**Written evidence submitted by Dr Gareth Owen, Reader in Mental Health, Ethics and Law, King's College London (MHB0048)**

The JPC asks the question: 'to what extent will the draft Bill achieve its aims of reducing the number of Community Treatment Orders (CTOs)?'

The MH Bill makes few amendments to CTO. In my opinion:

- The amendments will not make any significant contribution to the Bill's aim of reducing the number of CTOs.
- By tightening the risk criteria *identically* to admission to hospital, they intensify a paradox mentioned below and make the purpose of CTO more confusing.

**Recommendations**

I recommend that the committee, in scrutinising the MH Bill on CTO, specifically consider two options:

1. *Phasing out the CTO instrument in the MHA 1983 - along the lines of the recommendations in the Independent Review of the Mental Health Act 2018 (the Wessely Review).*

*or,*

2. *Remodelling CTO in the MHA with more clinical targeting, Mental Capacity/Best Interests legal criteria and Tribunal scrutiny.*

**Background**

CTOs were introduced into the Mental Health Act 1983 in 2007 as a new legal instrument with the public policy purpose to:

> "help ensure that patients comply with treatment and enable action to be taken to prevent relapse and readmission to hospital." (The Minister of State, 2006)

In 2007 a comprehensive international review of the evidence by KCL concluded:

> "It is not possible to state whether community treatments orders (CTOs) are beneficial or harmful to patients." (Churchill et al. 2007)

This review summarised evidence from 72 data-based empirical studies, with pluralistic methods, undertaken in six countries. It also analysed different legal models of CTO and ethical arguments for and against them. So in 2007 there was not an absence of evidence but, rather, evidence for the absence of clear benefit or harm. Therefore, it is fair to say that the introduction of CTO into the MHA 1983 was made under conditions of uncertainty. Other systematic reviews have concluded similarly (Kisely et al. 2014; Barnet et al. 2018).

In the USA, where CTOs have been public policy for longer than the UK, some new evidence since 2007 has been reported that they may help improve access to multi-disciplinary care and treatment and reduce hospitalisation for a group of people with severe mental illness at risk of drifting away from services and experiencing repeat crisis admissions (Swartz et al. 2010). This is not experimental evidence but analysis of a large *observational* dataset and so it is very difficult to infer strong conclusions about causation. It is also evidence from a very different context of mental health service provision to that in England and Wales and from a jurisdiction without a

Mental Capacity Act. Furthermore, analysis of a large observational dataset in England during a four-year period after CTOs were introduced (2011-2015) has not found this effect (Weich et al. 2020).

Since 2007 more *experimental* evidence on the effect of CTOs has also been provided – this time from the first randomised controlled trial conducted in England and Wales. This trial found no effect of CTO on various outcomes (including relapse and readmission to hospital) across a period of 2008-2014 (Burns et al. 2013 and 2015).

*Therefore, in 2022, compared to when KCL reported its findings in 2007, there is stronger evidence that CTOs do not cause measurable benefits or harms on outcomes like relapse and re-hospitalisation. In other words, they don't make much difference.*

CTOs in England and Wales have:

- Shown significantly more use than originally expected and a non-trivial financial cost.
- Shown marked ethnic/racial disparities. Black people have an approximately ten-fold increased rate (NHS digital, 2020-21).
- A paradoxical feature in that criteria are identical for admission to hospital.
- A particularly complicated interface with the Mental Capacity Act.

The Wessely Review, after hearing evidence in support of CTOs, concluded:

> "We want to see a dramatic reduction in the number of CTOs, and for them to be used in a much more targeted way. We propose a tightening of criteria (and requiring both community and inpatient clinicians agree a CTO is necessary), an extension of the powers of the Tribunal to include dealing with conditions of a CTO, and making it particularly difficult to extend beyond two years without a compelling reason. Expressed in the vernacular, CTOs are in the "Last Chance Saloon"." (Modernising the Mental Health Act, 2018, p28).

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