Aims of the workshop

- To have an overview of the current research studies related to SMI and community treatment
- To consider the research and clinical practice of CTO’s
- To discuss some of the ethical and moral issues related to CTO’s
- To consider some of the practical implications and issues e.g. the power of Recall, the SOAD, Tribunals and managers hearings.
- To discuss the role of Non medical AC/RC’s
Current Research projects:
The Real Study
7 Domains of care-
Living environment, therapeutic environment, treatments and interventions, promotion of self management and autonomy, promotion of social integration, human rights and recovery based practice.
Currently on phase 4 – planning to recruit 350 patients in rehabilitation units and follow them up for a year following the implementation of the “Get Real” targeted therapeutic interventions.
The Abandoned Illness, Rethink November 2012

The Abandoned Illness report has highlighted some of the biggest challenges in caring for individuals with Schizophrenia and their families/carers, has given us the opportunity to look at how we can work within a national network to improve that care provision and promote hope and recovery.

The objectives form the Schizophrenia Commission development Network are to create an active learning group for improving care and outcomes for people affected by schizophrenia and psychosis; provide an opportunity to test in practice recommendations made by the schizophrenia commission, evaluate their impact and to use the network to influence the shape of national and local policy and commissioning priorities and to share best practice.
Effectiveness of financial incentives to improve adherence to maintenance treatment with antipsychotics: cluster randomised controlled trial. (FIAT)

• To test whether offering financial incentives to patients with psychotic disorders is effective in improving adherence to maintenance treatment with antipsychotics

• Primary outcome indicated a significantly higher adherence rate in the intervention group, than in the control group

• what ethical and moral problems does this raise?
The Improving Physical health and reducing substance use in Psychosis – Randomised Control Trial (IMPACT RCT)

- Recognising the markedly increased mortality rate - cardiovascular, respiratory, metabolic syndrome.
- The impact of anti-psychotics.
- Low levels of motivation to engage in lifestyle changes.
- The use of non-prescribed substances
CTO’s

Supervised Community treatment/supervision has been developed internationally for the treatment of mentally ill people following the widespread closure of Acute mental health hospitals and the subsequent financial implications of infinite need and finite recourses.

CTO’s were introduced in Britain in 2008 following the 2007 revision of the Mental Health Act 1983. There is currently little research yet completed into the effectiveness of CTO’s and the other changes introduced within the 2007 revision.
Community Treatment orders for patients with psychosis (OCTET): a randomised control trial.

• Compared CTO with Section 17 Leave
• Results indicated that there was no difference in the proportion of patients readmitted to hospital between study groups, nor in the time to readmission over a 1 year follow up. The overall duration of hospital care did not decrease nor did clinical or social functioning improve despite an average six month additional compulsion.
• Findings confirm previous evidence that CTO’s do not confer benefits on patients with a diagnosis of psychosis and should be reviewed in light of the high usage.
What is your experience
Supervised Community Treatment:

*An actual case study, involving ‘Tania.’*

Miles France, Approved Clinician (& AMHP).
Case Vignette for ‘Tania.’

- Context of case history, from 1990 to 2009 (CTO imposition)
  - ‘Tania’ is 50 and lives in social housing with her partner, ‘Simon.’
  - Simon is alcohol dependent, drinking 8 – 16 cans of 9% larger pd.
  - Tania’s teenage years: “hostile, aggressive & uncooperative.”
  - Miscarriage at 16 - subsequent child adopted – resulting alcohol
    and drug misuse, plus diagnosis of ‘severe personality
    disorder.’
  - Subsequent threats to abduct a child and multiple admissions.
  - Depot treatments post 1999: Depixol (TDs) → Risperdal Consta
    (max. BNF) → Clopixiol 600mg IM 2/52 (since 2009).
  - CTO in June 2009: brief Clopixiol to Risperdal Consta change & relapse.
  - Frequent recalls – 2 + per year – given concordance issues & chaotic
    lifestyle – current diagnosis of Paranoid Schizophrenia.
General Ethical / Legal Concerns

- **Historical Pointers (1992 – 2007):**
  - “a catalogue of failures” in the management of his care & treatment.
  - Supervised Discharge (post 1995) did not include compelling patients to accept treatment in the community or recall to hospital.
  - *R v. Hallstrom:* Consultant believed that this gap could be bridged by placing patients on long-term Section 17 leave.
  - *R v. Gardener, ex-parte L.:* the revocation of Section 17 leave – for the sole purpose of renewing Section 3 MHA – was also not lawful.
  - *R v. Barking, Havering and Brentwood Community Healthcare:* renewal of Section 3 lawful, so long as elements of IP care occur.
  - *R (DR) v. Mersey Care NHS Trust:* Judge Wilson noted that “treatment in a hospital does not mean treatment at a hospital.”
Specific Ethical Concerns, for *Tania*

- **Effect of ‘Recall to Hospital’:**
  - Has repeatedly occurred: minimal changes to her care & treatment
  - Has variable capacity to engage with treatment, per se.
  - Home is chaotic – just reprieved from HA exercising ‘notice to quit’
  - Constant difficulties with gaining access and administering depot.
  - No active recovery goals, e.g. education & meaningful occupation.
  - No evidence that the power of recall has reduced the incidence of re-admission to hospital – but does it facilitate quicker access?
  - *Tania* has not initiated any informal admissions, in recent years.

- **Practicalities:**
  - CTO renewal not due to June 2014 – should it be discharged?
Some further reading:

- DH (2008); MHA Code of Practice, Chapters 25, 28 & 29.
- MH Alliance (2010): Briefing Paper 2 – SCT
- Burns et al (2013): CTOs for patient with psychosis (OCTEC) – a randomised trial
• The New Roles aim :-
  – To facilitate a more effective and efficient professional framework for the RC and AMHP role
  – To offer choice for the service user.
  – Offers the opportunity to staff, who have in the past, contributed significantly to patient care yet have not had the statutory power to make primary decisions, to become either an AC/RC or AMHP
  – Offset staffing and recruitment difficulties. (much cheaper option or value for money?)
Non medical AC/RC responsibilities

- Section 17 leave
- Risk assessments
- Interface with multidisciplinary team
- Tribunal reports
- CPA reviews
- Powers to renew detention, discharge, and recall
- SOAD requests
- Powers to issue a barring report
- Associated powers and duties related to medical treatment (emergency treatment)
Issues for consideration

• Interface between Approved Clinician and Responsible clinician
• Trust policy on development and maintenance of non medical AC/RC roles
• Role of non medical prescriber
• The Social worker AC/RC
• How does functionalisation to in-patient settings impact on RC role in CTO’s and managing care?
References

NIMHE 2008 Mental Health Act 2007 New Roles/ Guidance for the Approved Mental Health Professionals and Approved Clinicians. NIMHE London
DoH Mental Health Act 1983 revision 2007
DoH 2008 Code of Practice. Mental Health Act. TSO.
• Any questions

• Thank you