

What is the likely impact of supervised community treatment on existing service provision?

A new option for hospital discharge

The introduction of supervised community treatment (SCT) in England and Wales is one of the main modernising amendments of the Mental Health Act 2007. SCT is intended to address situations where previously detained patients leave hospital but do not continue with their treatment, leading to re-admissions – the so-called revolving door syndrome. It is intended that SCT will come into effect from October 2008.

This article reviews why SCT is being introduced, what it will mean in practice, and what is available to help practitioners prepare for it.

Context

SCT is not a new idea and nor is it unique to England and Wales. A number of other jurisdictions, including Israel, New Zealand, Australia, Canada and the US, have had powers of compulsory community treatment for some years.¹ Levels of use vary: around two per year per 100,000 population in parts of Canada; around 40 per 100,000 population in New Zealand, and over 60 per 100,000 in the state of Victoria, Australia.

Factors linked with these variations in use include the scope of the legislation within that jurisdiction; the attitude of mental health professionals towards compulsory community treatment, and their understanding of their powers. Practical aspects influencing use include the bureaucracy involved in making a community treatment order, the availability (or lack) of good community services, the number of inpatient beds available, and the overall prevalence of serious mental disorder among the population.² As a general rule, the number of people placed on a compulsory community treatment order is initially low, but builds up year on year – so the more mature the SCT system is, the greater the number of people subject to the order.¹

Community-based compulsory treatment orders (CCTOs) were introduced in Scotland from October 2005, under a legislative framework that requires every order to be authorised by the independent Mental Health Tribunal. Early evidence from the implementation of CCTOs in Scotland confirms the slow build up of numbers, with the highest use in urban areas. A positive finding is that, so far, the number of people detained in hospital has dropped, and there appears to

have been no overall increase in use of compulsion through the introduction of CCTOs.³

The introduction of SCT in England and Wales has not been without controversy. Much of the early concerns focused on civil liberties implications, and fears that SCT was a knee-jerk response to a small number of high profile incidents where people with severe mental illness were implicated in violent incidents and homicides, and arguments that the 1983 Act did not provide sufficient powers to detain people with dangerous and severe personality disorder.⁴ However, the government has argued that SCT should be seen as liberating rather than coercive, as use of SCT will allow some patients to be discharged earlier from hospital, and will help to maintain patients' mental health – and, consequently, their housing, paid and unpaid employment and social networks – while living in the community.

Many of the more contentious aspects of SCT were addressed as the Mental Health Bill passed through parliament. Amendments were made to limit the conditions that may be imposed on patients through SCT, and to give all patients on SCT the statutory right to advocacy services.

Supervised community treatment

Unlike most other jurisdictions (including Scotland, where the CCTO is a community-based alternative to a hospital order), SCT in England and Wales is effectively a discharge option for people already detained in hospital under the Act. This means it will only be used where a patient is already in hospital, and receiving compulsory treatment.

Many elements of SCT resemble provisions in the 1983 Act: namely, aftercare under supervision, section 17 leave, guardianship and restriction orders. Indeed, aftercare under supervision (section 25A of the 1983 Act) is replaced by SCT. All of these powers already allow practitioners to recall patients, but SCT provides a more structured system.

Once SCT is implemented from October 2008, the use of section 17 leave for longer than seven days will have to be justified by the patient's responsible clinician (RC). SCT allows for a patient to be recalled to hospital for up to 72 hours, for treatment – including medication – to be administered in a hospital or clinic setting, and for →

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→ the patient to return to the community without the need for additional powers. Importantly, SCT brings additional safeguards for patients, as (unlike section 17 leave) they can lodge a formal appeal against the order with the Mental Health Review Tribunal and hospital managers.

Concerns have been expressed about whether people who are subject to SCT can be forcibly treated in their own home. This issue is addressed in the Code of Practice. Compulsory treatment, such as medication, can only be administered in a hospital or clinic setting, following recall. The aim of SCT is to establish a clear and unambiguous contract for treatment in the community. If a patient defaults on their agreed treatment plan, this will trigger an assessment and, ultimately, they may be recalled to a clinic or hospital setting. It is envisaged that people on SCT will have frequent contact with a practitioner, so that relapse can be detected and acted on promptly, supported by SCT powers. The box (right) outlines a typical patient who might be suitable for SCT; figure 1 (below) outlines a typical SCT pathway.

Implementation programme

CSIP/NIMHE has been commissioned by the Department of Health to support the implementation of the Act in England. The implementation programme is being delivered through regional implementation plans, underpinned by a number of national initiatives covering advocacy, Mental Health Act implementation, training, workforce development, and SCT.

The CSIP/NIMHE work on SCT includes:

- information leaflets for carers and patients on what to expect
- a practice pocket book for practitioners who will be working with supervised community treatment, including health professionals, the police, and ambulance staff

- revised statutory forms to manage the SCT process
- a specific training module to develop good practice around SCT
- a care pathway diagram, with supporting information to help professionals
- a planning tool – a model that allows for scenario planning by showing the impact of changes in patient flows between hospital and the community when SCT is used.

Some pieces of work will be prepared in advance to help with the implementation of SCT. For example, the statutory forms were part of the secondary legislation consultation that concluded in January 2008.

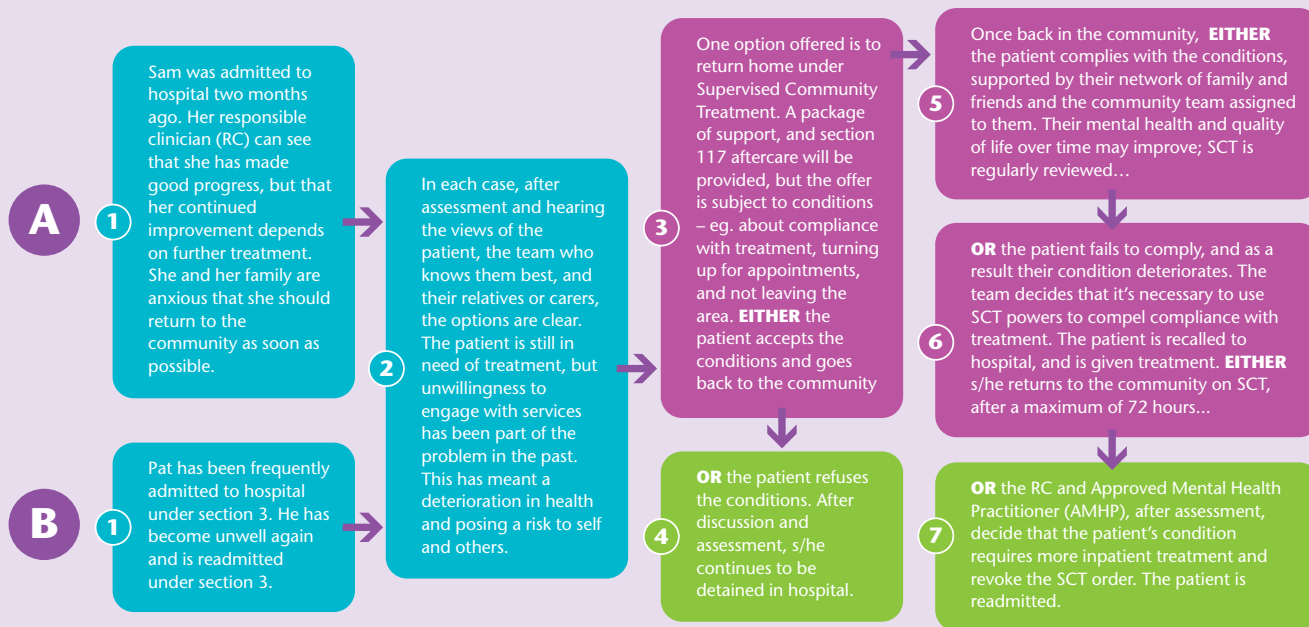
The best practice guide will provide step-by-step information for practitioners on how to work through the SCT process. The guide will be pocket-sized, so it can be easily carried.

The SCT care pathway diagram will complement the guide, and will be provided with supporting notes, both electronically and in hard copy. The diagram has been produced by the team developing the training module, as part of the broad set of training materials.

The planning tool is an electronic modelling tool,⁵ similar to a process map, that can be used both locally and nationally. It is intended to help local mental health services model the likely impact of SCT on patient flows within their system. It has been set up to model three representative sites or ‘scenarios’, covering urban, suburban and rural populations, and the data that have been inputted are taken from three real mental health services in England, using actual reports to the Department of Health.

The population data comprise people with severe mental illness, who are categorised as either ‘not in specialist service’, ‘on community caseload’, ‘informal in-patients’, ‘compulsory in-patients’, and ‘supervised in the

Figure 1: The patient pathway



William's story

William is in his mid-30s, and has been diagnosed with schizophrenia for the past 10 years, throughout which he has had intermittent contact with mental health services locally. He is very suspicious of the mental health services, and has a history of disengagement. He lives alone, in a local authority flat on a large estate.

William believes he is the true composer of a well-known hit single, and that the record company has refused to pay him and is broadcasting defamatory information about him on the radio and television. For the last two years William has been followed up by the assertive outreach team, who have tried creative and persistent approaches to engage him in ways he would find more acceptable. These include social, financial and practical assistance and working with his family. Sadly, the team feel they have exhausted collaborative options, and have concluded that William's suspicion and behaviours are part of his illness, and not a reaction to his past experiences of statutory services.

A year ago he had a long hospital admission under a section 3 and was treated with depot medication continuously for several months. By the time he was discharged by the Mental Health Review Tribunal, he was much less suspicious, was markedly more relaxed, talked only mildly about his persecution beliefs, and had re-established contact with his family. However he was still unable to explain his previous behaviour and would not accept that he had a mental illness. On discharge, he again immediately stopped his medication and two months later started avoiding community contact and his family. Recently there have been complaints from the local authority housing department and William's neighbours about his hostile and disturbed behaviour.

The assertive outreach team is considering the option of using SCT, following a brief hospital admission.

community'. The software has been designed to be user-friendly, and easy for teams to use. Organisations will be able to produce reports on the likely impact of SCT on bed numbers and community caseloads. Services will be able to use the information to inform planning, including the implications for workforce numbers. Teams will be able to see the likely impact on their clinical practice and resources by altering the parameters to reflect the situation of the local service. They can, for example, change the lengths of hospital inpatient admissions, patient flows from hospital to community, and SCT patient recall rates.

The model can be run over periods of up to ten years to show the patient flows before and after implementation of the new legislation. The results can be produced on graphs, allowing comparisons between different scenarios that can be used to inform discussions with

commissioners, voluntary groups, housing providers, police, ambulance staff, and other stakeholders.

The model is also designed to allow data to be separated out to show the likely impact of SCT on a particular sector of the mental health service, or on different ethnic groups. It may also be a useful way to highlight gaps in a trust's data collection, such as the rates of use of long-term section 17 leave.

To date, use of the model has shown that, even in inner city settings with populations of around a million, assuming a rate of severe mental illness of some one per cent, around 170 people would be subject to SCT at any given time. The model has also demonstrated that SCT will have only limited impact on the use of acute beds. For example, actual bed use is unlikely to reduce, as some patients who were out on section 17 leave may also have been counted as using beds, and these patients are likely to be moved onto SCT.

Mike Firt is chair of the National Forum for Assertive Outreach and a member of the design team. He has used the model locally to look at the implications of SCT for service provision:

'Our consultation with assertive outreach practitioners suggested that opinion was divided on SCT. Reasons for opposition were most likely to be based on values and ideology and from people who have misgivings generally about the use of legislative powers. Proponents cited the inadequacy and ambiguity of current community treatment options and welcomed the clarity and continuity brought by SCT in focusing treatment at home rather than in hospital. There was good consensus on SCT being applicable to a small, well-known sub-group of the caseload, and that the new powers would be used only when long-term constructive efforts were exhausted. Our estimates for numbers placed on SCT closely match those predicted by the systems dynamics modelling exercise.'

NIMHE will make the model available from early February, through a licence distributed to health and social care authorities. ■

For further information on the legislation implementation programme, visit the Mental Health Act 2007 implementation microsite at www.mhact.csip.org.uk or contact Sarah Haspel directly at t 07890 191361 Sarah.Haspel@londondevelopmentcentre.org

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