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SIMON LAWTON-SMITH

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# Community-based Compulsory Treatment Orders in Scotland

THE EARLY EVIDENCE

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# Community-based Compulsory Treatment Orders in Scotland

THE EARLY EVIDENCE

Simon Lawton-Smith

*King's* Fund

In recent years, a growing number of places around the world have introduced powers to compel certain people with mental disorders living in the community to engage with services and undergo treatment. This paper explores what has happened in the first six months since community-based compulsory treatment orders were introduced in Scotland in October 2005. It looks at how many people have become subject to the orders, the pathways to being placed on an order, the impacts on mental health staff, and resource issues. It also considers what lessons emerge for England and Wales, which will soon be introducing similar arrangements.

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## About the author

**Simon Lawton-Smith** is Senior Fellow in Mental Health at the King's Fund. He is responsible for the Fund's mental health work programme, including taking forward the work of the Fund's London Mental Health Inquiry (November 2003). He is on the editorial board of *Mental Health Review* and is a member of the advisory group to *Mental Health Today*; has advised the Parliamentary All Party Group on Mental Health; is a member of the Policy Group and Steering Group of the Mental Health Alliance, the 70-strong consortium of organisations established to comment on the government's proposals to amend the Mental Health Act 1983; and is author of a number of reports and articles on a range of mental health issues. From 1997 to 2003 he was Head of Public Affairs at the national service-provider mental health charity Together. Before that, he worked in the civil service in the Department of Health, The Northern Ireland Office and the Cabinet Office.

## Acknowledgements

Thanks are owed to Ashley Podoll from Iowa University, who worked on the project from January to May 2006 and was instrumental in obtaining and analysing early data on the use of community-based compulsory treatment orders (CTOs) in Scotland.

Particular thanks are owed to Rhian Hunter at the Mental Welfare Commission for Scotland and Ruth Steele at the Mental Health Tribunal for Scotland for their help in obtaining statistical data about the use of community-based CTOs during the first six months of the Mental Health (Care and Treatment) (Scotland) Act's operation.

# Summary

## Background

In recent years, a growing number of jurisdictions around the world have introduced powers to compel certain people with mental disorders living in the community to engage with mental health services and undergo treatment. The powers are aimed primarily at 'revolving door' patients. These are users of mental health services who become ill and have to be admitted to hospital where they recover and are discharged, but who then fail to engage with services, stop taking their medication and require further (and sometimes frequent) hospital admission.

In 2003, Scotland introduced such a power through the Mental Health (Care and Treatment) (Scotland) Act 2003. This allows clinicians to apply to the Mental Health Tribunal for Scotland for authorisation of a compulsory treatment order (CTO) that could be either hospital- or community-based. The community-based CTO supersedes the previous leave of absence powers and community care orders under which conditions could be placed on some people living in the community but treatment could not be enforced.

The application to the Mental Health Tribunal must specify whether it is for a hospital-based CTO or a community-based CTO. People may therefore be placed directly under a community-based CTO by the Tribunal. Alternatively, applications may be made to the Tribunal to convert an existing hospital-based CTO to a community-based CTO, if it is considered that a person's residence in hospital is no longer necessary.

The Act came into effect on 5 October 2005.

In England and Wales, the government had originally planned to introduce similar CTOs through the Draft Mental Health Bill 2004. Following concerns expressed during consultation, the government decided to drop this Bill and instead introduce a shorter Bill amending parts of the Mental Health Act 1983. This will probably be tabled in parliament in November 2006. This Bill will provide for clinician-authorized supervised community treatment (SCT) rather than Tribunal-authorized community-based CTOs. The effect, however, is similar.

This paper draws on lessons learned so far in Scotland to inform the debate surrounding supervised community treatment in England and Wales.

## **Aims of this paper**

The aims of this paper are:

- to establish the number of people in Scotland subject to compulsory community treatment in the first six months of operation of the Mental Health (Care and Treatment) (Scotland) Act 2003, that is, 5 October 2005 to 31 March 2006
- to analyse the various routes that people took to compulsory community treatment
- to explore the impact of the new arrangements on mental health staff
- to assess the likely early implications of introducing compulsory community treatment in England and Wales by drawing on Scotland's experience of CTOs.

## **Methodology**

The review carried out for this paper sought quantitative data on the use of community-based CTOs from the Mental Welfare Commission for Scotland. This data was supplemented with a more detailed breakdown from the Mental Health Tribunal.

Semi-structured interviews were carried out with 10 individuals involved in the implementation and monitoring of the compulsory CTO process in Scotland, between 24 and 26 May 2006. In addition, two telephone interviews were undertaken, and written comments on the interview questions were received from four mental health staff in Glasgow and one service user group.

The review looked at published articles and other literature on the international use of community-based treatment powers (drawn from a literature search undertaken by librarians at the King's Fund in 2004). The review supplemented this with a web-based search for articles, briefings and guidance written before and after the introduction of community-based CTOs in Scotland, in particular from the Scottish Executive, the Scottish Parliament and Scottish mental health bodies.

## ***Limitations***

It should be noted that not all the quantitative data on the authorisation of community-based CTOs is considered complete and it should therefore be treated with some caution. In addition, although efforts were made to interview a representative range of professionals involved in the community-based CTO process in Scotland, the qualitative data obtained was limited by the small number of those interviewed, and the fact that the views expressed by selected interviewees may not be wholly representative.

## ***Exclusions***

The review carried out for this paper excluded people placed on community-based compulsion orders authorised by the courts in the cases of people convicted of crimes. Data from the Mental Welfare Commission (Mental Welfare Commission for Scotland 2006a) suggests that 11 such community-based compulsion orders were made in the first six months of the Act's operation, all variations of hospital compulsion orders. The review also excluded consideration of interim community-based CTOs.

The review did not examine the clinical effectiveness of community-based CTOs as it was expected to be too early to make a judgement about this.



## **Findings**

Findings from the review focused on the numbers of people placed on community-based CTOs, the pathways to being placed on community-based CTOs, the Act's impact on mental health staff, and resource issues.

### ***Numbers of people placed on community-based CTOs***

Before the 2003 Act was passed, the Scottish Executive estimated that in Scotland, at any one time, there might be about 200 people subject to community-based CTOs.

In order to assess the accuracy of this estimate, available data was collected from the Mental Welfare Commission and the Mental Health Tribunal. The Commission does not consider all the data complete and it should therefore be treated with some caution.

The data suggests that a total of 176 people were subject to community-based CTOs during the first six months of the Act's use. One hundred and forty-four community-based CTOs were authorised during that period, and 32 people previously under community care orders (CCOs) were deemed transferred to community-based CTOs on 5 October without recourse to the Tribunal.

Although incomplete, a Mental Welfare Commission snapshot taken at 4 January 2006 indicated that 63 people had at that date been placed under a community-based CTO (either by the Tribunal or on a transfer from a CCO).

It has not been possible to source data on the numbers of people who may have been discharged from a community-based CTO in the first six months of the Act's use. However, allowing for a small number of discharges, the total number of people under a community-based CTO as at 31 March 2006 can be estimated to be about 160.

Of the 63 people placed on a community-based CTO at the time of the 4 January snapshot, only two were aged 18–24. This suggests that, as intended, community-based CTOs are largely being imposed on 'revolving door' patients. This theory was supported by interviews with mental health staff, which indicated that considerable emphasis is being placed on a person having a history of non-engagement and non-compliance, followed by deterioration in health, before a community-based CTO is authorised.

### ***Pathways to being placed on community-based CTOs***

In the first three months of the new CTO arrangements, slightly more people were placed under community-based CTOs following an original application to the Tribunal than following conversion of a hospital-based CTO. However, the second quarter shows significantly more people being placed under a community-based CTO following conversion of a hospital-based CTO. This bears out the perceptions voiced by mental health staff in interviews that by far the commonest pathway to a community-based CTO is via a conversion from a hospital-based CTO.

### ***Impact on professionals***

During interviews with mental health staff, issues were raised about the extra bureaucratic burden imposed on many staff by the application and Tribunal process. In particular there was concern that, as a consequence of this pressure, voluntary patients could lose out. At the present stage, however, this appears to be a theoretical rather than a proven outcome of the new arrangements.

Despite criticism of the process, there was unanimous agreement among interviewees that the new arrangements were an improvement over the previous ones in terms of fairness to the patient, the opportunity for many more people to have their views taken into account, and the clarity with which the Act sets out the criteria for placing someone under compulsion.

Many professionals are still learning about the Act with its new community-based CTO powers. Patients, families and carers, perhaps not surprisingly, appear to know relatively little about community-based CTOs unless they are personally involved in the process itself.

### ***Availability of resources***

Despite a Scottish Executive commitment to provide significant extra funding to implement the community-based CTO provisions, interviews suggest that there is little or no frontline awareness of any increase in resources. Staff feel that the extra work involved in applying for a community-based CTO and in providing services under a care plan is simply increasing an already heavy workload.

The care plans for people subject to community-based CTOs appeared to include a full range of services. However, it was not yet clear whether the services in the care plan were actually being delivered.

## **Conclusions**

A number of important points emerge from this review of Scotland's early experiences of introducing community-based CTOs. These have relevance not only for the Scottish Executive and Scottish mental health bodies, but also for the Department of Health in London, with respect to its plans to introduce similar arrangements in England and Wales.

### ***Key points for Scotland***

- Despite being criticised as burdensome, the new community-based CTO arrangements have generally been welcomed in Scotland. There is no evidence that the arrangements are failing or being abused. Inasmuch as this paper estimates that there were about 160 people living in the community under a community-based CTO as at 31 March 2006, the process appears to be working.
- Although mental health staff appear to appreciate the power that the new community-based CTO can provide, they have serious reservations about the process. However, as the Act becomes more entrenched and better understood, and as the Tribunal system overcomes some initial teething problems, the problems faced by staff should lessen.

- At the time of our interviews in May 2006 there was a widespread impression that no new resources had been made available on the ground to expand services for people on a community-based CTO. This suggests that the Scottish Executive, NHS bodies and local authorities need to provide clearer information about where the extra money earmarked for implementing the Act has been spent.
- At this stage, the picture appears to be one of cautious optimism. The process, despite some early difficulties, is largely working and the new community-based CTO arrangements seem to be reasonably well understood, and applied only to those for whom they were intended. However, this optimism is tempered by the burden of increased bureaucracy and workloads on mental health staff, who see little or no sign of extra resources, and a concern that, by sucking in resources, community-based CTOs may result in fewer services being available for other people with mental health needs. It also remains to be seen whether community-based CTOs will bring the hoped-for improvement in patient outcomes – an issue this paper does not address.

### ***Lessons for England and Wales***

- The limited initial use of community-based CTOs in Scotland reflects the general experience in other countries when new community treatment powers have been introduced. It therefore seems reasonable to suppose that there will be a similarly limited uptake of SCT in the first months of its use in England and Wales.
- The widespread acceptance of community-based CTOs in Scotland is the result of them being seen as fairer for the patient and applied only to 'revolving door' patients. If SCT is to be accepted in a similar fashion in England and Wales, then the legislation will need to ensure that the powers transparently bolster patient rights and are limited to this group of patients.
- The Department of Health should make clear at an early stage its transitional arrangements for people transferred from existing powers to new SCT powers, and ensure that the staff involved fully understand them before the date when the SCT powers come into effect.
- In order for new SCT arrangements to be used appropriately and effectively, it will be necessary to allay professionals' concerns about the possibility of an increased bureaucratic burden, while ensuring fairness for all parties and building in all necessary safeguards for patients.
- Commissioners of community mental health services in England and Wales will need to be aware that, as with community-based CTOs in Scotland, the introduction of SCT is likely to mean higher levels of services required in the community. They should plan and commission services to ensure that service providers have adequate resources to fully implement SCT patients' care plans, while in no way reducing the level of services available to other people with mental health needs.
- It will be important to ensure that any extra central government or local authority funding allocated for the implementation of the SCT arrangements is clearly seen to be spent for that purpose.

- Before any new powers come into effect in England and Wales, resources and time need to be made available so that all staff involved with SCT can be trained in the new powers, with regard to both their own and others' roles and responsibilities.
- Problems with data collection in Scotland suggest that in England and Wales clear arrangements must be in place from the outset for collecting, both locally and centrally, a minimum dataset on the use of SCT.
- In drafting new legislation and revising the Code of Practice, the Department of Health should consider how the reported benefits of the new Scottish Act, such as guiding principles having been written into the Act, advance statements, and patients' rights to advocacy, can be used to underpin the proposed SCT arrangements for England and Wales.

# 1

## Introduction

The story of mental health care in developed countries over the past 20 or 30 years has been one of de-institutionalisation: the closure of long-stay psychiatric institutions, a reduction in psychiatric beds and the development of community services for people with a mental disorder (Freeman 1999; Geller 2000). This has been driven both by the civil and human rights movements and by advances in drug therapies that allow patients' mental health to be better maintained while living in the community. It has meant that significant numbers of people with severe and enduring mental disorders are now cared for in the community rather than in hospitals.

In countries around the world, legislation allows for people to be compulsorily detained in hospital, under certain circumstances, if their mental health deteriorates to such an extent that they are at risk of harm to themselves or others. Today, a growing number of jurisdictions also allow for people to be placed under compulsory community-based treatment orders. This is generally referred to as involuntary outpatient treatment or commitment (IOT or IOC) or mandatory outpatient treatment (MOT). In some countries patients are placed under a community treatment order (CTO), although in Scotland the term 'CTO' stands for compulsory treatment order, which may be either hospital- or community-based.

### **The purpose of compulsory community treatment**

The primary objective of compulsory community treatment is to ensure that certain people living in the community with a serious mental disorder receive treatment that is considered necessary for them. It is intended to provide people with treatment and care in the least restrictive environment, in the community rather than in hospital, and to prevent relapse. It is aimed primarily at 'revolving door' patients. These are users of mental health services who become ill, have to be admitted to hospital, recover and are discharged, but who then fail to engage with services, stop taking their medication and require further (and sometimes frequent) hospital admission.

It is also intended to reduce risk, whether to patients themselves or to others. A number of countries passed compulsory community treatment laws as a result of a homicide or other act of violence committed by a patient who had refused to take their medication (Rolfe 2001; Applebaum 2001). This has led to 'Brian's Law' in Ontario, Canada, 'Kendra's Law' in New York and 'Laura's Law' in California, each named after the victim of a homicide by a person living in the community, diagnosed with schizophrenia, who was not taking any medication (Lawton-Smith 2005).

Community-based CTOs have been introduced in Scotland under the Mental Health (Care and Treatment) (Scotland) Act 2003, which came into effect on 5 October 2005. A new Bill

to amend the current Mental Health Act 1983 for England and Wales is likely to be tabled in November 2006, and is also expected to contain provision for some form of compulsory community-based treatment (see below).

## **Aims of this paper**

Originally, the Department of Health proposed a completely new Mental Health Bill for England and Wales that would have introduced, among other things, a Tribunal-authorised system of compulsory community-based treatment similar to Scotland's. The draft of the Bill was circulated among stakeholders for comment in 2004/5, and as a result of opposition from numerous quarters, the government decided to drop the Bill in March 2006. In its place, the government intends to introduce an amendment Bill for England and Wales, which is likely to be tabled in parliament in November 2006. This Bill will provide for a system of supervised community treatment (SCT) that will be similar, although not identical, to the existing supervised discharge powers contained in section 25 of the current Mental Health Act 1983. Its prime purpose is to ensure that so-called 'revolving door' patients continue to engage with services and take their medication while living in the community, thus reducing risk and preventing relapse and readmission to hospital.

In this context, the aims of this paper are:

- to establish the number of people in Scotland subject to compulsory community treatment in the first six months of operation of the Mental Health (Care and Treatment) (Scotland) Act 2003, that is, 5 October 2005 to 31 March 2006
- to analyse the various routes that people took to compulsory community treatment
- to explore the impact of the new arrangements on mental health staff
- to assess the likely early implications of introducing compulsory community-based treatment in England and Wales by drawing on Scotland's experience of CTOs.

## **Methodology**

### ***Statistical data***

During the passage of the Mental Health (Care and Treatment) (Scotland) Bill through the Scottish Parliament, the Health and Community Care Minister, Malcolm Chisholm, acknowledged fears that the new provisions might be misused and made a commitment to monitor carefully the overall numbers of community-based CTOs. The minister confirmed that he would 'establish a research programme that will monitor the operation of the new legislation, including community-based orders, to ensure that it is working as intended' (Scottish Parliament 2002a).

The review carried out for this paper sought quantitative data on the use of community-based CTOs from the Mental Welfare Commission. The Commission has a duty to monitor the operation of the new Mental Health Act, and to promote best practice in relation to the operation of the Act, including the principles. It has decided to visit all people subject to community-based CTOs and its monitoring programme includes community-based CTOs as a priority area.

The Commission's data was supplemented with a more detailed breakdown of the data from the Mental Health Tribunal.

### ***Semi-structured interviews***

Semi-structured interviews were carried out between 24 and 26 May 2006 with 10 individuals (see Appendix 2, p 31) who had been involved in the implementation and monitoring of the compulsory CTO process in Scotland. In addition, two telephone interviews were undertaken, and written comments on the interview questions were received from four mental health professionals in Glasgow and one service user group (the Highland Users Group).

Interviewees were selected in order to provide as representative a range of views as possible from the Scottish Executive, the Mental Health Tribunal, psychiatrists, mental health officers (MHOs), and mental health voluntary sector organisations with an interest in the operation of the new legislation.

The interview questions were based on concerns about the proposed community-based CTOs that had been raised during the parliamentary debate on the new legislation held on 11 December 2002 (Scottish Parliament 2002a). These concerns included the following.

- The introduction of community-based CTOs would require significant extra resources and investment in community-based services.
- Given the rise in the use of long-term leave of absence (LOA) for some patients (see p 6) over the previous 15 years, that trend was likely to continue or even escalate when the community-based CTOs were introduced, and might significantly increase overall levels of compulsion.
- User groups doubted that community-based CTOs would always be the least restrictive alternative; they might simply be used as a resource management tool to relieve pressure on hospital beds.
- Because of the many gaps that existed in community-based services, the new orders might amount to little more than compulsory medication in people's homes.
- International research suggested that the benefits of community-based CTOs were not proven.

### ***A search of selected literature***

The review looked at published articles and other literature on the international use of community-based treatment powers (drawn from a literature search undertaken by librarians at the King's Fund in 2004). It supplemented this with a web-based search for articles, briefings and guidance written before and after the introduction of community-based CTOs in Scotland, in particular from the Scottish Executive, the Scottish Parliament and Scottish mental health bodies.

### ***Limitations***

It should be noted that the Mental Welfare Commission does not consider all the quantitative data complete and it should therefore be treated with some caution.

In addition, although efforts were made to interview a representative range of professionals involved in the community-based CTO process in Scotland, the qualitative data obtained was limited by the small number of those interviewed. Although the Mental Health Tribunal interviewees had extensive experience of community-based CTO cases, some staff interviewed had personal experience of only one or two such cases. As a result, the views expressed by selected interviewees may not be wholly representative.

### ***Exclusions***

The review focused on people placed on community-based CTOs through the civil process of authorisation by the Mental Health Tribunal. It did not enquire about compulsion orders authorised by the courts in the cases of people convicted of crimes, which may be used to detain people in hospital or impose conditions on their residence in the community. Data from the Mental Welfare Commission (Mental Welfare Commission for Scotland 2006a) suggests that 11 such community-based compulsion orders were made in the first six months of the Act's operation, all conversions from hospital-based compulsion orders.

The review did not examine the clinical effectiveness of community-based CTOs in terms of patient outcomes, as it was expected that it would be too early to make a judgement about this.



# 2

## Background

### **Community-based compulsory treatment orders in Scotland**

The rationale for introducing community-based compulsory treatment orders (CTOs) in Scotland was set out by the Scottish Minister for Health and Community Care, Malcolm Chisholm, in the Scottish Parliament's debate on the Mental Health (Care and Treatment) (Scotland) Bill of 11 December 2002 (Scottish Parliament 2002a):

*One of the bill's most hotly debated aspects concerns community-based compulsory treatment orders. I welcome the fact that the committee has agreed with us and with the Millan Committee that, in principle, such orders should be possible. It must be right that a person who does not need to be in hospital should be able to stay at home, even if certain aspects of their care are delivered on a compulsory basis.*

*No compulsory treatment order, in hospital or the community, will be made unless the Mental Health Tribunal is satisfied that that is necessary to ensure that the patient gets the treatment they need and that a compulsory treatment order is the best available way of doing so.*

The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect on 5 October 2005 and in certain circumstances allows for the compulsory detention and treatment of people with a mental disorder both in hospital and in the community. The Scottish Executive has published guides to the new legislation (Scottish Executive 2003) and specifically to CTOs (Scottish Executive 2005).

Under the Act a mental health officer (MHO) can apply to the Mental Health Tribunal for a CTO. The application must specify whether the application is for a hospital-based CTO or a community-based CTO. People may therefore be placed directly under a community-based CTO by the Tribunal. Alternatively, an application may be made to the Tribunal to convert an existing hospital-based CTO to a community-based CTO, if it is considered that a person's residence in hospital is no longer necessary.

In the case of a community-based CTO, the Tribunal may set conditions such as requiring the patient to receive treatment as instructed, attend certain community care services, stay in a particular place in the community, and allow visits to their home by people involved in their care and treatment.

A brief description of the powers to impose community-based CTOs, and references to community-based CTOs in the Code of Practice, are set out in Appendix 1 (see pp 29–30).

## Previous powers to impose community-based treatment in Scotland

Under previous legislation, there were powers to impose community-based treatment on certain patients through leave of absence (LOA) powers, set out under section 27 of the Mental Health Act (Scotland) 1984, and community care orders (CCOs), which could be made under section 35 of the 1984 Act following an amendment introduced in the Mental Health (Patients in the Community) Act 1995. Both arrangements allowed for patients to reside in the community under certain conditions, rather than being detained in hospital, but neither included powers to enforce treatment in the community.

There were concerns about both sets of powers. Some LOA patients were recalled to hospital for a brief period at the end of their time on LOA and then discharged again under a new LOA – in effect extending the provision indefinitely without a robust review of whether in fact they should be formally discharged. The CCO powers were felt by many clinicians to be ineffective because they lacked effective sanctions in cases of non-compliance with medication.

The community-based CTO supersedes both sets of powers and is intended to counter these concerns. It introduces a more independent (Tribunal) authorisation of compulsory powers in the community and more regular review of individual cases – the patient's responsible medical officer (RMO) must carry out a formal review of the order in the two months before it is due to expire and must cancel the order if the compulsion criteria are no longer met. To provide a stronger sanction in cases of non-compliance with medication, the community-based CTO includes the provision for a patient who does not attend for medical treatment to be taken to hospital for the purpose of receiving that treatment and detained for up to six hours.

## Resources for implementation of the 2003 Act

The literature review that was commissioned by the Scottish Executive prior to the Act (Atkinson *et al* 2001) pointed out that the effectiveness of community-based orders cannot be divorced from the adequacy of community services and that, generally, community-based orders have been introduced with no additional resources.

The Health and Community Care Minister, Malcolm Chisholm, acknowledged that resources for community-based CTOs would be an important factor during the debate on the Bill on 11 December 2002 (Scottish Parliament 2002a):

*Community-based orders will not be a cheap option. The Tribunal will insist that a full care plan is in place to address the patient's need for health care, social care, and other support. It will want to be satisfied that the patient's views have been considered, and that the patient has had access to advocacy. It will also be able to identify particular services that it regards as essential for the patient and that cannot be withdrawn without reference to the Tribunal.*

The Financial Memorandum accompanying the Bill (Scottish Parliament 2002b) estimated that the additional costs associated with the new legislation would amount to £23.1 million per annum, with one-off start-up costs of a further £9.25 million to be met before the end of 2007/8. The total estimated costs to local authorities of £13 million

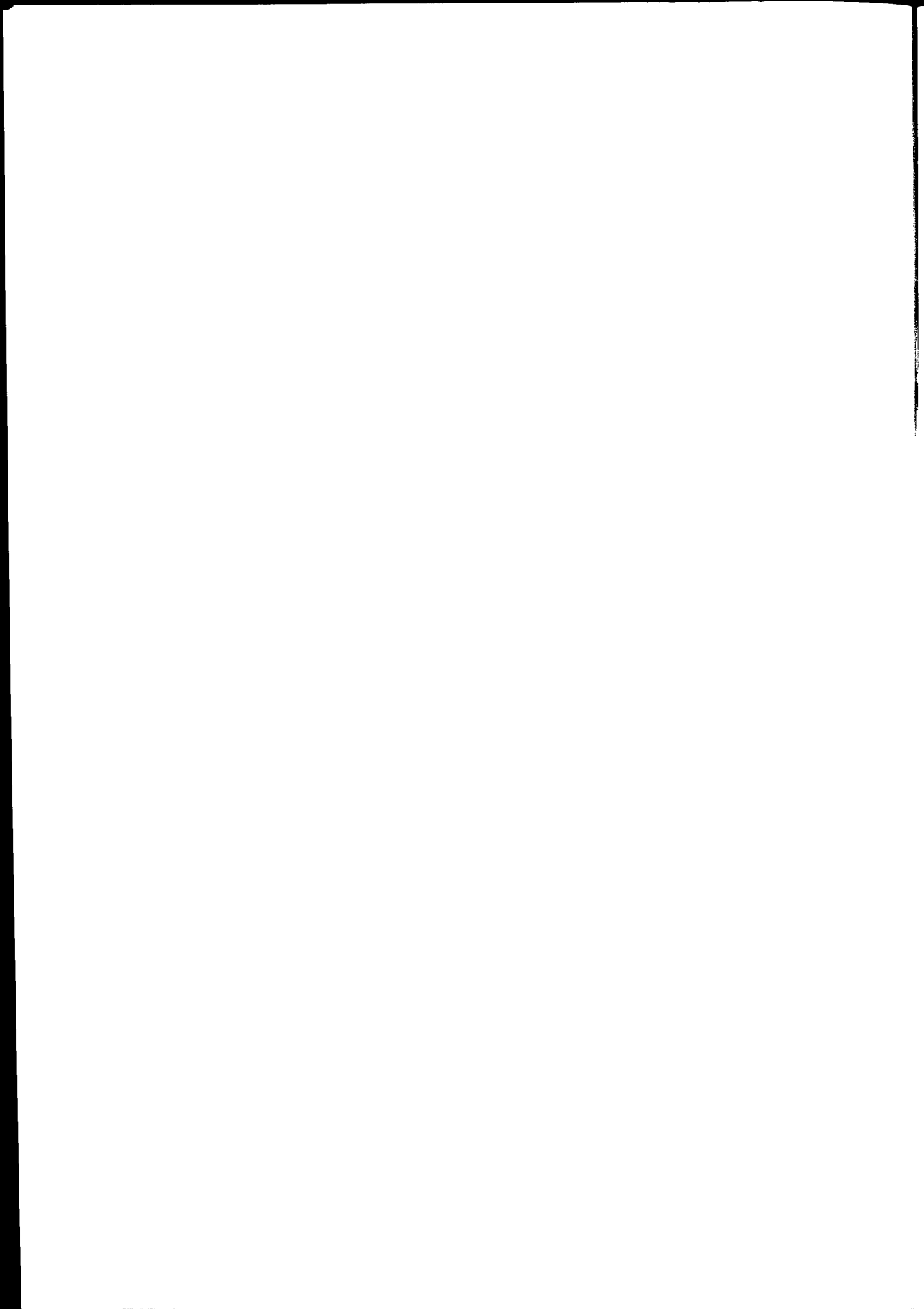
included £2 million for improvements in the packages of care available to people subject to community-based CTOs and £2.5 million for 45 new full-time-equivalent MHOs. NHS Scotland costs included £2 million for the principle of reciprocity and plans of care and £1.5 million for additional psychiatrist workload, including appearing at Tribunal hearings.

The Scottish Executive has provided local authorities' budgets with additional funding amounting to £1.2 million in 2003/4, £12.5 million in 2004/5 and £13 million in 2005/6 – to continue at that level thereafter unless a change is announced – in order to meet the demands of the Act. Since the passing of the Bill, additional funds have been distributed to NHS boards in Scotland (see Table 1, below) to be invested in implementing and delivering the Act.

**TABLE 1: ADDITIONAL FUNDS DISTRIBUTED TO NHS BOARDS IN SCOTLAND, 2003/4 TO 2007/8**

	Year				
	2003/4	2004/5	2005/6	2006/7	2007/8
<b>Funds distributed</b>	£0.95m	£4.76m	£5.08m	£5.00m	£5.00m*

\* provisional



# 3

## Findings

This section presents the findings of this review in relation to the following questions.

- How many people were placed on community-based compulsory treatment orders (CTOs) in Scotland during the first six months' of the Act?
- What were the characteristics of the people placed on community-based CTOs?
- What is the pathway to being placed on a community-based CTO?
- What is the process for applications to the Tribunal and how does the Tribunal operate?
- How well is the new community-based CTO system understood?
- What resources have been made available for implementing community-based CTOs and care plans?
- What impact are community-based CTOs having on patients?

The findings are based on a combination of quantitative data obtained from the Mental Health Tribunal and the Mental Welfare Commission, and qualitative data obtained from interviews with a number of individuals with an interest in the new CTO arrangements.

### **Numbers of people placed on community-based CTOs**

Concerns have been expressed, not only in Scotland but elsewhere in the world, that compulsory community-based treatment powers might be over-used, placing more people under compulsion than was planned or is necessary. The numbers of people per 100,000 population placed under such powers varies considerably in different jurisdictions around the world. To get a picture of whether the new powers are being used in Scotland as they were intended, it is therefore helpful to look at pre-Act estimates of the numbers of people who might become subject to compulsion, the numbers of people placed on community-based CTOs in the six months after the Act came into effect, how these figures compare with other jurisdictions around the world and possible future trends in the use of community-based compulsory treatment in Scotland.

#### ***Pre-Act estimates***

The financial memorandum presented by the Scottish Executive before the Scottish Bill was debated estimated that, at any one time, there might be about 200 people subject to community-based CTOs (Scottish Parliament 2002b). Dr James Dyer of the Mental Welfare Commission, giving evidence to the Scottish Parliament Finance Committee in 2002 (Scottish Parliament 2002c), suggested:

*The number of people on [community-based] CTOs will be fairly limited. I guess that there would be only a few hundred people who might otherwise be detained in hospital but who, under the principle of least restrictive intervention, could be made subject to CTOs and remain at home or wherever they are in the community. However, there will be a limited number of people for whom that treatment will be appropriate. I say that partly*

*because of my experience of extended leave of absence in Scotland. I, with others, studied people who had been on leave of absence for longer than one year... At the end of 1994, the figure was – I think – about 190. If we project that figure into the future, I guess that there will be between 200 and 400 people on CTOs.*

### **Numbers placed on community-based CTOs in the six months after the Act came into effect**

Quantitative data on the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 is published quarterly by the Mental Welfare Commission. Data from October to December 2005 was published in April 2006 and data from January to March 2006 was published in July 2006 (Mental Welfare Commission for Scotland 2006a). A further breakdown of data was also obtained from the Mental Health Tribunal.

The Mental Welfare Commission does not consider all the data complete and it should therefore be treated with some caution.

### **NUMBER AUTOMATICALLY DEEMED TRANSFERRED FROM COMMUNITY CARE ORDERS (CCOs) TO COMMUNITY-BASED CTOS**

The Mental Welfare Commission's data shows that 32 CCOs were open at 4 October 2005. People under those orders should have been deemed transferred to a community-based CTO on 5 October without recourse to the Tribunal.

### **NUMBER OF APPLICATIONS FOR COMMUNITY-BASED CTOS**

The Mental Health Tribunal (Mental Health Tribunal for Scotland, personal communication, 14 August 2006) considered 715 applications for new CTOs in the six months between October 2005 and March 2006. Of these, 658 were for hospital-based CTOs and 57 were original applications for a community-based CTO (that is, 8 per cent of original applications were for community-based CTOs).

Of the 658 applications made for hospital-based CTOs, 427 were subsequently authorised; and of those authorised, 170 were later subject to applications for a conversion to a community-based CTO. This means that of the 227 applications for community-based CTOs considered by the Tribunal, about one-quarter were original applications and three-quarters were applications to convert pre-existing hospital-based CTOs.

### **NUMBER OF COMMUNITY-BASED CTOS AUTHORISED BY THE MENTAL HEALTH TRIBUNAL**

Mental Health Tribunal data (Mental Health Tribunal for Scotland, personal communication, 14 August 2006) indicates that 144 community-based CTOs were authorised in the first six months of the Act's use. Added to the 32 people deemed transferred from a CCO to a community-based CTO on 5 October 2005, this makes an apparent total of 176 people being placed on a community-based CTO at some point during that period (see Table 2, opposite).

This paper has assumed that the number of community-based CTOs authorised and the number of people placed under such an order are the same. It is unlikely (although not impossible) that, before 31 March 2006, any person was placed on a community-based CTO, discharged from it, and then became subject to a further community-based CTO.

**TABLE 2: NUMBERS PLACED ON COMMUNITY-BASED CTOs, 5 OCTOBER 2005 TO 31 MARCH 2006**

	Numbers placed on community-based CTOs		
	Oct–Dec 2005	Jan–Mar 2006	Total
New community-based CTOs authorised	23	24	47*
Conversions from hospital- to community-based CTOs authorised	20	77	97**
<b>Total community-based CTOs authorised</b>	<b>43</b>	<b>101</b>	<b>144***</b>
Transfers from CCOs to community-based CTOs	32		32
<b>Total subject to a community-based CTO</b>			<b>176</b>

Source: Based on data from Mental Welfare Commission for Scotland and Mental Health Tribunal for Scotland

\* out of 57 applications

\*\* out of 170 applications

\*\*\* out of 227 applications

#### **NUMBER ON A COMMUNITY-BASED CTO ON 4 JANUARY 2006**

The Mental Welfare Commission published a snapshot of the number of people under compulsory powers on 4 January 2006. Although the data was incomplete, this showed that 63 people were under a community-based CTO on that date.

This is a higher figure than the 43 people that the Mental Health Tribunal data suggests had been placed under a community-based CTO between 5 October and 31 December 2005. This disparity might be explained by adding in the 32 people previously under a CCO who were automatically deemed transferred to a community-based CTO on 5 October 2005. Although this makes a total of 75 people, which is higher than the total of 63 people counted in the snapshot, the difference may be the result of a small number of people being discharged from their order prior to 4 January 2006. Alternatively it may be that the data is incomplete. Either way, it is clear that the data should be interpreted cautiously.

#### **ESTIMATED NUMBER UNDER A COMMUNITY-BASED CTO ON 31 MARCH 2006**

It has not been possible to source data on the number of people who may have been discharged from a community-based CTO during the first six months of the Act's use.

However, this paper estimates the total number of people under a community-based CTO on 31 March 2006 to be around 160, on the basis that:

- the Mental Health Tribunal data indicates that the number of community-based CTOs granted more than doubled from 43 to 101 between the two quarters and that there were at least 63 people under a community-based CTO shortly after the first quarter
- of the 176 people apparently subject to a community-based CTO in the first six months of the Act's use, it is likely that a small number of people were discharged from their order.

Six months after the Act came into effect, this figure is already approaching the estimated 200 people that, prior to the Act, the Scottish Executive suggested might be subject to a community-based CTO at any one time.

### ***International comparison per 100,000 population***

The numbers of people placed on similar community-based treatment orders per 100,000 population varies widely in English-speaking jurisdictions across the world (Australia, New Zealand, Canada and the United States) from about 2 to about 60, with lower numbers generally linked to newer systems and tighter criteria for compulsion (Lawton-Smith 2005).

Given that Scotland has a population of just over 5 million and an estimated 160 people subject to a community-based CTO after six months of the Act's use, this would mean that Scotland had about 3.2 people per 100,000 population under a community-based CTO by the end of March 2006. As expected at this early stage, this level is relatively low in international terms.

### ***Likely future numbers of community-based CTOs***

Although there has been relatively limited use of community-based CTOs in Scotland so far, it is not easy to estimate future use of these powers and whether numbers of people under such orders will grow above expectations or will level out at the estimated figure of around 200 people at any one time. Interviewees did not agree on the likely future trend.

The Scottish Executive has suggested that, in terms of overall levels of compulsion:

*The total number of individuals subject to compulsory powers shouldn't really change as a result alone of community-based orders being available. The theory runs that many of those on long-term (or longish-term) leave of absence under the 1984 Act may well become subject to a community-based order instead under the 2003 Act.*  
(Scottish Executive, personal communication, 25 November 2004)

Interviewees gave two different perspectives on the question of how many people might be placed on community-based CTOs and whether there would be an increase in the use of compulsion. On the one hand, these orders were seen, particularly by mental health charities, as effectively allowing the historical rising trend in the use of leave of absence (LOA) powers to continue. As one interviewee from a mental health charity said:

*Over the last few years the use of compulsion has increased quite significantly. I can't see that levelling off with the new legislation, and there is the potential [for it] to escalate with new community-based orders, because they are not limited by numbers of hospital beds, coupled with discussions with people who seem to want to use it in a preventative way.*

This perspective echoed concerns that had been expressed during the passage of the Bill through the Scottish Parliament, and in research suggesting that, using past behaviour as the best predictor of future behaviour, any sanction that exists (such as community-based CTOs) will be used and, as time goes on, used more extensively (Atkinson *et al* 2000).



The counterview to this was that, given that community-based CTOs were always intended to be used cautiously, they would be applied to many fewer people than had previously been under LOA powers, and especially long-term LOA. Many patients previously on LOA would not fit all the criteria, such as having impaired judgement, to be placed under a community-based CTO. In addition, the more regular system for review of people under these orders would mean, for some, an earlier discharge than under LOA.

In particular, psychiatrists who were interviewed felt strongly that there would be no increase in compulsion. One psychiatrist suggested that community-based CTOs would be used only:

*... for a very small number of patients, as you say, the revolving door/assertive outreach type patient. The overall length of detention will reduce under community-based CTOs; the overall levels of detention will drop.*

No interviewees felt that there had been any evidence of an increase in compulsion since the new Act came into effect. They suggested that two things chiefly lay behind this. First, the criteria for use of community-based CTOs were more restrictive than those for LOA, and subject to greater scrutiny by the Tribunal. Second, the high burden of bureaucracy involved in making and processing an application for a CTO, whether hospital- or community-based, might mean that mental health officers (MHOs) and responsible medical officers (RMOs) would think twice before starting the process, although this was speculative. This concern about bureaucracy was voiced variously by a number of interviewees:

*I think there are people in the community who are ill enough to be in hospital but aren't, primarily because of the complexity of the new system, is my impression. The chances are nothing bad will happen, but you are taking a risk.*

*It is quite a bit more inconvenient to use the new Act. It's more complex and also the Tribunal may not grant an order that a Sheriff would have [under the previous Act].*

*RMOs are not doing community CTOs because of the extra work involved in the care plan. There's lots of grumbling about the paperwork involved.*

*There are ten principles in the Act. The eleventh, unwritten, principle is one on maximising bureaucracy.*

The idea that additional bureaucracy was limiting the use of community-based CTOs was confirmed, interviewees felt, by what they believed to be the relatively small number that had been made in the first few months of the new Act.

## **Characteristics of people placed on community-based CTOs**

The Millan Committee, deputed by the Scottish Executive to review Scottish mental health legislation and reporting in 2001 (Scottish Executive 2001), believed that community-based CTOs would be relevant for patients for whom it would be an alternative to compulsory hospitalisation; who have relapsed while off medication in the community in the past, presenting a risk to themselves or others; who have a history of refusing to take their medication once there is no legal compulsion to do so; and for whom all other means of trying to negotiate with them and maintain them in the community without compulsion have been tried and failed.

Faced by concerns that community-based CTOs might be applied too widely, the Scottish Health and Community Care Minister, Malcolm Chisholm, indicated in the parliamentary debate of 11 December 2002 (Scottish Parliament 2002a) that he would seek 'to identify the kind of patient for whom a community-based order might be appropriate and to limit the orders to them'.

As long as the community-based CTO arrangements are restricted to the few 'revolving door' patients for whom it would be a less restrictive alternative than being in hospital, interviewees generally accepted that they could bring benefits to certain patients in terms of fewer symptoms and a better quality of life. As one front-line mental health worker put it:

*There are some people who really do need to be on these orders.*

Another spoke of a patient whose health had been inexorably deteriorating in the community, but had 'turned around' when required to take medication under a community-based CTO. Such a patient was:

*... ideal for a compulsory treatment order... If he's aware he's not under legal jurisdiction he will just say 'No, go away, I've had enough of the tablets'.*

Interviewees generally agreed that a good deal of emphasis in Scotland is being placed on a person having a history of non-engagement and non-compliance, followed by deterioration in health, before a community-based CTO would be authorised. As one psychiatrist put it:

*Community orders will not be used in first episodes of illness. There has to be disengagement to prove to a Tribunal that a community order is required. There should be a path of disengagement or lack of engagement pre-existing any such order. [Anyone] applying for a community order must demonstrate a history of non-engagement with services.*

This was confirmed by a member of the Mental Health Tribunal:

*A Tribunal will not authorise [an order] unless all the conditions are met – doctors don't always understand this. Unless you tell me they are very quickly going to collapse, we cannot authorise a community order. So you have to make the case on [the patient's] history. We [need to be] confident enough the same pattern would occur.*

Although few details of the characteristics of people placed under community-based CTOs to date have yet been released, it does seem evident that the initial cohort of patients under these orders are, very largely, the 'revolving door' patients with a history of non-compliance and deterioration that the new arrangements are intended to address. Of the 63 people placed on a community-based CTO at the 4 January snapshot (Mental Welfare Commission for Scotland 2006a), 57 were aged between 25 and 64. Given that the onset of serious mental health problems can often be in the late teens or early twenties, this suggests the likelihood of a history of mental disorder over some years. Only two of those placed under community-based CTOs were aged 18–24.

## Pathways to being placed on a community-based CTO

Thirty-two people who had been on CCOs at the date that the new legislation became effective (5 October 2005) were automatically deemed transferred to community-based CTOs without needing to go through the Tribunal process.

Setting those transitional arrangements aside, the quantitative data (see Table 2, p 11) suggests that, in the first three months of the Act's use, slightly more people were placed on community-based CTOs as a result of an original application to the Tribunal (23), than were placed on a community-based CTO as a result of a conversion from a hospital-based CTO (20). However, in the second quarter, the picture changes, with the data showing that significantly more people were placed under a community-based CTO as a result of a conversion from a hospital-based CTO (77) than as a result of an original application to the Tribunal (24).

This pattern was confirmed by interviewees involved in the application and Tribunal process who felt that, after six months, the chief route for a person to be placed on a community-based CTO was for them first to have been placed on a hospital-based CTO. Once they had recovered sufficiently, the hospital detention requirement of the CTO was suspended. Then, after a successful period of time in the community, the person was transferred to a longer-term community-based CTO following an RMO application to the Tribunal to convert their order.

A member of the Mental Health Tribunal suggested that:

*[Community-based CTOs] have been for variations from hospital orders. Patients were making progress, so a graded move towards the community. The RMO makes the application, not the MHO. The conditions are that the patient still has some signs of illness, his decision making is still impaired, he is not truly consenting to medication, usually more than one risk, three or four significant risks. [You] need a community order or [you] won't be able to discharge them.*

When asked about the difference between simply suspending the hospital detention requirement of a hospital-based CTO or formally applying to the Tribunal to convert it to a community-based CTO before a patient leaves hospital, one interviewee suggested that suspending the order was the easier option administratively to see how things worked out in the community:

*There is less administrative burden to just suspending the hospital requirement. You would fill in a form as with varying but with variation you would have to go back to the Tribunal.*

## The Tribunal application process and operation of the Tribunal

A number of interviewees spoke at length about their concerns regarding the process of making CTO applications and the potential impact this might be having on the services provided to patients.

The main concern for many was the extra administrative burden imposed on them by the application and Tribunal process – for example, the extra pressures on MHOs

to put together quite complex applications for CTOs (Dawson 2005). As one MHO put it:

*When people are out of hospital I'm finding it very difficult to offer the sort of support that I would want to give, because we have more people coming because of the Act and the statutory work takes so much time. The new Act involves us in more statutory work. There were people you would visit before just to keep the relationship going. You have to give a lot more considered reasons for the evidence for your application. That is really time-consuming. We're definitely putting in more applications with the new Act, and they are bigger, so the level of work is going up considerably.*

This extra burden on MHOs has also been reported by others looking at the initial impact of the new Act (Stewart 2006). The problem is compounded by shortages of MHOs. In a Scottish Executive survey of MHO staffing, carried out in March 2006, 24 of the 32 local authorities surveyed identified a shortfall of MHOs in their areas and identified 44 unfilled MHO vacancies (Scottish Executive, personal communication, 6 September 2006).

A number of interviewees said that a possible knock-on effect of spending more time dealing with applications for CTOs and Tribunal hearings was that voluntary patients might lose out. This could lead to a two-tier system – if a patient is under a community-based CTO they will get a service; if they are not, they won't, perhaps even to the extent that their health deteriorates to such an extent that they will need to be treated involuntarily. At this stage, however, this appears to be a theoretical rather than a proven outcome of the new arrangements.

The length of time that a three-person Tribunal hearing took out of a professional's day was compared unfavourably with the previous Act's arrangements for compulsion to be authorised through a Sheriff's court. Mental Health Tribunal data (Mental Health Tribunal for Scotland 2006) suggested that hearings typically last an hour of recorded time and two hours of actual time (including breaks and adjournments); the vast majority of hearings take under four hours.

A briefing report by the Scottish Association for Mental Health (2006) referred to the challenge of setting up the new Tribunal arrangements:

*It is perhaps inevitable with such a major development, working with new and complex legislation, which includes challenging timescales, that there will be teething problems. Unsurprisingly, reports from people participating in Tribunal hearings have been mixed. Some people appear to have had relatively positive experiences, whilst others have reported criticisms ranging from lack of adequate notice for hearings to excessive formality in the proceedings.*

Mental Health Tribunal interviewees accepted that there were some initial teething problems but spoke positively about the significant amount of improvement made over the eight months that (at that time) the new system had been operating. At first many professionals had been nervous about both writing reports and presenting them at Tribunal hearings, but had become more confident over time. They felt that the reports now being submitted to Tribunal hearings were often 'superb', and professionals, knowing what questions they would be asked at hearings, were better prepared.

Despite criticism of the process, interviewees agreed that the new arrangements were an improvement over the previous ones in terms of fairness to the patient, the opportunity for many more people to have their views taken into account, and the clarity with which the Act sets out the criteria for placing someone under compulsion:

*Compared to the old Act, there are more criteria to meet, but they are quite helpful. [We are] taking into consideration [the patient's] ability to make decisions. We get a much broader picture of people's vulnerability, and look at the quality of life you want them to have. [You] think harder about why you want the order.*

*Tribunal hearings are longer – I had one that was six and a half hours, and [they are usually] at least a couple of hours. It's really a half day out of your schedule. But they are much more focused on the patient who is involved much more.*

The confidence that professionals have in the application and Tribunal process may play a crucial role in the numbers of community-based CTOs applied for. It would appear that, despite reservations about the process, the new arrangements are considered better and fairer than the old ones, and that confidence is improving as all parties become more familiar with the arrangements.

### **Understanding of the new community-based CTO system**

The introduction of a complex new piece of legislation is always likely to tax those who are responsible for implementing it. For example, after 'Kendra's Law' was introduced in New York, 'Initially, many [local directors] felt challenged to manage their obligations under the Law and were unsure how to proceed', and the introduction of new community-based powers 'prompted novel legal issues, and required greater interaction between the court system and the community mental health services delivery system' (New York State Office of Mental Health 2005).

The new Scottish Act itself has been criticised as being difficult to understand. In the opinion of one commentator, 'The Act would win no prizes from the plain English campaign. Its cross-references are multiple and it is more difficult to follow than its predecessor' (Thomson 2005).

There is no doubt that many professionals are still learning about the Act, including the community-based CTO powers, and a number of interviewees were open about the fact that they were still on a learning curve:

*Mental health professionals should know the new Act, although I'm not entirely certain all do. There was lots of training around people who had statutory duties. I would expect most of them to be pretty clear about how things should be working but have heard of some strange discussions of people referring to uncertainties around the Act, especially the transitional provisions and how that works. There are probably still a sizeable amount of professionals who are still getting to grips with the mechanics of the legislation generally. There's no getting away from the fact that it is a complex piece of legislation.*

*I think that we have been overwhelmed with information and people are still getting their heads around [the new arrangements].*

Interviewees gave examples of some of the initial misunderstandings that had arisen when the new system was introduced. A Tribunal member said that some of the early MHO applications to the Tribunal had asked for both hospital- and community-based orders, rather than one or the other. In addition, there had been a lack of understanding among RMOs about the need to submit a copy of the care plan and an MHO report when a determination to extend a 'deemed' CTO is made for the first time (Mental Welfare Commission for Scotland 2006b).

Some interviewees were not sure whether patients, families and carers had a very good grasp of the community-based CTO arrangements, although they felt that user groups across Scotland should be 'quite clued-up'. However, the Highland Users Group felt, perhaps not surprisingly, that most service users probably knew very little about community-based CTOs unless they were on one, or subject to an application to be placed on one.

On the question of training, the six-month delay in implementing the Act (intended to ensure successful implementation, including 'dry runs' of Tribunal hearings) had been welcome as it meant that understanding of the Act was better when it came into effect. A number of interviewees felt that the training for staff had been good, although one commented that 'the training was late for everybody'.

### **Availability of resources**

The discussion about pressures on staff time and concerns about whether there will be true service reciprocity (in terms of treatment, care and support) for people who are placed under community-based CTOs raises the question of resources.

The extra funding for implementing the 2003 Act, including the community-based CTO arrangements, is set out in the Background section to this paper (see pp 6–7).

Despite the significant sums committed, none of our interviewees appeared to be aware of any increase in resources to cover the impact of community-based CTOs. Frontline staff in particular told us that the extra work involved in applying for a community-based CTO and in providing services under a care plan was simply increasing an already heavy workload.

An interviewee from a mental health charity linked the perceived shortfall in resources and the extra pressures caused by the Act:

*I think my main impression is complete overload. The sort of example I've had is this bit about if you have to attend a Tribunal that means you might not be able to have your clinic. It's a real practical difficulty and it's been quite a challenge for MHOs too because they've got a very much extended role. It's tended to be added on to existing workloads in local authorities. I think there's a lot of professionals feeling quite punch-drunk.*

Appearing to have no extra resources at local level does not necessarily mean, however, that patients' care plans are being ignored. A clear commitment was expressed by interviewees to provide services to people placed under community-based CTOs, as set out in their care plans. The Scottish Executive, in its guidance on the new compulsory powers (Scottish Executive 2005), points out that care and treatment is intended to cover not just medication but, for example, talking therapies, training services and services to

promote social and independent living skills. A number of interviewees confirmed that the care plans they had seen, although few in number, did appear to include a full range of services.

On the question of whether the services set out in the care plan were actually being delivered, interviewees thought that, on the whole, they were (which was one of the reasons why staff were under so much pressure and why work with other patients was, theoretically, at risk). In one case mentioned, the difficulty in delivering the services in a care plan was not that the services were not made available but that the patient had, after a while, simply disengaged from some of the services he was required to attend.

At present there has been no collective study of individuals' care plans to see whether the services they refer to are actually being delivered, so judgement will have to wait. The Mental Welfare Commission intends to examine care plans in detail to ensure that they meet individuals' needs, and check that they reflect the services patients are actually getting.

### **The impact of community-based CTOs on patients**

The review did not seek to examine the effectiveness of the community-based CTOs in terms of patients' clinical or social outcomes, as it was expected that many people would say it was too early to pass judgement – which indeed they did.

However, interviewees did provide some anecdotal accounts of the impact of community-based CTOs on patients. For example, in a small number of cases, patients placed under community-based CTOs had become non-compliant and had had to be recalled to hospital. This is supported by data from the Mental Welfare Commission (Mental Welfare Commission for Scotland 2006a), which indicated that, between October 2005 and March 2006, 12 people on community-based CTOs had been recalled to hospital on 17 separate occasions. It is clear that being placed under this order does not necessarily mean a patient avoids hospital admission (under the old LOA arrangements, 20 per cent of LOA patients actually saw an increase in admissions (Atkinson *et al* 2001)).

In another case mentioned, a community-based CTO had prevented default from medical treatment which a patient had made quite clear was likely to happen when the suspension of his hospital-based CTO had expired.

Despite concerns about the extra time and resource demands of the new arrangements, there was widespread approval among interviewees for the community-based CTO arrangements as compared with the previous LOA system. This was based primarily on the increased safeguards for patients and greater onus on professionals to explain why they wanted to use the power:

*There is more user and family involvement in the overall treatment package and the process for obtaining this, ie Tribunal services, named persons and advance statements, clients' right to advocacy and legal representation. There is also more accountability and transparency from professionals involved in care.*

*A previous concern was that LOA could be indefinite. There were cases where a patient was recalled to hospital often very near the end of 12 months, then discharged and*

*LOA starts at the beginning of 12 months again. The current system [has a] more rigorous review system. I suppose the fact there is more scrutiny and tighter safeguards for patients is a good thing, but the jury is out, so I can't tell if it will be sufficient.*

*The old leave of absence had a human rights issue. They just ended up running and running. One of the beauties of the new Act is this very strict review process. And you can't just take someone to compulsion, you must have a plan of care. If properly applied, a community order is a good thing.*

Some interviewees also stated that the community-based CTO arrangements helped to ensure that the Millan principles enshrined in the Act were met, especially those concerning participation of the patient in the process, the use of the least restrictive option, and reciprocity in terms of services provided to patients subject to compulsion.



# 4

## Conclusions

A number of important points emerge from this review of Scotland's early experiences of introducing community-based compulsory treatment orders (CTOs). These have relevance not only for the Scottish Executive and Scottish mental health bodies, but also for the Department of Health in London, with respect to its plans to introduce similar arrangements in England and Wales.

### Key points for Scotland

Despite being criticised as burdensome, the new community-based CTO arrangements on the whole have been welcomed in Scotland. If there were concerns among service users, families or carers that the arrangements were failing or being abused – either in an individual case or more widely – it might be expected that the voluntary sector mental health organisations would have become aware of, and championed, these concerns. As at May 2006, neither the Scottish Association for Mental Health nor the NSF Scotland (two of the largest of these organisations) had raised any such concerns. However, in interviews, representatives from these organisations pointed out that this did not necessarily mean that the new arrangements were working effectively in every case:

*We have had no calls at all from anyone saying the community orders appear not to be working. [We] haven't heard any horror stories yet.*

*[We] still have concerns although it's too early for us to see whether our fears are being realised. We are not getting service users coming to us post-implementation. There is no evidence to suggest they are not working effectively but I don't think that that means we are confident that they are working effectively, it just means we don't know.*

Although the Highland Users Group knew of no one who was on a community-based CTO, its members felt that the orders could make it easier to manage someone who is very ill in the community. If used as a genuine alternative to hospital detention, they felt that such orders could help to avoid the need for long stays in hospital and that the vast majority of people preferred to be treated at home rather than in hospital, as long as they received appropriate services and therapies.

Although mental health professionals appear to appreciate the power the new community-based CTO can provide, they have serious reservations about the process. There are clearly some added administrative and resource pressures for them, generally involving the extra time that it takes to complete application forms, write reports and take part in the Tribunal process. As the Act becomes more entrenched and better understood and as the Tribunal system overcomes some initial teething problems, some of these problems should lessen.

It should also be noted that much of the extra administrative burden placed on professionals is in fact caused by the creation of a more rigorous system of imposing compulsory community treatment that is widely considered fairer for the patient. Accordingly it might be considered a reasonable price to pay (although this would not excuse any shortfall in necessary extra resources to implement the arrangements).

### ***Concerns expressed prior to the Act becoming law***

Concerns were expressed as the legislation went through the Scottish Parliament that community-based CTOs would lead to an increase in compulsion and be unworkable in practice, and that a lack of services in the community would mean that they could become just 'community medication orders'.

In terms of the initial numbers of community-based CTOs, as one interviewee put it to us, 'The deluge has not happened.'

Given the similar experience of other jurisdictions around the world, this comes as no surprise. As expected, use of these orders is relatively limited at this stage, although the data available suggests that use has been increasing in recent months. The question of whether, in due course, there will be an overall increase in compulsion as compared with the situation under the previous legislation will require investigation at a later date.

Are community-based CTOs workable? Inasmuch as this paper estimates there were about 160 people living in the community under community-based CTOs as at 31 March 2006, the process appears to be working, despite the extra requirements imposed by the 2003 Act.

No evidence was found that community-based CTOs were being used just as vehicles for medicating people in their own homes. The combination of a community-based CTO and its care plan appears to offer people support other than just medication. However, it has yet to be confirmed beyond doubt that the resources required to ensure that people receive the range of care and support specified for them in their care plan are always being made available.

A particular concern expressed before the Act came into effect was that community-based CTOs would be used simply as a tool to relieve pressure on inpatient services. This paper found no evidence to suggest this was the case (with a relatively low uptake of community-based CTOs in the first six months) and it was firmly rebutted by a number of our interviewees as completely unfounded.

At the time of our interviews in May 2006 there was a widespread impression that no new resources had been made available on the ground to expand services for people on a community-based CTO. This suggests that the Scottish Executive, NHS bodies and local authorities need to provide clearer information about where the extra money earmarked for implementing the Act has been spent.

At this stage, the picture appears to be one of cautious optimism. The process, despite some early difficulties, is largely working and the new community-based CTO arrangements appear to be reasonably well understood and applied only to those 'revolving door' patients with a history of non-compliance and multiple hospital

admissions for whom they were intended. However, this optimism is tempered by the burden of increased bureaucracy and workloads on mental health staff who see little or no sign of extra resources, and a concern that, by sucking in resources, community-based CTOs may result in fewer services being available for other people with mental health needs.

It also remains to be seen whether community-based CTOs bring the hoped-for improvement to patient outcomes – an issue that this paper does not address.

### **Lessons for England and Wales**

As noted in the Introduction to this paper (*see p 2*), the Department of Health has dropped its original proposal for a wholly new Mental Health Act for England and Wales, including community-based orders administratively similar to the Scottish community-based CTOs. In its place, the Department of Health now intends to introduce supervised community treatment (SCT). This will be authorised not by an independent Tribunal (as in Scotland) but by clinicians, as happens with the current supervised discharge arrangements under section 25 of the Mental Health Act 1983 (as amended).

Despite this difference, there are a number of learning points that have emerged from Scotland's experience of implementing compulsory community-based treatment that should be of interest to the drafters of new legislation in England and Wales, and to those who will be responsible for implementing any new SCT arrangements.

#### ***Possible early numbers of people subject to SCT***

It is not possible to use the Scottish experience to forecast accurately the number of people who may be placed under SCT in the first months of its use. The precise conditions for the use of SCT are as yet unknown but briefings from the Department of Health (Department of Health 2006) suggest that they are unlikely to replicate the Scottish conditions for a community-based CTO. In addition, SCT will not require the independent Tribunal authorisation that is required for community-based CTOs in Scotland.

However, the limited initial use of community-based CTOs in Scotland does reflect the general international trend when new community treatment powers are introduced (Lawton-Smith 2005). It seems reasonable to suppose that there will be a similarly limited uptake of SCT in the first months of its use in England and Wales.

The widespread acceptance of community-based CTOs in Scotland is a result of their being perceived as being fairer for the patient and applied only to 'revolving door' patients with a well-recorded history of serious illness, non-compliance and relapse in the community and multiple admissions to hospital. If SCT is to be accepted in a similar fashion in England and Wales then the new legislation will need to ensure that the powers transparently bolster patient rights and are limited to this group of patients.

#### ***Transitional arrangements***

There has been some lack of clarity about the transitional arrangements experienced in Scotland, where people who had previously been on community care orders (CCOs) were automatically deemed transferred to community-based CTOs. The transitional

arrangements for people under section 25 supervised discharge in England and Wales are yet to be confirmed but will involve many more people (around 600 people are placed under supervised discharge annually). They may also be more complex, involving the continuation of the section 25 power until such time as the individual is either transferred to SCT or to another type of order that encourages compliance with treatment such as guardianship or leave of absence (LOA), or is discharged.

The Department of Health should make clear at an early stage its transitional arrangements and ensure that the staff involved fully understand them before the date that the SCT powers come into effect.

### ***Bureaucracy***

The new hospital- and community-based CTO arrangements in Scotland are considered by many to be extremely bureaucratic, even to the extent that this may limit the use of these powers.

In order for any new SCT arrangements to be used appropriately and effectively, it will be necessary to allay professionals' concerns about the possibility of an increased bureaucratic burden while ensuring fairness for all parties and building in all necessary safeguards for patients. Otherwise there is a risk that one relatively little used and complex system (section 25 supervised discharge) will simply be replaced by another (SCT), with no added benefit to either patients, health professionals or society.

### ***Resources***

Commissioners of community mental health services in England and Wales will need to be aware that, as with community-based CTOs in Scotland, the introduction of SCT is likely to mean higher levels of services required in the community, albeit for a relatively small number of patients (relative, that is, to the hundreds of thousands of patients who require some sort of community support and care). On the basis of the Scottish experience, they should plan and commission services to ensure that service providers have adequate resources to fully implement SCT patients' care plans while in no way reducing the level of services available to other people with mental health needs.

It will also be important to ensure that any extra central government or local authority funding allocated for the implementation of the SCT arrangements is clearly seen to be spent for that purpose.

### ***Training***

The delay in implementing the 2003 Act in Scotland was considered helpful in getting staff 'up to speed' with their new responsibilities and understanding of the new Act. Despite this, some staff felt that they were still on a learning curve, even after some months of the Act's operation. Before any new powers come into effect in England and Wales, resources and time need to be made available so that all staff involved with SCT can be trained in the new powers, with regard both to their own and others' roles and responsibilities.

### ***Data***

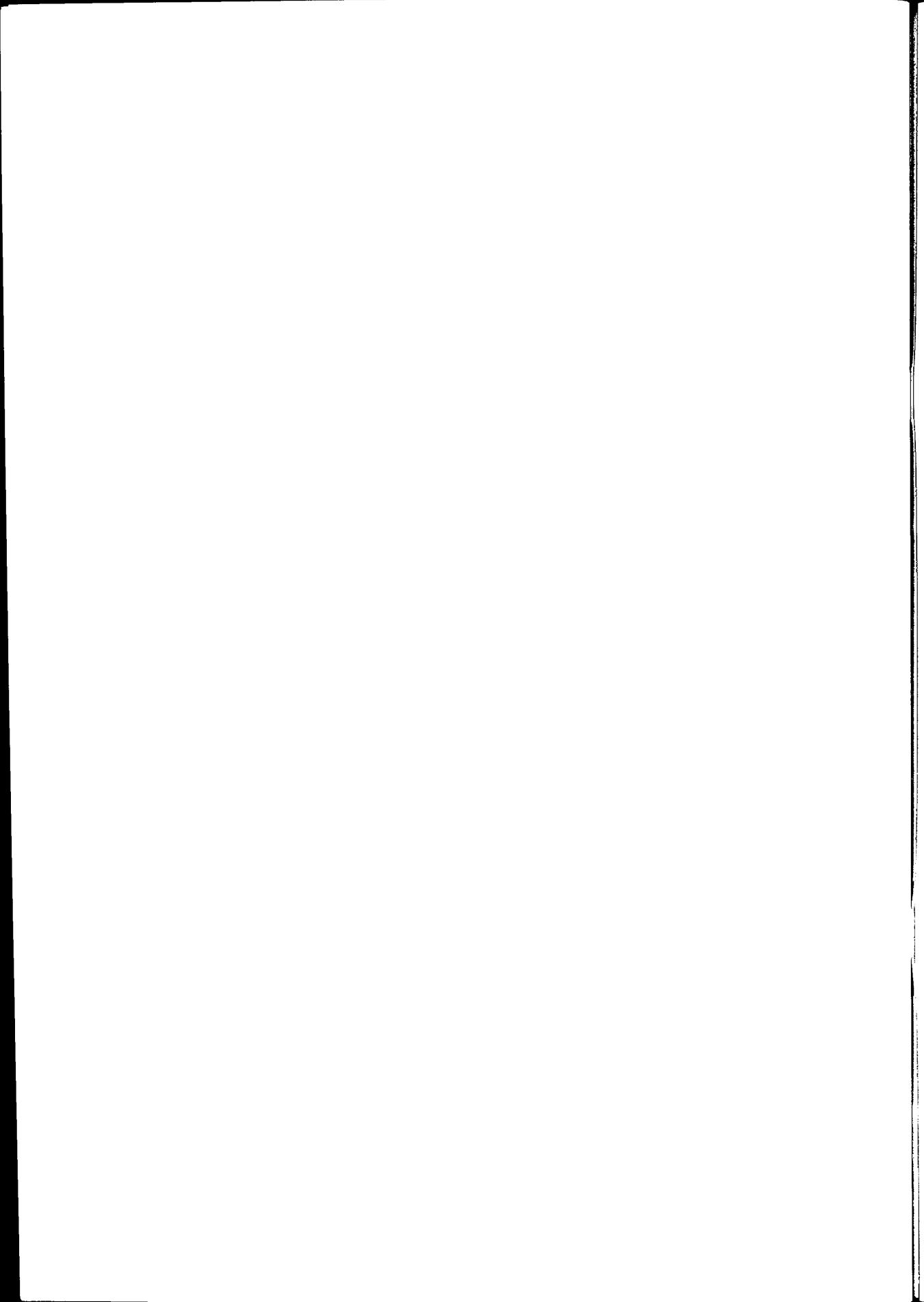
Although there was a strong commitment to collect data on how the new system was working, Scotland has seen some problems in collecting consistent, accurate and comprehensive data, both on actual numbers of community-based CTOs and about how well the new arrangements are working.

This suggests that in England and Wales clear arrangements must be in place from the start for collecting, both locally and centrally, a minimum dataset on the use of SCT. This might include the numbers and main characteristics (for example, age, gender, ethnicity) of people placed under SCT, their pathway into and out of SCT (including any readmissions to hospital), the length of time they remain under SCT, the number and type of breaches of SCT conditions, the conditions imposed on people subject to SCT and the provision of services as set out in their care plans.

### ***Picking up the best of the Scottish arrangements***

Finally, whatever misgivings some staff in Scotland have about the process that has to be followed in respect of the new CTO arrangements, there is general agreement that the arrangements are fairer for the patient, with greater involvement for them and their family and carers, and better safeguards.

In drafting new legislation and revising the Code of Practice, the Department of Health should consider how the reported benefits of the new Scottish Act, such as guiding principles having been written into the Act, advance statements and patients' right to advocacy (Stewart 2006), can be used to underpin the proposed SCT arrangements for England and Wales.



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# Appendix 1: The Mental Health (Care and Treatment) (Scotland) Act 2003 and Code of Practice

This appendix gives a brief summary of the main powers and procedures under which a community-based compulsory treatment order (CTO) may be made in Scotland. For a full explanation, please refer to Scottish Executive publications (Scottish Executive 2003, 2005).

Under the Act a mental health officer (MHO) can apply to the Mental Health Tribunal for a hospital- or community-based CTO by submitting a medical report from each of two different doctors, a report stating why they have made the application, and a proposed care plan laying out the care and treatment to be given. The application must specify whether the application is for a hospital-based CTO or a community-based CTO.

The application is considered by a Tribunal panel consisting of three people: one legal, one medical and one general. The Tribunal can either accept or reject the request for the CTO according to whether or not all the following criteria are met.

- The person suffers from a mental disorder.
- Medical treatment is available that is likely to prevent the disorder or relieve some of the symptoms of the disorder.
- There would be significant risk to the patient or any other person if treatment were not provided.
- The patient's ability to make decisions about treatment is impaired by their medical disorder.
- The compulsory treatment order is necessary.

In the case of a community-based CTO, the Tribunal may set conditions such as requiring the patient to receive treatment as instructed, attend certain community care services, stay in a particular place in the community, and allow visits to their home by people involved in their care and treatment. If the person breaches the requirements of their community-based CTO, they may be taken to a hospital for the specified treatment.

The Tribunal may authorise an interim CTO (hospital-based or community-based), which contains the powers of a full CTO, for up to 28 days while it seeks further information about the case.

The patient's responsible medical officer (RMO) is required to review the case from time to time and may cancel the community-based CTO if the requirements are no longer met, or may change the terms of the community-based CTO if they feel the patient's situation has changed. Unless a patient is discharged from it, a community-based CTO lasts for six months, at which point it may be renewed for a further six months, after which it can be renewed annually.

Patients, or their chosen 'named person', may apply to the Tribunal to cancel the community-based CTO or vary the measures specified in it.

The requirement that a patient be detained in hospital may be suspended for up to six months. Any other provision of an Order can be suspended for up to three months. This provision replaces the section 18 arrangements for leave of absence (LOA) in the 1984 Mental Health Act.

With respect to transitional arrangements, upon implementation of the legislation on 5 October 2005, civil patients previously on a community care order (CCO) (sections 35A to 35K of the Mental

Health Act 1984) were deemed to be on a community-based CTO, authorising the same conditions that were in place as a result of the CCO (see the Mental Health (Care and Treatment) (Scotland) Act 2003, (Transitional and Savings Provisions) Order 2005 SSI 2005/452).

## Code of Practice

The Code of Practice that has been published to help professionals implement both the letter and the intent of the Act correctly sets out when a community-based CTO should be considered (see box, below):

### **MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 CODE OF PRACTICE, VOL 2, CHAP 3**

- 30 It would be expected that a medical practitioner would only recommend imposing community-based compulsory powers in a limited range of circumstances. For example, a requirement to reside at a particular place should only be recommended in exceptional circumstances. Much will depend upon the individual circumstances of the patient who is subject to the application, but circumstances in which a medical practitioner might recommend recourse to community-based compulsory measures might include where:
- community-based powers would provide a safe and viable alternative to compulsory hospitalisation;
  - a patient has previously relapsed whilst off medication in the community, and as a result, has presented a risk to themselves and/or others;
  - all other means of trying to negotiate with the patient and maintain them in the community without compulsion have been tried and have failed; and
  - alternatively, less restrictive approaches to secure and adequate adherence with necessary treatments have been shown to be impracticable.
- 31 Before recommending that community-based compulsory measures be applied for, the medical practitioner would be expected to demonstrate in the mental health report that issues such as those listed above, in addition to any others relevant to the patient's case, have been fully taken into consideration. In doing so, it will be important to demonstrate that consideration has been given to the potential impact of these community-based compulsory measures on any carers or other persons who live with and/or care for the patient.
- 32 If it is expected that community-based compulsory measures would only be recommended under certain circumstances, as described above, consideration should similarly be given to whether community-based measures are being recommended as an alternative to hospital-based compulsory measures for the appropriate reasons. For example, community-based measures should not be recommended only because a hospital bed is not available or only because the carers or person(s) that the patient currently lives alongside do(es) not wish them to reside at that address. Best practice suggests that a medical practitioner would only recommend that the patient be treated in hospital where that patient requires the care, treatment and services which only a hospital inpatient service can provide.

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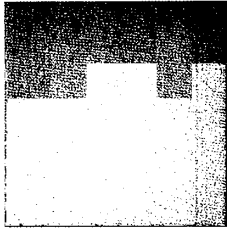
## Appendix 2: Interviewees

The following individuals very kindly agreed to be interviewed for this piece of work, or to provide written comments to our interview questionnaire:

Margaret Ashman, Mental Health Officer, CMHT Glasgow\*  
Dr Andrew Buist, GP\*  
Duncan Cartwright, Mental Health Tribunal for Scotland  
Jim Craig, Mental Health Tribunal for Scotland  
Eileen Davie, Mental Health Tribunal for Scotland  
Highland Users Group (HUG) members\*\*  
Sandra McDougal, Scottish Association for Mental Health (SAMH)  
Dr Tom Murphy, consultant psychiatrist, Edinburgh  
Jamie Pitcairn, Scottish Executive  
Shelagh Stewart, Mental Health Officer, Loanhead Social Work Centre  
Andrew Strachan and colleagues, Mental Health Act 2003 Implementation Team, Glasgow\*\*  
Dr Mark Taylor, consultant psychiatrist, Glasgow  
Rosemary Townsley, Mental Health Officer, Loanhead Social Work Centre  
Mary Weir, NSF Scotland

\* telephone interview

\*\* written comments to questions



## Linked publications

### **A Question of Numbers: The potential impact of community-based treatment orders in England and Wales**

*Simon Lawton-Smith*

Compulsory community-based treatment orders require patients at risk of harming themselves or others to comply with a set of conditions, such as taking their medication, while living in the community. The draft Mental Health Bill 2004 incorporates plans to introduce compulsory orders in England and Wales, but it is not clear how many people could be drawn into compulsory treatment as a result. This report sheds some light on how many people in England and Wales could become subject to non-residential orders if the Bill becomes law, drawing on examples from countries around the world with similar systems already in place.

ISBN 978 1 85717 531 8 September 2005 54 pages £7.50

### **London's State of Mind: King's Fund mental health inquiry 2003**

*Ros Levenson, Angela Greatley, Janice Robinson*

In 1997, a King's Fund inquiry expressed serious concerns about mental health services under extreme pressure, including long delays and gaps in key areas such as crisis support. This report presents the findings of a two-year inquiry into how far London's mental health needs and services have come since then. It offers a comprehensive overview of substantial changes to policy and governance structures in London and nationally, and probes the special challenges posed by London's population. Drawing on extensive consultations with mental health service users, carers, staff and policy-makers, it proposes key areas for development, including a London-wide strategy, primary care commissioning, and improved financial and service information.

ISBN 978 1 85717 482 3 November 2003 178 pages £20.00



**Community Renewal and Mental Health: Strengthening the links**

*Marsali Cameron, Teresa Edmans, Angela Greatley, David Morris*

The government's commitment to promoting social inclusion, regeneration and developing sustainable communities presents real opportunities for promoting better mental health. Poverty, depression, stress and relationship problems can exacerbate feelings of being isolated and excluded from mainstream society, particularly for people living in disadvantaged areas. This publication argues that agencies and partnerships need to work together to address the range of factors that can affect people's mental health. A key requirement, alongside funding flows, is an integrated knowledge of mental health issues and an in-depth understanding of local communities. This publication is designed to help individuals and agencies learn about each other's perspectives and find innovative ways to achieve common goals.

ISBN 978 1 85717 478 6 September 2003 54 pages £10.00

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In recent years, a growing number of places around the world have introduced powers to compel certain people with mental disorders living in the community to engage with services and undergo treatment. This paper explores what has happened in the first six months since community-based compulsory treatment orders were introduced in Scotland in October 2005. It looks at how many people have become subject to the orders, the pathways to being placed on an order, the impacts on mental health staff, and resource issues. It also considers what lessons emerge for England and Wales, which will soon be introducing similar arrangements.

ISBN 1-85717-555-7



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