he was picking up on points he had made at the Committee stage, 10 May 2007; Hansard Public Bill Committee Session 2006–7 Cols 305–358, in particular at cols 343ff.

119 For which he cited the Institute of Psychiatry study.

120 He raised the concern (at col 1187) that the government assumption as to the use of the CTO was a significant underestimate in light of the fact that 23% of treatment orders in Scotland were in the form of CTOs. He also suggested that there was a specific need for a time limit of three years because if a CTO had not achieved its objective within a certain period of time, it was clearly necessary to review its use for the particular patient. On the question of figures, see "A Question of Numbers", Simon Lawton Smith, Kings Fund, September 2005

(available at [www.kingsfund.org.uk](http://www.kingsfund.org.uk)). It noted that the rate of use of CTOs internationally ranged from 2 to 50 per 100,000 of population. Note also that the Regulatory Impact Assessment (November 2006, Department of Health) suggests that the average length of the CTO will be 9 months (see para 35 of Annex A); this is longer than the average in-patient stay of 3 1/2 months – so in its April 2007 Briefing on Supervised Community Treatment, the Kings Fund indicated that it was likely that there would be an increase in the use of compulsion because, inter alia, the length of time on a CTO was going to be longer than the length of in-patient treatment.

121 Such as a requirement that the patient have a history of a previous failure to accept treatment in the community after a formal admission, which resulted in a relapse and then successful treatment under compulsion.

122 Dawson report, p150 – see also n97 above.

*“... this consensus is correct. If we are to take patients’ human rights seriously, the administration of medication by force ... outside a properly supervised clinic or hospital should never be authorised ... [T]he experience of the Australasian jurisdictions demonstrates ... that conferring that kind of power on health professionals is not necessary to encourage the use of CTO regimes...”*

So, one important element of the Parliamentary debate was the undebated conclusion that there should be no element of force outside a hospital setting. Since the availability of force is not the central reason for the uptake of the CTO regime from the perspective of the clinical teams that put the orders in place, what is important? The key seems to be the provision of resources. The Institute of Psychiatry review of studies carried out indicates that

*“Lack of resources was almost universally acknowledged by mental health professionals as a reason for failing to use a CTO, or its failure to work.”<sup>123</sup>*

This was also a concern picked up by Dawson: for example, he records the experience of Victoria in the 1990s where there had been the growth in CTO use but without adequate resources, leading to criticisms from coroners in Melbourne investigating suicides by patients on CTOs. More resources were then found<sup>124</sup>. He added:

*“No one spoken to believed the introduction of CTOs was a successful way to save public money, because, to work effectively, the regime must be backed by well-resourced systems of community mental health care.”*

Given the target group, and the sensible aim of preventing the cycle of relapse into serious illness – preventive medicine having a role to play in mental health practice as much as in general practice – it is obvious that resources are the key. The new powers in the 2007 Act cannot alter the fact that there are patients who present difficulties because of features such as lack of insight or the presence of other problems, often drug and alcohol misuse, which make compliance with treatment a low priority for them. The new CTO regime requires their agreement to the conditions and their co-operation in practice: but if patients are to be nominated for the use of CTOs on account of shared features such as lack of engagement or lack of insight into the need to co-operate, a regime which depends on patient co-operation is unlikely to succeed. Rather, there has to be monitoring and persuasion, and that can only happen if there are people to carry out the monitoring and persuading. Dawson makes this point<sup>125</sup>: the use of CTOs seems most likely to produce positive outcomes when there is a regime which is well-embedded and supported by clinicians, with reasonably intensive resources provided by clinicians who visit patients, but also additional services such as accommodation and alcohol and drug services, plus co-ordination with in-patient services, and continuity of staff who are experienced and assertive. Every point he makes rests on matters of resources or the organisation of services, not on whether the regime is called a CTO.

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123 Churchill Report, p191.

124 Dawson p32.

125 Page 5.

### **E. CTO Fault-Lines**

In addition to the major fault-lines mentioned above, namely the questions of the role of capacity and the limitations on what was permitted by way of compulsory treatment in the community, Dawson identified other common problems, namely over-use of depot medication, de facto detention in sub-standard accommodation, overuse in relation to patients with affective disorders who may regain capacity after initial treatment, overuse for younger males with drug and substance abuse problems, overuse in response to pressure of beds, and inadequate reviews, particularly in relation to patients who have been on CTOs for a long time<sup>126</sup>.

Some of these problems are resource related (particularly the question of the use of the CTO regime for patients whose needs are for in-patient care if the beds are available); some are clinical, such as the over-reliance on depot medication and the lack of evidence of the efficacy of the CTO regime in relation to the two groups he mentions. There is also a question of attitude. Since a CTO does not take away liberty, it may be viewed as less invasive and so easier to justify: this is particularly so if the rationale has changed from it being the least restrictive method of providing treatment (ie as an alternative to detention, and so only available when detention would otherwise follow) to a matter of conferring benefits. Unless the central benefit conferred is viewed as allowing the patient to retain his or her liberty, a CTO will tend to be used more often than would an in-patient order, and so social control will be extended.

Building on the pitfalls identified by Dawson, what is therefore important is that those who use CTOs engage critically with the government's policy position, including any necessary reading between the lines. In the first place, the suggestion that there is some radical new power, along with the suggestion it will allow lives to be saved, must be accepted as political rhetoric. In the second place, the key for success remains the adequacy of resource provision not the nomenclature of the powers that exist as the overlay for those powers. And thirdly, the fact that CTOs are designed for patients who are already subject to intervention by way of detention (and that a CTO requires detention and is enforceable only by way of the pressure of recall to detention) must be borne in mind to ensure that the CTO is not used in relation to patients who would not at present be subject to intervention backed up by the same threat, namely of formal detention being imposed. Naturally, it will also be important for the Mental Health Review Tribunal when considering appeals in relation to CTOs to be aware of these matters.

As for the major fault-lines identified by Dawson, the one relating to forced treatment has been avoided by the legislation. The other, relating to capacity, arises from the basic proposition which usually commands approval in modern medical practice, namely the need to respect patient autonomy, even if the choices made are objectively difficult to follow. This is reflected in the Scottish legislation by the language relating to impairment (not lack of) capacity, and was incorporated by the House of Lords in express language which was removed by the Commons. It could be said to be reflected in practice because of the government's emphasis on the need to have patients accept the conditions of the CTO before it can be put into place and to co-operate in practice (since breach of a condition does not cause recall), and so there is still a requirement that the patient make a choice to co-operate. But the choice is not free in light of the compulsory powers which are in the background: whether viewed as a carrot or a stick, the regime induces co-operation without the patient's acceptance of the intrinsic value of the treatment. So the new legislation misses the opportunity to deal with the capacity fault-line.

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<sup>126</sup> Pages 5–6.



But since the absence of any true choice reflects the reality for patients who do not accept their illness or do not fully co-operate and relapse<sup>127</sup>, could it be said that it introduces greater transparency into the process, as Dawson suggested in relation to its use in New Zealand in place of leave<sup>128</sup> and should be welcomed as such? If a CTO is used in place of leave beyond 7 days (and so in relation to a patient whose present condition justifies liability to in-patient treatment), it really makes no difference whether the patient is liable to be detained or liable to be recalled to detention: the effect is the same, and it would be more honest to stay with the current regime and record the patient as being liable to detention. If the CTO is used in relation to patients currently under the aftercare under supervision regime, and so subject to monitoring and assessment as to whether they should be detained in the event of relapse, changing their status as liable to recall to detention is also less honest because of the perception that might be created that their co-operation is now conditioned by a power to swiftly detain them for breach of the conditions of the CTO, whereas the truth is that it will still depend on their mental condition justifying detention.

So it will come down to how the regime is operated in practice. The legal framework is much less important than resources and good practice: which makes it a real shame that the government made use of smoke and mirrors to create the impression of a problem which was not clearly reflected in the research it relied on and a new solution which merely repackaged what was already there.

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*127 And whose capacity in relation to the question of treatment may often be substantially impaired if they do not accept that they are ill.*

*128 Page 19.*