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The introduction and evaluation of Community Care Orders following the Mental Health (Patients in the Community) Act 1995

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Abstract

Community Care Orders (CCOs) were introduced in Scotland in the Mental Health (Patients in the Community) Act 1995, which also saw the reduction of leave of absence. The aim of the study was to evaluate the use of CCOs in the first 33 months of their availability and to assess psychiatrists' and patients' views on their usefulness. Three data sources were used: (1) Mental Welfare Commission; (2) a named patient survey to consultant psychiatrists; (3) interviews with patients. Forty-five CCOs were used between 1 April 1996 and 31 December 1998. Half of these were judged successful by consultants. Conditions were varied and the impact on patients' lives could be extensive. There is confusion over the ability of CCOs to enforce medication but 77% implicitly or explicitly mentioned medication. CCO use has been low but set against the negative expectations of psychiatrists might be judged more successful than expected.

Introduction

A series of well-publicised incidents involving people with severe mental illness during the late 1980s and early 1990s resulted in the Conservative Government questioning how patients were being managed in the community (Atkinson *et al.*, 1996; 1999). Although there was debate about community treatment orders (CTOs) Virginia Bottomley, then Secretary of State for Health, compromised with the introduction of the supervision register (Burns, 1994). This was followed by new legislation, the Mental Health

(Patients in the Community) Act in 1995. In England this introduced supervised discharge orders (SD) and in Scotland Community Care Orders (CCOs). Community Care Orders could be seen as a replacement to extended leave of absence (LOA), which, in Scotland, had been renewable indefinitely. In England, LOA had been restricted to 6 months following the court case *R v Hallstrom* in 1986. The new Act in Scotland restricted LOA to 12 months. It was expected that many of the patients on extended LOA would be transferred to a CCO. Most psychiatrists opposed these changes because CCOs were believed

not to allow the enforced medication of patients living in the community (Atkinson *et al.*, 1997). Leave of absence appears to have been interpreted by some as a *de facto* community treatment order.

Both CCOs and LOA were tied into the Care Programme Approach (CPA) in the Scottish Office Draft Guidance on the 1995 Act stating, 'it will be good practice for the care plans of all patients on leave of absence or subject to a CCO to comply with the requirements of the Care Programme Approach (Scottish Office, 1996).

This study looks at the use of CCOs following their introduction and evaluates their impact from both the psychiatrists' and patients' perspectives. As part of this study, consultant psychiatrists and mental health officers (MHOs)¹ were surveyed about their attitudes to the changes to LOA and the introduction of CCOs. The results of this postal questionnaire are published elsewhere (Atkinson *et al.*, 2000). A summary of the complete study including data relating to patients who reached the new maximum limit of leave of absence is available on the CRAG website (<http://www.show.scot.nhs.uk/crag>)

Method

Population

Everybody who was on a CCO between their introduction on 1 April 1996 and 31 December 1998 made up the population. Data were collected from three sources and each will be described separately.

Mental Welfare Commission records

The records of the Mental Welfare Commission for Scotland (MWC) were accessed to identify all those patients who were subject

to a CCO. Details regarding dates of CCOs, reasons for termination and conditions of the CCO were noted from computer and paper files.

Named patient survey

Responsible medical officers (RMOs) and Special Medical Officers (SMOs) were identified for each patient from MWC records. Many patients had more than one RMO over the study period and many RMOs had more than one patient. Questionnaires were sent to consultants about 45 patients on a CCO. Questionnaires were posted on 24 May 1999 with a reminder sent on 24 June 1999.

The questionnaire was devised to collect predominantly quantitative information on named patients, their compliance with medication, services they received and their satisfaction with the CCO and serious incidents relating to injury or reckless behaviour. Consultants were asked to judge the success or otherwise of the CCO on their own criteria. The questionnaire was piloted on a small group of Senior and Specialist Registrars. Consultants were asked to complete the forms from memory rather than not return the questionnaire if they did not have time to consult files. Basic demographic data on the patients was already known from MWC records.

Interviews with patients

Patients were contacted by writing to the last known RMO explaining that the researcher (HCG) would be contacting the patient's key worker to obtain up-to-date contact details and current state of health. If staff strongly recommended that a patient not be invited for interview for reasons relating to the patient's health this was respected. If there was doubt about whether a patient would

¹ Mental Health Officers are social workers with specialist mental health training and powers under the Mental Health Acts of 1984 and 1995. They are the Scottish equivalent of the English Approved Social Worker.

² SMO is usually the consultant psychiatrist responsible for a patient on a CCO.

be coherent, but invitation to be interviewed was not thought harmful, they were contacted. The majority of interviews were conducted at the interviewee's home. Where necessary the researcher was accompanied by an independent chaperone.

Patients received a letter explaining the research and asking them to contact the researcher if they would like to take part in an interview exploring the impact of the 1995 legislation. They were assured of anonymity and confidentiality.

The interview followed a semi-structured format and there was opportunity for patients to introduce and talk about topics, which were of particular concern to them. It was not thought appropriate that patients should have their legal rights explained to them as part of a research interview. If questions were asked seeking clarity the researcher directed the patient to their medical team and the MWC for further information.

The researcher made verbatim or paraphrased notes at the time of the interview and usually read them back to the patient for confirmation.

Ethics permission

Ethics permission was granted by the Multi-Centre Research Ethics Committee for Scotland and 13 Local Research Ethics Committees (LRECs) across Scotland. Ethics permission was not sought from either Orkney or Shetland LRECs as their patients receive in-patient treatment in Grampian and the SMO granting CCO would be in Grampian.

Results

In presenting the results, an indication will be given as to the source of the data. Numbers involved vary depending on the source of data. In the named patient survey details were obtained from psychiatrists on 39 (87%) of

patients. Twelve patients on a CCO agreed to be interviewed.

Description of population

Forty-five people were identified from MWC records as being on a CCO during the period under investigation. Of these, 36 (80%) started immediately after the new maximum LOA. Of the remaining nine, five had been on LOA for more than 300 days, three had been on LOA for less than 50 days and only one person was not on LOA immediately prior to the CCO.

In the first 12 months in which CCOs were available there were seven, in the second full year there were 27 new CCOs and in the first 9 months of the third year there were 11 new CCOs. As at the end of June 1999 there were 16 CCOs current, four still running from 1996/97, six from 1997/98 and six from April 1998 to December 1998.

Thirty-three (73%) patients were men and 12 (27%) were women. The age range was 26–67 years for men and 23–71 years for women with a median age for men of 39 years and for women 48 years (Mann Whitney Test, $p=0.03$).

Most patients, 35 (78%), had a diagnosis of schizophrenia, the remaining 10 having diagnoses of bipolar disorder/manic depression, four (9%), schizo-affective disorder, three (7%), learning disability plus another condition, two (4%) and one person (2%) with a diagnostic disagreement between schizo-affective disorder and manic depression.

The length of time for which CCOs ran is given in Table 1.

Conditions of CCOs

Conditions attached to CCOs were available for 44 of the 45 patients. Details are given in Table 2.

Examples of conditions regarding medication are: 'the patient will take medication as

Table 1: Length of CCOs in months, $n=42$

Length of CCOs in months	Terminated CCOs	CCOs current as of 27/6/99 and started before 31/12/98
1-5	3	0
6-11	14	6
12-17	7	2
18-23	2	3
24-29	0	2
30-36	0	3
Total	26	16

Table 2: Conditions attached to CCOs $n=44$ patients

Conditions	<i>n</i>	%
Residence at specified address	10	23
Give access to staff	36	82
Attend appointments	40	91
Attend therapeutic day activity	6	14
Comply with medication	34	77
Accept home help or similar	6	14
Attend CPA meetings	9	21
Accept assistance or control of finances	4	9
Other	14	32

prescribed by SMO as treatment for his/her mental illness'; 'Compliance with supervisory access by (named) CPN for purposes of administration of medication and assessment of mental state with respect to possible medication change.' The 19 'other' conditions for 14 patients cover a range of options and the need to preserve patient anonymity makes detailed description difficult. Conditions can encompass broad areas of life, including accepting staff support with living skills such as diet and socialising or keeping staff informed where the patient was living or working. Others which are more individual include: not sharing accommodation for more than three nights without agreement; abstaining from illicit drugs and co-operating with random drug screenings; co-operating with attempts to secure appropriate accommodation; to accept 24 hour monitoring; adhere fully to prescribed treatment plan and to

avoid unsupervised close contact with children and adolescents. One condition, which was unusual in that it placed conditions on someone other than the patient, required the patient's parents to keep in weekly contact to provide emotional support.

Of the 39 patients on CCO for whom a named patient questionnaire was returned, consultants reported no problems in delivering the services required by the CCO for 21 (54%) patients. There were problems reported for 14 (36%) and in four (10%) cases the information was missing or unknown. The other comments related to the length of time involved and 'poor social work support'.

Compliance with medication

Table 3 gives details of patients' compliance with medication while on a CCO. Few comments were made by consultants, how-

Table 3: CCO patients' compliance while on CCO $n=39$

Compliance with medication while on CCO	<i>n</i>	%
Compliant	19	49
Partially compliant	11	28
Not compliant	4	10
Don't know/missing	5	13
Total	39	100

ever, for patients who were compliant the three comments made indicated that compliance was still by no means unproblematic: 'constant haggle' and 'patient knows that he/she will be recalled to hospital and put on a s18 if he/she doesn't comply'. For patients who did not comply, comments indicated refusal, relapse and recall to hospital. For partially compliant patients the main themes were the use of persuasion and support and the need for a formal context for the patient's care: 'need for some form of legal framework in the hope that this would aid compliance'.

Outcomes of CCOs

Reasons for the 29 terminations of CCOs were established from both MWC files and from the named patient survey and are given in Table 4. Two cases were admitted to hospital for assessment (CCO8 form) and, as a result of being in hospital for more than 7 days the CCO lapsed. One of these patients was detained shortly afterwards and the other returned to the community with no formal

order for at least 3 months (end of follow-up period). There was no explanation available for the termination of the CCO for one patient.

At least two CCOs were allowed to run although the renewal papers arrived after the date on which the CCO terminated. It was considered that sending the papers before the termination date met the legislative requirements.

One CCO was only registered with the MWC at the time of its renewal (i.e. 6 months after its start date) and its status is unclear. It has been included as a terminated CCO in the number given above (i.e. it is considered a CCO until termination).

Psychiatrists made comments on outcome for 37 of the 39 (93%) patients on CCO for who survey forms were returned. Eighteen (49%) were judged successful or were commented on in positive terms. 'Successful in that the patient remained well and compliant throughout'; 'More successful than I expected because patient now seems to perceive his/

Table 4: Reasons for termination of CCOs $n=29$

Reason	1/4/96– 31/3/97	1/4/97– 31/3/98	1/4/98– 31/12/98	Total
Planned lapse as patient compliant	2	3	1	6
Lapse due to failure to renew	1	5	3	9
Terminated by admission 'on section'	0	7	0	7
Transfer of care successful or CCO judged redundant for other reason	0	4	0	4
CCO8	0	1	1	2
No renewal identifiable at MWC, no explanation	0	1	0	1

her illness as needing tackling and ourselves as support and not problems'. The notable feature of the positive comments was the surprise expressed by psychiatrists at the positive outcome. 'Better than I expected' featured a number of times.

Thirteen (35%) of CCOs were judged unsuccessful and many of the comments were in respect of non-compliance with medication: 'Not successful. No power to enforce. Legal process was antagonistic to patient and potentially at risk for staff'; 'Totally unsuccessful. Patient decided he/she did not want medication and we had no power to compel him/her.' Several comments noted the CCO was resented by the patient.

For six (16%) patients the comments were neutral or ambivalent: 'No problems – patient never tested out CCO'; other comments indicated that psychiatrists saw no advantage over LOA.

Patients' experiences of CCOs

Twelve (27%) patients were interviewed, 10 men and two women and all 12 knew that they were or had been on a CCO.

Responses have been collated under themes to give an overall picture of the patients' experience of being on a CCO although experiences tended to be individualistic and common themes were difficult to construct.

Positive views of CCOs

These tended to reflect the patient's awareness and acceptance of their illness, often including their need for medication: 'Doesn't bother me. I realise now that I've got to take the pills because I feel too much of a lack of adrenaline if I don't. They calm me down.'

Other patients liked the formal support that they thought the CCO gave them, one patient indicating his/her disappointment when the CCO lapsed. Others believed they received 'fringe benefits' being on a CCO such as not having to pay their council tax and others saw

changes in their care as a result of being on the CCO. This included: 'they have to keep in touch with me' which was contrasted with poor contact and poor services whilst homeless; access to community services, although it was acknowledged that this could be because of an improvement in their illness; acknowledgement in the CCO of them being chronically ill and entitled to benefits; acceptable and wanted changes to medication. The only two services which patients directly attributed to being on a CCO were a home help and access to chiroprody services.

Although most patients saw no difference between being on a CCO as compared to LOA, two expressed an increased sense of freedom being on a CCO. They perceived that they were more at liberty to go on holiday and travel abroad than previously.

Negative comments

A feature of many of the negative comments were the restrictions placed on the patient's life: 'Pretty bad. I'd like to live in the community under my own steam. The visits from X put me under a lot of pressure. X has had me admitted before so I have to watch what I say.'

Another patient said the CCO 'really annoys me – not got your own space on a section – you've just got to abide by the rules'. Some of this negativity was in relation to mental health legislation in general and not just CCOs. One patient expressed strong views about being constrained by any mental health legislation and did not like being told to do things by 'a mere slip of a lass'.

Some had a perception that the CCO was not planned in their interest. One patient thought he/she was on a CCO because he/she was 'a bit of a rebel' and had previously appealed against a section whilst in hospital. Another patient summed up his/her views as 'Deep down that is all their (the staff) con-

cern. Keeping themselves covered in case I go mad and kill someone’.

Some patients echoed psychiatrists’ views that CCOs ‘were too much bureaucracy’. Others saw this as impressive and indicating the formal (and legal) nature of the CCO. This was not always unwelcome.

Not surprisingly some patients objected to particular conditions of their CCO. Medication will be discussed later. Other patients were resentful of having to see an unknown social worker or attend particular groups. These conditions were described sometimes as being more restrictive than being on an LOA.

Mixed views

One patient with mixed views believed that being on a CCO would protect him/her from the consequences of breaking the law when he/she was not well but at the same time described the CCO as ‘an infringement of my human rights’. The other patient who was particularly ambivalent contrasted ‘I feel it’s alright, it does its part’ with ‘if they don’t agree with the things I am doing I will end up getting lifted back to hospital’. He/she believed this could happen as a result of a minor incident, which might happen to anyone.

Medication, sanctions and recall to hospital

It is difficult to separate these three issues. There was considerable confusion among some patients as to whether they could refuse medication while on a CCO and what would happen if they did refuse. Three patients were clear about the difference of being on a CCO compared to LOA in respect of medication. One patient reported refusing medication on CCO but had been compliant on LOA. Another patient had taken advice from the MWC to the effect that he/she could not be recalled to hospital simply for not taking medication. Several other patients, however, believed they could be recalled to hospital if

they did not take medication and did not appear to have been disabused of this view by their psychiatrist.

The threat of recall to hospital was real for a number of patients, some of whom believed they could be recalled almost ‘at whim’. This put pressure on them to always appear well to members of the mental health team. One patient indicated that he/she felt unable to trust or confide in any member of the team. He/she felt angry at his/her treatment but unable either to express this anger or negotiate a change. He/she feared that anger would be interpreted as illness and disagreement with treatment as lack of insight, even though he/she acknowledged he/she had a mental illness. The pressure to appear ‘well’ was noted by a few patients.

CCOs, consultation and legal changes

Most patients had not gone to the court hearing granting the CCO although there was some confusion among those who thought they had, as one recalled it being in the hospital. A minority of patients remembered being consulted about the CCO and its conditions, although even then, ‘consultant went through it carefully though I didn’t understand all of it.’ A minority was happy with the consultation process. One patient would have liked a specific trusted member of staff involved and others objected to conditions.

Four patients had considered challenging the order, one patient obtained ‘bleak legal advice’ which suggested that he/she would not win if he/she did challenge it. One patient reported being told that he/she would not get legal aid if he/she appealed against a CCO suggesting that this had prevented him/her pursuing this.

Half of the patients knew there had been a change in the law, including believing that LOA no longer existed. One patient asked if the rules had changed in relation to 28 days AWOL.

Discussion

Response rates

There is some data on all 45 CCOs from MWC records, responses from consultants for 39 (87%) named patients and 12 (27%) patients were interviewed. The good response from psychiatrists would seem to indicate that they took the survey seriously and saw its importance and we have no reason to believe that the other patients were different to those for whom there was information provided. The response by patients is more problematic. Ethics permission from MREC required a lengthy, complex letter explaining the research and some LRECs commented on its difficulty. Requiring patients to 'opt in', that is contact the researcher to arrange an interview, may have also limited response. Since interviews were being arranged across Scotland, however, we were reluctant to travel possibly several hundred miles and not find the patient at home. It is noteworthy that all interviews arranged were carried out at the arranged time and not one patient broke an appointment. This would seem to indicate the strength of feeling of the patients who responded to the invitation. It is possible that declining the offer of interview was due to 'interview fatigue' (CCOs were new there was more local monitoring than would be usual and CPA was also being monitored in some areas at this time) or that it was too distressing to patients to discuss their legal detention or that patients simply wanted minimum contact with services.

Thornicroft (2000) notes the 'heavy demands' in interviewing patients in multiple locations, including gaining ethical approval but suggests it is important to study the patient's perspective. Although limited in number the insights from these patients is a valuable addition to our understanding of CCOs.

Use and impact of CCO

Forty-five CCOs were used during the study period. Two hundred and fifty patients reached the maximum LOA (Atkinson *et al.*, 2002). Thus, the 36 starting a CCO after maximum LOA is only 14% of those who might have been expected to be seen as eligible. It is difficult to know whether this is a low use because it is a new legislative power and how far use of CCO will increase with familiarity. The generally negative view of CCOs held by psychiatrists might suggest that use would be low, at least in the beginning. The small number of psychiatrists who used CCOs must be seen as limiting the generalisability of the study. The comments of psychiatrists that the CCO they used had been more successful than they expected suggests more might be used in future. It is also interesting that half the CCOs were judged successful in the named patient survey compared with 60% judged unsuccessful in the previous attitude survey when psychiatrists were asked their views globally (Atkinson *et al.*, 2000). This suggests a general negative 'halo' around CCOs colours general views but asking about specific named patients gives a more accurate impression.

That they were judged successful by the psychiatrist must also be seen as positive given the apparent pessimism with which they were used. Davies *et al.* (1999) also note this in relation to supervised discharge. This might suggest that some of the issues surrounding the introduction of CCOs might best be seen within a management of change context. The statutory requirements for implementing a CCO necessitate more interdisciplinary consultation and recording than renewal of LOA. This was commented on by psychiatrists in the attitude survey who made frequent references to the burden of 'bureaucracy' in relation to CCOs and CPA (Atkinson *et al.*, submitted). There are also

references to this issue discussed here in relation to CCOs

There is not enough evidence from this study to say if these expressions indicate frustration at having to spend time recording existing practices when feeling short of clinical time and under pressure in other ways or if they are expressions of resistance to a change in working practices towards a more multidisciplinary consultative model.

Although the majority of patients on a CCO have a diagnosis of schizophrenia and indications from psychiatrists are that many have problems with compliance with medication, the range of conditions laid down in the CCOs and the patient's comments about them would indicate that the management issues for which they are being used varies widely.

Clearly, patients could have different views on the impact of the same CCO condition and with the conditions of CCOs varying considerably it is difficult to make generalisations about impact. Some patients talked at length about the impact of the CCO on their lives and in a few cases it affected every aspect of the patient's life, including housing, socialising, limiting where they could go and with whom. For a number of patients the CCO was seen to have considerable control over their lives, which was in contrast to the comments made by the consultants about CCOs not having any power. It is maybe not surprising that this extensive impact was usually resented. The resentment expressed was not always limited to the CCO but more widely to any detention or coercion under the MHA or, indeed, perceived coercion by the doctor.

The issue arose of whether patients could be charged for services they were compelled to receive as a condition of a CCO. Local authorities have the discretion to waive charges for services such as home helps. The evidence is incomplete but it seemed that some patients were being charged for serv-

ices that were a condition of their CCO and some were not. Although this could be an effect of means testing, the cases recorded suggested that it resulted from different authorities having different practices. Although it seems unjust that patients should be charged for services they do not want but are compelled to receive there is also concern that if charges are waived for patients on a CCO then this might act as an incentive to use CCOs.

Termination of CCOs

Unplanned lapse was the most common reason for the termination of a CCO. This would not appear to be in anyone's interest and requires systematic attention from all agencies involved. One consultant commented that there was no system in place to alert him/her to the need to renew the CCO. Whether it was expected that this should come from the trust or the MWC was not expressed.

One of the patients whose CCO terminated because of failure to renew regretted this as the CCO made him/her feel more secure. Conversely, a psychiatrist commented that, the CCO expiring unknown to both psychiatrist and patient was of no practical importance as it did not affect the patient's behaviour in respect of compliance.

Legal uncertainty

Section 35A of the Mental Health (Scotland) Act 1984 provides for a patient to be subject to conditions specified in a CCO 'being conditions imposed with a view to ensuring that he receives (a) medical treatment; and (b) after care services provided for him under Section 8'... It further provides that the sheriff, if approving an application, shall make a CCO in respect of the patient, 'subject to the conditions set out in the application or to such other conditions as the

sheriff considers appropriate'. There is no further guidance in the legislation as to what the conditions may be or whether or not they may include a condition requiring medical treatment to be taken. However the section further provides that on the coming into force of a CCO the patient ceases to be liable to be detained and therefore not subject to part X of the Act, which authorises treatment in the absence of the patient's consent. It would therefore appear that the conditions could contain a requirement for the patient to comply with medical treatment but that this falls short of an authority to administer the treatment against the patient's will. These issues have not been tested in court.

Section 35G provides that if the mental condition of a patient on a CCO has deteriorated and is, or is likely to become, such as to give grounds for serious concern regarding his health or safety or the protection of other persons, the patient can, with various safeguards, be compulsorily admitted to hospital for a period of up to 7 days, during which treatment without consent can be given.

It is clear from earlier surveys that psychiatrists believed that CCOs could not be used to enforce medication in the community (Atkinson *et al.*, 1997, 2000). This may have led to some believing that the acceptance of medication could not be a condition of a CCO. A consequence may have been less use of CCOs than might otherwise have been the case. This may be important since three-quarters of CCOs required patients to take medication. If this becomes recognised other psychiatrists may be more willing to use them.

Patients also displayed some confusion about whether they had to take medication on a CCO and what would happen if they refused. The problem was compounded by there being no written information available for patients at the time from the MWC.

It would seem that there needs to be some clarification on medication around CCOs, for the benefit of both patients and psychiatrists. An impression is gained from both patients and patients' records that some psychiatrists chose to risk their relationship with their patient by being economical with the information they gave them about their right to refuse medication. In other cases the ambiguity about the law may contribute to a lack of trust in the doctor-patient relationship, which is not of the psychiatrist's making.

The availability of sanctions if the conditions of a CCO are not adhered to and when such sanctions are activated is also ambiguous. From both the previous questionnaire (Atkinson *et al.*, 2000) and the comments made in the named patient survey there appears to be a strong view amongst psychiatrists that the CCO is a 'toothless order'. As already mentioned, patients may see the CCO as having an excessive impact on their life. The procedures, which doctors complained about for their length and complexity, have apparently in some instances impressed the patient with the authority of the law. This might have contributed to compliance with conditions. Similar observations are made by Knight *et al.* (1998) and Franklin (2000) in surveys relating to SD in England.

The question of how many times a patient can be 'warned' and what happens after such warnings was raised. This may be reflected in a different understanding by consultants and patients of what the lower threshold for admissions to hospital while on a CCO as compared to a new admission under the Mental Health Act (Scotland) 1984 means. It appears that some patients perceive the CCO in the same way some voluntary patients experience their voluntary status, i.e. they think that if they try to leave hospital they will be detained (Sugarman & Moss, 1994a, b;

Eastwood & Pugh, 1997). The CCO equivalent is that patients feel they are free to refuse medication but if they do they will be recalled to hospital, even if they are not ill. Generally, research indicates that patients' knowledge of their legal status and rights is poor (Goldbeck & Mackenzie, 1997; Mental Welfare Commission, 1998) and nothing heard in interviews would lead us to question this.

CCOs in the wider context

Community Care Orders are only one of a range of measures to restrict patients who live in the community (Atkinson & Paterson, 2001). Supervision registers were also unwelcome (Caldicott, 1994; Holloway, 1994; McCarthy & Roy, 1995). Compared to the Royal College of Psychiatrists' estimate that 0.3% population who could be on a supervision register (Caldicott, 1994) a survey of South West Thames Region gave an actual figure of 0.012% of the population (Cohen & Eastman, 1996). All the surveys of estimated and actual use indicate an idiosyncratic interpretation of the guidelines for supervision registers (Atkinson & Patterson, 2001).

Like CCOs, SD has been criticised for failing to allow for compulsory treatment and expected low use (Holloway, 1996). A survey looked at its use in 1997 and 1998 in all Mental Health Trusts in England (Pinfold *et al.*, 1999). With responses from 92% (165/180) trusts in 1997 and 99% (178/179) trusts in 1998 the number of SD orders used in 1997 was 160 and in 1998, 378. Forty-five trusts had no SD orders in either year. Those responding to the surveys were largely senior administrators or managers. Respondents in 43% of trusts believed that SDs were powerless although almost a quarter of trusts were positive about the process and the impact on patients. The bureaucratic nature of the orders was commented on by 22% of trusts and 65% of comments were about problems in its

use. The 'power to convey', heatedly debated and opposed before its introduction, had only been used by 10% of trusts, although its use by patients for a 'free lift' to a day centre was noted. The authors conclude that although its low usage might suggest failure of the legislation they note its use is rising and attribute low usage to the negative views expressed about it (Pinfold *et al.*, 1999).

Another survey, this time of psychiatrists in South and West Region Health Authority in England suggested that although 21% were not using the Act because of the paper work involved and 13% because of fear of litigation, 28% of consultants were not using it because of lack of resources (Mohan *et al.*, 1998). It might be that administrators either would not know of this reason or be unenthusiastic about admitting it.

It is difficult to make direct comparisons between CCOs and SD as one might be seen to represent a reduction in power and the other an increase and, thus, will be experienced differently by both psychiatrists and patients.

The Committee of Review, chaired by the Right Honorable Bruce Millan, which considered changes to Mental Health legislation in Scotland suggested that community care orders should be abolished and replaced by a community order (Scottish Executive, 2001). The Committee further suggests that those who would previously have been on leave of absence for more than a year would be 'the people most suitable for an order for treatment in the community'. Compulsory, but not forcible, medication is possible but there is also a suggestion that the range of compulsory measures, which could be imposed, should be specified in regulations. The Scottish Association for Mental Health (SAMH) in its submission to the Millan review argued for CCOs to be given more time and more resources before other forms of compulsion

in the community were introduced (Scottish Association for Mental Health 1999). SAMH is still of this opinion (Personal Communication, 2001)

If community orders come into being the information gathered from the evaluation of CCOs will be useful in developing practice guidelines.

Conclusions

The low use of CCOs may be a reflection of the negative views consultants hold about CCO. When asked about named patients, however, half of the CCOs were judged successful. Patients' views are variable but the range of conditions is very wide and the extent of the impact on patients' lives should not be underestimated.

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