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The purpose of this document is to assist the responsible clinician and other healthcare professionals in the decision-making process regarding placing a person on a community treatment order (CTO). Underlying this document is the rebuttable presumption that all patients will be discharged from hospital, free of compulsion, as soon as possible, unless there are clear reasons or individual evidence to indicate that a CTO would be beneficial.

This document draws on the good practice guidance outlined in the Code of Practice: Mental Health Act 1983 (Department of Health, 2015) and Supervised Community Treatment: A Guide for Practitioners (National Institute for Mental Health in England, 2008). It seeks to distil this guidance into a clinically useful form by suggesting a series of questions. The proposed approach might also be useful in helping construct the letter to the patient, responding to the request of a tribunal to consider a CTO, preparing tribunal reports (if challenged after deciding to use a CTO) and considering when a CTO can be discharged.

This document assumes a working knowledge of CTOs and is intended for psychiatrists who are practising in England or Wales. Its scope is limited to deciding whether to use a CTO or not and does not cover other decisions about use of compulsion in the community, such as section 17 of the Mental Health Act 1983 (the Act), leave or guardianship.
Why we need to think carefully about CTOs

The CTO, which came into force in October 2008, was one of the most debated amendments to the Act. Although many psychiatrists have adopted CTOs into routine practice, there are others, including some clinicians, who question both their effectiveness and the ethical basis of such provisions.

CTOs were introduced despite a lack of international evidence of their effectiveness. Recent evidence, including a randomised, controlled trial in the UK (Burns et al, 2013), has confirmed previous findings that CTOs do not have any significant effect on hospitalisation or other service-use outcomes (Churchill et al, 2007; Kisely & Campbell, 2014; Maughan et al, 2014).

The use of CTOs seems to have been a factor in the increase in the number of people subject to compulsion (Health and Social Care Information Centre, 2015). People from South Asian and Black ethnic backgrounds are disproportionately more likely to be subject to a CTO (Care Quality Commission, 2011).

The House of Commons Health Committee (2013), when it reviewed the effects of the 2007 amendments to the Act, questioned the geographical variation in the use of CTOs and invited professionals to critically examine how they are currently using these powers. Although the Committee was satisfied that the operation of CTOs reflected the intention of the legislation, it noted that:

‘Compulsory medical treatment, whether in the community or in hospital, raises serious civil rights issues and needs to be supported by evidence of its need and its effectiveness.’

The final report of the Mental Health Taskforce (2016) took a negative view of CTOs. The report noted that:

‘In the light of rising rates of detention and the high and potentially inappropriate use of CTOs, highlighted by research published by Oxford University in 2013, there is a strong case for considering whether the current legislative framework strikes the right balance between risk and consent.’

Given these concerns, patients and their representatives will rightly require professionals to justify their reasons for opting for compulsory treatment in the community. Indeed, this is now a requirement in the revised Code of Practice, which states at paragraph 29.17 that:
'The responsible clinician should inform the patient of the essential legal and factual grounds for the CTO and other information about the CTO (paragraphs 4.13–4.17) both orally and in writing.'

To put it another way, there is now a need to 'show your workings'.

A professional decision

The Act does not require a professional to make use of these powers if criteria are met; it simply enables their use should this be necessary, having considered all other less-restrictive options.

As the Code of Practice states at paragraph 29.10:

‘The decision as to whether a CTO is the right option for any patient is taken by the responsible clinician and requires the agreement of an approved mental health professional (AMHP). The responsible clinician should consider the principles, in particular the least restrictive option and maximising independence principle. A CTO may be used only if it would not be possible to achieve the desired objectives for the patient’s care and treatment without it.’

CTOs should, therefore, be considered on an individual basis and should never be a routine part of the discharge package for qualifying patients.

When must a CTO be considered?

The responsible clinician is required, under the current legal framework, to consider the use of a CTO in certain circumstances. Considering the use of a CTO does not necessarily mean that using one is actually appropriate. If the below circumstances are applicable, the responsible clinician should document the reasons for their decision about whether or not to proceed with a CTO.

- When considering whether to grant more than 7 consecutive days of leave, or when the effect of extending a shorter period of leave is that it will be for more than 7 consecutive days in total (section 17 of the Act).
- When invited to consider this by a tribunal (section 72 of the Act).

The Code of Practice notes in paragraph 29.19 that:

‘When a detained patient makes an application to the Tribunal for discharge, the Tribunal may decide not to order discharge, but to recommend that the responsible clinician should consider a CTO. In that event, the responsible clinician should carry out the assessment of the patient’s suitability in the usual way. It will be for the responsible clinician to decide whether or not a CTO is appropriate for that patient taking into account the factors outlined above. The responsible clinician should record the reasons for their decision.’
Questions for clinicians to consider

What is the patient’s view on the use of a CTO?

It is essential to give the patient the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Whenever practicable, care plans should be produced in consultation with the patient (Department of Health, 2015). It might be helpful to gather information about history in a collaborative way, looking at factors that might aid or potentially hinder recovery. Understanding what recovery means to the patient is important, as patient, professional and perhaps even family perspectives might differ. Skilled Independent Mental Health Advocates (IMHAs) can have a constructive role in assisting patients with this dialogue.

Patient views about a possible CTO are relevant from a practical perspective, because if the patient will not recognise the authority of the CTO then it is unlikely to succeed. As stated in the Code of Practice in paragraph 29.17:

‘Patients do not have to give formal consent to a CTO. But in practice, patients should be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.’

It is important to acknowledge the leverage/compulsion and imbalance of power inherent in the use of CTOs and to take steps to maximise patient involvement wherever possible. If the decision to go ahead with a CTO is contrary to the clearly expressed wishes of the patient, the reasons for going ahead with it should be transparent, clearly explained and documented.

What are the views of the family members and carers on the use of a CTO?

Family members and carers should be involved where possible, although some patients might be reluctant for this to happen, particularly if they have different perspectives about the nature of the problem and the proposed care plan. Carers, in particular, might be keen on the use of a CTO, hoping this will break a pattern of repeated...
admissions or other negative outcomes. Although it is important to consider these views, it will be a matter of professional judgement to decide whether a CTO is warranted. As is the case with the patient’s wishes, if the decision regarding a CTO is contrary to the clearly expressed wishes of the family or carers, the reasons for going ahead with it should be explained.

**Does the patient have capacity?**

If a patient has capacity to consent to or to refuse treatment, this raises important questions. Although it is lawful in the jurisdiction of England and Wales (see Dawson (2006) for approaches in other jurisdictions) to impose a CTO on a patient who has capacity to refuse treatment and meets the legal criteria, the clinician should ask whether this decision can be ethically justified, given the importance that is generally placed on respect for self-determination. The principle of parity of esteem would suggest that if a decision to refuse treatment for physical disorder is respected (even though there could be serious consequences), clinicians should also respect a decision to refuse treatment for mental disorder by a patient who has the capacity to make this decision.

**Why is compulsory community treatment required?**

It is important to remember the principles underpinning the Act, particularly principle one – the least restrictive option and maximising independence – and principle two – empowerment and participation.

Clinicians considering using a CTO should be mindful of whether it is possible to work with the patient’s agenda when discussing recommended treatments in the community (this will probably be about the use of medication, though not exclusively). Is it possible to be flexible and monitor the situation without using a CTO, or is the risk of harm to the patient so great that this would not be clinically justifiable?

The *Code of Practice* does not preclude the use of a CTO after a first illness, but in such cases there should be particular consideration of the potential risk to the forging of a positive long-term relationship by using compulsory community powers at this early stage. Additionally, at an early stage, the pattern (or nature) of the illness is not established and it is not possible to predict the course of the illness. In several other jurisdictions, it is a prerequisite to the imposition of a CTO that there be a demonstrated pattern of relapse and recovery after effective medication.

Although the *Code of Practice* states that the purpose of a CTO is to prevent the ‘revolving-door scenario’, evidence given to the House of Commons Health Committee by the Department of Health in 2013...
pointed out that an amendment to limit the use of CTOs to patients who had previously been detained more than once was proposed but not voted through, reflecting ‘Parliament’s intention […] not to restrict it to just that group but to put it to the clinical decision about the risk in the community rather than that group of [revolving-door] patients’ (House of Commons Health Committee, 2013).

Although both Parliament’s and the Department of Health’s focus on risk should be noted, clinicians might prefer to adopt a more nuanced approach that balances a range of factors, taking into account other important considerations, such as engagement, recovery and positive risk-taking. Therefore, a CTO after a first episode of psychosis should only be used in exceptional cases and the reasons for this decision must be clearly argued and documented.

Can you clearly describe the risks and the seriousness of these risks for this individual?

Concern about risk was a major political driver of the introduction of CTOs and is echoed in the Department of Health’s response to the House of Commons Health Committee, quoted above. This, coupled with concern among professionals about potential blame should there be a serious incident if all available powers are not used, might lead clinicians to be extremely risk-averse and more likely to make use of the powers available to them. Although understandable, concern about such criticism is not a valid reason for using a CTO.

The Code of Practice states in paragraph 29.16 that:

‘A risk that the patient’s condition will deteriorate is a significant consideration, but does not necessarily mean that the patient should be discharged onto a CTO rather than discharged. The responsible clinician must be satisfied that the risk of harm arising from the patient’s disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment.’

If the only identified risk is that the patient will become unwell again without any significant risk of self-harm or suicide, or risk to others, it is important to consider the patient’s attitude to relapse and/or re-admission, as they might give different weight or meaning to these outcomes compared with professionals. Risk of relapse alone would not usually be sufficient reason to implement a CTO.

On a practical note, it is important to carefully scrutinise the risk history and to avoid transferring erroneous or poorly described risk events by using a ‘cut and paste’ approach to report-writing and risk-assessment documentation.
If a CTO is thought necessary to ensure medication adherence, is there evidence that the treatment is likely to be effective?

As the Code of Practice highlights in paragraph 29.16:

‘CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual. Such evidence may include:

• a clear link between non concordance with medication and relapse sufficient to have a significant impact on wellbeing requiring treatment in hospital
• clear evidence that there is a positive response to medication without an undue burden of side effects
• evidence that the CTO will promote recovery, and
• evidence that recall may be necessary (rather than informal admission or reassessment under the Act).’

Some patients do not benefit from antipsychotic medication, and for some the burden of side-effects might be more unacceptable than the symptoms of their illness. If treatment is imposed under a CTO, it is necessary to demonstrate that such treatment will be of substantial benefit. It is helpful to clarify exactly what benefits you think the proposed treatment will confer and what evidence there is to support this view. This needs to be balanced by a clear understanding of the patient’s views regarding medication and potential side-effects. If they are available, interventions should be clearly identified to mitigate any harms arising from the proposed treatment.

Is the intervention proportionate?

A CTO affects the patient’s right to a private and family life under Article 8 of the Human Rights Act 1998, via not only the conditions imposed by the CTO but also the imposition of treatment under the duress of a CTO. As Khurmi & Curtice (2010) state in their article on CTOs and human rights:

‘Proportionality is a well-established principle of the European Convention on Human Rights and is becoming increasingly important within mental health tribunals (especially when assessing conditions attached to a CTO). It is a way of addressing tensions and conflicts between competing claims and rights (i.e. a patient’s human rights v. the need to protect others, self and health). In practical terms, a proportional decision ‘is appropriate and not excessive in the circumstances’ and ‘the more substantial the interference the more that is required to justify it’.

A simple way to consider this point is to ask ‘Am I using a sledgehammer to crack a nut?’
Can you justify the power of recall?

When justifying the use of a CTO, you should clearly state the reasons why recall is an essential component of the treatment plan. There is evidence that clinicians misunderstand the nature of recall (Doughty et al, 2014) and view this as a means of admitting a patient to hospital without the need for a full Mental Health Act assessment, instead of as a means of preventing admission by taking pre-emptive action.

The Code of Practice notes in paragraph 29:45 that:

‘the recall power is intended to provide a means to respond to evidence of relapse or high risk behaviour relating to mental disorder before the situation becomes critical [emphasis added] and leads to the patient or other people being harmed.’

Recall might be to an out-patient department or hospital to give treatment because of a potential risk of deterioration – that is, reflecting ‘a change in the patient’s circumstances giving rise to increased risk’ (Department of Health, 2015). This would be before clear signs or symptoms of relapse emerge and at an earlier stage than might warrant detention under the Act. The Code of Practice does, however, point out in paragraph 29:48 that negotiation and discussion of the options with the patient could avert the need for recall.

There have also been concerns among clinicians that such use of ‘preventive recall’ is in some way unlawful. John Dawson, a legal academic, suggests that using recall in this way is indeed lawful and is what the CTO is designed to deliver. If recall is used as a means of bringing an already clearly relapsing patient into hospital, the purpose of the CTO – to maintain a person in the community – is defeated. Dawson (2015) gives helpful practical guidance about when recall should occur:

‘So when should preventive recall occur? It will be lawful when it can reliably be predicted – on the basis of the patient’s history – that relapse in illness would follow cessation of treatment and would present the necessary risks. Some situations in which that prediction could be made – even for a person who is not acutely unwell – would be those in which they had previously demonstrated one or more of the following:

• either, a pattern of rapid relapse; repeated or prolonged episodes of illness;
• severe consequences during relapse, such as serious violence to self or others;
• or early loss of insight during illness, leading to inability to take the steps required to prevent its deterioration.

What is needed, above all, is a sufficiently convincing prediction of the probabilities of relapse and the seriousness of the likely consequences.’
Are you responding to resource concerns when considering recall?

The College has been informed that some parts of the country do not have an adequate number of doctors approved under section 12 of the Act or approved mental health professionals. Therefore, there might be worries that a Mental Health Act assessment could not be convened with sufficient urgency to respond to evidence of relapse, especially where there are potential risks. Using recall as a less labour-intensive means of securing admission might be superficially attractive, as recall only requires authorisation by the responsible clinician and indeed might not even require face-to-face assessment. (The Code of Practice makes it clear in paragraph 29:45 that the responsible clinician does not have to interview or examine the patient before deciding to recall; however, it is good practice to see and discuss the options with the patient unless there are cogent clinical reasons for not doing this.)

There are also concerns that a CTO is used in preference to a longer, but potentially beneficial, hospital stay to facilitate early discharge because of a lack of beds for more acute patients. In addition, some might hold the view that being a recalled patient would confer priority for scarce beds.

None of these reasons, of course, fits the purpose of recall as discussed in the previous section. Clinicians must always be alert to the complete unacceptability of using compulsory powers in response to resource concerns. Compulsory powers such as a CTO should not be used where, but for resource constraints, a less-restrictive option would be available. Clinicians must report any such instances to the relevant parties within their organisation, escalating their concerns as appropriate. The College recommends that all trusts have governance mechanisms that can respond urgently to such concerns.

Can others assist in decision-making?

Having a forum outside the immediate team to discuss finely balanced decisions might be helpful, in providing a chance to debate decisions from ethical and clinical perspectives. Discussing personal drivers such as risk aversion, concern about a culture of blame or the negative impact of a recent serious incident with colleagues might be very helpful. Perhaps the most interesting question to ask might be ‘For whose real benefit is this CTO?’

The unacceptable reasons for considering the use of a CTO are summarised in Box 1.
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<td>●</td>
<td>Because it has become routine for all patients detained under section 3 of the Mental Health Act 1983</td>
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<td>To take a ‘belt and braces’ approach to risk management when less-restrictive options are available</td>
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<td>Because trust management seems to favour it</td>
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<td>As a result of misunderstanding the invitation of a tribunal to consider a CTO as an instruction to use it</td>
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<td>As a response to inadequate resources to facilitate urgent assessment under the Act</td>
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<td>●</td>
<td>Because it is easier to recall than to organise and participate in a Mental Health Act assessment</td>
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