Editorial

Lawfulness of preventive recall from a community treatment order

John Dawson

Summary

Preventive recall to hospital of a patient on a community treatment order can be lawful when it is based on a convincing prediction that relapse in illness would otherwise occur. The legislation for England and Wales provides several indications that authorising preventive recall in those circumstances is a purpose of the community treatment order regime.

Declaration of interest

None.

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Clinicians in England and Wales seem uncertain or at odds about the circumstances in which patients can be recalled early to hospital for failure to meet the conditions of a community treatment order (CTO).[1] The authors of a recent Yorkshire study ask:[2] must 'the risk of harm . . . be immediate' for recall to occur, or can it proceed where 'it is reasonable to predict' that breach of a condition, such as accepting depot medication, will lead relatively quickly to relapse and associated risk of harm? If 'the patient must have demonstrated signs of relapse before recall', they argue, this would render 'CTOs ineffective at preventing relapse, one of their core aims'.

What is the correct legal position, therefore, in England and Wales, on preventive recall from a CTO, under the Mental Health Act 1983 (UK) (the MHA)? To put a patient on a CTO, the MHA specifies that it must be 'necessary that the responsible clinician should be able to exercise the power . . . to recall the patient to hospital' (section 17A(5)(d)). This is an essential criterion for use of a CTO. But is it then possible to recall a patient on a CTO to hospital for failing to accept out-patient treatment at an earlier stage in the deterioration of their illness than would usually justify the 'sectioning' of a person under the front end of the compulsory treatment process (that is, under section 2 or 3 of the MHA)? If the CTO confers an extra power of preventive recall, clinicians could claim it was 'necessary' to have that power available in some situations, and then they could argue that those were the very situations in which it would be lawful to put a patient on a CTO – giving coherence and a clear preventive purpose to the CTO regime.

Is preventive recall lawful?

So does a CTO confer an extra power of preventive recall? The main argument against that idea is that the standards governing compulsory admission to hospital – under both the initial sectioning (or certification) process and under the recall power – are basically the same. Both of these sets of standards are broadly stated in the legislation and both are open to a wide range of clinical interpretations. If they are functionally equivalent, early intervention would be authorised either via recall or via re-sectioning. Then it would be hard to point to any situation in which it was genuinely 'necessary' to have the recall power available in addition to the existing power of clinicians to section and admit freshly to hospital a patient who has failed to follow the essential requirements of a community treatment plan.

So a key question is: are the standards governing recall and re-sectioning basically the same? The MHA says recall to hospital from a CTO is possible when: '(a) the patient requires medical treatment in hospital for his mental condition; and (b) there would be a risk of harm to the health or safety of the patient or to other people if the patient were not recalled' (section 17E(1)). Both legs of this standard must be met. The first is expressed in the present tense ('requires . . . hospital'), the second in the conditional ('would be a risk . . . if . . . not recalled'). Both these standards could clearly be met before marked deterioration had occurred in a patient's condition.

First, it can be said that treatment in hospital is 'required' when treatment is urgently needed – to prevent deterioration in the patient's condition – that could not lawfully be provided outside hospital without their consent (with 'urgently' here usually meaning that treatment needs to provided within a matter of hours or days). Second, it can be considered that 'there would be a risk . . . if the patient were not recalled' when it can reliably be predicted – based on the patient's history – that relapse would follow cessation of treatment and result in the necessary risk.

Nevertheless, it can still be argued that patients who have been discharged from hospital to voluntary out-patient treatment can be readmitted to hospital, via re-sectioning, on the same preventive basis. The standards governing sectioning are expressed in slightly different terms than the standards governing recall from a CTO, but their focus is similar – the need to detain a patient in hospital for assessment or treatment, and the need to reduce the risks to the health and safety of the patient or others. So the two sets of standards are to similar effect.

Law on preventive use of the recall power

Nevertheless, the legislation provides several indications that the standards governing recall may properly be interpreted as permitting intervention at an earlier stage in the deterioration of a patient's condition. First, there is the requirement – for putting a patient on a CTO – that the responsible clinician must consider it 'necessary' to have the recall power available. Including that requirement in the regime strongly implies that there are indeed situations in which admission to hospital could only proceed lawfully via exercise of the recall power.

Second, the MHA requires a clinician who is thinking of exercising that power to 'consider . . . having regard to the patient's

history of mental disorder . . . what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to take the medical treatment he requires for his mental disorder)' (section 17A(6)). This provision explicitly links use of the recall power to the need to prevent deterioration in the condition of a patient who fails to comply with out-patient care.

Third, the precise standard governing recall from a CTO, under section 17E(1), refers to the patient's need to receive 'medical treatment' in hospital, not to their need for 'detention' in hospital (the formulation used in sections 2 and 3). This seems to constitute a significant difference in the standards, particularly because the process to be followed after recall from a CTO clearly seems to contemplate that the patient may be treated without consent even if their further detention is not required.

A 72 h holding period is provided, during which the patient's condition is to be assessed, and in that time treatment can be provided without consent, and the patient can then be immediately released from hospital back on to the CTO. This suggests preventive treatment following recall is authorised even when no further detention in hospital is contemplated. The Code of Practice[3] therefore says immediate recall from a CTO for failure to take medication 'could be indicated' (para 25.20), recall could occur 'before the situation becomes critical' (25.47), and 'outpatient' recall without overnight admission is possible (25.61) – provided this is 'proportionate to the level of risk' (25.50). Considering early, preventive recall from a CTO to be lawful in some situations generates the best interpretation of these provisions as a whole.

The indications for preventive recall in practice

So when should preventive recall occur? It will be lawful when it can reliably be predicted – based on the patient's history – that relapse in illness would follow cessation of treatment and would present the necessary risks. Some situations in which that prediction could be made – even for a person who is not acutely unwell – would be those in which they had previously demonstrated one or more of the following: either, a pattern of rapid relapse; repeated or prolonged episodes of illness; severe consequences during relapse, such as serious violence to self or others; or early loss of insight during illness, leading to inability to take the steps required to prevent its deterioration. What is needed, above all, is a sufficiently convincing prediction of the probabilities of relapse and the seriousness of the likely consequences.

Limiting use of CTOs

In those situations, preventive recall could lawfully proceed when the patient had failed to follow the requirements of the out-patient treatment plan, and it could properly occur at a somewhat earlier stage in the deterioration of the patient's illness than would usually justify sectioning a person under the MHA. In those circumstances, an additional power of preventive recall could be considered 'necessary', and conferral of that power could be considered a clear purpose of the CTO regime.

This approach has the advantage that it makes sense of the legislation as a whole. It also clarifies and limits – simultaneously – the reach of the CTO regime. It shows that CTOs should be used – and only used – in those situations in which early preventive recall could properly occur, because only in those situations will the argument be fully convincing that recall is a necessary supplement to the other powers available to clinicians to enforce out-patient care.

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References

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2 Smith M, Branton T, Cardno A. Is the bark worse than the bite? Additional conditions used within community treatment orders. *Psych Bull* 2014; **38**: 9–12.

3 Department of Health. *Mental Health Act Code of Practice*. TSO, 2008.