Community treatment orders in England and Wales: national survey of clinicians' views and use

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Aims and method To ascertain the views and experiences of psychiatrists in England and Wales regarding community treatment orders (CTOs). We mailed 1928 questionnaires to members of the Royal College of Psychiatrists.

Results In total, 566 usable surveys were returned, providing a 29% response rate. Respondents were generally positive about the introduction of the new powers, more so than in previous UK studies. They reported that their decision-making regarding compulsion was based largely on clinical grounds.

Clinical implications In the absence of research evidence or a professional consensus about the use of CTOs, multidisciplinary input in decision-making is essential. Further research and training are urgently needed.

Declaration of interest None.

Community treatment orders (CTOs) represented one of the most controversial elements of the substantial amendments to the Mental Health Act in England and Wales in 2007.[1] Their introduction followed a prolonged and heated debate among clinicians regarding the ethical grounds and evidence base for (and the practical implications of) their use. This debate had not been resolved when CTOs came into force in November 2008 and the issue remains contentious today.[2–8]

The move of psychiatric services 'into the community' and the closure of large numbers of psychiatric beds over recent decades has led to an increased focus on powers to compel outside hospital and the progressive introduction of such powers.[9] Similar legal regimes have existed for some time in different jurisdictions in Australasia and North America. More recently, several European jurisdictions, including Scotland in 2005, have introduced a version of CTOs.

CTOs in England and Wales

In England and Wales, CTOs allow the treating team to make conditions in a number of different domains. An individual can be required to attend for appointments with services, reside in particular accommodation, or adhere to medication. However, CTOs do not allow for the forcible administration of medication in the person's home. Two mandatory conditions apply in all cases: for the individual to attend for assessment by a second opinion approved doctor (SOAD) when requested and to present for assessment regarding renewal of the order at the appropriate time.[10,11]

Across different jurisdictions, the legal powers to compel allow for clinical discretion. This means that there are no situations where a clinician must use a CTO, rather that there are situations where he/she may use one. The use of CTOs varies substantially between and within jurisdictions. Dawson[12] proposes that much of this variation can be explained by the manner in which clinicians use their discretion. Given the relative lack of research evidence on which to base their decision, he suggests four main factors play a part in clinical decision-making:

1 the legal structure of the CTO regime
2 the community mental health services available
3 the clinician's views about the possible impact of coercion on his/her relations with patients
4 the expectations of third parties for use of the scheme.

The use of CTOs in England and Wales has substantially outstripped predictions, with nearly 3000 orders being enacted in the first 8 months.[12] By March 2010, over 6000 orders had been made in England alone.[13] A lack of research evidence or clinical consensus regarding their usefulness may have contributed to CTOs being used more widely than forecasted.[14–16] It is important, therefore, to ascertain the views of those using CTOs in regard to their usefulness and disadvantages.

CTO use internationally

Crawford and colleagues[1] sent a short postal survey to consultant psychiatrists in England and Wales in 2000 when changes to the Mental Health Act were being debated. This survey focused on attitudes towards the planned extension of compulsory powers into the community. Of 1171 respondents, 46% were in favour of a system allowing compulsory treatment in the community. The remainder

either disagreed (35%) or were unsure (19%). Written comments confirmed a considerable polarisation of views, with some believing that the introduction of compulsory community powers was long overdue, whereas others believed such measures would be anti-therapeutic. In New Zealand, where similar legislation was established in 1992, a survey of consultant psychiatrists conducted in 2002 found that the vast majority (79% of 284 respondents) preferred to work in a system with CTOs.[17] Clinicians in New Zealand believed that when appropriately used the benefits for individuals of being on a CTO outweighed the disadvantages. A smaller survey of 50 psychiatrists in Saskatchewan, Canada, reported that 62% of respondents were satisfied or extremely satisfied with the effect of CTOs on patient care.[18] Two studies in the USA exploring clinicians' views on outpatient commitment through interviews[19] and discussions based around clinical vignettes[20] revealed similar opinions: appropriate use of compulsory community treatment was regarded as preferable to involuntary hospital admission.

Study design

In this paper we report on a survey of members of the Royal College of Psychiatrists in England and Wales, which explored their views and experiences of CTOs 12–18 months after their introduction. The survey instrument was based on that used by Romans and colleagues in New Zealand.[17] We aimed to determine mental health clinicians' views about CTOs on a range of issues that might be expected to influence how CTOs are being used.

Method

Sample

A postal survey was conducted of members of the Royal College of Psychiatrists in England and Wales who were listed as members of the General and Community Psychiatry or Rehabilitation and Social Psychiatry faculties ($n = 1928$). Questionnaires were sent in December 2009, with a reminder 16 weeks later. All surveys returned in the second wave were cross-checked with those received in the first wave to remove potential duplicates. Ethical approval was obtained from the Isle of Wight, Portsmouth and South East Hampshire Research Ethics Committee.

Survey instrument

The survey instrument was designed to capture opinions in a range of domains and to compare findings with the New Zealand survey.[17] We adopted several themes from that survey and a number of items were reproduced with kind permission of the authors. Our survey contained questions concerning:

- the respondents' characteristics and number of CTOs he/she had applied for;
- views on the importance of a range of potential factors influencing CTO practice; this used a five-point Likert scale (ranging from 1, very important, to 5, not important at all);
- level of agreement with a range of statements about CTOs; this also used a five-point Likert scale (ranging from 1, strongly agree, to 5, strongly disagree).

The instrument is available from the corresponding author on request.

Statistical analysis

Statistical analysis was carried out using SPSS v. 17 for Windows. A descriptive analysis was carried out with data presented as appropriate for the distribution (mean and standard deviation for normally distributed data, median and interquartile range for non-normally distributed data, and number and proportion for categorical data).

Results

Of the 1928 surveys sent out, 714 were returned, an overall response rate of 37%. Of these, 566 (29% of the total sample) were usable, the remainder being either identified as duplicates, incorrectly filled out, or left entirely blank. Whereas the response rate was lower than the 44% rate achieved by Crawford and colleagues,[1] the sample comprised 34% women and the breakdown of respondent ethnicity did not significantly differ from that of the membership of the Royal College of Psychiatrists.[21,22] Respondents had a wide range of clinical experience, the majority (73%) having worked as a psychiatrist for between 10 and 30 years. The mean number of CTOs applied for was 3.3, with a range from 0 to 25. The overwhelming majority of respondents (89%) reported that none of their applications for a CTO had been turned down.

Despite the fact that there was little space for written comments, many respondents chose to add their own remarks, suggesting that they were actively interested in this topic. Where appropriate, we compare our results with that of the UK survey pre-dating the introduction of CTOs[1] and the New Zealand study, where the CTO regime was well embedded prior to assessing clinicians' views.[17] Since the debate that preceded the introduction of CTOs in England and Wales to a large extent focused on the circumstances surrounding the issuing of and discharge from CTOs, we report on these data in greatest detail (Tables 1 and 2).

'Which system would you prefer to work in?'

Respondents were asked whether they would prefer to work in a system with or without CTOs. In our sample, 60% expressed a preference for a system that included CTOs compared with 79% in New Zealand and 46% in the previous UK sample[1] (Fig. 1).

'What is the impact on the therapeutic relationship?'

Respondents were asked whether they considered that CTOs helped, hindered, or had no effect on their therapeutic relationships with patients. Some participants gave more than one answer to this question, stating that the answer depended on the patient. Of those who gave a single response ($n = 520$), 45.8% thought that CTOs helped, 19.8% that they hindered and 34.4% that they had no effect on the

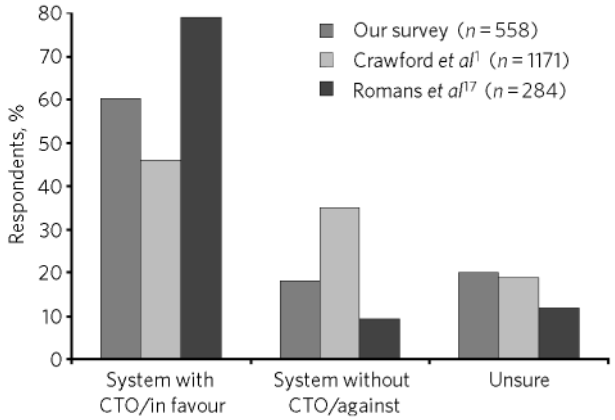

Fig 1 'Which system do you prefer to work within/Are you in favour of or against compulsory treatment in the community?' Comparison between our survey and the previous UK[1] and New Zealand[17] surveys. CTO, community treatment order.

therapeutic relationship. The psychiatrists in New Zealand who responded to this question were a little less positive regarding the effects of CTOs: 42.1% believed that CTOs helped, 31.2% that they hindered and 25.2% that they had no effect on therapeutic relationships.

'What are the important factors in your decision to use a CTO?'

The survey presented 12 factors and asked respondents to rate the importance of each when making the decision to use a CTO on a five-point Likert scale with 1 signifying very important. Their rating for each item, and how it compares with the New Zealand survey, is shown in Table 1.

This question also produced 49 written comments, many of which emphasised the importance of providing the best possible care in the community (particularly ensuring adequate accommodation), reducing readmission, and promoting recovery in specific patient groups, particularly 'revolving door' or 'nomadic' patients. A number of respondents alluded to complex organisational politics involved in the decision to use a CTO, such as the preference or recommendation of the mental health review tribunal, pressure from within mental health services or from carers, and/or the obligation on responsible clinicians to consider a CTO.

'How important are the following factors in discharging a patient completely from a CTO?'

We presented 15 possible reasons for discharging a patient from a CTO and asked clinicians to rate the importance of each one as applied to their practice, again on a five-point Likert scale. As previously, we have ranked these in order of the importance attributed to them based on the mean score given, with 1 signifying the highest level of ascribed importance, as shown in Table 2.

'Please rate the impact of the following mechanisms in influencing how CTOs work'

Respondents were presented with nine possible mechanisms by which CTOs may affect patient outcome and were asked to rate their importance. The three mechanisms considered most important (represented by the lowest mean) were: ensuring medication adherence for a lengthy period during which other changes can occur (1.95), ensuring a greater period of stability (2.26), and signalling

Table 1 The importance attached by UK psychiatrists to key factors in decisions to use a community treatment order and comparison of factor rankings in the UK and New Zealand

	Factor importance,[a] UK: *n* (%)					Mean (rank)	
Factor	1	2	3	4	5	UK	New Zealand
Promote adherence to medication	278 (50)	189 (34)	55 (10)	15 (3)	23 (4)	1.78 (1)	2.03 (4)
Protect patients from the consequences of relapse in their illness	271 (49)	179 (32)	58 (10)	30 (5)	20 (4)	1.83 (2)	2.08 (5)
Ensure contact with health professionals	274 (49)	173 (31)	52 (9)	29 (5)	28 (5)	1.86 (3)	1.79 (1)
Provide authority to treat the patient	226 (41)	169 (30)	89 (16)	42 (8)	32 (6)	2.08 (4)	1.81 (2)
Ensure rapid identification of relapse	177 (32)	189 (34)	106 (19)	49 (9)	35 (6)	2.24 (5)	1.90 (3)
Facilitate readmission to in-patient care	118 (21)	175 (31)	135 (24)	92 (17)	37 (7)	2.56 (6)	2.43 (7)
Reduce the risk of violence to others	97 (18)	185 (33)	154 (28)	76 (14)	43 (8)	2.61 (7)	2.68 (8)
Provide greater security for patients' family or caregivers	68 (12)	179 (32)	187 (34)	88 (16)	31 (6)	2.70 (8)	2.41 (6)
Reduce the risk of self-harm by the patient	78 (14)	163 (29)	154 (28)	104 (19)	55 (10)	2.81 (9)	2.74 (9)
Enhance obligations of service providers to the patient	50 (9)	140 (25)	143 (26)	132 (24)	87 (16)	3.12 (10)	2.97 (10)
Ensure police assistance with patients will be available	29 (5)	50 (9)	130 (24)	169 (31)	172 (31)	3.74 (11)	3.31 (11)
Reduce substance misuse by patient	21 (4)	51 (10)	124 (24)	142 (28)	179 (35)	3.79 (12)	3.73 (12)

a. Scores ranging from 1, very important, to 5, not important at all.

Table 2 The importance attached by UK psychiatrists to reasons for discharging an individual from a community treatment order and comparison of factor rankings in the UK and New Zealand

	Factor importance,[a] UK: *n* (%)					Mean (rank)	
Factor	1	2	3	4	5	UK	New Zealand
Development of insight	320 (59)	152 (28)	42 (8)	15 (3)	12 (2)	1.61 (1)	1.56 (2)
Clinical improvement	315 (58)	165 (30)	37 (7)	16 (3)	11 (2)	1.61 (1)	1.58 (3)
Adherence to treatment	309 (57)	178 (33)	32 (6)	16 (3)	10 (2)	1.61 (1)	1.53 (1)
Reduced risk to others	171 (32)	232 (43)	98 (18)	25 (5)	15 (3)	2.04 (4)	1.84 (4)
Reduced risk to self	157 (29)	229 (42)	105 (19)	32 (6)	17 (3)	2.12 (5)	1.87 (5)
Suitable accommodation and community supervision	154 (29)	208 (39)	115 (21)	42 (8)	18 (3)	2.18 (6)	2.12 (6)
Reduced substance use	107 (20)	232 (43)	142 (27)	36 (7)	19 (4)	2.31 (7)	2.25 (7)
Improved lifestyle	105 (20)	205 (38)	150 (28)	52 (10)	24 (5)	2.41 (8)	2.65 (11)
Employment	112 (22)	198 (38)	123 (23)	58 (11)	31 (6)	2.41 (8)	2.60 (9)
To increase the patient's freedom	142 (27)	138 (26)	130 (24)	82 (15)	43 (8)	2.53 (10)	2.84 (12)
Improved family relationships	62 (12)	193 (36)	189 (35)	67 (13)	26 (5)	2.64 (11)	2.32 (8)
Enhanced social/cultural networks	54 (10)	179 (34)	203 (38)	70 (13)	29 (5)	2.71 (12)	2.64 (10)
Patient's desire to be discharged	67 (13)	146 (27)	189 (35)	88 (17)	44 (8)	2.81 (13)	3.09 (14)
Suitable recreational activities	43 (8)	113 (22)	172 (33)	122 (23)	74 (14)	3.14 (14)	3.02 (13)
Enhanced cultural identity	29 (6)	80 (15)	172 (32)	137 (26)	113 (21)	3.42 (15)	3.19 (15)

a. Scores ranging from 1, very important, to 5, not important at all.

to the patient that they have a serious mental health problem which needs active management (2.28). The same three mechanisms were considered most important in the New Zealand survey. The remaining factors, in order of importance, were: a CTO commits service providers to the person (2.76), gives others the confidence to care for the person (2.79), binds community services in place (2.89), encourages the individual to take responsibility (3.15), mobilises social support for the individual (3.25); and the individual gives up conflict areas to external agents (3.30). Again, these rankings are very similar to those in the New Zealand study.

'In your experience, how important are the following factors in undermining the effectiveness of CTOs?'

Nine possible factors which could potentially act as barriers to the effectiveness of CTOs were rated by respondents. Those considered most undermining (i.e. lowest mean score) were judged to be substance misuse (2.06), lack of supported accommodation for people with challenging behaviours (2.17), and failure to enforce medication adherence (2.45). The same three factors were identified in the New Zealand study. The remaining items, in rank order of the importance attached to them, were: unavailability of some medications in injectable form (2.84); inadequate access to psychological therapies (2.90); lack of trained mental health staff (3.08); inadequate access to recreational opportunities (3.09); premature discharge by courts or tribunals (3.21); and difficulty managing this service user group in rural areas (3.47).

Factors discouraging clinicians from using CTOs

Eight factors which might discourage the use of CTOs were also rated by respondents. No individual factor was considered the most clearly important by respondents as mean ratings (low scores indicating high importance) for the most important three factors were clustered close together: concern for the person's civil liberties (2.61), the administrative burden (2.62), and the degree of coercion involved (2.81). The remaining items, in rank order, were: preference for the use of in-patient leave (3.20); availability of SOADs (3.20); concern about being held responsible for the individual's conduct (3.34); cultural politics (3.49); and increased cost to the mental health service (3.82). Again the responses were very similar to those from the New Zealand study.

Factors in the introduction of CTOs to England and Wales

Six possible factors which may have played a role in the introduction of CTOs in England and Wales in 2008 were presented for respondents to rate. In rank order of perceived significance these were:

1 to enforce better community services and follow-up for those at risk
2 a response to public pressure (in respect to acts of violence committed by individuals with mental illness)
3 a result of procedural evolution – moving from Sections 17 and 25 to a more explicit framework for treating those with mental illness in the community
4 to reduce pressure on acute psychiatric beds

5 to reduce coercion by reducing the length of in-patient stay in psychiatric hospitals
6 a result of international research evidence.

Support for the introduction of CTOs in England and Wales

Clinicians were then asked to rate their level of agreement with several general statements regarding CTOs. Statements with a mean score of <3, suggesting overall agreement with them, were (ranked from stronger to weaker support):

1 'I feel that CTOs complement existing legislation to provide a greater choice of treatment options for clinicians'
2 'The increase in compulsory powers that may result from the introduction of CTOs is appropriate for the potential clinical and social benefit for patients'
3 'I supported the introduction of CTOs'
4 'There is sufficient clinical guidance for me to feel comfortable placing patients on CTOs'
5 'I think the benefits of CTOs can already be seen'.

Those statements with a mean of >3, suggesting overall disagreement, were (ranked from strongest to weakest disagreement):

1 'The introduction of CTOs has been a retrograde step for mental health services'
2 'Well-resourced voluntary community services could provide the same benefits as CTOs without extending compulsory powers'
3 'There is insufficient clinical evidence for me to feel comfortable placing patients on CTOs'
4 'I think that in the long term, the use of CTOs will not show any overall benefit'.

Key themes in respondents' written comments

Written comments by clinicians reflected a wide range of opinion and highlighted differences within the profession regarding the use of community compulsion and attitudes towards it. A number of respondents described CTOs as providing the 'best possible care' for certain individuals and being 'ethically acceptable', and the potential for CTOs to 'promote recovery' was cited more than once. Others expressed strong negative views of CTOs, describing them as 'a waste of time', 'more bureaucratic' without added benefits, 'unethical', or 'a power of conveyance and little else other than covert persuasion'.

There was astonishing variation when respondents were asked to estimate how many orders they believed would be used each year in England and Wales, with a range from 20 to 300 000. Whereas the estimates at the extreme ends of this continuum probably reflect strong views about CTOs and not serious suggestions regarding levels of use, the most commonly given figure was 2000 per annum, substantially less than that recorded since November 2008.

Discussion

Our survey suggests that there has been a noticeable shift in the profession's views on CTOs since the previous survey by Crawford *et al*,[1] although our response rate means some caution is needed when comparing the results directly. Nevertheless, the proportion of those preferring to work in a system with CTOs seems to have increased substantially (from 46 to 60%). If these results represent a real shift over the past decade, this may reflect changes in attitudes once new legislation is enacted, or it may be that attitudes have become more positive with time. In New Zealand, rates of preference for a regime involving community compulsion were 79% when surveyed after powers were well embedded into practice, and it might be the case that we will continue to see increased support for the regime in this jurisdiction.

Clinical reasons were rated as being more important in decision-making than ethical or bureaucratic concerns. For example, the most important factors in initiating an order were considered to be promoting adherence to medication, protecting individuals from the consequences of relapse, and ensuring contact with health professionals. Regarding reasons for discharging an order, most importance was attached to the development of insight, clinical improvement, and adherence to treatment. Clinicians seemed to be of the opinion that (if successful) orders worked by ensuring periods of medication adherence, which in turn led to longer periods of stability, or by signalling to the person the severity of their mental health problem. Of factors discouraging the use of CTOs, most importance was attached to concerns over civil liberties, administrative burden, and the degree of coercion involved.

Our respondents believed that CTOs were more likely to have been introduced as a response to public pressure than because of accumulating research evidence, yet despite this the majority were in favour of the new system. Our results suggest that clinicians are deciding on the use of CTOs largely on clinical grounds, both in terms of starting and ending orders. However, it is clear that opinions regarding the use of compulsion vary and this seems to be reflected in practice. A substantial number of respondents (128, 23%) had used no orders and 41 (7%) had used ten or more. Although there are differences in respondents' clinical roles in different service configurations, these figures appear to reflect significant individual variation in the use of CTOs which may stem from differences of opinion. This variation in rate of use within England and Wales is similar to that found within and between different jurisdictions around the world.[23]

There remains considerable disagreement and uncertainty regarding the clinical usefulness of CTOs. It is important that clinicians are mindful of this. They should seek multidisciplinary input when making such fundamental treatment decisions in the face of enabling legislation, a lack of evidence, and (perhaps more challengingly) a lack of professional consensus or guidance. Multidisciplinary discussion and decision-making should reduce variability in the use of compulsion. The need for research in this field remains pressing as those considering whether or not to compel need evidence to inform their decision-making. The practical, legal and ethical issues surrounding the use of coercion and compulsion in community psychiatry should be introduced into postgraduate training schemes and continuing professional development. A combined approach of multidisciplinary input in

clinical decisions, ongoing research, and improved and regularised training should promote more uniform and evidence-based practice.

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