



The use of Community Treatment Orders (CTOs) in England: Ethically justifiable?

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Community Treatment Orders (CTOs)

- A legal regime for community mental health services that enables mental health treatment at home upon discharge from hospital, but that obliges a patient to adhere to certain conditions. A patient can be recalled if the conditions are not met.
- Commonly interpreted as the ‘least restrictive’ alternative to hospital-based treatment, or as ‘preventative’ of re-hospitalisation
 - “Reduces admissions”
 - “Stops revolving door syndrome”

Setting the scene: CTOs in England

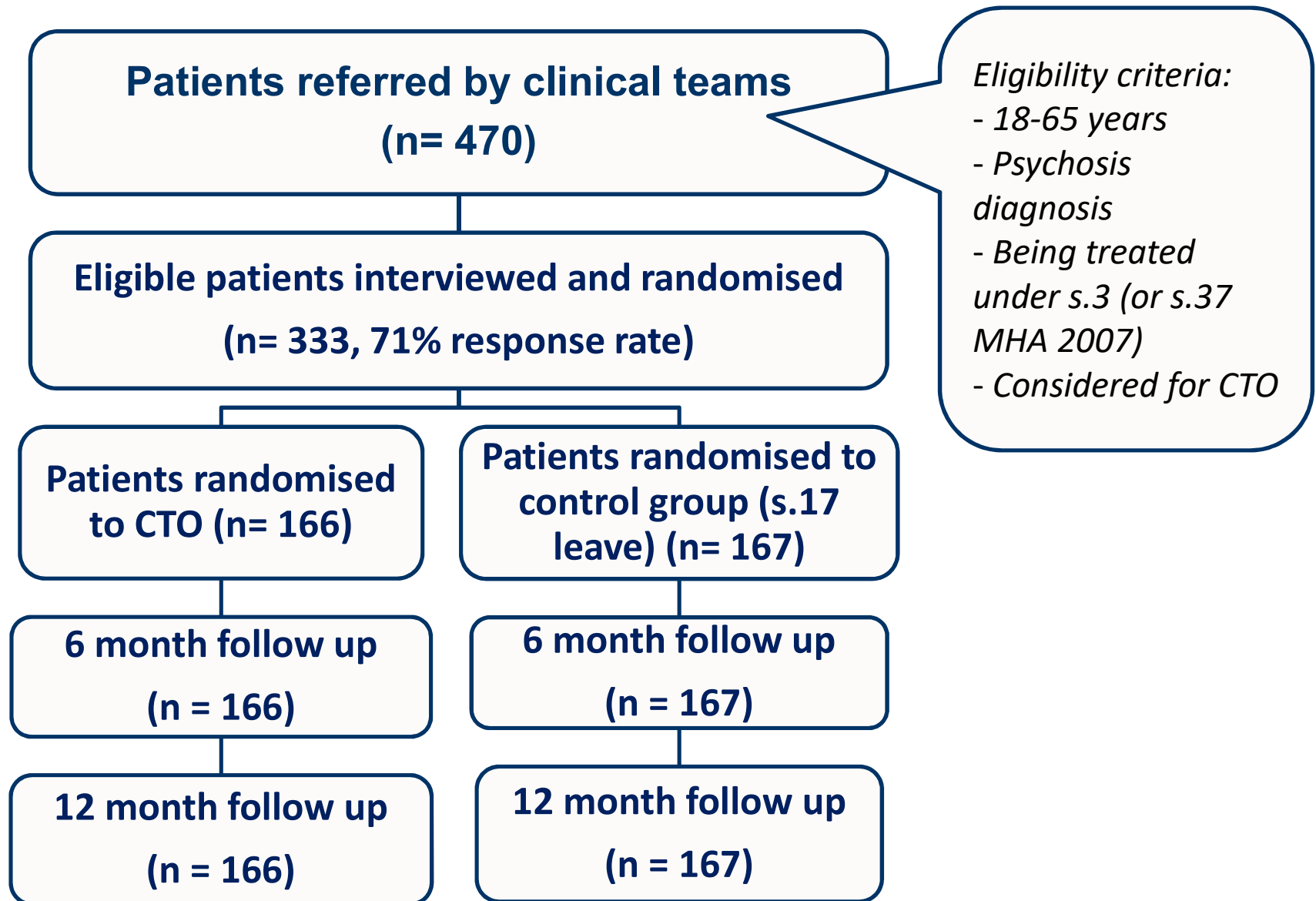
- Regimes of supervised community treatment were introduced in the MHA 2007
- Heavily debated, but professional opinion has been (and remains) tentatively supportive of these powers in the UK
- Until recently, there was an absence of evidence about the efficacy of CTOs in England

Service variation in CTO use

- **UK variation**
 - Between hospitals, 4-45% of discharge from detention
 - Between psychiatrists, 1-100 reported used
- **International variation**
 - 10 per 100,000 in the UK
 - Hardly used in some US states
 - 86 per 100,000 in New Zealand
 - 100 per 100,000 in Victoria, Australia

Are CTOs effective?

The OCTET Study



THE LANCET

Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial



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Summary

Background Compulsory supervision outside hospital has been developed internationally for the treatment of mentally ill people following widespread deinstitutionalisation but its efficacy has not yet been proven. Community treatment orders (CTOs) for psychiatric patients became available in England and Wales in 2008. We tested whether CTOs reduce admissions compared with use of Section 17 leave when patients in both groups receive equivalent levels of clinical care.

Published Online
March 26, 2013
[http://dx.doi.org/10.1016/S0140-6736\(13\)60107-5](http://dx.doi.org/10.1016/S0140-6736(13)60107-5)

Methods CTOs were compared with Section 17 leave for patients with a diagnosis of psychosis or bipolar disorder who were admitted to hospital or discharged to the community. The primary outcome was the rate of admission to hospital either inpatient or outpatient within 12 months and six, and 12 months of discharge. Secondary outcomes included patient satisfaction, quality of life, and patient compliance with treatment. The patient compliance model adjusted for baseline characteristics. The trial is registered on ISRCTN73

OCTET conclusion:

*“In well functioning mental health services, **CTOs do not reduce the readmission rate, time to readmission or time in hospital for patients with psychosis in the 12 months following discharge**”*

Outcomes tested in randomised controlled trials and meta-analyses

RCT/Review	North Carolina RCT	New York RCT	OCTET RCT	Coch- rane 2 RCTs	Meta- analysis 2 RCTs 5 CBAs	Meta- analysis 3 RCTs
Outcome	N=264	N=142	N= 336	N=416	N= 1108	N= 749
Readmission rate	x	x	x	x	x	x
>1 admission		x	x			
Number of days in hospital		x	x		x	x
Number of readmissions		x	x			
Remaining in contact with services		x				
Service intensity	x		x		x	
Compliance with treatment	x	x	x	x	x	
Symptoms/mental state		x	x	x		x
Functioning (GAF)		x	x	x		x
Victim of crime	+			+		
Accommodation/homelessness	x	x	x	x		
Quality of life	x	x	x			
Imprisonment/violence/arrest	x	x		x		
Employment			x			
Alcohol/drugs problems			x			
Satisfaction with services			x			
Therapeutic relationship			x			
Perceived coercion	x	x	x	x		
Experienced treatment leverage			x			
Family carer satisfaction	x					

X= no effect

+ = positive effect

**Have the ethical arguments been
settled?**

CTOs: the ethical debate

- Extending legal powers into the community equates with unjustified restrictions on patients' freedoms and autonomy, threatening the principles of respect for liberty and self-determination that are already compromised in mental health care

vs.

- People who have severe, enduring mental illnesses lead difficult lives characterised by poor adherence to treatment. CTOs are a pragmatic response to this challenging reality that can improve patients' quality of life, autonomy and liberty in the longer-term

CTOs: the ethical debate

- The values of benefit, autonomy and liberty have been identified in ethical arguments, but the same values are drawn upon to make opposing claims
- **Benefit:** The extent to which patient and/or carer quality of life improves through the use of a CTO
- **Autonomy:** The ability of a patient to formulate and enact a life of value to her when a CTO is used
- **Liberty:** The extent to which a patient's (objectively determined) freedoms are enhanced or restricted when a CTO is used

Ethical arguments and mental health practice: The rationale for empirical research

- The literature makes general claims involving these 3 values, but it is not clear how these claims connect to complexities in the needs and life circumstances of patients and caregivers for whom this power is now being used
- Therefore, it is uncertain how professionals should make sense of, and balance, these values in making judgements about whether a CTO is ethically justifiable

CTOs in England: Ethically justifiable?

Empirical Ethics

CLINICAL ETHICS

Clinical Ethics
2016, Vol. 11(4) 130–139
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sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/1477750916657654
cet.sagepub.com

An empirical ethical analysis of community treatment orders within mental health services in England

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Abstract
Community treatment orders are a legal mechanism to extend powers of compulsion into outpatient mental health settings in certain circumstances. Previous ethical analyses of these powers have explored a perceived tension between a duty to respect personal freedoms and autonomy and a duty to ensure that patients with the most complex needs are able to receive beneficial care and support that maximises their welfare in the longer-term. This empirical ethics paper presents an analysis of 75 interviews with psychiatrists, patients and family carers to show how these ethical considerations map onto the different ways that community treatment orders are used and experienced in practice. A complex and nuanced account of how the requirements to respect patients' autonomy, to respect patients' liberty and to act beneficently should be interpreted in order to make judgements about the ethics of community treatment orders is presented. The article argues that, due to such complexity, no general ethical justification for community treatment orders can be provided, but a justification on the basis of the promotion of patients' autonomy could provide an ethical reason for community mental health practitioners to make use of a community treatment order in some limited circumstances.

Keywords
Community treatment orders, mental health, psychiatry, psychiatric ethics

Introduction
In recent years, research in psychiatric ethics has begun to shift its attention away from hospital care and onto those services provided for patients in the community.^{1–3} This shift has been characterised by a refocusing of inquiry onto the ethical issues arising in the long-term long-term approach to the provision of legally supervised care in the community (Mental Health Act 2007, s.17A-G). An order should be issued under the CTO regime prior to the patient being discharged from hospital, and this order permits the recall of the patient to hospital in two circumstances. First, when the patient requires treatment in hospital and in the absence of

- A focused thematic re-analysis of qualitative data collected alongside the CTO study to highlight ethical dimensions explicitly.
- 75 qualitative interviews (26 patients; 25 consultant psychiatrists; 24 family carers)
- Data re-coded and re-categorised according to the three ethical values of 'benefit', 'autonomy' and 'liberty'

Dunn, M., Canvin, K., Rugkasa, J., Sinclair, J and Burns. T. (2016) 'An empirical ethical analysis of community treatment orders within mental health services in England', *Clinical Ethics*, 11: 130-139.

Central findings

- Considerations of benefit, autonomy and liberty played out in complex, multi-directional ways within individual patient care. No general justification for CTOs was present in the data
- The re-analysis of the qualitative dataset revealed that CTOs can, in some situations, ***promote a patient's autonomy***
- This account was in conflict with the experiences of some other patients: reported feeling controlled by the use of the legal power, limiting possible scope of self-determination

Data concerning the value of the CTO

CTOs provide a ‘window of opportunity’ to establish a new stable treatment relationship...

- A number of patients emphasised the role that agreement with the CTO conditions plan could improve the treatment relationship, and consequently patients’ engagement with services:

“the thing is when I was unwell I’d function and I’d do the groceries and make the dinner and stuff but I’d be drinking and making up all this stuff in my head and I’m not doing that now. I’m well and I’m stable but I think CTO just because it is threat, threat is the wrong word but it’s the safeguard, it’s the safeguard that if I was to think of going on a bender I just wouldn’t because I wouldn’t want to jeopardise all this work that I’ve put into being well again” (P – CTO)

Data concerning the value of the CTO

BUT: CTOs can stagnate the care planning process...

- The concern expressed by a number of family carers and two clinicians was that an advance plan outlining the CTO conditions risks not meeting broader needs and could undermine a dynamic process of planning changes in the services received as required

“This is the downside I feel of the CTO that we’re not getting anywhere... time we asked about possibly reducing the frequency of the depot or its volume, the dosage, we were told well, that’s going to be very difficult you have to go back to the original prescribing doctor in the hospital if we can alter anything once you’re on a CTO and that would be difficult.” (FC)

Data concerning choice-making under a CTO

- Only a minority of patients were concerned about the way in which being placed on a CTO equated with a restriction of choice
- One psychiatrist described how CTOs could have positive and negative impacts on the foundations upon which patients' can make choices:

“You know where you stand...”

“I suppose potentially I think CTOs could be seen as being the better of the two from the patient’s perspective because at least the conditions are clear and sort of it’s not, whereas in Section 17 leave it can you know, it can just be used completely in a coercive way because you’re not really sort of setting out what you want, you’re saying, you’re still under the section” (Psych – CMHT)

Data concerning choice-making under a CTO

CTOs as the route back to control over life planning...

3 patients reported how the strict requirements of the regime freed them from constraints they placed upon themselves:

“I’m not under pressure. I’m an entirely free agent. I’ve got a little area on top of my writing bureau; I’ve got all my things set out and I know what time, exactly what time I take it and the quantity, how many and yeah I’ve got a little; it’s like a little altar it is to my medication and these little pots.” (P - CTO)

Data concerning choice-making under a CTO

BUT: Being held back...

- But, for other patients, CTOs were seen as infantilising, invoking a regime of supervision that held back their ability to pursue their own life goals.

[Upon being discharged from a CTO] “I feel that I’m a free man again you know. I don’t need to tell, to let them know of everything I want to do. I’ve got a bit of privacy. I’m a grown man and I should be able to look after myself.” (P - CTO)

Data concerning choice-making under a CTO

BUT: Limited opportunities for self-development...

- And, for a number of family carers, CTOs were viewed simply as a form of 'containment', managing the patient without enabling the requisite supports for the patient to lead an autonomous life:

“It would be a lot better if the team were active and found something for this intelligent man to do. You know he just sits doing crosswords from the newspaper and that’s about it now. You know, he’s becoming more and more isolated and more and more withdrawn. I think the CTOs just contain him.” (FC)

Reflections

- The justification for using CTOs is entirely contextual: no overarching ethical justification for this legal regime can be provided
- (Perhaps oddly), the **promotion (nurturing) of autonomy** provides a distinctive kind of reason in support of CTOs in some cases, so long as:
 - enhanced self-determination is justified i) at the expense of a loss of freedom, and ii) in recognition that patients will not benefit with regards to well-established health outcomes in psychiatry
- Uncertainty remains, however:
 - Are practitioners obliged to promote/nurture autonomy as a treatment goal in community mental health (and should community MH law be formulated on the basis of this moral requirement?)
 - Are CTOs a necessary condition for promoting autonomy in this way?

CTOs and advanced planning in mental health

- Suggestion that CTOs should only be used as a form of advanced directive (Szmukler 2015)
- Better, perhaps, to see promoting autonomy in community mental health as a broad justification for patient-led advance care planning
 - Advance care planning could either:
 - occur without legally-mandated community-based treatment, or
 - it could take advantage of the current CTO regime to support the process when judged necessary in specific cases. More research needed here
- **One suggestion:** shift the ethical focus away from legal mechanisms of coercion and towards proactive and properly-resourced mechanisms to promote patient autonomy in the community

Thank you.

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