

Correspondence

Community treatment orders in England: review of usage from national data

We read with interest the paper by Gupta *et al* on community treatment orders in England.¹ This and other reports on the use of compulsory mental health powers are particularly welcome now, as legislation is being reviewed.²⁻⁴ Scotland's distinct but comparable law and practice may be more relevant than those of the other jurisdictions mentioned. We are pleased to provide data from Scotland to broaden the picture and consider unique Scottish community provisions for mentally disordered offenders.

Community-based detention was made possible in Scotland by the Mental Health (Care and Treatment) (Scotland) Act 2003, enacted in October 2005. It allows mental health officers (social workers) with two supporting medical reports to apply for a compulsory treatment order (CTO). The Mental Health Tribunal for Scotland can grant either a hospital-based or a community CTO. The criteria are that: the patient has a mental disorder; medical treatment is available which alleviates the effects of the disorder or prevents it from worsening; without the provision of medical treatment there would be a significant risk to the health, safety or welfare of the patient, or the safety of any other person; the patient's decision-making ability with respect to medical treatment for mental disorder is significantly impaired; and the making of the order is necessary. Only the Tribunal can vary the powers between hospital-based and community provisions. Unlike in England and Wales, a community-based CTO can therefore be sought without admitting the patient to hospital and, when they are returned to hospital, it is by varying the order not by revoking it.

Gupta *et al* note that new CTOs in England have been stable at around 4500 per year over the past 5 years.¹ This is in contrast to Scotland, where the use of CTOs (with community-only powers) has increased from 11.2 to 20.5 per 100 000 population between 2008 and 2017.⁵ The proportion of CTOs with community-only powers was 44.9% in January 2017.⁵ If the legislation was similar in England (taking CTOs as a proportion of the total long-term sections, i.e. new CTOs and Section 3s), this was only slightly lower at 37% in 2014/2015.¹

Uniquely in the UK, Scotland also has a provision whereby a community-only compulsion order can be made by a criminal court (which is distinct from the equivalent of a probation order). Compulsion orders with community-only powers operate similarly to their civil equivalent, with breaches addressed by the mental health rather than the criminal justice

system. In the 10 years leading up to 2017, three orders with community-only powers were made (where the patient was unfit or lacking criminal responsibility), representing only 2% of compulsion orders made in those circumstances.⁵ Over the same time scale, 14 community-only compulsion orders were made as disposals, representing 2.6% of such disposals.⁵ The role of community detention as a criminal disposal is therefore much less prominent in Scotland than in civil mental health legislation.

We hope this Scottish context adds to the review provided by Gupta *et al*, and we agree, having considered these figures for community-based detention, that it seems 'sensible to take whatever steps possible to see that it is used effectively'. We respectfully suggest that adopting a broader range of data and jurisdictions for such a study would assist in that regard.

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- 1 Gupta S, Akyuz EU, Baldwin T, Curis D. Community treatment orders in England: review of usage from national data. *BJPsych Bull* 2018; 119-22.
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- 4 Taylor M, Macpherson M, Macleod C, Lyons D. Community treatment orders and reduced time in hospital: a nationwide study, 2007-2012. *BJPsych Bull* 2016; **40**: 124-6.
5. Mental Welfare Commission for Scotland. *Statistical Monitoring Mental Health Act Monitoring Report 2016/2017*. MWC, 2018 (https://www.mwscot.org.uk/media/409318/mha_monitoring_report2016-17_may2018.pdf).

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