



**University of Brighton**



**National Institute for  
Health Research**

# AN EXPLORATION OF SERVICE USER AND PRACTITIONER EXPERIENCES OF COMMUNITY TREATMENT ORDERS

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## EXECUTIVE SUMMARY

### CONTEXT

This research study investigates Service User and practitioner experiences of Community Treatment orders (CTOs) within a climate of personalisation of services that aims to provide service users with increased autonomy and choice over their care. The 2007 amendment to the Mental Health Act 1983 stands at odds with this general thrust in policy-making towards personalisation in providing for a number of key changes for the use of compulsion within mental health services. This study explores experiences and uses of CTOs within the tension between autonomy and choice on one hand, and compulsion and control on the other.

### WHAT ARE COMMUNITY TREATMENT ORDERS (CTOS)?

A CTO is the legislative power by which patients with mental health difficulties who are treated involuntarily in hospital can be discharged into the community but still remain subject to compulsory treatment. The CTO thus extends the setting for involuntary treatment from being exclusively confined to the hospital ward to the community.

### RESEARCH METHODS

The study included an analysis of existing quantitative data, as well as collection and analysis of qualitative interview data from a range of practitioners, Service Users and Nearest Relatives within the Sussex Partnership NHS Foundation Trust (SPFT).

### QUALITATIVE SAMPLES

72 participants in total were interviewed using a semi-structured interview schedule.

TABLE 1: ALL PARTICIPANTS INTERVIEWED

Service Users	21
Nearest Relatives	7
Care Coordinators	16
Responsible Clinicians	10
Approved Mental Health Professionals	9
Service Providers (housing)	9
<b>Total</b>	<b>72</b>

### QUANTITATIVE STUDY

In addition, a complimentary statistical analysis of CTO use in SPFT was carried out to explore the characteristics (age, gender, ethnicity, diagnosis, marital status, employment status) of those service users who had been placed on a CTO, and the outcomes of those CTOs (i.e. number still in force and numbers of discharges, recalls to hospital and revokes by tribunal). The sample for this analysis comprised of CTO records made between July 2010 and December 2012.

## RESULTS

### QUANTITATIVE DATA

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A statistical analysis of Trust records from the year before the study commenced (July 2010 – June 2011) and the time period of the study (July 2011 – December 2012) was undertaken. In the earlier sample, 138 new CTOs were made, 61 CTOs were discharged, 36 were recalled to hospital, 22 had their CTOs revoked and 115 CTOs were renewed. Since those on CTOs which had been discharged, renewed, revoked, or those who had been recalled to hospital during this time period, may have received a CTO before the time period, we could not calculate the percentage by outcome of those who had received a CTO in the time period. However, during the period of the study (July 2011 – December 2012) 199 new CTOs were made and information was provided about the outcomes for these CTOs within the time period: 52 were discharged (26%), 72 were still active (36%) and eight were allowed to lapse (4%). 60 (30%) Service Users whose CTO was made in this time period were recalled to hospital and of these 11 (18%) were subsequently returned to the CTO, whilst the large majority (49, 82%) had their CTO revoked. It should be noted that the figures are affected by the fact that a significant proportion (41%) of CTOs were made after June 2012 and would therefore not have yet been due for review. If those which may not have been reviewed by end December 2012 were excluded, 36% had been discharged, 39% revoked and 20% were still active (i.e. presumed renewed).

The majority of those subject to CTOs in both samples were diagnosed with a type of schizophrenia or schizoaffective disorder, the most common of these being paranoid schizophrenia (37% in the earlier sample and 53% in the later sample). In both samples, the majority of Service Users on CTOs were male (61% in the first sample and 62% in the later sample), but the majority of Service Users over the age of 50 were female. The large majority of Service Users on CTOs were recorded as 'White British' (80% in the earlier sample and 85% in the later sample).

In addition to the mandatory conditions on the CTO, Service Users were most likely to have a condition attached to CTOs that was linked to taking medication, i.e. to remain compliant with medication regime as prescribed, to accept medication as prescribed or to attend a specified unit for the administration of medication (43% in the earlier sample and 33% in the later sample). The later sample shows a marked decline in the specification of additional conditions on the CTO, especially those relating to illegal substances.

### QUALITATIVE INTERVIEW DATA

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A qualitative interview study reports the perspectives of each of the groups of participants interviewed and in addition identified four broad themes emergent across the different groups (Service Users, Nearest Relatives, AMHPs, Care Coordinators, Responsible Clinicians and supported housing Service Providers). The themes are:

- The CTO provides a legal recognition of the need for care;
- The care is defined as predominantly medical;
- The CTO provides a structure and containment for the 'right' Service User;
- There is ambivalence surrounding the power and conditions of the CTO

These are discussed briefly below, following discussion of perspectives from each of the groups.

### PERSPECTIVES BY PARTICIPANT TYPE

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#### SERVICE USER PERSPECTIVES

Many Service Users reported that having refused medication in the past had led them to be placed on a CTO after multiple hospitalisations. Many saw the CTO as a preferable alternative to hospitalisation. All the Service Users interviewed reported that they had felt they had little or no choice about going onto the CTO or the

conditions specified. Most Service Users did not recall receiving written information, although staff stated in most cases that this was given to Service Users. Service Users were not always clear about discussions around renewal/ discharge and tended not to be actively involved. Advocates had been involved in some cases although it was unclear if Service Users always received info about advocates as this would be available when in hospital but perhaps not explicitly explained to the Service User. Service Users tended not to recall having had an advocate even where (in one case) the Care Coordinator said they did have one.

Service Users generally did not consider that they had a great deal or any choice concerning the CTO being made. Many felt they had no choice about whether they were on the CTO many felt that raising objections also had very limited effect. Most felt the CTO did not make a difference for the care plan or support provided. Some felt the care plan was inadequate (not enough activities) whereas others felt it was adequate and same as before CTO. Some Service Users found that the level of interpersonal support diminished once discharged into the community on the CTO, compared to while in hospital when there had been more opportunities to speak to staff, even in just a social capacity.

Relationships with professionals were generally thought to work fairly well even though there could be tensions at times. These could be particularly evident through the recall process and at tribunals, e.g. with Responsible Clinicians (RCs) who would need to present evidence Service Users may not like to hear or not agree with. However, others felt that the honesty involved in this was important and such tensions should not be avoided. The Service Users tended not to note any negative effects of the CTO upon their relationship with family and friends – although one Service User noted some tension where the Service Users father was in support of the CTO/ keeping the Service User on medication which the Service User did not agree with.

## NEAREST RELATIVE PERSPECTIVES

Whilst regarding CTOs positively, many Nearest Relatives had an incomplete or patchy understanding of the CTO and its powers. Nearest Relatives overwhelmingly said they preferred verbal information over written information and the information they had retained about the CTO was that which had been imparted by a clinician or Care Coordinator involved in their relative's care. Many could not recall what information they had had, or said that the written information that they had received had been hard to understand and filled with jargon. All the Nearest Relatives interviewed had experiences of their relative being admitted to hospital under different sections of the Mental Health Act and many viewed the CTO as simply 'another section'. What many Nearest Relatives valued about the CTO was that it enabled their relative to be admitted to hospital more quickly and without having to go through a new assessment under the Act.

Many Nearest Relatives felt that the CTO had made a positive impact on their own relationship to services and that communication between their relative's care team and themselves had improved; however not everyone felt the care team was approachable, especially the consultant psychiatrist. Some Nearest Relatives interviewed recognised that CTO was mainly there to provide medical treatment and did not add to, or change, the care plan outside of medication. Some Nearest Relatives described the social care element as inadequate and poor in relation to the emphasis on medical treatment.

## RESPONSIBLE CLINICIAN PERSPECTIVES

RCs were often ambivalent about the utility of the CTO framework and its legal powers. More often than the other professional groups, they referred to the CTO as having 'no real teeth' in terms of its legal powers in relation to the administering of medication in the community and recall to hospital. Many RCs found the CTO process administratively burdensome. RCs generally viewed the CTO as beneficial for two reasons; i) encouraging compliance with medical treatment and ii) early and speedy recall. However, as some pointed out, these were benefits also associated with S. 17 Leave, although the S. 17 had some draw-backs in relation to out-patients counting towards the bed days on the ward and in relation to various concerns around responsibility. Many RCs recognised that CTOs were in part a result of pressures from the Bed Management Policy to discharge in-patients and reduce bed days. Thus, some of the administrative tensions around the use



of S. 17 Leave were mitigated by the use of CTOs and highlighted that there is a policy drive to use the CTO instead of S. 17 Leave.

Patients deemed suitable for a CTO overwhelmingly had psychosis or dual-diagnoses and a history of disengagement with services and non-compliance with medication. In relation to Service Users diagnosed with treatment-resistant schizophrenia or schizo-affective disorders, some RCs felt that the CTO gave them a framework for trying more complex and demanding treatment regimes, such as the use of Clozapine that requires careful monitoring. Opinions about the CTO amongst clinicians varied greatly. Whilst some RCs did not believe CTOs made much of a difference in terms of reducing hospitalisations or improving engagement, and had various concerns or misgivings about the real versus the perceived powers and incentives to use CTOs from a managerial and administrative perspective, other RCs were much more positive. However, positive opinions about the efficacy of the CTO were commonly tempered by the cumbersome paperwork and the challenges of the Tribunals. However, whilst some RCs felt the CTO made little difference to most Service Users, some deemed the CTO potentially effective for Service Users on depot injections, as these can be monitored and there is no doubt as to whether the Service User is taking their medication. As an adjunct of being able to administer the depot medication, the CTO helps to monitor progress and pick up relapse signs early.

As per other professionals involved in the process of recall, RCs also felt that there was confusion around the roles and responsibilities around recall. Whilst recall was found to be both administratively and practically complex, it was sometimes found to be helpful in reinforcing the powers of the CTO and encouraging future compliance. The length of time that the CTOs for which the RCs were (or had been) responsible, varied greatly, with some having been in force since they came in in 2008 and others having been discharged at the first six month review.

## AMHP PERSPECTIVES

Many AMHPs spoke of the lack of clear guidelines in relation to CTOs and the process of learning through experience. They do, however, have regular team meetings and good peer support and many AMHPs mentioned this as a crucial strength in their work. Many felt it was helpful to have one member of the team in particular who has a strong interest and knowledge of CTOs and many could identify such a person, whom they could ask of advice. However, possibly as an effect of relying heavily on peer support, many AMHPs raised the issue that there were few general guidelines and therefore different people (and in extension different teams) had developed different ways of working.

AMHPs were perhaps the most critical of CTOs of all the cohorts interviewed, often voicing concerns about the increasing use of CTOs as opposed to Section 17 Leave. Many AMHPs stated that they were strongly critical of CTOs and concerned about the lack of understanding and input on the part of Service Users. Tensions between AMHPs and RCs on the ward were reflected in some of the interviews with AMHPs. Some AMHPs mentioned instances where RCs unwillingness to accept the final decision of the AMHP resulted in angry emails and requests that a manager reviewed the decision. There was a perception amongst several AMHPs that the Service User's care team seemed to have made a decision before involving the AMHP. In some cases the Service User had been informed that they were going to be put on a CTO before the AMHP had been involved. This puts additional pressure on AMHPs to agree to the recommendation, as it would be considered a 'spanner in the works' if they were to disagree after discussions had already been had and the Service User informed. A related concern was the relationship between the ward team and the community team, which AMHPs felt undermined the social care aspect of the CTO. Some AMHPs who had previously found there were tensions in their relationship with RCs reported that this had slowly improved since the early days of the CTO.

AMHPs thought that the information patients were given about advocacy and Independent Mental Health Advocacy (IMHA) service was not sufficient, and sometimes lacking altogether; it was generally felt that such information needed to be built into the system in a more solid way. AMHPs were in general more critical about Service User's understanding of how recall worked and the implied threat that a breach of conditions meant

instant recall to hospital. AMHPs often felt that this was misleading and should be made clear to the Service User.

## CARE COORDINATOR PERSPECTIVES

Experiences of CTOs varied amongst Care Coordinators with both positive and negative experiences. The CTO was often viewed as a complex framework, with some benefits and some drawbacks, all dependent on individual circumstances. Many Care Coordinators recognised that there was a lot of contention around the use of CTOs. Care Coordinators often felt the tension around information and choice more acutely in their relationship with the Service User. The ethically complex terrain around choice and compulsion was often something that more directly affected their relationship with the Service User, in comparison to other professional groups. Honesty was something that Care Coordinators often raised as an important, but contentious, aspect of their relationship with the Service User. Care planning was sometimes found lacking and the emphasis on medication while on a CTO in some cases meant there was little input in respect of social support for the Service User. However often social support came at a later stage when compliance with medication had provided a platform of stability which could be built on. Care Coordinators often viewed the utility of the CTO to rest on the capacity to recall quickly in case of deterioration and in that they were in agreement with the other professional groups.

The potential effect of CTOs on therapeutic relationships between Care Coordinators and Service Users makes for a complex picture, with both negative and positive comments from the Care Coordinators interviewed. There were some strong concerns from some Care Coordinators, particularly those who were nurses, about the negative impact on therapeutic relationships and incompatibility with principles of nursing. However, other Care Coordinators had more positive experiences and some felt that the CTO had very limited impact on their relationship with the Service User. The experiences of Care Coordinators depended to a large extent on the type of cases they had, where negative experiences of CTOs were connected to Service Users who found the CTO punitive and were difficult to engage, whereas Service Users who were willing to accept the authority of the CTO, and after a while could start to appreciate that they were more stable due to the medication, made for a much easier relationship. In these situations, the Care Coordinator was able to provide a more holistic approach to their care and less focus needed to remain on complying with medical treatment.

The change in practice in relation to CTOs were understandably more strongly felt by Community Psychiatric Nurses (CPNs), whilst Care Coordinators with a social work background and training in working with involuntary Service Users did not necessarily feel that working with CTOs made any difference to their relationship with Service Users or any tangible difference to their practice in general.

## SERVICE PROVIDER PERSPECTIVES

Much like Nearest Relatives, Service Providers were overwhelmingly positive about the CTO, even if several participants reported they had initially been sceptical when they were first brought in because of views that they were too restrictive and an infringement on Service Users' human rights. However, such reservations seemed to quickly fade into the background when CTOs were found to impact positively on service provision, staff safety concerns and relationship to other services. None of the Service Providers had received any formal training or information about CTOs. They had all sought out their own information, mostly on the internet or by talking to colleagues who were more knowledgeable.

Having a direct telephone number to a named Care Coordinator, for example, was highly valued by Service Providers and having a more direct relationship with other services was attributed to the CTO framework by several Service Providers. However, the constraints within the system were recognised and there was still a varying degree to which Service Providers were informed or involved in the CTO process, such as being aware of conditions, receiving paperwork, and being invited to accompany the Service User to review meetings and so on. Some said they had a good relationship with the Care Coordinator and consultant and that they would

be invited to reviews and were well aware of the CTO conditions. Others had not seen the paperwork and were not aware of conditions or routinely invited to review meetings.

Not all, but some Service Providers commented that they did not see themselves as having any particular involvement with the CTO process or any decision-making, whilst others were more proactive about being involved in the review process and 'invited themselves' or let the Care Coordinator know they expected to attend. Several Service Providers commented that the CTO makes a difference if something goes wrong, i.e. if the Service User's mental health deteriorates or refuses their medication or something else happens that has a negative impact on the Service User's mental health. Several Service Providers mentioned importance of getting through to other services when something happens 'on a Friday afternoon'. However, some mentioned negative experiences and lack of information from other services.

None of the Service Providers thought that the recall of a Service User had negatively impacted on their relationship afterwards in the cases where the Service User had returned to a housing project, even if the Service Provider had been the person to start the recall process by informing the Care Coordinator of the situation. Some Service Providers commented that it was helpful for them to not be seen as 'the bad guy' as they were not seen to be directly involved in enforcing the CTO. Many Service Providers commented that their Service Users on CTOs had poor insight into their own mental health and if they were not on the CTO they would not be taking medication. In this regard the CTO was seen as necessary to keep the Service User from deteriorating and ending up back in hospital. There were relatively few mentions of negative experiences. The only negative experiences mentioned related to multiple recalls of Service Users, so it was felt the CTO was not working very well as the Service User had stopped taking the medication.

## OVERARCHING THEMES

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### THE CTO PROVIDES A LEGAL RECOGNITION OF THE NEED FOR CARE

The Community Treatment Order was found to provide not only a legal framework to support enforced care in the community but many – especially Service Users and Nearest Relatives – felt that the order extended a recognition of the Service User's need for care. For some, especially for Service Users and Nearest Relatives, this legal recognition of the need for care was experienced as reassuring; especially if there had been concerns about receiving adequate care in the past. The CTO framework was often reported to make a difference in how available and forthcoming support was. The CTO being in place and acting as a 'safety net' in case of re-admission to hospital was experienced as reassuring for a number of reasons. The specific advantages of re-admission to hospital under the CTO was felt to be; i) the speed with which recall could be issued; ii) that a new Mental Health Act assessment was not needed upon admission; iii) that the Service User could come into hospital for 72 hours and thereafter be discharged back into the community under the same CTO.

### CARE DEFINED AS PREDOMINANTLY MEDICALLY DRIVEN

The CTO's primary function was found to be a framework for administering and monitoring of medical treatment and it was found that the medically driven aspect of the CTO outweighed social care elements. For all the Service Users in this study, the CTO was in place in order to administer and oversee medical treatment in the community. The CTO was most often utilised when the Service User had a history of non-compliance with medication and this non-compliance was seen to have a detrimental effect on their mental health having led to several hospitalisations. Even though the relationship Service Users had to their medication was often one of difficulty or at best ambivalence, a significant proportion of the Service Users who took part in the study could identify in retrospect a positive outcome from the medication, in many cases related to more stable mental health. The CTO initially is medically driven and primarily used for the purpose of administering medical treatment in the community and care plans reflected this. Although, many professionals, Nearest Relatives and Service Users themselves conceded medication was a key factor in achieving stable mental health, some said

that the focus on medication took emphasis away from social aspects of care that are also crucial for the long-term success of treatment.

## THE CTO PROVIDES STRUCTURE AND CONTAINMENT FOR THE 'RIGHT' SERVICE USER

Many Service Users, Nearest Relatives and Service Providers felt the CTO's legal requirement to 'check-up' on the Service User made a big difference to the amount of contact the Service User had with services. Across the groups participants reported that the CTO could work in providing stability and (for some) a reassuring 'safety net', backing up positive decisions and empowering personal relationships as a result. The 'right' Service Users were often seen as those individuals who were treatment resistant prior to being subject to the CTO and often had little or no 'insight' into their own mental health. However, whether the CTO was successful or not depended on a range of other, individual, factors:

- a) Motivation to get well and/or progress to independence;
- b) Find structure and/or legal recognition of need for care reassuring;
- c) Respect for legal power and/or regard recall to hospital as a deterrent;
- d) (Grudging) acceptance that conditions of the CTO are in their best interest (although this often comes after being on the CTO for some time and recognising they are more stable as a result).

However, many mentioned that the Service User also needed to regard the legal power of the CTO as a motivating factor, that is, they needed to respect the authority of the CTO and view it as either a deterrent or as a reassuring 'structuring force'. The element of control, which for some Service Users is experienced as restrictive and punitive, can be experienced by others as reassuring or helpful in that it shifts an element of responsibility away from them as individual and onto the services and structures their engagement with services. However, some practitioners mentioned that for the 'wrong' kind of Service User, the CTO is ineffective and potentially harmful for therapeutic relationships.

## THERE IS AMBIVALENCE SURROUNDING THE POWER AND CONDITIONS OF THE CTO

There is a level of ambivalence around the actual power of the CTO and its conditions. This ambivalence often makes itself known in terms of inconsistencies around the perception of the power of the CTO by Service Users and Nearest Relatives and the understanding of those powers by professionals such as Care Coordinators, AMHPs and clinicians. Often Service Users were under the impression that if they did not keep to the conditions of the CTO they would be automatically returned to hospital, which constitutes an implied threat. It did not seem to be generally explained to Service Users that they should only be recalled if there was a significant deterioration in their mental health. There is an ethical question about whether increased honesty would negate the effectiveness of the CTO in relation to this implied threat of recall.

Conditions on the CTOs of those 21 Service Users who took part in the study, and reportedly of others (according to those practitioners involved in the study), were mostly around taking medication and engagement with services. Sometimes there were more specific conditions around residency, usually in those cases where a Service User lived in supported accommodation, and more contentious conditions around use of substances and travel restrictions. None of the Service Users interviewed had been recalled so had generally complied with the conditions (although in one case the Service User had voluntarily admitted herself to hospital for a period). This constitutes a somewhat positive bias in those Service Users interviewed, although experiences and opinions were far from unanimously or unambiguously positive.

## CONCLUSIONS

### KEY ISSUES FOR PRACTICE

The CTO is a relatively new tool and it is still an evolving practice with many contentions, concerns and ethical questions to iron out. As shown above, each of the cohorts interviewed for this study has a different role and thus a different perspective. In relation to CTO practice therefore there were a number of apparent tensions and key issues which are summarised here.

### WORKING RELATIONSHIPS

This study found that in most cases there tended to be agreement between the professionals around most aspects in relation to the CTO. However there were some disagreements, particularly between RCs and AMHPs. For example, some AMHPs viewed RCs as too risk averse and were unhappy about Responsible Clinicians and Care Coordinators deciding upon the CTO and even informing the Service User before involving the AMHP. RCs were sometimes unhappy if AMHPs were not in agreement.

### SERVICE USER INVOLVEMENT

There was some concern about raising the issue of the CTO with Service Users on ward rounds – some thought this was not necessarily the best environment as discussions can be rushed and there can be too many professionals involved which can be overwhelming for the Service User. Service Users generally didn't consider that they had a great deal, or any, choice concerning the CTO. However, not all were particularly concerned about this and some felt in retrospect that the CTO had made a positive impact on their recovery.

Our results point towards a range of important tensions in the CTO framework. One of these tensions is around the clarity of information given to Service Users and the level of understanding Service Users have of their rights under the CTO and the limits to the powers of the CTO when it comes to medication and recall. There is an ethical question about whether increased honesty would negate the effectiveness of the CTO in relation to the implied threat of recall as many Service Users admitted they only took medication (at least at first) because they believed they had to in order to stay in the community.

Most Service Users did not recall receiving written information although staff stated in most cases that this was given to Service Users, usually a letter sent by the Mental Health Act Office. It was recognised by the practitioners that this letter was not user-friendly and contained too much jargon to be intelligible for most Service Users. Service Users were not always clear about discussions around renewal/ discharge and tended not to be actively involved. There also seemed to have been little room for negotiation with Service Users around the conditions on their CTOs.

### FAMILY INVOLVEMENT

Where families were involved they generally tended to be supportive of the CTO and regarded it as a safety net that enabled speedy intervention if their relative's mental health deteriorated. Some staff felt families could be involved to a greater extent where they were actively involved with Service Users. Often, however, Service Users were estranged from their family.

### SUPPORT

The aftercare support was described by most as being the same as for those not on a CTO, although at least one Service User said that the support she received had decreased after being discharged. Also the support may be increased in the sense that Service Users were obliged to engage as a condition of the CTO. Therefore,

in fact, the level of *engagement*, as opposed to support, often tended to be greater. Some Service Users would have liked more therapeutic support. Some staff acknowledged there were resource issues in providing this.

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## INDICATORS FOR GOOD PRACTICE

A number of indicators for good practice have emerged in the data from Service Users and practitioners.

## INFORMATION

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There is a need for better information about CTOs in all its aspects and at all levels. Service Users and Nearest Relatives were found to often have a poor, or lack, understanding of CTOs. Information for Service Users was often delivered verbally. Even if this is repeated several times, a user-friendly leaflet with the key points of information about CTOs is still needed. This leaflet needs to make clear what the CTO is, why it is used, what its legal powers are in relation to medication and recall and what rights the Service User has under the CTO, including details of their right to advocacy. A similar concise leaflet could be produced for Nearest Relatives.

## ADVOCACY

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Many Service Users said they were not aware of their right to advocacy and the Independent Mental Health Advocacy (IMHA) service. A leaflet about the advocacy service should be made available to the Service User on the ward in relation to early discussions about discharge onto a CTO, however this was often not the case. Whilst many AMHPs made sure to inform the Service User of their right to advocacy, there needs to be clear written information as part of a general information leaflet that the Service User can keep and refer to.

## WORKING RELATIONSHIPS AND DECISION-MAKING

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Whilst multidisciplinary teams usually worked well together, some of the AMHPs raised concerns about their professional role not being well understood and being expected to provide a 'rubber stamp' for the CTO. Best practice would be to include the AMHP in any team discussions about a potential discharge onto a CTO as early as possible. The Service User should not be informed about being subject to a CTO before an AMHP has been involved.

There were concerns about the rushed nature of decision-making and that this most often happened in ward rounds, which is not an ideal environment for these discussions since this can be disempowering for the Service User as well as not providing enough time for discussion. Support from colleagues was found to be a strength in developing good practice in relation to CTOs as few general guidelines are available. More opportunities for exchanging experiences with other practitioners and learning from others would be helpful across the professional roles.

## CONDITIONS

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It was generally found that CTOs were most effective when conditions were kept to a minimum and included only the essential stipulations about complying with medication, allowing access to care staff or residing in a specific place if appropriate, and engaging with services. More specific and restrictive conditions (such as those around substance use or restricting people they were allowed to see and places they were allowed to visit or setting curfews) were commonly found to be difficult to enforce and meaningless when a breach cannot automatically result in a recall to hospital.

## INTRODUCTION

In order to understand why it is important to research CTOs in the current climate, this section introduces the broad context of social care provision England and Wales by briefly outlining current issues and policy drivers. An understanding of contemporary political and policy debate surrounding adult social care will highlight the complexities of compulsory community treatment and its position within the general thrust towards personalisation and increased opportunities for choice and control on the part of Service Users.

### POLICY CONTEXT AND DRIVERS

The White Paper *Caring for our future: reforming care and support* (DH, 2012) recently set out a ‘new vision’ for a reformed care and support system, which was aimed at refocusing services which currently ‘[do not] offer enough support until people reach a crisis point’ (p.8). Instead the new system is envisioned to ‘promote wellbeing and independence at all stages to reduce the risk of people reaching a crisis point, and so improve their lives’ (p.8). Re-ablement services and crisis response is envisioned to help people regain their independence at home. The key contention in this White Paper is that people need to be given access to good, clear information at early stages, which will enable them to *make choices* about their future care needs, make informed choices about their care when the need arises, and make decisions about how their individual budget is spent while in receipt of care. What we are seeing exemplified here is a ‘person-centred’ system of care, which hinges on the vision that people can make good informed choices about their care and have insight and control over how their care and support is delivered.

However, it has been argued (e.g. Beresford, 2012) that this White Paper signals ‘a policy disaster, but a political victory’ for the current Government, which avoids taking a decision on the issue of social care funding by steering the debate into the arena of providing outsourced care solutions as the vestige of ‘consumer choice’. The ‘benchmark for crisis’ (Beresford, 2012) is arguably last year’s Dilnot recommendations, which were based on capping social care costs and the ‘partnership model’ which seeks to draw more private funding into the system. Personalisation of services have developed as a response, it is argued, to user demands for more tailored, effective and flexible forms of health and social care support (Powell, 2011). However, the rhetoric of involvement, choice and control has been seen as part of a ‘consumerist agenda’ that is increasingly evident across Western social policy (Powell, 2009). Personalisation has been part of the recasting of the traditional relationship between the State as provider of care and the citizen as receiver of care, to a system where the responsibility for social welfare is shifted from the State onto the individual. The personalisation agenda in social care can be seen a means for shifting care provision increasingly towards communities and individuals.

### MENTAL HEALTH ACT 1983 AND THE 2007 AMENDMENTS

The Mental Health Act (MHA 1983) replaced the MHA 1959 and is concerned with reception, treatment and care of people with mental health problems. It provides the legislation by which people diagnosed with mental health disorders can be detained in hospital or police custody and have their mental health assessed or treated under compulsion. The MHA 1983 sought to strengthen patients’ rights in regards to their treatment, solidifying the right to seek independent reviews of treatment, for instance. The MHA 1983 made several key changes largely focused on public protection and risk management. The amended legislation extends the powers of compulsion and introduces Community Treatment Orders (CTOs). The MHA is reviewed and regulated by the Care Quality Commission, whose 2011/12 report will be discussed in further detail below.

Legislation governing the compulsory assessment and treatment of people with mental health difficulties is a response to various different pressures and considerations (Barnes et al., 1990). The legislative use of compulsion in relation to treatment of mental health problems reflect wider attitudes to risk, mental health and health in general. As Barnes et al. point out ‘the Mental Health Act defines what may be called mental disorder in our society, and under what circumstances the freedom to seek or disregard treatment may be



suspended and the individual obliged to accept medical advice' (p.12). Being sectioned means that you no longer have any choice in how your condition is to be interpreted and have no choice in whether to accept treatment or not; the person who has been sectioned has been stripped of these aspects of personal autonomy (Barnes et al., 1990).

Involuntary in-patient care is a widely used intervention in the management of people receiving care for mental health difficulties, increasing by 50% in the last decade (Hughes et al. 2009 p.152). The MHA 1983 aimed to balance the dual objectives of providing care for the mentally ill with hospitalisation conceived as affecting a therapeutic intervention, alongside ensuring public safety by reducing risks to both patients and members of society. However, it has been argued that over the past decade public and governmental concern has moved away from a focus on therapeutic care towards a more explicit focus on issues of public safety and perceptions of risk (Hughes et al. 2009). This shift towards concerns about risk and safety can be seen to permeate the amendments to the Act in 2007. Significant amendments included: broadening the criteria for detention, extending the range of settings in which compulsory treatment can be administered, broadening the definition of mental disorder, and expanding the definition of medical treatment to include psychological intervention (Hughes et al. 2009 p.153). The new roles of the Approved Mental Health Professional (AMHP) and the Responsible Clinician (RC) created opportunities for professionals from a range of disciplines to use powers under the Act. These roles bear relevance to the CTO and are thus briefly explained here, followed by a discussion of some of the key aspects of CTOs and some of the associated concerns and controversies.

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## APPROVED MENTAL HEALTH PROFESSIONALS (AMHPS)

An AMHP is defined in the Act as a practitioner who is responsible for coordinating assessments and making applications for detention under the Act. The AMHP has the authority to sign off the CTO. The AMHP is involved in the CTO process in three ways; in the making of the CTO, the AMHP is presented with a form (CTO1) largely filled out by the RC on a ward. It is the AMHP's duty to make a decision as to whether he or she agrees that the patient meets the legal criteria, that the CTO is appropriate, and that the conditions that the RC has made are necessary or appropriate. The AMHP also fills in a report about the wider social circumstances of the Service User (MH1). When it comes to the AMHP assessment for the purposes of a CTO, there are fewer requirements to meet as opposed to those laid out in the Act (or in guidance in the form of the Reference Guide or the Code of Practice) in regards to detention under the Act in hospital (Section 3 for instance). When it comes to the CTO, there is no requirement to write a report unless the AMHP disagrees with the RC. Department of Health guidance published in 2008 states:

*'In making these judgements, the AMHP is expected to bring knowledge of the patient's social situation into the discussion. This may require discussion with the patient's Care Coordinator or key worker so that information about the patient's home, family, informal support networks, cultural background, and so on can all form part of the decisions which are taken about SCT.'* (DH/ NIMHE, 2008a p.16)

There is no actual requirement even to interview the Service User or consult with the Nearest Relative. There also seems to be no guidance as to what would constitute grounds to disagree with the RC's view. When it comes to renewal of the CTO after the initial 6 months (CTO7), the AMHP (sometimes a different AMHP to the one involved in the initial decision-making) has to agree that the Service User meets the criteria and the extension is appropriate. If a Service User has been recalled to hospital under the powers of the CTO by the RC in the community, and the service user needs to remain in hospital beyond the 72 hours allowed under the CTO, the RC will reinvolve the original Sec. 3 by revoking the CTO. In this case the AMHP simply has to agree on form CTO5 that the patient meets the criteria for detention in hospital and that it is appropriate to revoke the CTO.



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## APPROVED CLINICIANS AND RESPONSIBLE CLINICIANS

An Approved Clinician (AC) is a healthcare professional, usually a consultant psychiatrist, who is competent to become responsible for the treatment of a patient with a mental health problem and who has been compulsorily detained under the Act. Once an AC takes on the care of a particular patient they become known as the RC for that patient. There are further in-patient RCs who have responsibility for patients who are hospitalised under the Act, and community RCs who are responsible for the care of patients who have been discharged into the community (but who may be subject to a CTO). A CTO gives the RC a legal power to recall the Service User to hospital if necessary for his/her treatment or if there is a risk of harm.

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## COMMUNITY TREATMENT ORDERS

On November 3 2008, Community Treatment Orders (CTOs) became available in England and Wales through the 2007 amendments to the Mental Health Act 1983 as a means to supervise treatment of mental health patients in the community, following involuntary treatment in hospital (Rugkasa and Burns, 2009). CTOs are a form of compulsory treatment law that began to appear in North America and Australia during the 1980s. As the Department of Health systematic review (Churchill *et al*, 2007: 17) points out:

*‘CTOs were originally conceptualized as one way of addressing problems thought to have occurred as a result of a policy of deinstitutionalization – the homeless mentally ill, jails populated by those with chronic mental illness, the revolving door syndrome and the dangerous mentally ill in the community’.*

The CTO was a new legal regime for Supervised Community Treatment (SCT) for people with mental health disorders. The intention behind the amendment to the Mental Health Act (MHA) was:

*‘... to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery’ (DH, 2008b 25.2 p.220).*

A patient can be put on a CTO when he or she is deemed well enough to leave hospital after a period of being detained under Section 3 or Section 37 of the MHA. The CTO enables a patient to be discharged into the community even though they are considered to need further supervision in order to maintain stable mental health. While living in the community, the CTO provides a legal framework for coerced treatment with the possibility of recall to hospital if the patient does not comply with conditions and treatment and there is a risk of harm. A recall to hospital can last up to 72 hours, after which the patient is either discharged to continue treatment in the community under the CTO or the CTO has to be revoked and the patient returns to involuntary hospital treatment under Section 3. According to the amendment to the MHA in 2007, each CTO has two mandatory conditions attached which required the Service User to make themselves available for i) assessment for renewal of the CTO and ii) assessment by Second Opinion Appointed Doctor (SOAD) to confirm treatment. However, in 2012 the necessity for a SOAD to be involved in the setting of the order was removed. The high rates of uptake of CTOs led to a shortage of SOADs to complete authorisation of medication within the given timeframe for the order and this contributed to a change in practice, removing the SOAD authorisation from the initial process of setting up the order if the Service User agrees to the CTO.

Further conditions can be added by the RC who initiates the order, and the AMHP who agrees it. Conditions commonly include requiring the Service User to take medication; to attend meetings with his or her clinician and other members of their care team at regular intervals; and/or admit members of their care team into their residence; and reside at a specific address. Sometimes further conditions specific to the individual Service User are included, such as not to travel abroad; not to use alcohol or drugs; or not to frequent certain places, such as the pub. However, such restrictive and specific conditions were often felt by our professional participants to be unenforceable and infringe unnecessarily on a Service User’s human rights and thus were not commonly used.

A CTO initially lasts for six months. It can be renewed for another six months and then subsequently for twelve months at a time. There is some controversy around how long a Service User can be kept on an order and in our case study there was some evidence of orders which had been renewed indefinitely since they first became available in 2008, although CTOs were also used for shorter periods of time and reasons behind the length of usage varied. Before the change in legislation in 2007, there were three main provisions for supervised community treatment; i) supervised discharge (Section 25 of the MHA, now abolished), ii) leave of absence (Section 17) and iii) guardianship (Section 7). Guardianship is primarily reserved for those with cognitive impairment (Rugkasa and Burns, 2009). Supervised discharge did not legally sanction coercion in getting Service Users to take medication in the community and therefore was considered to lack 'teeth' and its use was patchy and inconsistent (Rugkasa and Burns, 2009 p.493). However, Section 17 leave of absence was extensively used and remains the main alternative to a CTO under the amended MHA. The change in legislation now requires clinicians to consider a CTO when granting leave of more than seven consecutive days, in contrast to earlier use of such leave which could stretch to months at a time. That clinicians now must consider a CTO instead of Section 17 leave and the removal of supervised discharge signals that the Government sees the CTO as the preferred method of providing supervised care in the community (Rugkasa and Burns, 2009). The fact that higher numbers of CTOs have been made than was first expected, indicates that this is also how NHS Trusts interpret this new provision.

## CONCERNS AND CONTROVERSIES

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When CTOs were introduced they were highly controversial, even though some level of treatment pressure or coercion has long been a recognised part of psychiatric care in the community (Churchill et al. 2004). Arguably, the rapid reduction in the number of psychiatric hospital beds (from 154,000 in 1954 to 33,000 in 2005 across England and Wales (Gledhill, 2007)) contributed to 'a gradual general acceptance of the need for compulsory treatment outside of hospitals' (Rugkasa and Burns, 2009 p.493). However, how such compulsory treatment should be used in the community has been hotly debated, with some arguing that the CTO is an infringement of civil liberties of the Service User, while others see the constraints and compulsion of the CTO as justifiable if combined with readily available services and the likelihood of beneficial outcomes for the Service User. There has been a longstanding and on-going debate around the use of compulsion in mental health services which predates the introduction of CTOs in 2008 and goes back to when they were first proposed over 20 years ago. A common argument in favour of using CTOs is that they may help "revolving door patients", particularly those who do not comply with medication, to stay out of hospital and progress to increased independence in the community following the stabilising effect of medical treatment. Others argue that the CTO only represents a minor change in the law to harmonise it with common practice, in particular use of Section 17 leave for extended periods of time (Rugkasa and Burns, 2009). Section 17 leave requires a bed to be kept available for the patient while they are on leave in the community, which is not a requirement of the CTO, so the pressure on beds more than likely contributed to this legislative change and the popularity of discharging patients onto CTOs.

Further, the use of compulsion is controversial within the current climate of personalised care and drive towards increased choice exercised by Service Users. Current social care policy prioritises the exercise of choice by Service Users in order to enable control over important aspects of their lives. The mechanisms by which this is to be achieved include direct payments, personal budgets and self-directed support (HM Government, 2007). Choice and control are considered values relevant to most Service Users, including those with mental health problems (MIND, 2009). The use of mental health legislation to require Service Users with diagnosed mental health problems to receive services against their will can be seen as embodying precepts in direct contradiction to the broad principles which guide adult social care services in general.

Tensions between the control embodied within mental health legislation and the supportive, therapeutic or caring principles that many practitioners espouse are not new (e.g. Satyamurti, 1979), but two factors have highlighted this contrast. One is the explicit appeal to the exercise of choice within the personalisation agenda, and the other is the extension of the use of compulsory powers from hospital into community settings

consequent on the introduction of Community Treatment Orders (CTOs) in the 2007 amendment of the Mental Health Act 1983. Together, these policy developments have created a situation in which one group of users of community based social care services, i.e. adults whose mental health problems are deemed to pose a risk to themselves or others if they do not receive treatment, are subject to constraints on their ability to make basic decisions about their lives in a way which is fundamentally at odds with adult social care policy in general. Key in this tension is the level of the Service User's *insight* into their need for on-going treatment, care and support.

Under the MHA 1983, compulsion was used to facilitate admission to a psychiatric hospital and to receive medication whilst in hospital. A decision to remove those who were 'sectioned' from their everyday lives and interactions with other community members, indicated that these patients, and potentially others, were at risk from the impact of their illness, and that care, support and treatment needs should be met in hospital rather than in the community. The introduction of compulsory treatment within the community implies that perceived risks can be contained by a combination of community based surveillance and support.

Whilst the use of compulsion is not necessarily associated with an absence of therapeutic possibilities within relationships between mental health Service Users and workers, legal powers have been described as an 'intrusion' into such relationships (Caldicott, Conlan and Zigmond, 1999). At the same time, the use of compulsion within the defined legal context set out in the MHA 1983 was often seen to be accompanied by constraints on everyday actions that were not required by law. One finding from a study of users' experiences of compulsory detention under the MHA 1983 Act was that: 'It was as if the imposition of compulsory powers removed any obligation on professionals to discuss, consult or negotiate matters of crucial personal importance' (Barnes et al, 2000 p.13).

The introduction of CTOs was preceded by lengthy debate about compulsory powers of treatment outside hospital settings. CTOs were introduced 'ostensibly to enable services to provide support and treatment to those in need who would otherwise refuse it, deteriorate and return to hospital as a result' (Macpherson et al., 2010 p.353), a pattern referred to as the 'revolving door'. Those in favour of CTOs pointed to the change in mental health service provision, with community based care and treatment the preferred option alongside reduced hospital admissions. Why admit someone to hospital to ensure compliance with treatment when they could receive treatment in less restrictive settings and maintain contact with families and social networks? Those arguing against, pointed to the evidence of disproportionate use of compulsory powers in relation to particular groups (e.g. people of African and Caribbean origin: CQC/ NMH DU 2010) and the danger of discriminatory practices developing. There was also concern about forcing people to take medication in their own homes.

CTOs were introduced in the context of continuing media and political scrutiny which centred on issues of risk and public protection. A key policy objective of CTOs was addressing non-compliance with medication and agreed treatment plans (Fennel, 2007). However, Service Users and professionals expressed some opposition to CTOs (Mental Health Alliance, 2007). Concerns focused on:

- Human rights implications of extended powers which could order recall to hospital *even* if treatment conditions had been met to protect other persons (Fennel 2007).
- Ethical issues: imposition of CTOs on individuals who retain capacity to refuse treatment. This is considered to be discriminatory and contradicts policy statements concerned with increasing choice and autonomy among mental health Service Users (CSIP, 2006).
- Whether adequate community services existed to support the introduction of CTOs.
- Increased use of compulsion, given the duration of CTOs, their wide remit and the fact that a history of recurring hospitalisation is not a necessary ground (Lawton-Smith, 2008).

Despite opposition and concerns, the use of CTOs has far exceeded estimates. 1755 CTOs were in place after 12 months (IC, 2009). This high level of use has continued. For example, the CQC/ NMDU (2010) report showed

that 4% of all mental health patients surveyed (n.1371) were on a CTO. Evidence also suggests that the use of CTOs follow the same patterns as the use of existing compulsory powers with disproportionately high use among users of African, Caribbean and South Asian heritage (CQC, 2011).

## RESEARCH

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The evidence base for efficacy of CTOs is weak. International evidence suggests well-resourced and co-ordinated systems, with substantial community support and services make positive outcomes and experiences more likely, but risks associated with CTO use include: overuse in groups where efficacy is unclear, overuse to deal with pressure on beds and inadequate reviews of use of CTOs over extended periods (Dawson, 2005). There is also limited evidence that CTOs address the 'revolving door' issue (Kisely & Campbell, 2007).

The systematic review of international research on CTOs commissioned by the Department of Health (Churchill *et al.*, 2007 p.14) found 'very little evidence of positive effects of CTOs in areas where they might have been anticipated', such as hospital readmissions, length of stay or compliance with medical treatment. The systematic review, undertaken in anticipation of CTOs being brought in under the Act in England and Wales, called for further research on the efficacy of CTOs; 'Like any medical intervention, in order to be adopted as a form of best practice, CTOs should demonstrate effectiveness in terms of improved health outcomes compared with the available alternatives' (p.18). A small number of non-randomised studies suggested possible improvements in contact with services. However, only patchy evidence was found to exist on the direct effects of CTOs on Service Users.

In England and Wales, and in the current climate of policy agendas focusing on personalisation, choice and autonomy, there is no published research on Service Users' experiences of CTOs, or on the place of social support and intervention. Equally, while practice guidance has been issued (DH/ NIMHE, 2008), there is currently no published UK research on professional practice issues associated with the use of this new legal power. However, a recent randomised control trial (Burns, 2013) and the CQC report (2012) highlight some notable findings. These are outlined below. A relevant research study focused on the experiences of mental health service users under compulsion is also noted below.

## THE OCTET STUDY

The OCTET trial was a response to the Department of Health systematic review (Churchill *et al.*, 2007), which highlighted that there was little evidence internationally for the effectiveness of CTOs. The OCTET trial evaluated the effectiveness of CTOs in England and Wales on patients with psychosis. OCTET was a non-blinded, parallel-arm randomised controlled trial carried out to investigate the impact of CTOs on patients with psychosis. They postulated that patients with a diagnosis of psychosis discharged from hospital on a CTO would have a lower rate of readmission over 12 months than those discharged on the pre-existing Section 17 leave of absence. However, the results of the study negated this assumption and the report argues that CTOs had no measureable effect on outcomes for the Service Users included in the study.

336 patients were randomly assigned to receive either a CTO (167 patients) or Section 17 Leave (169 patients). Three patients were eliminated from the trial (one withdrew and two were found ineligible), so the outcome was measured for 333 patients. It was found that primary, secondary or clinical outcomes did not differ between groups. After 12 months, neither the number of patients readmitted, nor the time to readmission from randomisation, nor the number of days in hospital differed. However, the amount of time in the community after hospital discharge under compulsory treatment was substantially longer in the CTO group (median 255 days) than for those on S. 17 leave (102 days), which corresponds with our findings that CTOs are often renewed for a significant period of time. The study shows that;

*'despite a more than three-fold increase in time under initial supervised community care, the rate of readmission to hospital was not decreased by CTOs. Neither was the time to readmission decreased nor was*

*there any significant difference in the number or duration of hospital admissions. We also recorded no difference in clinical or social outcomes' (Burns et al, 2013 p.1631).*

The OCTET study chose readmission to hospital as their primary outcome because CTOs have arguably been legislated explicitly to reduce hospital readmissions, combating what has been called the 'revolving door syndrome'. However, the study did not find that CTOs had any measurable impact, nor were they found to have an impact on the length of time to readmission in a 1-year follow-up. This study found that overall, hospital care did not decrease nor did clinical or social functioning improve despite an average of 6 months additional compulsion. The study shows that CTOs do not confer benefits on patients with a diagnosis of psychosis and argues that the current high usage of CTOs should be urgently reviewed.

Notwithstanding the significant findings of this randomised controlled trial, it is important to put these findings in context. These results reflect only on a specific group of patients diagnosed with psychosis and excluded more difficult cases. Our study included a more wide-ranging population of Service Users, Nearest Relatives and practitioners so this constitutes a sample that is different from the OCTET sample. It is also worth balancing the findings of the OCTET trial with the *experiential* focus of our study.

## THE CARE QUALITY COMMISSION REPORT FOR 2011/12

The CQC (2012) report states that the number of people subject to detention under the MHA 1983 is rising, having risen by 5% on the previous year. When it comes to Community Treatment Orders in particular, this rise is even more significant at 10% compared to the previous year. The report found a number of areas of concern across the board of detentions under the Act: primarily focusing around care planning, where 15% of the care plans examined did not meet basic care planning expectations. However, this amounted to no change since 2010/11.

During 2011/12 there were 48,631 detentions under the Act in England, and a further 4,220 patients were made subject to a CTO. In 2011/12 revocations accounted for 3% of overall detentions, up on 1.7% of detentions in the first full year after CTOs were introduced in November 2008. The CQC report indicates a general trend toward using section 2 (detention for assessment for up to 28 days) instead of a section 3 (detention for treatment for up to six months and renewable after that). A significant reduction in the use of section 3 over the last 5 years has been recorded, although the overall use of the Act is increasing. This shift away from using section 3 may partly be explained through the increase in use of compulsory community treatment, as the report puts it '[a] factor may be the success of community teams in maintaining people in the community, so they do not deteriorate to the point where they need to be admitted to hospital' (CQC, 2012 p.14). However, the reasons that involuntary detention under a section 3 is decreasing is likely to be manifold and complex, for instance they may reflect broader changes to the organisation of mental health teams into 'functional' teams who only deal with parts of a patient's care pathway, which may mean that services know less about their patients. On 31 March 2012 there were 17,503 patients detained in hospitals in England, with twice as many men as women detained. This gender imbalance in detentions remains constant in figures from the previous 5 years. The findings of this research in relation to the gender split of patients subject to a CTO shows a similar trend in the CTOs issued in the Sussex Partnership NHS Foundation Trust (SPFT) area since July 2010.

The CQC report found that the use of CTOs varies significantly across Trusts. In an analysis of NHS organisations, the lowest reported 'discharge rate' onto a CTO was 4.0% and the highest was 45.5%. In some cases, NHS organisations that showed considerable rates of detention under the Act sometimes provided nil returns for use of CTOs. In regards to Service User feedback, the report states that patients are worried that it is not clear when a CTO 'will have served its purpose' and that patients need to know what to do in order to have their CTO discharged.

## SERVICE USER INVOLVEMENT IN RESEARCH

It is important to understand and value the experiences of Service Users subject to compulsion under the Act. This study is part of such an effort and contributes to previous research that has taken the experience of Service Users seriously (e.g. Barnes et al., 2000). Barnes et al. (2000) investigated Service User experiences of coercion under the Mental Health Act 1983, before the CTO was brought in. Their research found that whilst Approved Social Workers (ASWs, now AMHPs) had the duty to assess the person being considered for compulsory detention in order to determine the least restrictive option, Service Users still reported there was little discussion of options, they could not recall being given clear information and were left with the impression that they had no choice about their treatment. This research showed that detention in hospital was experienced very negatively by Service Users, commonly described by such words as scary, not therapeutic and humiliating (Barnes et al., 2000). This points towards two important aspects; firstly, that the traumatic experience of being detained under a section in hospital may provide motivation to agree to a CTO in order to 'get out' of an environment that was described by Service Users in Barnes et al.'s study as 'prison-like'. This also highlights that the 'choice' that Service Users have to either agree or disagree to the CTO is not a choice free of coercion, as it is often experienced as a choice between two evils. Secondly, the Service User experiences of CTOs reported in this study shows that the recent policy drive towards personalisation and choice has made little difference to the experience of compulsion, as the Service Users still said they had little or no choice over going onto the CTO and could recall little clear information about the CTO or their rights under it. However, whereas Barnes et al.'s (2000) study found that compulsory detention in hospital could have a serious adverse impact on Service User's relationships with mental health services, our study has found much more nuanced experiences around the CTO, where in some cases it was experienced to have a positive impact on the willingness to engage with services.

## RESEARCH METHODS

### AIMS AND OBJECTIVES

The principal research question of our study, developed as part of the ethics approval, was:

**What are Service User and practitioner experiences of the use of community treatment orders in an environment of social care policy focused on personalised social care service provision?**

Responding to the broader context of adult social care provision in England and Wales – as outlined in sections above – the study aims were:

1. To understand how compulsory powers are being used in an environment in which practitioners are encouraged and Service Users expect to be consulted and to exercise choice to a greater extent than previously.
2. To understand what social care supports can be drawn on and whether these are affected by being provided in the context of the use of compulsory powers.
3. To explore Service Users' and practitioners' experiences of CTOs and identify good practice in relation to assessment for, and management of, CTOs which maximises Service User participation, minimises risk to self and others and reduces the likelihood of hospital re admission.

The objectives of the study were;

1. To explore and identify the reasons for making of CTOs and the characteristics (age, gender, ethnicity, diagnosis, mental health history) of those subject to SCT.
2. To identify the nature of discretionary conditions attached to CTOs, and the extent to which these (and associated care plans), include social care supports and interventions from statutory, voluntary or private services.
3. To explore the practices and processes associated with the assessment of Service Users for a CTO, the arrangements for implementing this and the associated care plan.
4. To explore users' experiences of CTOs and the choices and support offered and identify user defined criteria for good practice in this context.
5. To identify opportunities and constraints to developing enabling supportive and therapeutic relationships in this context from the perspectives of Service Users, RCs, AMHPs, Care Coordinators and social care Service Providers.
6. To review existing evidence available relating to positive and negative outcomes of the use of compulsory community treatment.

### RESEARCH DESIGN

The research utilised a case study approach with mixed methods, combining; a) a statistical analysis, of a sample of CTO records ranging from July 2010 to December 2012, to gain an understanding of the broader picture of CTO use within the SPFT; and b) a qualitative case study approach investigating Service User experiences of being subject to a CTO and practitioner experiences of working with CTOs. The SPFT covers an area which is mixed demographically and socio- economically.

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## RATIONALE

The rationale for the focus on CTOs in particular was driven by the need to investigate the Community Treatment Order as a new power that stands at odds – in several important ways – with the main thrust of social care, which has been moving towards increased personalisation of services and towards greater choice and autonomy on the part of Service Users. The power of the CTO to restrict, monitor and provide enforced treatment in the community is a new power and research was needed to clarify the status of CTO use, and how those subject to CTOs experience their care, within the broader context of contemporary adult social care in England and Wales.

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## THE CASE STUDY: QUALITATIVE AND QUANTITATIVE ELEMENTS

The qualitative element of the study comprised of semi-structured interviews with Service Users, Nearest Relatives, Service Providers and practitioners. The research took place within the SPFT area (including West Sussex, East Sussex and Brighton and Hove). The study recruited Service User participants based on records of CTOs from November 2008 to August 2012. Nearest Relatives were recruited from records of current CTOs and Service Providers and practitioners were recruited based on records of involvement with Service Users currently subject to a CTO.

The quantitative element of the research utilised anonymised Trust records relating to CTOs issued in the year prior to the research, i.e. July 2010 to June 2011, and subsequently during the entire research period, i.e. July 2011 to December 2012.

The research had a Project Advisory Group, which included Service Users, social care practitioners/Service Providers, Care Coordinators, RCs and AMHPs. There were also a research group of four Service Users who were involved in designing interview schedules, conducting some of the interviews with Service Users, reviewing findings and data analysis and in other aspects of the research process. This group was recruited through the Lived Experience Advisory Forum (LEAF) of SPFT.

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## ETHICAL AND GOVERNANCE APPROVAL

The study received ethics and governance approval from the University of Brighton's Faculty of Health and Social Science Research Ethics and Governance Committee (sponsors of the research); NHS Research Authority NRES Committee South East Coast – Surrey; the SPFT; Brighton and Hove County Council; West Sussex County Council, and East Sussex County Council.

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## METHODS

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### SAMPLING

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### STATISTICAL ANALYSIS

Anonymised Trust records, from July 2010 to December 2012, provided by the Clinical Study Officer at the SPFT were analysed to provide a statistical overview of the CTO use in the area.

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### QUALITATIVE CASE STUDY

The final sample of Service Users for the study included all those included in CTO records from November 2008, when CTOs became available, to August 2012. This was an amendment to the original recruitment strategy which involved two samples; one prospective sample from the study period and one retrospective sample from the year prior to the study period. However, as the study progressed and challenges in recruiting



desirable numbers of Service Users for interview emerged, the data was aggregated and further retrospective data was added of Service Users made subject to a CTO from inception in 2008. Ethical and governance approval was sought and gained for this change.

The Clinical Study Officer at the SPFT had access to the database of all people who have received a CTO in the area. Initially this was used to obtain a sample of 10-15 Service Users (18-65 years) who received a CTO in the year prior to the study. Subsequently a sample of 20-30 people who received a CTO during the study period was taken (participants were then approached for interview 3-6 months after the CTO had been made to avoid the early stages of recovery). These were stratified random samples which were taken in order to be representative as far as possible of types of Service Users e.g. in terms of age groups, gender, type of diagnosis and location (rural/urban). However, as the numbers agreeing to participate were not sufficient using this approach, a retrospective total population sample going back two years prior to the study, and later an extended total population sample going back to 2008, was taken, resulting in a total of 242 Service Users.

Care Coordinators were approached by the Clinical Study Officer in the first instance and asked to pass on a letter of invitation to take part in the study to the Service User(s) in their care. In line with the ethical approval, the Care Coordinators were thus able to make an initial judgement as to whether it was appropriate to approach the Service User to take part in the research, based on their insight into the mental health state or stage of recovery of the Service User at that time. A sample of Nearest Relatives of Service User participants were also taken and contacted by Trust staff in the first instance. Those interested were asked to respond to the researchers (by posting in a form with their contact details) to take part in an interview. The sample of social care professionals/ practitioners/ providers were made up of those professionals involved in the care of/provision of services for Service Users subject to a CTO and were contacted directly by the researchers. A list of Care Coordinators, RCs and AMHPs were provided by the Trust. A list of Service Providers were drawn up with advice from the Project Advisory Group and contacted directly by the researchers.

The tables below (1 and 2) show further details of the breakdown of the participants in the case study and the overall numbers of interviews in total for each participant group.

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## RESPONSE RATES

Of the 242 Service Users included in the sample, we were informed that 68 people were not invited to participate because the Care Coordinator deemed they were too unwell (68). 21 of the remaining Service Users were interviewed which equates to a response rate of 12%. However this may not be an accurate figure for reasons expanded on below. Firstly, our two-step approach of accessing records of Care Coordinators working for the Trust through the Trust's Research Officer and using Care Coordinators as gate-keepers and letting them contact the Service User on our behalf, meant that it was difficult to manage and monitor the recruitment process closely, and it is difficult to know for certain how many Service Users actually received the invitation letter. Secondly, again it is difficult to calculate an exact number of instances where the Care Coordinator felt it was inappropriate to pass on the invitation to take part because of the mental health state of the Service User or because the Service User had been recalled for in-patient care at the time of contact. There were also instances where Care Coordinators reported not passing on information owing to a 'lack of insight' (despite being advised that this was not a valid reason for exclusion) which may have had a positive bias on findings. Further, some practitioners may not have received the correspondence because they were on leave/had retired/had left their post. Indeed, in 76 cases the Care Coordinator confirmed that the Service User had declined to take part in the research, which means that the reason for non-participation, or whether the invitation was ever received, is unclear in 77 cases. However, for Nearest Relatives the response rate could be accurately calculated and was 16%, the same stands for Service Providers, which constituted the most accessible group with a response rate of 50%.

## INTERVIEWS

The data collection comprised of in-depth qualitative semi-structured interviews exploring experiences of CTOs with Service Users, Nearest Relatives, Care Coordinators, RCs, AMHPs and Service Providers. Most interviews took between 30-60 minutes and were digitally recorded.

## PARTICIPANTS

TABLE 1: SERVICE USER INTERVIEWEES

Code	Gender	Age-range	CTO status at time of interview	Co-researcher
SU 1	F	25 - 34	Current	No
SU 2	M	55- 64	Current	Yes
SU 3	M	25 - 34	Current	Yes
SU 4	M	25 - 34	Discharged	Yes
SU 5	M	45 - 54	Discharged	Yes
SU 6	M	35 - 44	Current	No
SU 7	M	18 - 24	Discharged	No
SU 8	F	65 - 74	Discharged	No
SU 9	M	25 - 34	Current	Yes
SU 10	F	18 - 24	Discharged	Yes
SU 11	M	25 - 34	Discharged	No
SU 12	F	45 - 54	Discharged	Yes
SU 13	F	45 - 54	Discharged	No
SU 14	M	25 - 34	Current	No
SU 15	M	55 - 64	Current	Yes
SU 16	M	35 - 44	Current	No
SU 17	M	25 - 34	Current	No
SU 18	M	25 - 34	Current	Yes
SU 19	M	25 - 34	Discharged	No
SU 20	M	35 - 44	Current	No
SU 21	F	35 - 44	Current	No
<b>Total</b>	<b>21</b>			<b>9</b>

TABLE 2: ALL PARTICIPANTS INTERVIEWED

Service Users	21
Nearest Relatives	7
Care Coordinators	16
Responsible Clinicians	10
Approved Mental Health Professionals	9
Service Providers (housing)	9
<b>Total</b>	<b>72</b>

## CONSENT AND PARTICIPANT INFORMATION

The consent of all participants was sought, based upon them having full information about the research. In the first instance, potential participants were approached by their Care Coordinator who then provided them with a participant information sheet providing full information on the study, including how the study would be carried out, what commitment their participation would involve, safeguards to confidentiality and anonymity, and highlighting the fact that there may not be personal benefit in being involved. The information sheet also included contact details of University of Brighton staff that could provide further information about the research, including the Head of School should they wish to make a complaint. University researchers were not provided with names and contact details of Service Users until after they had read this information, decided whether they would like to take part and completed a form consenting to the researchers making contact to arrange an interview.

At the interview, information about the research was iterated and participants were asked to sign another consent form relating to the interview process. Participants were made aware they were entitled to stop the interview at any time without giving a reason and were asked whether they consent to the interview being recorded (none of the participants objected to the interview being recorded). Only those Service Users who had capacity to consent were involved in the study.

Similar procedures were undertaken for other participants involved (i.e. Nearest Relatives and practitioners/ Service Providers/ professionals). Apart from Nearest Relatives who were selected according to a sample taken by SPFT staff, professional participants (i.e. AMHPs, Care Coordinators and RCs) and Service Providers were contacted directly by the researchers with an invite to take part in the research and given an information sheet about what taking part would involve, similar to that given to Service Users. Information sheets and consent forms are available in Appendices A – G.

## RECOMPENSE

Service User participants were refunded travel expenses and given a £10 voucher for an interview in line with INVOLVE guidelines in order to militate against inconvenience. Practitioners, Service Providers and professionals were not paid but the researchers met them for the interview at their place of work which cut out any travel expenses on their part. Service User researchers were recompensed at a rate of £10.31 per hour of meeting or interview time plus travel expenses.

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## DATA ANALYSIS

Data from interviews with Service Users, social care providers/practitioners and professional staff was analysed qualitatively (thematic analysis) with the help of QSR software (NVivo). The findings and report structure have been reviewed with the Service User Research Group and Project Advisory Group.

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## COLLABORATIVE RESEARCH PROCESS

This section outlines elements of the research process which include working with the Project Advisory Group and the Lived Experience Advisory Forum (LEAF).

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### THE PROJECT ADVISORY GROUP

An advisory group including individuals from all the professional groups as well as Service Users was set up to advise, assist and give feedback on the research process and findings. The Project Advisory Group met three times annually during the study period and consisted of the following members;

- *Dr Chris Jones, Consultant Psychiatrist, SPFT;*
- *Dr Mark Hayward, Director of Research, SPFT;*
- *Mr Robert Buxton AMHP, Brighton and Hove City Council;*
- *Ms Amanda Tuckey AMHP, East Sussex County Council;*
- *Dr Richard Whale, Consultant Psychiatrist, SPFT;*
- *Mr Fraser Cooper, AMHP, East Sussex County Council;*
- *Dr Rick Clarke, Consultant Psychiatrist, SPFT;*
- *Ms Rachel Nightingale, Team leader (AOT), SPFT;*
- *Ms Sine Sayers, AMHP, West Sussex County Council;*
- *Ms Emma Seymour, Senior Manager, Brighton Housing Trust;*
- *Ms Jane Nicol, AMHP Manager, Brighton and Hove City Council;*
- *Ms Ruth Chandler, Coordinator for Service User and carer involvement in research, Lived Experience Advisory Forum (LEAF), SPFT;*
- *Mr Michael Sherlock, Service User Co-researcher, LEAF;*
- *Ms Helen Ashdown, Service User Co-researcher, LEAF;*
- *Ms Lucy Walsh, Service User Co-researcher, LEAF;*
- *Mr Stephen West, Service User Co-researcher, LEAF;*
- *Ms Laura Banks, Research Fellow, University of Brighton;*
- *Dr Karolina Doughty, Research Fellow, University of Brighton;*
- *Dr Julia Stroud, Principal Investigator, University of Brighton.*

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### THE LIVED EXPERIENCE ADVISORY FORUM (LEAF) AND SERVICE USER CO-RESEARCHERS

In addition to the Project Advisory Group, the Lived Experience Advisory Forum (LEAF) of SPFT was invited to collaborate on the project and be members of the Project Advisory Group. Service User researchers were provided with preparatory training for conducting Service User interviews together with university research staff. Service User researchers did not take part in conducting interviews with professionals, Nearest Relatives or Service Providers. INVOLVE (an NHS funded organisation supported by NIHR which aims to ensure active involvement of members of the public in research) has best practice guidelines (e.g. policy and pay) which were followed in the elements of collaboration:

- We worked with LEAF in the initial stages of the project in developing detailed design issues and engaged their support to seek approval from the relevant research ethics and governance committees.

- Service User Research Group: We worked with five Service Users to design interview schedules to ensure that the research engaged appropriately with issues important from a Service User perspective. Two representatives of LEAF were also part of the Project Advisory Group.
- Three LEAF members were involved as co-interviewers with users interviewed.
- We gave LEAF members the opportunity to give feedback and input into the data analysis.

In total, nine interviews were carried out with a Service User co-researcher present. Out of the three Service User co-researchers who took part in conducting interviews, one carried out six interviews; one carried out two and one carried out only one. As the nine interviews conducted with a Service User co-researcher amounts to almost half of the total of 21 interviews with Service Users, this involvement can be considered a success in light of some of the challenges to carrying out research with Service Users (this is elaborated in more detail below).

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## REFLECTIONS FROM LEAF AND A SERVICE USER CO-RESEARCHER

Helen Ashdown, the LEAF member and Service User co-researcher who carried out the majority of the interviews with the university researcher has provided us with her reflections on taking part in the research process and conducting interviews with fellow Service Users about their experiences of being subject to a CTO:

*As a member of LEAF, I was given the opportunity to participate in the CTO Project in conjunction with the University of Brighton. Whilst I had no personal input into the planning of the project as I was not a LEAF member at that time, I did have some say in how the interviews were conducted. A narrative approach was agreed upon. The actual interviews themselves were as varied as the participant's experiences of the CTOs. The criteria for the interviews were well set out and I felt confident that I could conduct the interviews satisfactorily. It has proved to be a positive experience and has helped me in my own recovery. I hope to participate in more research studies in the future.*

In addition, Ruth Chandler, coordinator for Service User and carer involvement in research with SPFT, adds the following reflection on LEAF involvement throughout this research study:

*The CTO study is the first collaboration with SPFT to complete. On the whole this worked well. There was extensive involvement in the design of the study and in developing the interview protocol. Peer Researchers reported positively about the opportunity to develop new skills and felt that their lived experience was helpful in establishing rapport in interviews. There was opportunity to comment on the interpretation of the analysis and involvement made its presence felt on the Steering Group for the study, giving advice initially about payment and support for Peer Researchers which was acted on. LEAF have agreed to write a leaflet when the study ends based on the findings to help current Service Users and caregivers better understand CTOs and their rights within them. Next developments for working with LEAF could include involvement in discussion around the interpretation of results.*

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## CHALLENGES IN SERVICE USER RECRUITMENT

This section discusses the challenges of recruiting and interviewing a hard-to-reach (or 'less-heard-from') group i.e. Service Users who are currently or have been subject to a Community Treatment Order. We also discuss elements of the research design which had to be rethought as the project progressed because of constraints surrounding how CTOs are used.

In the recruitment of Service User participants, our two-step approach of accessing records of Care Coordinators working for the Trust through the Trust's Research Officer and using Care Coordinators as gate-keepers and letting them contact the Service User on our behalf, meant, as was seen above, that it was at times difficult to manage and monitor the recruitment process closely. It was sometimes difficult to know for certain if the Service User had, in fact, received the letter of invitation to take part. Another consideration was that the Care Coordinator acting as gate-keeper may have resulted in the more challenging cases, and

instances where the therapeutic relationship had broken down, not being passed on to us. Going through the Care Coordinator as a gate-keeper for contact with Service Users was still considered the best route to recruitment for ethical reasons, as Care Coordinators would be able to make an informed judgement about the ability of the Service User to take part in the research without it affecting their mental health negatively, or being well enough to handle any emotional stress brought on by the interview.

The process of recruitment involved a letter of invitation to take part in the interview being sent to the Service User by the Care Coordinator, the Service User would then fill in a one-page form asking: i) to fill in their contact details; ii) to tick a box to indicate that they are willing to take part in an interview, and; iii) give their consent to being contacted directly by the researchers to arrange the interview. There could be further challenges involved in both arranging and conducting the interview. Some Service Users, although they had indicated their willingness to take part in the interview and be contacted by the researchers, were still difficult to reach. Many did not use e-mail and for some Service Users answering the phone to an unknown number was not something they would normally do, therefore reaching the Service User to make the practical arrangements for interview was sometimes challenging. To mitigate this, many interviews were arranged with the help of the Care Coordinator and scheduled after an already arranged meeting between the Service User and the Care Coordinator or clinician, which meant that the Service User did not need to make an additional trip just to attend the research interview.

However, this did not always work where in effect four different schedules had to match; that of the researcher; the Care Coordinator, the Service User and potentially the Service User co-researcher, in addition to arrangements having to be made for compensation for the Service User and co-researcher. An additional consideration was the overall time-frame for the data collection, which imposed a constraint towards the end of the project. As it was often attempted to conduct an interview with the Care Coordinator after the interview with the Service User had been done, this was an additional element of scheduling.

Taking part in research was a new experience for the Service User co-researchers and although there was an uneven distribution of interviews amongst the three co-researchers who took part in the project and whilst it may have been challenging in different ways for them personally, their involvement was a successful first step for LEAF towards greater involvement of Service Users in research. The co-researchers occupied a status in-between end user and producer of knowledge and although it was difficult to draw any conclusions about the potential impact this may have had on the research interviews in this instance, this is something that could be picked up in future research involvement. Notwithstanding the challenges in recruitment and practical aspects of arranging interviews, the project successfully recruited 72 participants for interview, out of which 21 were Service Users, which has to be considered a significant achievement.

## FINDINGS

The following section presents the findings of the research. Firstly outlining the statistical analysis of CTO use in the SPFT area and secondly discussing the findings from the qualitative case study element of the research.

### STATISTICAL ANALYSIS OF CTO USE IN THE SUSSEX PARTNERSHIP NHS TRUST

Anonymised Trust records were used to compile a statistical overview of CTO use in the Trust in the year prior to the commencement of the study – July 2010 to June 2011 – and later collected for the period during the study itself – July 2011 to December 2012. The results are presented below.

#### THE YEAR PRIOR TO THE STUDY PERIOD - JULY 2010 TO JUNE 2011

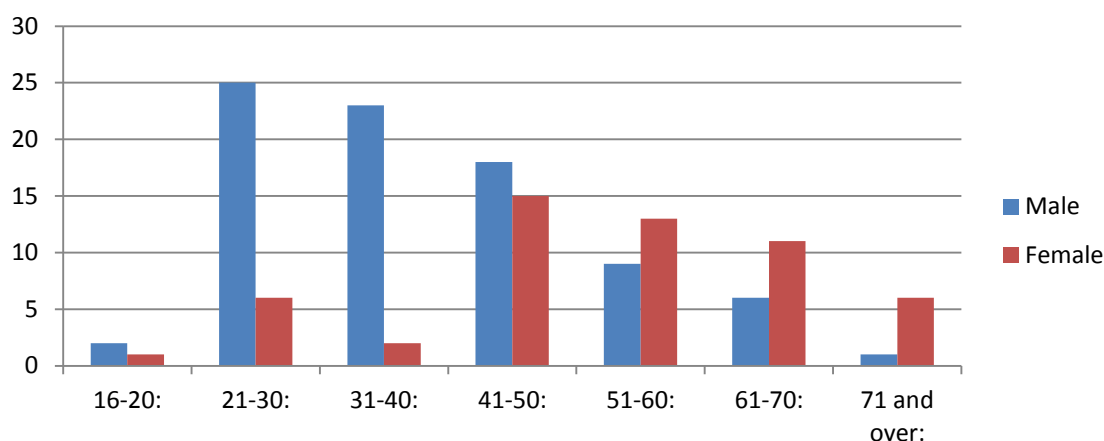
##### NUMBERS OF CTOS ISSUED AND OUTCOMES

138 new CTOs were made in the time period. 61 people on CTOs were discharged in the period, 36 were recalled to hospital, 22 had their CTO revoked and 115 CTOs were renewed. Since those on CTOs which had been discharged, renewed, revoked, or those who had been recalled to hospital during this time period, may have received a CTO before the time period, we cannot calculate the percentage by outcome of those who had received a CTO in the time period.

##### GENDER AND AGE

The majority of those receiving a new CTO in the time period were male (84; 61%). However, the majority of those in the older age groups were female. In terms of the whole sample, the majority (57%) were aged over 40. However, male Service Users were more likely to be aged 40 or under (60%) whereas females on SCT were much more likely to be aged over 40 (83%). The chart below illustrates the breakdown by age and gender.

FIGURE 1: BAR CHART SHOWING THE NUMBER OF PEOPLE ON SCT BY AGE AND GENDER



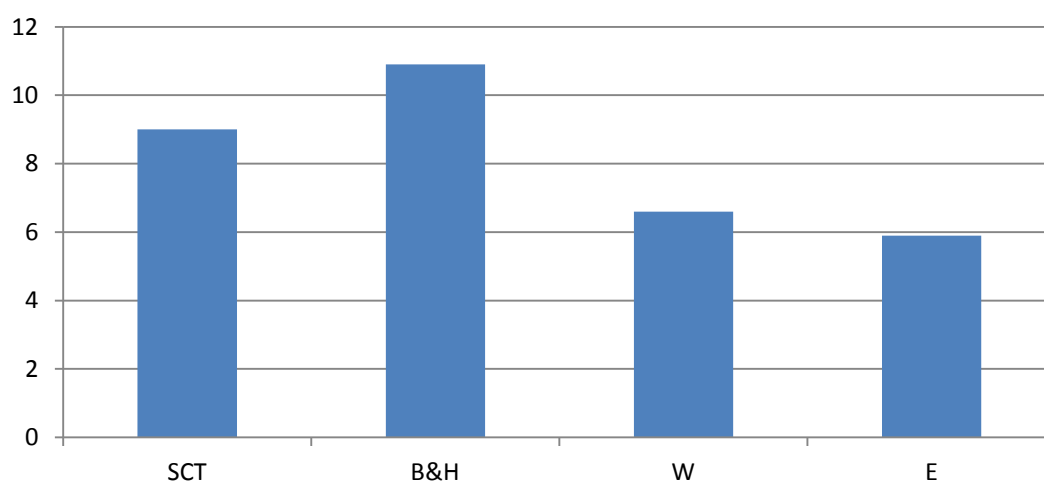
##### MARITAL STATUS

Even when accounting for the younger age profile of the population on a CTO, those subject to a CTO were more likely to be single (i.e. never married: 65.5%) or divorced or separated (15%) than the general population. Only 9% were married or in a civil partnership, which compares to 37% of the general population of Brighton and Hove, 53% in East Sussex and 55% in West Sussex (2001 Census figures). 6.5% were widowed, which compares to 8% in Brighton and Hove, 10% in West Sussex and 11% in East Sussex (i.e. a relatively high rate when accounting for the smaller proportion of people in the population aged 60+).

## ETHNICITY

The large majority of Service Users in the population under study are recorded as 'White' (88%), with 80% recorded as 'White British'. However, although non-white Service Users constitute a small minority, they appear to be over-represented in comparison to the general population. 9% of those on SCT were recorded as BME (i.e. Black, Asian, Mixed or other Ethnic group) and 3% as unknown. According to the 2011 census, 10.9% of the Brighton and Hove population, 6.3% of West Sussex, and 3.9% of the East Sussex population are classed in categories other than 'White'. For the area combined, the total percentage of non-white residents equates to 6.3% (ONS, 2012a). However, it is likely that this difference is negligible if the age profile is taken into account, since both the CTO service user profile and the BME general population is younger on average than the white population in general (12.5% of the Brighton and Hove and Sussex population under 60 are classed in groups other than 'White' in the 2011 census) (ONS, 2012b). It should be noted that the minority of older service users on a CTO (i.e. those aged 60+) were all classed as 'White British' or 'White Irish/ Other'.

FIGURE 2: BAR CHART SHOWING PROPORTION OF BME (NON-WHITE) SERVICE USERS ON SCT COMPARED WITH THE GENERAL POPULATION OF BRIGHTON AND HOVE, WORTHING AND EASTBOURNE.

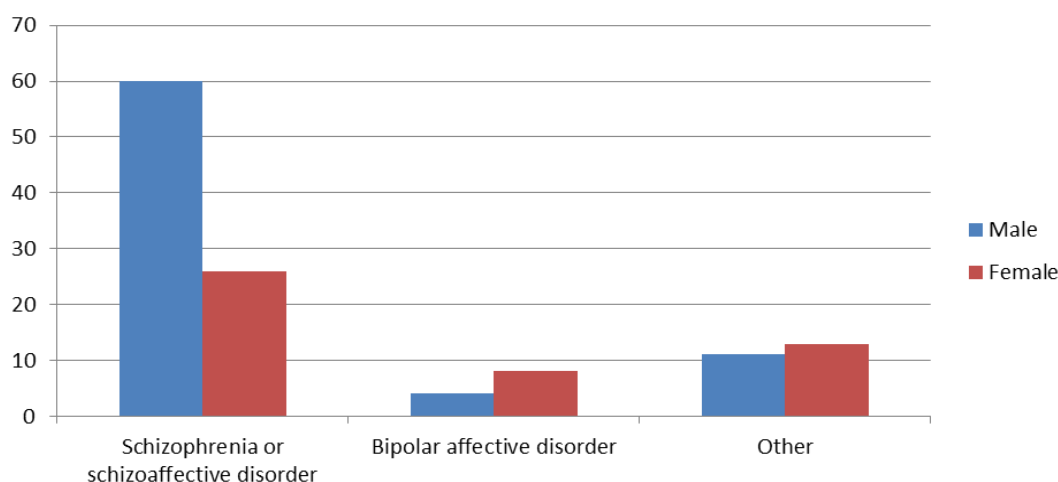


## DIAGNOSIS

The majority of those on a CTO in the time period had been diagnosed with a type of schizophrenia or schizoaffective disorder (62% of all Service Users), the most common of these being paranoid schizophrenia (37%). 10% were diagnosed with bipolar affective disorder, whilst no diagnosis was specified in 12% of cases. Other diagnoses included personality disorders, depressive and psychotic disorders, Asperger's and behavioural disabilities relating to alcohol use and anorexia. 70% of those with schizophrenia or with a schizoaffective disorder were male. Of those with diagnoses specified, 50% of males had paranoid schizophrenia, compared with 28% of females. Females were more likely to have been diagnosed with a bipolar affective disorder (17%) than males (5%).



FIGURE 3: BAR CHART SHOWING THE NUMBER OF PEOPLE ON A CTO BY DIAGNOSIS TYPE AND GENDER (EXCLUDING UNSPECIFIED/ NO DIAGNOSIS)



### CONDITIONS OF THE CTO

All Service Users were subject to the compulsory conditions of being available for medical examination to allow 2nd opinion doctor to provide Part 4A certification and to be available for medical examination when renewal is being considered. Apart from these, Service Users were most likely to have a condition attached to CTOs that was linked to taking medication, i.e. to remain compliant with medication regime as prescribed, to accept medication as prescribed or to attend a specified unit for the administration of medication (43%). Almost a quarter (24%) were subject to conditions around keeping in contact with professionals, including keeping appointments, and allowing professionals into the home. 18% were obliged to reside at a specific address, 6% to adhere to the care plan and 5% were subject to conditions around drug abstinence, support with this or to be available for drugs testing/ blood tests. One person was subject to a condition to be weighed frequently as specified by the care team. Social care conditions were not specified.

### HOUSING STATUS

The information available is unclear because the question or understanding of the information required appears to have been inconsistent. Under 'housing status' the information recorded is mixed in terms of type of tenure and household type. Therefore the data is not meaningful or useful. For example the data states that 4% live alone and that 7% live in housing association type properties, but it is not clear as to whether those who live in housing association type properties live alone or with others, nor is it clear as to what type of housing those living alone are residing in. Also under 'housing status' over a third (38%) of Service Users are recorded as 'not specified'.

### EMPLOYMENT STATUS

Of those for whom employment status was available (58%), the large majority were unemployed (73%). 8% were in paid employment. Around half of those in paid employment (4% of total) were part-time employed and 1% were self-employed. 20% were retired. There was no data on other daily activities Service Users may be engaged in such as volunteering, education or caring roles.

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## NUMBERS OF CTOS ISSUED AND OUTCOMES

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During the period of the study (July 2011 – December 2012), 199 new CTOs were made. Unlike the earlier data that pertains to the year prior to the study, we were able to accurately calculate the outcomes (within the time period); during the period of the study (July 2011 – December 2012) 199 new CTOs were made and information was provided about the outcomes for these CTOs within the time period: 52 were discharged (26%), 72 were still active (36%) and eight were allowed to lapse (4%). 60 (30%) Service Users whose CTO was made in this time period were recalled to hospital and of these 11 (18%) were subsequently returned to the CTO, whilst the large majority (49, 82%) had their CTO revoked. It should be noted that the figures are affected by the fact that a significant proportion (41%) of CTOs were made after June 2012 and would therefore not have yet been due for review. If only those which should have been reviewed by end December 2012 were included, 36% had been discharged, 39% revoked and 20% were still active (i.e. presumed renewed).

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## GENDER AND AGE

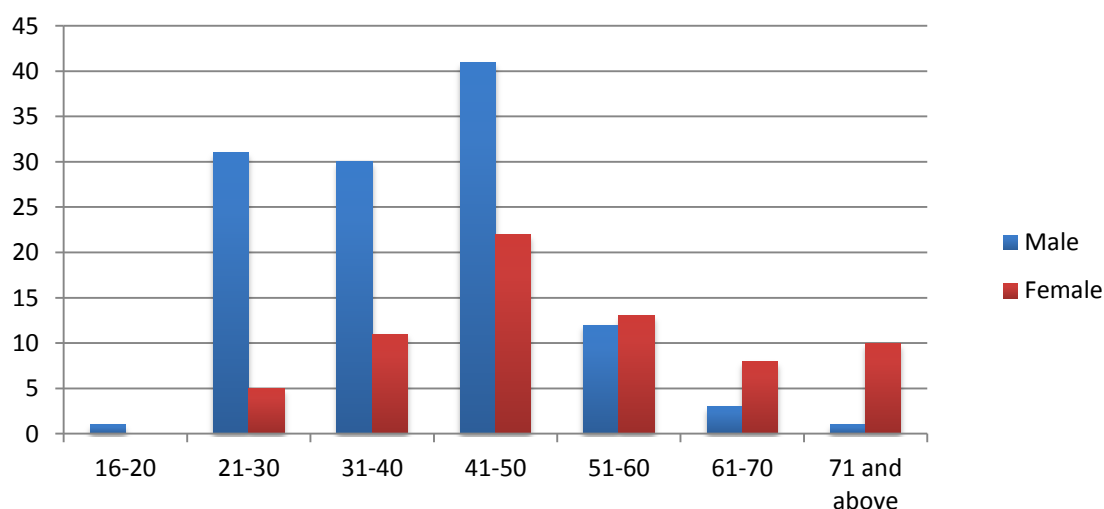
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In accordance with the earlier statistics, the majority of those who received a CTO during this period were male (62%). In terms of age, the median age of Service Users who were made subject to CTOs in this time period was 52 years, with an age range from 18 to 85. As with the earlier sample, a relationship between gender and age emerges. The difference in age and gender when looking at the population of Service Users over 40 as a whole was almost non-existent; with 27.6% of Service Users over the age of 40 being female (55), compared to 27.1% male (54). However, over 40% of male service users were in the 41-50 age group, whilst only 20% of women were in this age group. The majority of Service Users over the age of 50 were women, whilst the reverse is the case for service users under 50, as the chart in figure 4 shows.

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FIGURE 4: BAR CHART SHOWING THE NUMBER OF PEOPLE ON SCT BY AGE AND GENDER

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## MARITAL STATUS

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Much like the earlier statistics, Service Users subject to CTOs were more likely to be single (75%) or divorced/separated (11%). Only 9.5% were married or in a civil partnership and 3% were widowed.

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## ETHNICITY

As in the earlier sample, the majority were recorded as 'White British' (84.9%) and a further 6% recorded as 'Any Other White'. 9.5% of those who became subject to CTOs during the study period were recorded as BME (i.e. Black, Asian, Mixed or other Ethnic group). This is a slight increase from the previous year and according to the 2011 census is higher than the population for as a whole. Therefore, a crude comparison would suggest those from a BME background are over-represented. However, as is noted above, age is also likely to be a confounding factor, since both the CTO population and the BME population have a younger profile than the population as a whole. Therefore it is likely that if age is taken into account this apparent over-representation would not be observed.

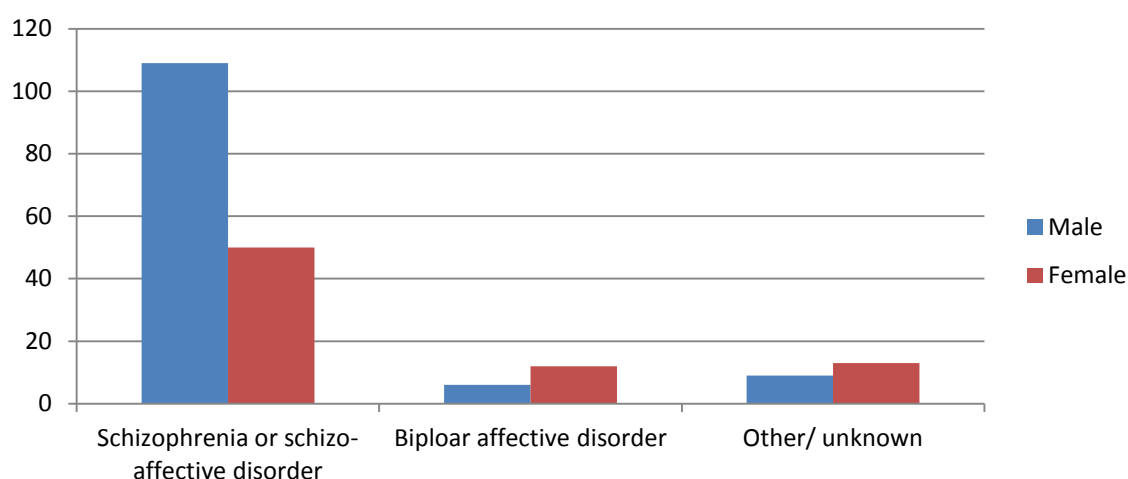
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## DIAGNOSIS

Like the earlier data, the majority of Service Users who became subject to a CTO during this period had a diagnosis of some type of schizophrenia (62%) or schizoaffective disorder (18%), the most common diagnosis by far being paranoid schizophrenia (53%). 9% were diagnosed with a bipolar affective disorder, which is similar to the earlier figure of 10%. 8% were diagnosed with another type of disorder, including personality or delusional disorders, obsessive compulsive disorder, depression and acute stress. Diagnosis was missing for 3% of Service Users, a much reduced number compared to the earlier data.

Similarly to the first sample, 69% of those with a diagnosis of schizophrenia/schizoaffective disorder were male. Of those who had a diagnosis specified (97%), 90% of males had a diagnosis of schizophrenia/schizoaffective disorder, which compares with 69% of females, whilst 65% of males and 39% of females were diagnosed with paranoid schizophrenia (which constitutes a proportionate increase for both sexes). As found in the earlier sample, females on CTOs were still more likely to have a diagnosis of bipolar disorder (16%) than men (5%).

FIGURE 5: BAR CHART SHOWING THE NUMBER OF PEOPLE ON CTOS BY DIAGNOSIS TYPE AND GENDER



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## CONDITIONS OF THE CTO

All Service Users were subject to the compulsory conditions of being available for medical examination to allow 2nd opinion doctor to provide Part 4A certification and to be available for medical examination when renewal is being considered. Apart from these, Service Users were most likely to have a condition attached to CTOs that was linked to taking medication, i.e. to remain compliant with medication regime as prescribed, i.e. 'take/accept medication as prescribed' (33%), a reduction compared to the earlier data. 23% had a condition

relating to keeping/attending appointments and engaging with the care team. However, a third of CTOs had no extra conditions specified (33%). This highlights a move towards specifying fewer conditions on CTOs, which is reflected in the findings from the interviews with practitioners. Conditions that were specified included: to live at an address agreed with care team (11%); accept visits from a mental health professional (2.5%); and to adhere to the care plan (2%). Significantly, only one CTO had a condition relating to abstaining from drugs and alcohol and to accept regular tests for evidence of drugs or alcohol.

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## HOUSING STATUS

Like the earlier data, the information available is unclear because the question or understanding of the information required appears to have been inconsistent. Again, under 'housing status' the information recorded is mixed in terms of type of tenure and household type and like the earlier data the information available is not helpful in terms of gaining an accurate overview of the housing situation for those on SCT. 33% of the cases are recorded as 'unspecified', 8% are recorded as living in local authority housing and 8% in residential care. 4% are recorded as homeless.

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## EMPLOYMENT STATUS

Of those for whom employment status was available (61%), the large majority were unemployed (80.8%), only 5% were in full-time employment (there were no records for part-time employment). 10% were retired. There was no data on other daily activities Service Users may be engaged in such as volunteering, education or caring roles.

## KEY EMERGENT THEMES

The qualitative interview data collected from Service Users, Nearest Relatives and professionals was thematically analysed to identify a number of key themes emerging from the data, both across the groups taken as a whole and within each specific cohort. This led to the identification of four major overarching themes from all groups:

- The CTO provides a legal recognition of the need for care;
- The care is defined as predominantly medical;
- The CTO provides a structure and containment for the 'right' Service User;
- There is ambivalence surrounding the power and conditions of the CTO.

Following the elaboration on each overarching theme and letting the data from across the groups speak to these themes, the perspective of each cohort is explored in turn to highlight the experiences and explore the processes and practices specific to each of the participant groups. An elaboration on each of the participant cohorts separately will highlight both differences and similarities in the experiences and concerns of each group.

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## OVERARCHING THEMES

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### THE CTO PROVIDES A LEGAL RECOGNITION OF THE NEED FOR CARE

The Community Treatment Order was found to provide not only a legal framework to support enforced care in the community but many – especially Service Users and Nearest Relatives – felt that the order extended a recognition of the Service User's need for care. Whereas the CTO legally sanctions medical treatment in the community (Churchill et al. 2004), this theme relates to the other side of this coin; the experiential value for Service Users and relatives relating to the legal recognition the CTO provides for their need for care. This theme is emergent across all the different groups (Service Users, Nearest Relatives and professionals). For some, especially for Service Users and Nearest Relatives, this legal recognition of the need for care can be

experienced as reassuring; especially if there have been concerns about receiving adequate care in the past. A Service User comments:

*I'm on my own. I need someone like a social worker to come and drop off my medication, a doctor to come in every six months to see me, to make sure I'm alright. I've got no one. People like me need things like that (SU1).*

Depending on the individual circumstances of the Service User, the legal imperative for care implied by the CTO can be experienced as reassuring and as a 'safety-net' in case of deterioration, but most significantly it can be regarded as an assurance that care will be provided and it will be speedy. In the current climate of public spending cuts and increasing limits on resources, an assurance of care can be a significant thing indeed. Alongside these experiential aspects, the CTO – and its legislative status – can provide significant benefits when it comes to organising the more practical aspects of housing and income benefits.

The transfer of responsibility from the individual Service User to the care team monitoring progress under the CTO were in some cases experienced by the Service User as a safety net, should their mental health deteriorate. Although many Service Users said that their relationship with services, in particular with their Care Coordinator, clinicians and other support workers (including housing support workers) had not changed since they had been subject to the CTO, the imperative of the order for the continuity of care was sometimes a factor in their subjective assessment of being under the order. Some Service Users worried about what would happen to their care if the CTO was discharged. They worried that the withdrawal of the containing, structuring and monitoring aspects of the order would affect their mental health in negative ways, and that without the CTO in place to facilitate monitoring and speeding up the admission process they may be allowed to deteriorate.

Whilst the CTO would not always be at the top of the list of priorities for practitioners in their engagement with the Service User, and many Service Users acknowledging that the CTO did not substantially impact their relationships with members of their care team, the reassurance that the CTO provided a legal imperative for care was a significant emotional experience which had an impact on the wellbeing of the Service User. Notwithstanding constraints on resources and time available to services, the CTO framework was often reported to make a difference in how available and forthcoming support was. That the CTO was perceived to produce an 'imperative to care' and that this was experienced as reassuring was not something that only came through in interviews with Service Users and Nearest Relatives, but was referred to in interviews with practitioners. For example, one clinician comments:

*My experience is that most of the families are actually saying don't discharge him or her from CTO because they think that... we have to have that support really (RC1).*

Practitioners also reflected these concerns in accounts of working with Service Users on CTOs, recounting the legal framework as something that could channel and contain their relationship with the Service User, in ways which dictated the roles and responsibilities of both parties:

*Since the Community Treatment Order come [sic] it gives you a framework to work with and the patient knows their rights and their limitations and we know the same and so we work within a system (RC1).*

This was echoed by AMHPs who commented that a positive aspect of the CTO is that it places more emphasis on the team to have more involvement; they want to make it work so they have to be 'on the ball', as one AMHP comments:

*There is no point having a CTO which allows you to recall someone if you as a Care Coordinator never see the person. So I think it does make them more active really (AMHP2).*

However, as one RC points out, there are also legal requirements in place under the CTO to make care available to the Service User, which are not entirely dictated by need:

*See, these are legal issues, and it makes it incumbent on the team as well to provide, by law, certain basic treatments for the patients even when you are restricting their liberty and you are restricting them to do this, you are confining them to follow a certain engagement protocol, then you also have to be available to provide them more, you are duty bound to do so. So it works for the patient as well in that sense. When they are no longer on the CTO, then it is purely on the need basis (RC7).*

However, as the same RC makes clear, the CTO should not be a way to access services, but rather be used in order to contain the Service User within a particular treatment regimen:

*In an ideal setting the treatment is led by the need of the patient, and depending on what the need is, the patient does not have to be on a CTO, or should not be on a CTO to get the appropriate treatment (RC7).*

Most Service Providers and Nearest Relatives felt that the CTO had made it much easier for them to communicate with professionals providing support to the Service User, giving them a direct line to someone they could call if things went wrong. They also appreciated being asked for their input at review stages. However, not everyone knew who to contact or who was who in the care team. Nevertheless, a majority of Nearest Relatives interviewed for this study felt that their relative being subject to the CTO had made a clear difference to their care and their own opportunity, as a Nearest Relative, to be listened to by members of their relative's care team. One mother comments on the experience of her son being placed on the order:

*the other big thing about the CTO as I've understood it is that they are now allowed to include in this case parents in consultations, medical consultations. Which we were never allowed to do before, and this has made a huge difference, not so much because of being involved in consultations about treatment but they now listen to us, I can ring the CPN and say, "I'm worried about him", and she goes to see him, and before it was: "Well I'll go and see him but I can't really do anything because of his human rights" (NR1).*

Whether or not the perceived changes in how responsive and approachable the services were could actually be attributed to the CTO, this perceived change was attributed by Nearest Relatives to the legal imperative of the CTO. The same Nearest Relative comments further:

*It was the first time that anything like that had ever happened, we were consulted, we were given a voice ... I now have a voice which I didn't have before, it was: "Well you can let me know what you think about how your son is, but I can't listen to you, you're not involved and by law you can't be, I'm clocking and taking down what you're saying in my head and I'm monitoring it but I can't do anything because of what you said, and we can't discuss with you what we would do either, nor can we go to him and do anything until he becomes so ill that he's got to be sectioned", and this system does away with all of that (NR1).*

Even though Nearest Relatives did not always feel well supported themselves by the services, Nearest Relatives often felt that the legal imperative of the CTO 'secured' speedy care for their relative, especially in case of deterioration and re-admission to hospital. One Nearest Relative comments:

*So this order allows him to be asked, or whoever, to get him admitted much more quickly without all the fuss as soon as he stops taking his tablets, so it's like a security blanket really to make sure if he were to stop taking them (NR4).*

All the Nearest Relatives in this study had experienced multiple hospitalisations of their relative, which were frequently traumatic in nature. The CTO being in place and acting as a 'safety net' in case of re-admission to hospital was experienced as reassuring for a number of reasons. The specific advantages of re-admission to hospital under the CTO was felt to be; i) the speed with which recall could be issued; ii) that a new Mental Health Act assessment was not needed upon admission; iii) that the Service User could come into hospital for 72 hours and thereafter be discharged back into the community under the same CTO. On the whole, Nearest Relatives were overwhelmingly positive about CTOs.

It is worth bearing in mind here, however, that it is not uncommon for those struggling with mental health problems to be estranged from their families and other people close to them, and the involvement and engagement of Nearest Relatives in this study may not be representative of the overall picture, either locally or nationally. It is conceivable that those Nearest Relatives who are more actively involved in the life and care of their relative were more likely to respond to our call to take part in the study. Thus, our findings reflect a group of Nearest Relatives who may be more invested in their relative's care than other groups where relationships may be strained, severed or absent.

What we have termed the 'imperative to care' embodied in the legislative powers of the CTO was also reported by Service Providers to have made a positive difference in a number of key areas. Firstly, several Service Providers reported that the fact that a Service User was subject to a CTO made a difference if something were to go wrong. Similarly to Nearest Relatives, Service Providers commented that the CTO enabled a speedy intervention in the case of deterioration of the Service User's mental health. Secondly, such professional 'back up' was regarded as crucial both from a perspective of providing appropriate care for the Service User without causing undue stress and anxiety at time of recall, and from the perspective of ensuring staff safety.

*There is an intervention that can be sought so that the person doesn't deteriorate too far... from my point of view it is good to get the extra support you need if a Service User is deteriorating... you can get support for the Service User quicker (SP1).*

*Rather than having to wait until it gets to, you know, quite a chronic stage it just means that [the Service User will] be seen more quickly (SP6).*

Care Coordinators made similar statements about the usefulness of the CTO in terms of the speediness of recall it enables. One Care Coordinator comments:

*There was very little recovery work going on because we hadn't reached the engagement process at that point but we were able to use the CTO in some way to try and encourage engagement but what it actually enabled us to do was to recall her into hospital at an earlier stage (CC5).*

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## THE CARE IS DEFINED AS PREDOMINANTLY MEDICAL

It may come as little surprise that the CTO is medically driven from a care planning perspective, as it is primarily designed to be a legal sanctioning of involuntary medical treatment in the community. The CTO's primary function is as a framework for administering and monitoring of medical treatment and it was found that the medically driven aspect of the CTO far outweighed social care elements. Care Coordinators often spoke of the utility of the CTO in maintaining medical treatment when Service Users were non-compliant:

*As a nurse I favour it if someone's on a depot and they have got a history of not engaging with the depot, then you are able to recall them for the purpose of the depot and then discharge them back into the home address. You avoid a prolonged period of them being non-compliant leading to further deterioration (CC8).*

For all the Service Users in this study, the CTO was in place in order to administer and oversee medical treatment in the community. The CTO was most often utilised when the Service User had a history of non-compliance with medication and this non-compliance was seen to have a detrimental effect on their mental health having led to several hospitalisations.

*The way I understand it, it's a way for you, it's a way to ensure you take your medication (SU16).*

*I came to be on a Community Treatment Order because I was refusing to take medication and so they put me on that so I couldn't refuse it (SU8).*

Medication is often a contentious issue and the Service Users' experience of taking their medication, dealing with side-effects and their subjective assessment of the actual or potential benefit of taking the medication heavily impacts on their experience of the CTO. Many Service Users spoke about their dislike of their medication and the trauma of dealing with negative side-effects:

*I had horrific experiences with the medication to start with. I used to have full on near death experiences when I first started taking it. So the dose they gave me was way too much and I used to have like, feel like I was going to cripple and be hallucinating and really like strong experiences from it and I hated the medication and then they lowered the dose (SU2).*

Even though the relationship Service Users had to their medication was often one of difficulty or at best ambivalence, a significant portion of the Service Users who took part in the study could identify in retrospect a positive outcome from the medication, in many cases related to more stable mental health. The same Service User comments:

*I feel much better from having been taking the medication even though it wasn't agreeing with me at first it seems to have settled down. So that's probably the only good thing that's come of it, it's simplified my energy a lot (SU2).*

We suggest that this 'grudging acceptance' is a key aspect of Service User experience of the CTO in cases where it has had a perceptible positive effect on their mental health state and ability to function socially and live life in the community. The following quotation exemplifies the way some Service Users in retrospect came to appreciate the benefits of their medical treatment under the CTO:

*The way I understand it [the CTO], it's a way to ensure you take your medication; which I think is a really good idea because if you're willing to take medication then you should be able to take it in the community and you should be able to live your life how you want. You don't have to be locked up in hospital all the time because, I would know this from past experience, if you stop taking medication every time that you're out of hospital, you're just going to go straight back in again. So the truth of the matter is some people actually physically do need medication all the time and the CTO is the perfect thing for them. With me, I want to take medication (SU3).*

The gradual acceptance of the medication can sometimes come from realising the stabilising benefits after a period of continued treatment, often under the CTO rather than in hospital, possibly because under the CTO the Service User can appreciate the benefit of more stable mental health in the context of everyday life and relationships, which may help them to more clearly judge the difference. Such as in the case of the Service User quoted above, who emphasises:

*I like taking medication now; I see the benefits of taking medication (SU3).*

However, there were Service Users who did not perceive their medication to be making a positive difference to their mental health. For example, one Service User commented:

*The kind of medication they're offering you, forcing you to have under the auspices of the CTO, in my mind's eye is not doing me any good at all (SU1).*

There were differences in opinion amongst practitioners in regards to whether the CTO was of any real long-term benefit when Service Users did not comply with medication and were not likely to continue treatment once the CTO had been discharged, leading in some cases to CTOs being renewed indefinitely with little hope of being discharged due to concerns that the Service User would instantly disengage with services. Some practitioners commented that some level of engagement and motivation was needed for the CTO to be successful, while others argued that the CTO may become a platform for re-engagement due to increased stability of the Service User's mental health thanks to continued medical treatment.



Several Service Providers reported that Service Users in their care ‘lacked insight’ into their own mental health, commonly evidenced by a belief that they did not need medication which resulted in reluctance or unwillingness to take medication. It was particularly in these cases that the CTO was seen as a ‘useful tool’ in that conditions which forced the Service User to keep up with their medical treatment provided a stability of their mental health that had previously been hard to achieve.

*Basically he doesn't believe that he has a mental health problem ... he was on 300 milligrams [of XXX] at night-time, [but he] decided that some days you'd take 100, sometimes you would take 200... eventually he was taken into hospital, and put on a section and then [he was discharged on a CTO], they got his Clozaril sorted out and believe it or not he's totally a different person, you know? And he doesn't actually believe it but he is a completely, quite a different person because he's been taking that medication regularly; but he still doesn't like it and he still argues about it and, which is fair enough but it doesn't matter how much you actually say: "Well, a couple of years back we wouldn't be able to have this conversation, you know, while we can now" (SP3).*

One RC relates the utility of the CTO to the framework that it provides for those Service Users who are receptive and ready for it, where the aspect of coercion in relation to medication is found to be helpful:

*It is the final piece in a bio-psychosocial jigsaw for some people and what it usually is is that it, it forces them to take their medication and that's not a bio-reductionist statement, it gives them an excuse to take their medication, which gives them the ability to engage with a psychological and social care package (RC2).*

So whilst the CTO is medically driven, it is recognised by a number of professionals as well as Service Users themselves that the medically focused conditions sometimes provide the stable ground for further engagement and social support activities. In those cases where compliance with medication made a significant positive impact on the mental health state of the Service User, the medical treatment became a platform for continued progress and engagement with services.

## SOCIAL SUPPORT

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The CTO initially is medically driven and primarily used for the purpose of administering medical treatment in the community and care plans reflected this. None of the Service Providers interviewed made mention of social support services – even if these were actually provided – as being part of the CTO framework for treatment. The CTO with its medically focused conditions was seen to provide a platform onto which social rehabilitation could be built. The medically driven conditions of the CTO seemed in many cases to make little difference to overall service provision in many cases, as one Service User comments:

*There weren't any new appointments that I had to go along to, it was just a case of getting my injection and seeing the Doctor as per usual once every six weeks or ten weeks or something (SU18).*

This was also confirmed by practitioners, as one RC reports:

*[Social care is] not any different for other patients who are not on CTO. If they need that kind of therapeutic support, it is available and it is provided, but there's no other additional therapeutic support, just because they're on a CTO (RC7).*

This stands in interesting contrast with the perception of the ‘readiness of response’ from services associated with the CTO, as elaborated above. Although, many professionals, Nearest Relatives and Service Users themselves conceded medication was a key factor in achieving stable mental health, some said that the focus on medication took emphasis away from social aspects of care that are also crucial for the long-term success of treatment.

*If we talk about his general psychiatric care, that's a different story... I think when he comes home there's never enough done to help him to get interested in doing anything and I honestly think that he could perhaps be helped a bit more (NR6).*

*So I think he just needs integrating somehow into the community but it's what to do ... if you don't see anybody else, it's like old people isn't it? They go into a little shell, don't they? (NR3).*

## THE CTO PROVIDES A STRUCTURE AND CONTAINMENT FOR THE 'RIGHT' SERVICE USER

Many Service Users, Nearest Relatives and Service Providers felt the CTO's legal requirement to check up on the Service User made a big difference to the amount of contact the Service User had with services. Across the groups participants reported that the CTO could work to providing stability and (for some) a reassuring 'safety net', backing up positive decisions and empowering personal relationships as a result. The legal aspect was seen to work as a motivating factor for the 'right' Service User:

*I see it much as a sort of external locus of control or something or, you know: "I don't want to take my medication or see my CPN but I have to" (RC2).*

The containment of the CTO can also be a very reassuring aspect for Nearest Relatives and in some cases, professionals. The 'right' Service Users were often seen as those individuals who were treatment resistant prior to being subject to the CTO and often had little or no 'insight' into their own mental health. However, whether the CTO was successful or not depended on a range of other, individual, factors:

- a. Motivation to get well and/or progress to independence;
- b. Find structure and/or legal recognition of need for care reassuring;
- c. Respect for legal power and/or regard recall to hospital as a deterrent;
- d. (grudging) acceptance that conditions of the CTO are in their best interest (although This often comes after being on the CTO for some time and recognising they are more stable as a result).

Service Providers who are on the 'front-line' of care, often seeing the Service User on a daily basis and able to assess their day-to-day progress, often reported that the CTO provided a structure and a sense of control that they might not otherwise have. One Service Provider comments:

*"So, from my point of view and I did ask the staff what they thought about it so it wasn't just my opinion, I have had a bit of consensus, we quite like them [CTOs] because there is a degree of control there that otherwise wouldn't be so that is a bit of security for us" (SP5).*

Across the professional groups many considered the 'right kind' of Service User to be someone who had little or no insight into their mental health and/or was treatment resistant. One Service Provider comments about a particular case where he has regarded the CTO as being a helpful tool in the treatment of a Service User who has experienced frequent and lengthy hospitalisations.

*He's in his thirties now but he's been in the system since his early teens and he's never been particularly successful for any long periods of time of coming back out into the community but I really feel now that he's, the CTO is going to really be useful because he deteriorates so rapidly once he stops taking his medication... I'm not necessarily saying that he will particularly enjoy the idea of it but I feel that it's appropriate in this case because of his lack of insight (SP6).*

The same Service Provider goes on to generalise these sentiments:

*It certainly works well with people who lack insight into their mental illness and certainly when they start feeling better they start wanting to stop taking their medication. So I think it's, it's really a potentially very, very useful tool (SP6).*

However, many mentioned that the Service User also needed to regard the legal power of the CTO as a motivating factor, that is they needed to respect the authority of the CTO and view it as either a deterrent or

as a reassuring 'structuring force'. One AMHP comments that CTOs are most successful in cases where the Service User would benefit from a sense of structure:

*People for whom CTOs works are people who would benefit from a sense of structure - they know that things will kick into place quickly if they get unwell (AMHP2).*

Service Users themselves sometimes recognised that the structuring power of the CTO had a beneficial impact when they felt they lacked control over their own situation. The perception that they had no choice but to comply with the conditions of the CTO meant that medication and engagement was kept up when it might not have been otherwise. One Service User comments:

*No I didn't have a choice which was just as well really as I could have gone off on the same tangent" (SU7).*

The element of control, which for some Service Users is experienced as restrictive and punitive, can be experienced by others as reassuring or helpful in that it shifts an element of responsibility away from them as individual and onto the services and structures their engagement with services. One Service User comments:

*With the CTO there's a good mixture between freedom and control (SU11).*

The containing and structuring force of the CTO was sometimes experienced as a deterrent, ensuring that conditions were met because although the Service User did not enjoy taking the medication they were ordered to take under the CTO they did so because the alternative of an involuntary readmission to hospital was seen as worse.

*I don't mind taking the medication. I still would rather not but I have to otherwise I'll go back to hospital (SU20).*

This could sometimes be seen as a secure transition into the community after a lengthy hospitalisation:

*[The CTO was used] to keep me in check and to make sure that I didn't stray off the path. And now I'm off the CTO and officially off my section, I was on the CTO for about four, five months (SU4).*

Similarly, clinicians reported that the element of structure and control served to re-engage some of those Service Users who had struggled to engage previously. One RC comments:

*These patients who we're putting on Community Treatment Orders, they start to reengage better, they comply with the treatment with the view that they know that if they won't, they could be recalled to hospital. So they almost become more engaged because of that. However there are a few patients who probably wouldn't take their treatment if they're not on a Community Treatment Order (RC1).*

It is recognised by most clinicians, as well as other professionals, that the authority of the CTO may have an impact on engagement and compliance, at least while it is in force and affecting an implied threat of hospitalisation if conditions are broken:

*They know that if they don't comply or they don't adhere to the care plan they could be recalled or... so it's not really threat in a way but it just kind of gives them a structure themselves, they can blame something else and, you know, carry on with their treatment in a way (RC1).*

Another RC echoes the same sentiments:

*Like one patient says "Oh I know I won't take my depot if I'm not on CTO but I'll take it because I am on CTO" (RC5).*

Thus, the 'right kind' of Service User was often deemed to be those who are more compliant:

*CTOs in my experience have worked for some patients and have not worked for the others. They have usually worked for patients who are more compliant, really, in my opinion (RC7).*

CTOs were also felt to be most appropriate for those Service Users who appreciated a sense of containment and structure:

*[In the team we have one woman who] has been on supervised discharge, section 3 or a CTO for six or seven years and wants to be on the CTO and finds it containing (RC2).*

However, some practitioners mentioned that for the 'wrong' kind of Service User, the CTO is ineffective and potentially harmful for therapeutic relationships. One Care Coordinator says:

*Where people don't buy into it and don't accept the authority in which it is granted then you can recall them, you can try to enforce it but it doesn't, it's not therapeutic, it's not building their relationship of trust and moving towards engagement at all or effective treatment (CC6).*

Similarly, another Care Coordinator comments that Service Users need to have some level of acceptance of the CTO or it will be fruitless:

*For Service Users that have little understanding or little knowledge of the process and no agreement with the process it's, it's going to be difficult to make it work (CC14).*

Nevertheless, in cases where the Service User wanted to stay on the CTO and the Care Coordinator and RC were happy for them to remain on the CTO, the AMHP may not agree and recommend discharge. AMHPs were in general less happy to keep a Service User on a CTO purely because they appreciated the sense of containment it provided, if they were otherwise engaging and showing progress. For many AMHPs, the ethical considerations outweighed the experiential benefits by the Service User, which may be tempered by less positive aspects of being under compulsion. For example, an RC reports:

*We have two Service Users who the AMHPs within the team have recently refused to, well not refused that's too strong, but not agreed with renewal. In both cases Care Coordinator, consultant and Service User were recommending renewal [Laughs] (RC2).*

## GRUDGING ACCEPTANCE

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It was often recognised by participants that service users in general did not like taking medication and often only appreciated the stabilising benefits of medication in retrospect. The way that Service Users related to the CTO was often described in terms of a 'grudging acceptance':

One Service User, for example although acknowledging negative aspects around "the restrictions I suppose of not being able to, to come off it", also emphasised how:

*It's for my own good you know? Yeah, it's for my own good (SU1).*

Practitioners also often commented on how Service Users often despite displaying some negativity towards the concept of the CTO were subsequently fairly accepting of it. An AMHP, for example states:

*Generally around medication they sort of grumble a bit especially if they're very anti-medication and they say "Oh, alright then" (AMHP5).*

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## THERE IS AMBIVALENCE SURROUNDING THE POWER AND CONDITIONS OF THE CTO

The interviews with professionals and Service Users and Nearest Relatives show that there is a level of ambivalence around the actual power of the CTO and its conditions. This ambivalence often makes itself known in terms of inconsistencies around the perception of the power of the CTO by Service Users and Nearest Relatives and the understanding of those powers by professionals such as Care Coordinators, AMHPs and clinicians:

*It seems that it probably does keep them, a few of the patients, in check and more compliant, some of them because they think the CTO is some huge thing and this can happen or that can happen when you're on a CTO (RC7).*

Whilst this was not universally the case and the same RC mentioned that there had been some relapses due to disengagement while on the CTO, this quote still highlights an important ambivalence around understanding. Many Service Users had a perception of the powers of the CTO that did not entirely correspond with the reality of those powers. This again becomes clear in the following interview passage with a different RC:

*RC9: I think it's a bit of a fudge really because I think the only reason it ever works is because people think it gives you more power than it does or because when you've discharged them, they think you've still got the power, if that makes sense.*

*Interviewer: Yeah, I know what you mean. So, in the sort of process of the CTO and giving information to the patients and the families, do you think they understood what it was about?*

*RC 9: No. I really don't, because I think if people really understand what it's about they would recognise that it doesn't have any teeth at all.... The daughter of [the patient] did get it but she knew that what the system was effectively doing was tricking her mother into thinking that we could compel her to have medication.*

There is an ethical question here regarding a situation where the efficacy of the CTO is seen as being essentially dependent on poor understanding or outright misunderstanding on the part of Service Users.

## AGREEMENT AND UNDERSTANDING

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The MHA does not require patients to formally agree to a CTO, however in practice it is understood that it will not work unless there is a degree of agreement and motivation to engage within the framework of the CTO. In practice the consent and involvement of the patient and Nearest Relative is sought in line with the Trust's Care Programme Approach Policy (DH 2008):

*Although I'm sure it wasn't originally the intention of the legislators to have patients necessarily agreeing to the CTO it's very clear that unless a patient has some understanding then, or agreement with the process, then it's not going to work and experience has borne that out (AMHP4).*

Often Service Users were under the impression that if they did not keep to the conditions of the CTO they would be automatically returned to hospital, which constitutes an implied threat. It did not seem to be generally explained to Service Users that they would only be recalled if there was a significant deterioration in their mental health (so taking substances in itself would not be sufficient to recall someone unless this resulted in a fast deterioration in mental health).

Often AMHPs were aware and critical of the culture of not informing Service Users properly about their right to disagree and clearly explaining the restrictions on the legal power of the CTO around recalls. AMHPs often raised concerns about the tension between full Service User understanding and the utility of the CTO as a deterrent:

*There is no investment in explaining it clearly (AMHP2).*

The written information available for Service Users was generally agreed to be too riddled in jargon and difficult to understand. It also did not really address the concerns of Service Users in explaining what the CTO entails and what their rights are under the order. One AMHP comments:

*Although we do have a bog standard letter saying what a Community Treatment Order is, it's quite difficult to understand. I think maybe that could be broken down so it's easier to understand. It sort of goes on about the law too much and talking about revoking and recalling and people say what does recall mean? What does revoke mean? What's the difference? (AMHP5).*

Some other AMHPs who took part in the study were not even aware of there being any standardised written information available. There is an ethical question about whether honesty/ increased clarity would negate the effectiveness of the CTO in relation to this implied threat of recall. The following interview excerpt exemplifies this:

*Interviewer: Did you feel you had any choice really about it?*

*SU1: No choice.... No I had no choice whatsoever because basically if you refuse then they call the police in and pin you down and jab you in the bum and it gets quite nasty I think.*

Another Service User tells of a similar threat of recall unless the CTO is complied with:

*They said to me the CTO is this, this is the A-Z, you must comply with this or you'll back in here, in [the Unit] (SU2).*

However, the same Service User recognised that the enforcement of the conditions was a question of judgement and discretion on the part of the clinician and Care Coordinator and that failure to take medication, for example, would not automatically lead to a recall if it was just a question of a short lapse:

*A short while ago I left my home on several occasions and I forgot my medication. I was away all night so they gave me the appropriate going over for that (SU2).*

But in many cases, Service Users were allowed to believe the implied threat of instant recall in the case of non-compliance, and this was sometimes mentioned by practitioners as favourable to Service Users having full knowledge of the fact that the CTO, as one clinician put it, does not have any real 'teeth' when it comes to enforcing the condition to take prescribed medication. As some practitioners pointed out, if Service Users knew that they had the right to refuse the medication, even under the CTO, this would be unhelpful and potentially detrimental for their progress as many Service Users would resist their medication if they believed they had that right.

AMHPs were often critical of this ambivalence and felt Service Users need to be properly informed and that communication needs to be improved. Many AMHPs interviewed for this study recognised that Service Users commonly thought they have to take medication or else they will be recalled. As one AMHP comments:

*I worry that there is a misunderstanding that they have to be on the CTO, that they have to take medication (AMHP2).*

The same AMHP raised concerns about the lack of active involvement on the part of Service Users in the decision-making process and the fact that no Service User had raised any objections in any of the cases she has been involved in. This AMHP attributes this to the reigning 'culture' within services that encourage the use of CTOs:

*[Service Users have] all been a bit passive and I think that is about the ward culture and the community team culture, which almost says this is going to happen (AMHP2).*

Other AMHPs agreed that none of the Service Users they had dealt with had raised any objections and one referred to their 'grudging acceptance' of the CTO as a preferable option to staying in hospital. The difficulty here is that the Service User does not experience that they have any choice in the matter; if they do not agree to the CTO they will not get out of hospital so although the CTO may not be what they want, it at least means that they can live in the community, which leads to a grudging acceptance of what seems the lesser of two evils.

## CONDITIONS

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Conditions on the CTOs of those 21 Service Users who took part in the study, and in most other cases (according to the data recorded by SPFT and according to those practitioners involved in the study), were mostly around taking medication and engagement with services. Sometimes there were more specific conditions around residency, usually in those cases where a Service User lived in supported accommodation, and more contentious conditions around use of substances and travel restrictions. None of the Service Users interviewed had been recalled so had generally complied with the conditions – however in one case the Service User had voluntarily admitted herself to hospital for a period – which constitutes a somewhat positive bias, although experiences and opinions were far from unanimously or unambiguously positive. The condition of the medication – often a depot injection, but sometimes oral medication – was the one which Service Users generally disliked the most. The positive side of the conditions were that they tended to give a sense of structure, support and motivation – for instance to attend meetings with support workers, the Care Coordinator or clinician, which was seen as helpful. Conditions around residency – i.e. staying in supported housing were often seen as helpful and sometimes as a key to improvement, perhaps more so than the CTO itself.

In terms of the power to influence the conditions, Service Users often reported they had felt that they had no say at all at the time the CTO conditions were set, as exemplified in the following excerpt:

*Interviewer: did you have any say in those conditions?*

*SU2: No that's policy.*

This particular Service User believed that the conditions were 'policy' and as such not negotiable or discretionary. However, in some cases Service Users felt able to have more of a say/ have their voice heard later in the process, in relation to renewals/ potential discharge. More specific conditions were felt to be less helpful by clinicians in most cases, as these are difficult to enforce, especially when it comes to substance misuse. Some clinicians reported that they had initially set more detailed conditions on CTOs, such as not to use illegal drugs, not to visit certain places or associate with certain individuals. However, such conditions are difficult to monitor effectively and several clinicians had found that specifying such specific conditions only served to set the Service User up to fail. Further, if a breach of conditions was known to have occurred – if a drug test came back positive, for example – it was also not enough to recall the Service User in itself unless it could be argued to have a real and lasting detrimental effect on their mental health, and therefore such specific conditions could also be considered fairly meaningless. In addition, Service Users may experience the CTO to be unnecessarily punitive and restrictive if such conditions are specified.

However, sometimes it was felt necessary to set more restrictive conditions. In many cases this related to overseas travel. The condition not to travel was reportedly used on the grounds that the Service User was known to have spent significant periods abroad in the past and that this had had a negative impact on their mental health, or because there were concerns about the safety of the Service User whilst abroad. In one reported instance, the Service User had broken his conditions and ended up travelling abroad and staying with relatives in another country for several months. In this instance, the clinician felt that the condition not to travel abroad had been meaningless in the face of not being able to enforce it. Nevertheless, one example was given in which the Care Coordinator had been informed in time that the Service User intended to travel abroad and the Service User was successfully stopped from doing so. This Service User comments about her experience of being stopped from travelling abroad:

*I wanted to go to [country] and I had to, I got stopped at the airport by the police.... And I had to cancel my flight and I didn't get a refund and yeah... because of it. Yeah, I told them too late so they stopped me at the airport (SU1).*

This particular Service User had not adequately understood the condition on her CTO not to travel abroad and it was because she informed her Care Coordinator of her plans that this condition could be enforced:

*I phoned up that morning to tell [Care Coordinator] I was going away and so she said "Oh no, no, no I can't let you do that". So she just said "Do what you want", so I went to the airport to go, and there were the police (SU1).*

However, with hindsight the Service User could appreciate the reason she was stopped from travelling, even if she did not fully put this in context with the risks to her mental health but attributed it more to the restrictive nature of the CTO:

*I was fine with it. I understand now how it works so... (SU1).*

Further, it was often felt by practitioners that if recall could be avoided through communicating with the Service User and to some extent using the implied threat of recall as a resource for encouraging the Service User to re-engage with services or start taking their medication again:

*I think the Care Coordinator is quite key here in continuing to talk to the patient about the CTO and about the reasons for recall and I've... and where it's been effective, and I have sort of seen case notes and talked to Care Coordinators and seen their records where perhaps they're starting to relapse and I've seen the Care Coordinators talk to them, to the patient, about the CTO, just reminding them about the conditions for recall and they could be recalled and sometimes recall is then averted in that instance simply because the Care Coordinator had understanding about how to have that communication with the person rather than going through all the nuts and bolts of recall (AMHP4).*

Some Care Coordinators found that the CTO legally 'backed up' their attempts to persuade a Service User to keep taking their medication. One AMHP who also worked in the capacity of Care Coordinator commented:

*If somebody isn't going to take the medication we can, you can sort of enforce it a little bit more rather than in the past... I felt very much like I was coercing somebody to do something that they didn't really want to but if I went on about it enough they would. Umm, but I had no law backing me up whereas now I do, you know: "you're under a CTO, you need to do this" (AMHP5).*

## AMBIVALENCE AROUND EFFECTIVENESS

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Several practitioners were ambivalent about the potential effectiveness of CTOs and many felt that more research was needed in order to assess whether they did reduce hospitalisations and whether they had any effect in the long term, especially after discharge when the implied threat of recall is no longer a factor:

*The problem is that, sooner or later, you have to take them off it, and the next time you want to put them on it is when they become unwell. For six months they remain on it, they are okay and after that... I think it's a law which, on paper suggests that it will be more helpful than it is, so on paper it certainly feels that, oh, you can get them in and you can do that, but practically, it doesn't always happen like that. So I think, in the small group of people it helps, it has not been as effective as, I think, one thought that it can be when it was first started (RC7).*

However, the readiness of response, again, was mentioned as one of the benefits of the CTO, and one area in which they made a difference:

*One thing it does, it gives you an opportunity to act quicker and to go in faster and prevent more deterioration of the patient, I think. In some cases it works because of that (RC7).*

## NEGOTIATING THERAPEUTIC RELATIONSHIPS

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When it comes to the important relationship between the Service User and the Care Coordinator, the CTO adds an element of ambivalence that has to be carefully negotiated. CTOs have brought a new way of working



with compulsion in the community and therapeutic alliances between Service Users and Care Coordinators need to adapt to this:

*Obviously we've had orders for inpatient treatment but it's a new way of working and certainly the Service Users I've spoken to, the Care Coordinator in that relationship has been absolutely key and all the people I've spoken to really got on with their Care Coordinator and had managed to negotiate this tension; but a very challenging way of working for the professional involved I think, not as clear as when somebody's either in the community and they're not on an order or they're in hospital and they are on an order (RC2).*

When the therapeutic relationship is able to progress without being overshadowed by the authority of the CTO, but nonetheless the CTO can help contain and encourage engagement, this can work very well. However, when the element of compulsion is overshadowing all other therapeutic work and the Service User becomes resentful of the CTO, there can be a breakdown in the relationship with the Care Coordinator. Sometimes it was seen as helpful that the Care Coordinator was not the one who made the decision about the CTO (unless they were also the AMHP, but added another layer of complexity to the relationship) and in a sense the 'blame' could be shifted onto the psychiatrist.

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## THEMES BY PARTICIPANT TYPE

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### SERVICE USER EXPERIENCES

The 21 Service Users that were interviewed constituted a diverse range of people, with a diverse set of circumstances and personal histories. However, what they had in common was a number of involuntary hospitalisations which had culminated in being placed on a CTO.

Many Service Users reported that having refused medication in the past had led them to be placed on a CTO:

*I came to be on a Community Treatment Order because I was refusing to take medication and so they put me on that so I couldn't refuse it (SU1).*

Many saw the CTO as an alternative to hospitalisation and therefore preferable:

*I was in hospital, mental hospital, and it was an option, rather than being in hospital, come out on a CTO and... my understanding of it was that I still take medication, I have to take medication, but they let me take it in the community (SU3).*

Some Service Users had been discharged onto the CTO after a relatively lengthy hospitalisation:

*I got sectioned last year and it was quite a hardcore section. I ended up staying in hospital for between nine and ten months and my psychiatrist in the hospital let me back into the community with a CTO (SU4).*

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### INFORMATION AND UNDERSTANDING

Most Service Users did not recall receiving written information although staff stated in most cases that this was given to Service Users. Service Users were not always clear about discussions around renewal/ discharge and tended not to be actively involved. One Service User had actively raised the subject of being discharged which had been agreed to, but in most cases there seemed to have been little room for negotiation with Service User and they were not involved in decisions around conditions.

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### ADVOCACY

Advocates had been involved in some cases although it was unclear if Service Users always received info about advocates as this would be available when in hospital but perhaps not explicitly explained to the Service User. Service Users tended not to recall having had an advocate even where (in one case) the Care Coordinator said

they did have one. Staff generally thought advocates could be useful – although some RCs felt advocates on occasion were too pushy of their own agendas rather than that of the Service User.

## CHOICE AND CONTROL

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Service Users generally did not consider that they had a great deal or any choice concerning the CTO. Considering many felt they had no choice about whether they were on the CTO, many felt that raising objections also had very limited effect. One Service User says in response to a question about whether she has ever raised any concerns or objections:

*No, no, no. I used to in the beginning but then I just, I just gave up (SU10).*

Another described having very little say in the decision-making process:

*From the initial meeting I had with the psychiatrist, anything I've said wasn't tended to count. So I had no say in the matter really. From my own point of view, my wellbeing, I would like to be off the CTO and off the medication but because everybody, the whole thing is shaped up, that won't happen for quite a while apparently....The CTO was reviewed last week and they decided to extend my time on the CTO (SU2).*

However, not all were particularly concerned about having much choice or control in the matter and saw it as simply a preferable option to being in hospital, and the benefit of being able to live in the community was sometimes felt to weigh up the downside of having to comply with medication and attending meetings with care staff, a downside that was grudgingly accepted.

## CARE PLANNING

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Most felt the CTO did not make a difference for the care plan or support provided. Some felt the care plan was inadequate (not enough activities) whereas others felt it was adequate and same as before CTO. Some Service Users found that the level of interpersonal support diminished once discharged into the community on the CTO, compared to while in hospital when there had been more opportunities to speak to staff, even in just a social capacity. One Service User comments:

*I mean that's the key one really, being able to communicate with someone. I mean in [hospital] you've got a whole host of people who will sit down, have a cup of tea and talk with you but out here it's different [...] I've had several meetings here where we've gone into the first five minutes and I think you can tell that they don't want to talk anymore and instead you have to rush, rush, rush, rush (SU8).*

In the community, Service Users may experience more keenly the pressures on resources and time facing services and staff in adult social care. However, not all Service Users wished to have more contact with services or support staff, it was perhaps Nearest Relatives that most frequently mentioned that they wished their relative had more social contact, not just with support workers but with other people in general, and what was seen to be lacking was adequate support to engage in activities that appealed to the Service User.

## RELATIONSHIPS WITH PROFESSIONALS

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Relationships with professionals were generally thought to work fairly well even though there could be tensions at times. These could be particularly evident through the recall process and at tribunals e.g. for RCs who would need to present evidence Service Users may not like to hear or not agree with. However, others felt that the honesty involved in this was important and such tensions should not be avoided. Service Users often did not like having to take medication and this could also cause tension but in some cases after seeing an improvement in their condition accepted that this was necessary and helpful to some extent. Some attended tribunals – one in particular was disappointed with the outcomes but accepted in retrospect that professionals were “looking out for me” (SU3). Another Service User had taken the initiative to ask for the CTO to be

discharged early and this was agreed – she felt she had a very good relationship with the professionals involved. Most felt that the support they had received from Care Coordinators and Support Workers (if in supported accommodation) was very good. However, there was likely to have been a positive bias in this respect, owing to the self-selection of participants and the exclusion of some Service Users by Care Coordinators on the grounds that the Service User was not an appropriate participant because they ‘lacked insight’ etc. Service Users usually attended appointments outside the home. Where Care Coordinators came to the Service User’s home this tended to be by mutual agreement and did not seem to have caused any tensions or problems.

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## RELATIONSHIPS WITH FAMILIES/ FRIENDS

The Service Users tended not to note any negative effects of the CTO upon their relationship with family and friends – although one Service User noted some tension where the Service Users father was in support of the CTO/ keeping the Service User on medication which the Service User did not agree with. Some felt that the CTO was beneficial to familial relationships in comparison with being in hospital. Others were not in touch with family. Some of those who were in supported accommodation noted the importance of the support of staff and other residents who to some extent took on the role of ‘family’.

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## CONDITIONS

As stated above, conditions were mostly around taking medication and engagement. Sometimes there were more specific conditions around residency and more contentious conditions around use of substances and travel restrictions. None of the Service Users interviewed had been recalled so had generally complied with the conditions which indicates a potential positive bias. The condition of the medication was the one which Service Users generally disliked the most. The positive side of the conditions were that they tended to give a sense of structure, support and motivation (e.g. to attend meetings), which was seen as helpful. Conditions around residency, i.e. staying in supported housing were often seen as helpful and sometimes as a key to improvement (perhaps more so than the CTO itself).

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## NEAREST RELATIVE EXPERIENCES

Nearest Relatives have a particularly ambivalent relationship to services, as the degree to which they can be involved in the planning and delivery of care for their relative is limited. The ‘Nearest Relative’ as a legal term used in the Mental Health Act 1983 has certain legal rights in relation to someone who is, or may be, detained under the Mental Health Act. However these rights do not include automatic rights to information about the Service User’s care, which depends on whether the Service User consents to information being shared. In this study, seven Nearest Relatives were interviewed about their experiences of their relative being ‘detained’ under a CTO in the community. In this study, all Nearest Relatives interviewed were biological parents (either the mother or father) of the Service User and all were closely involved in the Service User’s life.

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## INFORMATION AND UNDERSTANDING

Many Nearest Relatives had an incomplete or patchy understanding of the CTO and its powers. Many could not recall what information they had had, or said that the written information that they had received had been hard to understand and filled with jargon. All the Nearest Relatives interviewed had experiences of their relative being admitted to hospital under different sections and many viewed the CTO as simply another section, albeit this one allowed their relative to receive care in the community. One Nearest Relative comments:

*They don’t actually seem to go into it fully do they? I mean I always get a little letter to say that, you know, he’s under a certain section or well, I mean I know that anyway because he’s normally gone to hospital anyway before that happens (NR2).*

The same Nearest Relative goes on to comment:

*I mean I think he is a bit of a trial and error case so maybe they don't know, perhaps it's all learning all the time. I don't know.... I don't really feel that I fully know exactly what is going on (NR2).*

What many Nearest Relatives did pick up on – which has been mentioned above – was that the CTO enabled their relative to be admitted to hospital quicker and without having to go through a new assessment under the Act. One Nearest Relative says:

*[The CTO] just means that he can be hospitalised more easily, that's all I've really picked up, that's been the main focus for me and the main reason for doing it (NR7).*

The theme of viewing the CTO as a safety net in relation to potential deterioration of mental health and valuing its benefits in terms of a speedy admission to hospital in order to re-establish medical treatment has been discussed in more detail above in relation to the CTO providing an imperative to care. Nearest Relatives overwhelmingly said they preferred verbal information over written information and the information they had retained about the CTO was that which had been imparted by a clinician or Care Coordinator involved in their relative's care. One Nearest Relative really valued the relationship she had with the relative's Care Coordinator, a Community Psychiatric Nurse (CPN), who had been on hand to explain the process and powers of the CTO:

*I don't do going online, I don't read leaflets, I don't, I'm not good at that sort of thing, but I talk to people and I find that helpful and informative.... the CPN has probably been the person I've learnt the most from (NR1).*

Another Nearest Relative echoes the same sentiments when it comes to written information, saying:

*I'm hopeless at reading things because I hate papers, just burn the whole lot, it's always a good feeling with paper. Yeah, they did give me stuff in writing and I had to sign things, and it's been renewed I think at least two times now and each time they call and they speak to us and they speak to him, I think they do that very conscientiously (NR7).*

Whilst many Nearest Relatives said that they did not fully understand the CTO, all the Nearest Relatives interviewed still felt that they had an adequate understanding for their role as a Nearest Relative and the general feeling was that it was unnecessary to understand all the ins and outs of the CTO process and its legal powers, what was important was their perception of the benefits of the CTO; the control and structure provided around their relative whilst in the community and the speedy response should something go wrong. As one Nearest Relative puts it:

*I've never felt a lack of knowledge but every now and then I learn something new and that's helpful (NR1).*

## RELATIONSHIP WITH SERVICES

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Some of the Nearest Relatives interviewed felt that the CTO had made a positive difference for their relationship (as NR) with services. Some Nearest Relatives had experienced a qualitative difference, since their relative had been on a CTO, in terms of their communication with their relative's care team. One Nearest Relative felt that the CTO had impacted strongly on her ability to make herself heard in relation to her relative's care:

*The other big thing about the CTO as I've understood it is that they are now allowed to include in this case parents in consultations, medical consultations, which we were never allowed to do before, and this has made a huge difference, not so much because of being involved in consultations about treatment but they now listen to us. I can ring the CPN and say, "I'm worried about him", and she goes to see him, and before it was: "Well I'll go and see him but I can't really do anything because of his human rights" (NR1).*

The same Nearest Relative continues:

*I now have a voice which I didn't have before, it was: "Well you can let me know what you think about how your son is, but I can't listen to you, you're not involved and by law you can't be, I'm clocking and taking down what you're saying in my head and I'm monitoring it but I can't do anything because of what you said, and we can't discuss with you what we would do either, nor can we go to him and do anything until he becomes so ill that he's got to be sectioned" (NR1).*

However, not all Nearest Relatives felt listened to or able to communicate well with services, in particular in regard to the consultant psychiatrist. As one Nearest Relative comments:

*When I've known he's going downhill and I have felt that I wasn't really being listened to enough then and I had tried to speak to the doctor but I've never been able to. I mean I used to be able to when he had [name of consultant] occasionally but this new doctor I never seem able to... I don't think I've ever spoken to him, no ... No, it's just one of the nurses I get, you know (NR2).*

This Nearest Relative felt that the complexity of the relative's mental health condition and history was a factor in the difficulty she had in communicating with services and often changing care teams:

*[The relative] is quite a difficult case so you know, it is quite difficult to make somebody else understand what I'm trying to get across ... And that's always a bit difficult (NR2).*

## SOCIAL SUPPORT

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Some Nearest Relatives interviewed recognised that CTO was mainly there as a medical requirement and did not add to or change the care plan outside of medication which may in some cases be lacking. Some Nearest Relatives described the social care element as inadequate and poor in relation to the emphasis on medical treatment, whereas the CTO was appreciated due to the perception that it provided a secure framework around their relative. Many Nearest Relatives were critical of the social care aspect and often felt there was a lack of social support, especially in providing social activities and opportunities to engage with others, either support workers or other people.

## AMHP EXPERIENCES

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The nine AMHPs interviewed for this study had all worked on a number of CTO cases. The number of cases varied, but it was AMHPs who worked as part of Assertive Outreach Teams (AOTs), forensic wards and dedicated AMHP teams that had dealt with the biggest number of cases (up to 45-50 cases individually). Although this varied and a couple of AMHPs who worked for dedicated teams had only dealt with 10-15 cases. The AMHPs who worked in community teams had commonly dealt with around 20 CTOs. All the AMHPs interviewed had worked with CTOs since they came into force in 2008. Two of the AMHPs interviewed were also Care Coordinators and had ongoing involvement in cases they had made application for as an AMHP.

There were some differing views around the practice of different AMHPs being involved at different stages of the CTO process, for instance one AMHP making the initial application and another AMHP being involved at the review stage. The positive aspect of this is the ability for a new AMHP to assess the case with 'fresh eyes', but on the other hand the AMHP who was involved at the start will have a deeper knowledge of the case.

## TRAINING

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Some AMHPs reported they had had little training on CTOs, most often consisting of a couple of days at the University of Brighton. Many AMHPs spoke of the lack of clear guidelines and the process of learning through experience:

*Really have been learning as we've been going along (AMHP2).*

*It hasn't been without trial and error along the way (AMHP5).*

They do, however, have regular team meetings and good peer support and many AMHPs mentioned this as a crucial strength in their work. Many felt it was helpful to have one member of the team in particular who has a strong interest and knowledge of CTOs and many could identify such a person, whom they could ask for advice. However, possibly as an effect of relying heavily on peer support, many AMHPs raised the issue that there was few general guidelines and therefore different people (and in extension different teams) had developed different ways of working. Some mentioned they would ask AMHPs working in AOTs because they had more experience with CTOs.

There were initially many aspects that were unclear and the complexities around recall often cause confusion:

*When somebody's on a CTO and they agree to come into hospital, that one threw us initially because we thought are we recalling them? Are we revoking them? Or are they going to be an informal patient or are they still detained? You know we sort of, that was initially and I mean now we've got our heads round it but it was quite complicated at first (AMHP5).*

Despite the mentioned brief dedicated training, many AMHPs felt that they had received adequate training and support, and updates on training, especially around legal aspects (often focusing around the CTO) met some of the need for further training, although a few felt that a bit more training would be useful.

## SKILLS

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AMHPs regarded the necessary skill set to do their job to include awareness of Service User's needs, which meant they need good interviewing and assessment skills and being able to look broadly at a person's situation, having empathy and being Service User focused, to have a good understanding of the law and be able to interpret the law, assess risk and make a reasonable plan to manage risk. AMHPs also need an understanding of the law and the spirit of the Act and need the confidence to say no if necessary and argue the case based on understanding of the law and human rights legislation. Other AMHPs mentioned that being aware of the possibility that certain types of Service Users with certain characteristics or types of diagnoses are more often placed on CTOs and that this could be tantamount to discriminatory practice:

*I think we have to be very clear about anti-discriminatory practice to be sure that those people who are being considered for CTO don't perhaps fit some particular profile of a person. I get a sense that there are more males considered for CTO than females and I'm not quite sure why that is but I get a sense of that really - perceptions of dangerousness perhaps and we have to be sort of very careful about that (AMHP4).*

Some AMHPs also mentioned the importance of being able to impart information to the Service User about their rights under the CTO and about tribunals and their right to the Independent Mental Health Advocacy (IMHA) service.

## PROFESSIONAL ROLE AND DECISION-MAKING

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The new AMHP role as set out in the 2007 amendment to the Mental Health Act 1983 involves:

*'to agree (or not) to the making of a Community Treatment Order (CTO) (s.17A); the extension of a CTO (s20A); conditions to be included in a CTO (s17B); and revocation of a CTO (s17F)' (NIMHE, 2008 p.8).*

The AMHP role involves being responsible for organising, co-ordinating and contributing to Mental Health Act assessments. Upon the recommendation from the RC on the ward, it is the AMHPs duty to decide whether an application for CTO should be made. It is the AMHPs role to take into account social factors and circumstances in their assessment. In terms of writing a social circumstances report, this is currently not a requirement (as in the case of detaining someone under a S. 3) but several AMHPs interviewed regarded this as best practice:

*I generally like to do a social circumstances report to suggest that we have looked at the least restrictive options and that we've had full discussions and it is a multi-disciplinary team sort of agreement that this is the way forward, that it's not forever and that we will keep reviewing this in the future.... I don't think it's mandatory as it is with detaining somebody under a section 3. I might well be wrong there but it's something I like to do and I know my colleagues like to do. I'm sure it's best practice (AMHP5).*

An AMHP is not involved in the ongoing monitoring of the Service User's progress under the CTO, this is the remit of the Care Coordinator and community RC. However, in those cases when an AMHP is also working as a Care Coordinator, these two professional roles cross over. Of all the cohorts interviewed, AMHPs tended to be the most critical of CTOs, often voicing concerns about the increasing use of CTOs as opposed to Section 17 Leave. Many AMHPs were concerned about the lack of understanding and input on the part of Service Users. Some AMHPs argued that the reason that CTOs are not properly explained because of fears that this may lead to the Service User failing to agree. One AMHP felt that there are in some cases alternatives to CTOs which should be explored:

*There have been times when you feel some of them are very borderline and that you wonder what a section 17 leave could do instead of a CTO because section 17 leave has got a limited period of time and the patient could be called back and then actually discharged.... We, as an AMHP team, are very mindful here that we, you know, we have to be very aware that there are not always compelling grounds to place people on CTOs (AMHP1).*

The role of the AMHP is to ensure that the CTO is an appropriate choice for the Service User in question, making a psychosocial assessment of their circumstances. Several AMHPs raised concerns that there was still an inadequate understanding of their role in the CTO process and that RCs expected the AMHP to only provide a 'rubber stamp' to sign off the CTO:

*There's [sic] been certain psychiatrists that just look upon it as it's a given, it's a rubber stamp, that we're just sort of wandering in just to agree (AMHP1).*

*Well I think a lot of the doctors would like it just to be a rubber stamp on the bottom or just signing the bottom of the paperwork, in fact I have been asked, this is really straightforward why can't you just sign the paperwork without any kind of contact with the person at all (AMHP6).*

Tensions between AMHPs and RCs on the ward were reflected in some of the interviews with AMHPs, here elaborated on by the same AMHP:

*The doctors need to realise that the final say goes with the AMHP, as does the Mental Health Act Assessment, and I think it's taken a while for them to get to understand that because often they'll say, "I want this person on a CTO" and you'll say, "Well actually I'm here to discuss whether it's of benefit for the patient" (AMHP 1).*

One reason for this tension may be that the roles have in effect been reversed and the new AMHP role has taken on the deciding power when it comes to CTOs, the decision-making power and responsibility that previously rested with the consultant psychiatrist. There was a perception amongst several AMHPs that the team seemed to have made a decision before involving the AMHP. In some cases the Service User had been informed that they were going to be put on a CTO before the AMHP had been involved. This puts additional pressure on AMHPs to agree to the recommendation, as it would be considered a 'spanner in the works' if they were to disagree after discussions had already been had and the Service User informed. In order for the CTO process to work well, with all parties able to perform their duties to their full capacity, it is important that the AMHP is involved as early as possible:

*When it works well the Care Coordinator involves us at an early stage and just sort of talks to us and says "Well, look we're thinking about a CTO for Joe or Jane, why don't we have a meeting to talk about it?" And if you can have a discussion with all the parties beforehand it can be quite helpful. We've had some very difficult circumstances where all those discussions have taken place before the AMHP has been called in. There's a ward*



*review, it's done and dusted, they want to discharge them on a CTO that day and the AMHP is asking all sorts of questions (AMHP4).*

Some issues have been raised by AMHPs in relation to saying no to a CTO application and going against the opinion of an RC. For example in the area of care planning, where a disagreement may have surfaced around the emphasis on medical care rather than social care provision or in cases when the Service User clearly objected to being subject to the CTO. A related concern was the relationship between the ward team and the community team, which AMHPs felt undermined the social care aspect of the CTO. One AMHP comments:

*It won't work unless they have a good relationship with the community team. There was no link between the community team and the ward team. That is absolutely vital. It is all based on the quality of the relationship, that's the critical thing. If it's not there, it's not going to work (AMHP2).*

Other cases of disagreement between AMHPs and RCs sometimes related to whether it was thought the CTO would have any utility for that particular Service User, particularly in cases where the Service User already fully complied with their medical treatment. Disagreements between AMHPs and RCs about whether to put in an application for a CTO could sometimes lead to tension and even anger and resentment, when the AMHP found themselves in a position of having to emphasise the ethical issues around compulsion and make sure the least restrictive option was chosen:

*Well it's really difficult because if when I choose not to put somebody on a CTO, when I say no, there's quite often quite a lot of anger or resentment in the team around well you know, why couldn't you just do that and they are going to get unwell now, or, and I think without sort of them looking at how we are restricting somebody's liberty here [...] so around kind of the ethical issues (AMHP6).*

Some AMHPs mentioned instances where the RCs unwillingness to accept the final decision of the AMHP resulted in angry emails and requests that a manager reviews the decision. Some AMHPs commented that the role necessitates not being 'intimidated by doctors'. Others felt the relationship between AMHPs and RCs had taken a step backwards since the introduction of the CTO and the necessity to work together more closely:

*ASWs and doctors didn't always routinely work together so well as we do now in terms of mutual respect for roles, in terms of expectations and it feels with CTOs we've somehow gone back a bit, that sort of doctors expect if they do a CTO the AMHP will just go along with it and I think we've had to work quite hard not to come across as just being sort of awkward about not agreeing to CTOs because RCs have had this imperative I think from hospital managers to discharge people from hospital (AMHP4).*

## CONCERNS ABOUT THE RUSHED NATURE OF DECISION-MAKING

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Often the decision-making and consultation with the patient happens on a ward round meeting, which many AMHPs raised concerns about as this is not an ideal setting and the Service User has little opportunity to give input. There is not enough time and there are too many people around, making it a disempowering environment for the patient.

*There's too much of this: "Let's do it in the ward round and get it done".... It suits the doctors, it's more convenient for them.... sometimes it feels like you and the patient have been bulldozed into this (AMHP2).*

AMHPs sometimes saw it as their role to slow down the process, as the same AMHP comments:

*If things happen in a ward round it is a very disempowering situation for a patient. I've seen people agree to all sorts..., which is very counter therapeutic (AMHP2).*

Another AMHP (AMHP3) reported that they had taken up the practice of going back to the Service User after the initial discussion to give them an added opportunity to raise any queries they may have. Some AMHPs who had previously found there were tensions in their relationship with RCs reported that this had slowly improved



since the early days of the CTO. Some commented that it used to be that there wasn't as much opportunity for discussion in the early days as there is now – RCs expected the AMHP just to sign off the CTO – but that this has been changing slowly. Other AMHPs considered their working relationship with RCs to be good and that full and reasoned discussions could always be had at the time of making a decision about a CTO.

## CONCERNS AROUND OVERUSE OF CTOs

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There were some concerns raised around the issue of potential overuse of CTOs. One AMHP comments:

*I am worried that there is a culture of an acceptance that the CTO will happen, a culture that this is what we automatically do (AMHP2).*

Another aspect of potential overuse centred around the pressure on hospital beds and whether RCs push for CTOs in response to administrative pressures and target numbers. One AMHP raises this issue:

*Sometimes we get little spurts I suppose. Sometimes perhaps one of the Responsible Clinicians on the ward, I think perhaps because of pressure from the Trust to discharge people, we had a few months ago one of the consultants was under pressure to discharge people and there was a perception that if someone's on extended section 17 leave they're not really discharged whereas if you put them on a CTO then that's somehow off the bed books and that may be so (AMHP4).*

## ADVOCACY

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Many AMHPs thought that the information patients were given about advocacy and the IMHA service was not sufficient, and sometimes lacking altogether. It often fell to the AMHP to make sure the patient had this information and it was generally felt that such information needed to be built into the system in a more solid way. Leaflets should be available on the wards, but in practice these do not seem to be handed out very often. Some AMHPs reported that they knew of no leaflets available to give to Service Users and that they had to rely on verbal information only. Concerns were raised about this as it was felt that the Service User needs something to look back on to reiterate and clarify the complicated verbal information provided, which may be difficult to retain.

Many of the AMHPs interviewed for this study pointed out that unless they gave the Service User information about their right to advocacy, the Service User would not receive this information, despite the fact that this information should be made available on the ward by staff there. Many AMHPs mentioned that they will as far as possible try to meet with the patient before the CTO meeting, even though this is currently not a requirement. However, it seemed to vary greatly between teams how frequently advocates were used, with some insisting on most of their Service Users on CTOs having them and other teams less so:

*Sometimes we will suggest it if there's a really complicated situation that's going on, will suggest that sometimes people won't want them but you know, not often, not often has there been advocates involved when I have been doing CTOs (AMHP6).*

Some AMHPs were concerned that Service Users felt powerless in the process and did not feel they had any power to affect their CTOs or contest them at Tribunals:

*The ones that I work with have been on CTOs since they came into effect, so a good few years, and so we've had Tribunal after Tribunal because even if they don't appeal they automatically get their hearing. I think initially some of the Service Users were very much getting a solicitor and coming and over the years that seems to have reduced. As much as I really do try to encourage them to get legal representation and attend the hearings they just say "What's the point? It's a waste of, you know, getting legal money. I'm never going to get off it, you've got all the holding power", and it feels awful that they feel that they've got no power (AMHP5).*

## CONDITIONS

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AMHPs recognised that conditions usually focused on medication, with the additional condition to attend meetings with the team:

*The RC will talk about medication quite a lot, alcohol use, drug use, where somebody will live, seeing us on a regular basis. Sometimes we even stipulate, you know, to see the Assertive Outreach Team and how many times per week, to engage with us and to attend CPA reviews (AMHP5).*

Some AMHPs were critical of conditions that had been suggested by RCs. Examples included conditions that were felt by the AMHP to be too restrictive, punitive or an infringement on the Service User's human rights. Many AMHPs mentioned that it was important to make sure the conditions were achievable and reasonable and did not set the Service User up to fail:

*We need to make sure that what we're putting on there is achievable and umm... not necessarily that Service Users are always going to agree with it but it's things that we can put into place because there's no point in putting loads of things down on paper and we know none of it's going to happen (AMHP5)*

*There was one recently that I was asked to do but then I expressed a little reluctance and suddenly another AMHP was found when I was off but I don't know quite what that was about but he wanted to put, the doctor involved wanted to put on mountains of appointments with substance misuse services, and this guy I mean even from, I had never met him but from the little I knew of him had never attended substance misuse services and had never shown any inclination to do so. I thought that was just completely inappropriate. I thought it was really setting him up to fail. He doesn't want to do it, he has got no, he has got no incentive to do it you know, we are not a probation service, we are not going to drive somebody along there and what will you do? Try and drag him back into hospital if he smokes weed or something, I don't know. It was just, I wasn't very happy with it (AMHP6).*

AMHPs were in general more critical about the ambivalence surrounding Service Users understanding of how recall worked and the implied threat that a breach of conditions meant instant recall to hospital. AMHPs often felt that this was misleading and should be made clear to the Service User.

## CARE PLANNING AND SUPPORT

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AMHPs are currently not involved in care planning, although they ascertain that there is a care plan as part of their assessment of the case before a decision is made. Some AMHPs felt that it would make sense if they were involved in the care planning at the review stage of the CTO, but currently this is not the case.

## RECALL

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AMHPs interviewed noted how recall, which could be an upsetting and messy procedure, was often complicated by a lack of clarity and confusion in regard to professional roles and responsibilities in relation to the recall process.

## THOUGHTS ON IMPACT OF CTO ON SERVICE USERS

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Some AMHPs regarded the CTO as having been successful in reducing the 'revolving door' syndrome for many Service Users and thus providing some level of stability due to continued medication. Some AMHPs regarded the CTO as more useful than S. 17 leave because the CTO gives rights that the former does not. Moreover, unlike Guardianship, the CTO addresses medication compliance. It was often felt that the Service User needs a certain level of understanding of not only the CTO, but also of their mental health history and willingness to engage with services:

*In terms of the Service Users that most benefit, those who have had lots of admissions to hospital and are likely to be admitted again but have a certain level of understanding of their mental health issues, are able to reflect on the circumstance that brought them to hospital, maybe when they're well, less when they're unwell but there's a beginning of understanding and sort of collaboration with services (AMHP4).*

## DISCHARGE

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Some AMHPs mentioned ending the CTO as a challenge and argued for the need for more guidance and standardisation around reviews and discharges. A general trend seems to be that CTOs are renewed more often than they are discharged. One AMHP reported:

*I would say that probably there are more that are not discharged after it than are discharged (AMHP4).*

There were sometimes tensions between the concerns and perspectives of AMHPs and those of Care Coordinators and RCs. The same AMHP goes on to explain:

*I tend to find, as an AMHP, I'm often the one advocating for consideration of the CTO being discontinued. That doesn't always happen and I'm often persuaded to continue it but I'm, perhaps sometimes I can feel that Responsible Clinicians and perhaps, particularly the Care Coordinators just want to continue without necessarily looking at all the umm, about the civil liberty ramifications of it (AMHP4).*

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## RESPONSIBLE CLINICIAN EXPERIENCES

The RC role is split between those working with in-patients on the hospital ward and those working with Service Users who have been discharged into the community. It is the ward RC that initiates the CTO, but often the community RC is invited to the meeting when the CTO is discussed with the AMHP. As soon as a patient is discharged into the community on a CTO that patient is transferred to the community consultant who becomes the RC for the CTO. Amongst the 10 RCs that were interviewed for the study, eight were responsible for Service Users in the community and two were responsible for both in-patients and out-patients as part of a forensic unit. No RCs interviewed were currently solely responsible for in-patients, but all had worked on the ward in the past, so also had experience of initiating CTOs.

RCs have contact with Service Users on CTOs with varying frequency depending on clinical need, most would see the Service User once or twice per period of detention (initially six months and thereafter a year), and especially prior to a consideration of renewal/discharge. At the point of review there would be a team discussion. However, those RCs who worked in Assertive Outreach Teams had weekly team discussions about their Service Users so stayed updated about their progress throughout the period, even if they did not have direct contact.

There would be an automatic tribunal if the Service User is not discharged in the first six months. The tribunal would require a report from the RC. Many RCs found the CTO process administratively burdensome and some reflected that S. 17 Leave would give similar powers of treatment in the community without much of the administrative load. Similarly, one RC argued that discharging a patient from a CTO after the initial six months and then intervening early with a de novo application should they deteriorate, may be preferable to the process of renewal and dealing with tribunals. However, arguably this would be less advantageous for Service Users considering they would have to be re-sectioned under a S. 3 and go through an assessment under the Act before a new CTO application could be made.

RCs generally viewed the CTO as being of potential benefit for two reasons; i) encouraging compliance with medical treatment and ii) early and speedy recall:

*Being able to treat, having engagement in the whole of the treatment package and early recall (RC2).*

However, as some pointed out, these were benefits also associated with S. 17 Leave, although the S. 17 has some draw-backs in relation to out-patients counting towards the bed days on the ward and in relation to various concerns around responsibility.

## DECISION-MAKING AND INITIATING CTOS

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Different teams had different ways of working and the amount of what one RC referred to as 'therapeutic risk taking' varied between different types of teams, arguably with AOTs set up to handle high-risk and high-need cases. Not all RCs were as happy to work with compulsion unless deemed absolutely necessary:

*We inherit people who have been on CTOs or who are on CTOs and we take them off because we're able to provide more intensive community support, we're more able to... we feel a bit more secure with therapeutic risk taking and we feel that, I certainly feel that, you know, there is a level of violence in inverted commas in compulsory treatment that, you know, I can't countenance (RC2).*

The concerns for RCs were often around whether the Service User had the capacity to consent to the CTO or not, and if they had the capacity to consent, if they actually chose to do so. If a patient has the capacity to understand what the CTO is, and to make a decision about whether they consent to being placed on it, and makes the decision they do not want to be placed on a CTO, this means the team cannot go ahead with the CTO. One RC comments:

*Where a patient has the capacity to consent and is not consenting, then you can't go ahead with the CTO, and that creates the biggest problem sometimes, because they may have the capacity to understand and to decide but they're refusing to be on it, and the legislation is such that we then cannot put them on a CTO and it becomes just impossible to do so.... we had a recent problem when the patient, I thought, needed to be on a CTO, because she was refusing treatment, but I really can't say that she did not have the capacity, she could understand what we were telling her (RC7).*

If the Service User does not have the capacity to consent, the RC can go ahead with the CTO, however if they do have capacity and do not consent this prevents the RC from making the application for a CTO:

*It would be seen as illegal. So that is a bit of a drawback, I think (RC7).*

One AOT used a particular framework focusing on disadvantages to help in their team decision-making together with the Service User:

*The framework we try and use when we can remember [Laughs] is... one of the AMHPs went on a conference and came back with a framework that is used elsewhere that focuses on going through with the individual the disadvantages of being on a CTO and the disadvantages of not being on a CTO and it, and both from Service User perspective and from service perspective. So that's the way that it's framed, the disadvantages (RC2).*

In this case, when the disadvantages of not being on a CTO outweigh the disadvantages of being on one, the CTO is deemed to be the best option for that Service User. When it came to working relationships with AMHPs the RCs interviewed generally viewed this as a positive relationship. Some reported that AMHPs were less positive towards CTO use compared with other professionals, but one RC said that in his experience AMHPs had been more positively disposed towards recommending CTOs than himself:

*I think once or twice myself and the AMHPs have had discussions, probably the AMHPs are slightly more keen on CTOs than me.... I think possibly they see the slightly wider picture around staying well and maintaining accommodation.... I think there's research showing 89 percent of RCs have never had an AMHP decline a CTO, so... I think it probably represents working in teams though, really. I think some areas... I think some areas are a bit more contentious. I think sometimes, well, especially in the early days, the inpatient RC used to put people on CTOs without necessarily involving the community teams, but I think that's better now (RC10).*

As this RC points out, the nature of working relationships and agreement within the team is highly dependent on the way of working within different teams and the nature of team discussions around the potential CTO.

## THE INFLUENCE OF THE BED MANAGEMENT POLICY

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Many RCs recognised that CTOs were in part a result of pressures from the Bed Management Policy to discharge in-patients and reduce bed days:

*As an inpatient consultant and as a former lead for the acute services umm, a CTO means a patient is discharged from hospital and therefore they don't count towards the bed days. Somebody on extended section 17 leave counts towards the bed days.... and there are government targets to reduce the length of stay.... it's a bureaucratic advantage [to use a CTO] (RC6).*

Thus, some of the administrative tensions around the use of S. 17 Leave which were mitigated by the use of CTOs and highlighted that there is a policy drive to use the CTO instead of S. 17 Leave. One RC elaborates on some of the complexities of using S. 17 Leave, although it might sometimes be deemed more appropriate than the use of a CTO:

*The Act is very clear to my mind and I'm very clear and the Care Coordinators are very clear because of the experience we've had of when extended section 17 leave might be more appropriate.... which is when we're not convinced about either the utility or the need for a CTO, where someone's mental state isn't yet stable enough and we're thinking that well they might need to come back into hospital quite quickly, or those situations where the mental state is stable but there's concern about will the person immediately stop taking their medication.... where the patient isn't ready for a CTO (RC2).*

In this case, the RC views the CTO as a framework that could be facilitative for a Service User who is ready and motivated to stay engaged and compliant but may still need the level of containment that the CTO provides. However, when Service Users are not deemed ready to go on the CTO and a S. 17 Leave is viewed as more appropriate as a first step into the community, there are a number of administrative and legal barriers in place that inadvertently encourage the use of CTOs:

*The conflict with the ward and the acute services management is that.... administratively people on extended section 17 leave, they're counted as being inpatients and having bed days. So the legitimate concerns of the ward have been, you know, who's responsible for these patients when they're on our books, who's responsible for them? We're responsible for them, you know, the Review Tribunal is clear that we're responsible. The coroner is clear that we're responsible.... what happens if there's a suicide and so on? (RC2).*

Thus patient-led services and support are tempered by the administrative challenges around responsibility as well as management goals and economic drivers when it comes to the Bed Management Policy.

## CONDITIONS

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The majority of RCs interviewed in this study regarded more specific and restrictive conditions, for example around alcohol or drug use, to be less useful and difficult to monitor effectively, as exemplified in the following quote:

*It is a lifestyle choice, people still engage if they are open about the substance use, you know, it's important that they, you know, seek help. So I think if all the other conditions are met then, you know, it would be picked up and what do you do? I mean if somebody drinks... if you were to set that I wouldn't want somebody in hospital just because, you know, they drink alcohol when they shouldn't or take substances. I don't think it's helpful (RC6).*

Conditions were generally around medication and engagement, attending outpatient clinics and community clinics when required, and CPA reviews, and allowing access to staff to see them at home, and in some cases to

reside at a specific address (usually in cases where they resided in supported housing). There appeared to be a tendency over time for RCs to regard specific, individual, conditions to be of limited value, unless the Service User requested something in particular that they would find helpful if it was included. One example of such a condition was one Service User who was under pressure from his mother to live with her, whereas it was felt both from the Service User's and the clinician's perspective that it would be preferable for the Service User to live elsewhere. In this case a condition not to live with the mother was specified on the CTO, and the Service User found this helpful in terms of backing up his decision not to live with his mother. Many RCs had with experience, however, arrived at the practice of keeping conditions as broad and basic as possible, in order not to set Service Users up to fail, or to be caught in a situation where a condition is either difficult to monitor or to enforce if it is breached. One RC reports:

*We try and be as light touch as possible so we haven't gone along the route of being over prescriptive in, and it's really broadly speaking adherence to the recommended treatment plan. Equally, when people don't stick chapter and verse to the conditions then, you know, again it helps to take a broader view than having, you know, ah you're not keeping to, you know, condition 19, sub-section 3, we have to recall you because you've breached that condition (RC2).*

## SERVICE USER INFORMATION AND UNDERSTANDING

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Many RCs reported that there were no user-friendly written information for Service Users, such as a leaflet that in simple and clear terms explained what the CTO is and what powers it has. Many recognised that the letter sent out by the Mental Health Act Office was filled with jargon and very difficult to understand. It is particularly unfortunate when several things happen close together (as they often do when a patient is discharged from having been detained under a S. 3 in hospital) as in the case elaborated on by one of the RCs:

*There was this Section 117 meeting, then there was the discharge from the Section, then there was the kicking-in of the Community Treatment Order. So, they got three similar looking but different letters from the Mental Health Act Administrators and they had no idea what they all meant. They were out of date. You know, by the time they got the paperwork for the Section 117 meeting, she was already on the CTO, and they just didn't understand it (RC9).*

When it came to Service Users understanding what the CTO is, most RCs recognised that there is a wide spectrum of understanding from those who have a very limited notion of what the CTO is and why they are on it to those who have a much fuller understanding. However, this is a complex area that is not perhaps as straightforward as it may seem, as one RC elaborates:

*The individuals who want to be on the CTO, I'm not sure how you would describe that level of insight. It's, you know, it's working on a number of different levels of understanding and both conscious and unconscious and symbolic and so I think it varies. You know, I think it's a professional struggle to understand a CTO and the various intricacies of revocation, recall, the conditions, consent, capacity. So I think it's a struggle for, you know, vulnerable people (RC2).*

As this RC points out, the Service User may not understand the professional intricacies of the CTO but is more likely to understand the key aspects of how the CTO is going to affect their life in the community and their level of engagement with services:

*What is understood is the coercion, the leverage, the legal powers (RC 2).*

However, some RCs commented that some Service Users they worked with had a very limited understanding:

*I don't think it's made any difference to her. I think actually she still thinks that she has to take medication. I'm not sure that she realised the difference between the Section 3, Section 17 leave and the CTO and not being under any restrictions at all (RC 9).*

## TYPES OF DIAGNOSES AND TYPES OF SERVICE USERS

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In accordance with the analysis of Trust records presented above, one RC who works in AOT reports that his patients on CTOs are overwhelmingly diagnosed with schizophrenia:

*Out of... was it 19 periods of CTO and 18 patients, all but two of them have got schizophrenia (RC10).*

An RC who works in a forensic unit has a similar experience:

*It's worked very well so I've used it with quite a few patients. So these patients, generally their main diagnosis is paranoid schizophrenia. A few will just have paranoid schizophrenia, most will also have some co-morbid personality disorder and usually substance misuse as well and usually they have a history of non-compliance, poor engagement with services, hence the reason for the use of the CTO to ensure that they, you know, attend appointments, take medication and so forth (RC3).*

In relation to Service Users diagnosed with treatment-resistant schizophrenia or schizo-affective disorders, some RCs felt that the CTO gave them a framework for trying more complex and demanding treatment regimes, such as the use of Clozapine that requires careful monitoring:

*I think a CTO gives us the confidence to start people on Clozapine who maybe we wouldn't start off on Clozapine because, I don't know whether you know, if you stop your medication for 48 hours you have to come back into hospital and you can get quite significant rebound and in certain cases symptoms. So I think those type of people, I've got five people on Clozapine of my CTOs (RC10).*

## EFFECTIVENESS AND IMPACT ON SERVICE USERS

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Opinions about the CTO amongst clinicians varied greatly. Whilst some RCs did not believe CTOs made much of a difference in terms of reducing hospitalisations or improving engagement, and had various concerns or misgivings about the real versus the perceived powers and incentives to use CTOs from a managerial and administrative perspective, other RCs were much more positive. One RC stated:

*It has been a very, very good idea.... but we don't go for it unless we have to (RC4).*

However, positive opinions about the potential efficacy of the CTO were commonly tempered by the cumbersome paperwork and the challenges of the Tribunals:

*I think it adds a lot more complexity and administration but without a great deal more benefit (RC8).*

Whilst some RCs were critical of the utility of the CTO in that it did not infer any real power of coercion, which some argued meant they were largely meaningless and unenforceable:

*It's not something I'm enamoured of to be honest. I worked in New Zealand where they'd had them for a long time and people basically just didn't bother anymore because it's sort of largely unenforceable, the people that generally were quite amenable for after-care went along with them and the people that weren't didn't, so they were almost sort of very toothless really (RC8).*

However, whilst some RCs felt the CTO made little difference to most Service Users, some deemed the CTO potentially effective for Service Users who are on depot injections, as these can be monitored and there is no doubt as to whether the Service User is taking their medication. One RC comments:

*I find it useful for patients who are on a depot where I know that they have missed that injection, then immediately we can do something so that they cannot deteriorate, while the patients who you see after a mandate, they are not taking the medication, there is no way you can find out until they become unwell again (RC7).*



Other RCs echoed this point e.g.:

*I think a CTO is only helpful if somebody's on a depot injection. I don't think it's helpful if somebody is on [oral medication] because how do you enforce it? (RC6).*

However, as an extension of being able to administer the depot medication the CTO helps to monitor progress and pick up relapse signs early:

*If a patient is on CTO we can pick up the relapse signs quicker than when the patient is not. You see that's the difference I think (RC 4).*

Nevertheless, as another RC points out, it is always difficult to assess the efficacy of the CTO as you can only speculate about the nature of the progress that Service User would have had without the CTO:

*It seems to have been quite helpful but you just don't know if it's getting that balance wrong in society about we're overly paternalistic, overly controlling, you know, would they have managed if we hadn't put them on a CTO?... I think by definition we probably overestimate the risk and we probably overly use too many powers (RC3).*

## NEAREST RELATIVE INVOLVEMENT

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Although it is not a requirement to involve the Nearest Relative in CTOs, it is often regarded as good practice to do so if they are involved in the Service Users life. One RC comments:

*As part of good practice, it is best to involve them, especially if the family is involved, and there are a lot of times when there is no family around or the family is not particularly engaged or involved, but then you at least, you know, the next of kin, the Nearest Relative should be informed and I think that procedure is followed (RC7).*

However, the Service User has the right to deny the Nearest Relative to be involved or ask that no information is shared with family members, unless the RC feels their objection could be justifiably overruled and there has to be strong reasons for that. The experience of RCs was that Nearest Relatives tended to be very positive about the CTO.

## RECALL

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As per other professionals involved in the process of recall, RCs also felt that there was confusion around the roles and responsibilities around recall. Whereas it is the RCs responsibility to issue a recall letter, the hand delivery of the recall letter to the Service User is sometimes delegated to a Care Coordinator. Some difficulties reported around recall included such practical details as the recall form not being produced in duplicate:

*We went round to see the patient, did the paper, told them they were a recall, gave them the paper, they ripped it to shreds. So now I always try to take a picture of it on my phone so there's some evidence. That's quite difficult on a windy day, trying to take a picture of it, it starts blowing down the street. Once I've had to go into a newsagents that had a photocopier and say, "I need to photocopy something but you can't see it," [laughs] which... was slightly bizarre! And it throws up all sorts of really bizarre experiences about... why the form isn't in duplicate I really don't understand (RC 10).*

Upon being handed the recall letter the Service User is given the chance to present themselves willingly to be admitted, but the time frame depends on perceptions of the risk the Service User poses to themselves or others. However, as soon as the Service User has received the recall letter they are AWOL (immediately if the recall note is handed to the patient, at 00.01 the next day if put through the letter box and the next but one working day if posted) and becomes the responsibility of the ward to which they are being recalled to, which



may or may not be the same hospital that manages the CTO. However, some RCs also mentioned difficulties concerning the time-frame of recall in relation to the Bed Management Policy:

*The chap I've just seen, he doesn't have a post-box in his flat and there's no way of getting into the flat, so we had to send one to him in the post once, and again, that wasn't, it was a bit disastrous, it doesn't work with the Trust's Bed Management Policy cos you get 72 hours, and by that time the bed's given away. That's the other huge difficulty, that the Trust Bed Management Policies don't... can't deal with the recall process, i.e. that it may be a period of time before making a decision to recalling someone, and actually then arriving on the ward (RC10).*

The communication pathways between the community team and the ward are not always clear and become especially difficult out of hours, where it has been reported that Care Coordinators have had a hard time liaising over the admission of a Service User. Other issues around recall included the involvement of the police in forcibly recalling someone to hospital, where a lack of information sometimes meant the police questioned their right to forcibly bring someone to hospital.

All RCs interviewed had dealt with a recall of a Service User under a CTO. Whilst this was found to be both administratively and practically complex (and often traumatic for the Service User). However, it was considered more straightforward than the process would be for Service Users not on a CTO:

*It's a bit of a pedantic palava but easier than sorting out a fresh Mental Health Act assessment that's for sure (RC3).*

Recall was sometimes found to be helpful in reinforcing the powers of the CTO and encouraging future compliance. One RC tells the story of a Service User who was on oral medication, which her carers were supposed to supervise her taking, however they had not watched her closely enough and it was found that she had been spitting the pills out, which had led her to relapse:

*Because I'd explained to her beforehand that this was the power that the CTO gave me and that she hadn't actually complied, she only needed to have the three days in hospital before she recognised that we actually needed to take the medication if she was going to be able to stay out. So, she only needed that one recall to work out for herself that the best thing to do was just to take her medication. She's been absolutely fine for the last 18 months or two years since that happened (RC 9).*

## DISCHARGE

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The length of time that the CTOs that the RCs were (or had been) responsible for had been in force varied greatly, with some having been in force since they came in in 2008, and others having been discharged at the first six month review. Reasons for discharge or renewal were assessed on an individual basis and there did not seem to be a general pattern, except that Service Users under a forensic section tended to be kept on their CTOs longer, due to the perceived higher risk.

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## CARE COORDINATOR EXPERIENCES

Every Service User on a CTO has a Care Coordinator, in accordance with the Care Programme Approach (DH, 2008), who can be a social worker, a CPN or occupational therapist – and they are the professionals most closely involved with the Service User. The role of the Care Coordinator is to provide holistic care, offering support in every area (medication, housing, moving forward in life and so on) and to agree a care plan with the Service User. Monitoring that the CTO conditions are adhered to falls to the Care Coordinator, as part of a wider monitoring of progress:

*Usually monitoring mental state, monitoring risk and what the person's mental health needs are. In relation to the CTO it's around the conditions. So for example with all of the people I have on CTO, the conditions are they take their medication as prescribed (CC15).*

Many Care Coordinators recognised that there was a lot of contention around the use of CTOs, as one explained:

*It seems that even though CTOs have been around for a few years there seems to be a lot of ambiguity about them and also they seem quite political, there seems to be different opinions about them, when they should be used, when they shouldn't be used and they're not necessarily to do with the Service User but to do with people's opinion and the interpretation of the law and the guidance (CC7).*

It was also sometimes felt that it was difficult to get a clear overview about CTOs as their use is so heavily value-laden, as the same Care Coordinator comments in regards to Trust training available on CTOs:

*It depends who gives [the training], if it's a medicalised person you get one view, if it's a social model person you get another view so that's perhaps why I haven't gone for the training, I'm just learning from other people as I go (CC7).*

As with other professional groups, Care Coordinators experiences of CTOs were varied and both positive and negative instances were reported.

## INFORMATION, CHOICE AND UNDERSTANDING

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Practices varied from those who routinely informed their Service Users about the CTO conditions at each meeting and those who did not revisit it that often after the initial setting of the order unless conditions were being breached. When it came to understanding of the CTO this varied widely, as in the experiences of other professionals. It was found that some Service Users had very poor understanding or 'insight':

*[the Service User] had no insight, would not discuss the CTO, didn't acknowledge its existence (CC3).*

In the case of Care Coordinators, they often felt the tension around information and choice more acutely in their relationship with the Service User. The ethically complex terrain around choice and compulsion was often something that more directly affected their relationship with the Service User, in comparison to other professional groups that had a more removed position in relation to the Service User. Honesty was something that Care Coordinators often raised as an important, but contentious, aspect of their relationship with the Service User:

*I certainly think sometimes they don't necessarily feel like they have a choice when they go on the CTO even though you are you know you are very clearly saying you have a, you have this choice but sometimes the other option is me staying on a section or staying on section 17 leave. And I think it is a practice as a Care Coordinator it is about just being honest and transparent about it (CC1).*

## CARE PLANNING

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Care planning was sometimes found lacking and the emphasis on medication while on a CTO in some cases meant there was little input into social support for the Service User. However often this came at a later stage when compliance with medication had provided a platform of stability which could be built on. The Service User should be involved in the care-planning, or at least be happy about what's in the care plan and agree to it. However in interviews with Service Users it was found that most Service Users were not aware of what was in their care plan, or if it included anything beyond the taking of medication.

The potential effect of CTOs on therapeutic relationships between Care Coordinators and Service Users makes for a complex picture, with both negative and positive comments from the Care Coordinators interviewed. There were some strong concerns from some Care Coordinators, particularly those who were nurses, about the negative impact on therapeutic relationships and incompatibility with principles of nursing. One CPN felt powerless in not feeling she had any option in working with CTOs even though she disapproved of them and found it harmful to her relationship with the Service User, and too risky for herself in administering the depot. However, other Care Coordinators had more positive experiences and some felt that the CTO had very limited impact on their relationship with the Service User. In some cases the CTO was not 'at the top of the agenda' but figured only at times of review, in cases where the Service User was compliant with the conditions. Whilst other Care Coordinators made sure to remind the Service User about the CTO and its conditions at each meeting.

The experiences of Care Coordinators depended to a large extent on the type of cases they had, where negative experiences of CTOs were connected to Service Users who found the CTO punitive and were difficult to engage, whereas Service Users who were willing to accept the authority of the CTO, and after a while could start to appreciate that they were more stable due to the medication, made for a much easier relationship where the Care Coordinators was able to provide a more holistic approach to their care and less focus needed to remain on complying with medical treatment. One Care Coordinator (CPN) comments about the role:

*You need to be able to be truly multidisciplinary in working with obviously the medical side of things and the social care side of things, and I think that's the most important thing to just stick to being multidisciplinary. The second CTO was rather difficult because there wasn't a social care component, so there was no continuity there. And I feel that the role of the Care Coordinator, it's vital really... because you can use your therapeutic relationship with the patient to actually determine whether you think that person's going to deteriorate (CC11).*

Care Coordinators often had to negotiate a difficult ethical terrain, trying to strike a balance between support and coercion:

*So you are working with them [Service Users] and trying to be therapeutic and supportive, but you are also the person that makes that phone call to set up the section through assessment and that relationship kind of continues really with a CTO (CC2).*

Similarly, another Care Coordinator elaborates on this difficult balance:

*I think people need to be really skilled in being able to engage someone in that therapeutic relationship because there's a bit of a conflict there between that person being on a section, for want of a better word, and still keeping that therapeutic relationship going. I think especially if someone's understanding of what they're experiencing and why they've been in hospital and why they need treatment is different to what the team are feeling. So I'm talking about insight and understanding and that's a real challenge I think (CC15).*

At times, when the Service User was not accepting of the CTO, Care Coordinators found it was detrimental to the therapeutic relationship, but still had some utility in that it gave the professionals the ability to act more quickly:

*Any discussion about the CTO pretty much ended the visit there and then, she pushed me out the door so, but what it did enable us to do was to recall her to hospital at an earlier date so over a period of weeks it probably got in the way of treatment but at the end of the day it enabled us to be more proactive (CC3).*

The CTO was often viewed as a complex framework, with some benefits and some drawbacks, all dependent on individual circumstances. Some Care Coordinators reported that the CTO process, such as taking part in tribunals and making social circumstance reports, could have a damaging impact on relationships:

*Tribunals can be quite damaging as well because you're having to sit there, on one hand you're sitting there supporting them, on the other hand you're saying, "well actually if you take this person off a CTO they're going to do x, y and z" (CC7).*

Equally, some Care Coordinators regarded the efficacy of the CTO to be dependent on the willingness to work with the CTO and engage with services, however when this willingness was lacking the CTO was found to compromise therapeutic alliances with staff:

*Where people don't buy into it and don't accept the authority in which it is granted then you can recall them, you can try to enforce it but it doesn't, it's not therapeutic, it's not building their relationship of trust and moving towards engagement at all or effective treatment. I know some people will be pure medical model and they are thinking and think if you just give medication to people that will keep them well. In my experience that has never been the case (CC4).*

Some Care Coordinators were less happy about working with CTOs and felt compromised by not having a choice to work with Service Users under CTOs that had been transferred to them from other Care Coordinators. One Care Coordinator in particular had had a very difficult experience with CTOs and found it difficult to reconcile the aspect of coercion – and a Service User who was heavily resisting the CTO – with her professional identity as a nurse. This Care Coordinator comments:

*I've been unhappy with the responsibilities of [the Service User] being on the CTO, I find that ethically I was being compromised because of the nature of her illness and the type of person that she is, she, I think it put both herself and me at risk whenever I tried to administer the depot.... I got very kind of distressed by her distress and how ugly it all felt, how difficult it was and I felt that all the responsibility lay with me as I was the CPN and a Care Coordinator, so I was responsible for ensuring that she kept to the conditions and of course she failed to so it would mean a whole heap of work for me, a lot of drama, a lot of unpleasantness (CC13).*

Further, this Care Coordinator voiced concerns about the changing nature of roles in social care:

*I feel as if the legal strand of what was Social Worker's practice has now entered the nursing domain and is compromising the nurse patient relationship, I do think that and I see that and I feel it very strongly, and I get very distressed that we have had a change of practice that has that kind of effect on us actually, and I sort of really quite strongly object to it (CC13).*

However, this is a mixed picture. The change in practice in relation to CTOs were understandably more strongly felt by CPNs, whilst Care Coordinators with a social work background did not necessarily feel that working with CTOs made any difference to their relationship with Service Users or any tangible difference to their practice in general. One Care Coordinator comments:

*I see my role actually with people on CTOs as no different from a role with people who aren't on CTOs (CC7).*

## EFFECTIVENESS AND IMPACT ON SERVICE USERS

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Care Coordinators gave examples of CTOs having a beneficial impact through increased compliance with medication over a period of time and subsequent improvements in insight and mental stability, e.g. as one describes:

*I think it was the fairest and option at the time.... probably has been helpful for her, over the last six months, to actually have a chance to let, to see that the medication has been helpful which is where she's at now and that she's happy to stay on it 'until the evil spirit goes' .... I went through the report briefly with her about a week ago, I have offered a couple of times for her to come tomorrow, she is aware that it's her chance to you know to say "I don't want to be on it", but doesn't want to come along because she's OK to be on it for another six months (CC1).*

Care Coordinators also often viewed the CTOs to be particularly useful in their capacity to recall quickly in case of deterioration and in that they were in agreement with the other professional groups:

*There was very little recovery work going on because we hadn't reached the engagement process at that point but we were able to use the CTO in some way to try and encourage engagement but what it actually enabled us to do was to recall her into hospital at an earlier stage (CC3).*

## CONDITIONS

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Care Coordinators for the most part agreed with RCs in that specific and restrictive conditions were not viewed as helpful:

*The more restrictive you make them the less useful they are and the more you're kind of selling people up to not be labelled to do what you're asking them to do. So we've, I guess there's been occasions when we've had stuff on there about attending drug and alcohol services for instance or providing drug screens. But even, that, we tend not to do really now because again we've got sort of a high percentage of dual diagnosis - people who it's just not always realistic that they would be able to do that (CC2).*

When it comes to monitoring of the conditions, Care Coordinators also recognised that if the Service User was not on a depot injection it was very difficult to monitor their medication and know whether they were complying with treatment:

*[The Service User] was on oral medication and I couldn't monitor that on a day to day basis so I was having to take her word for it (CC3).*

When it came to monitoring oral medication Care Coordinators have a more delicate job in assessing whether the medication is actually taken and put this in context of the Service User's mental health state, as one Care Coordinator points out:

*With tablets there's room for people maybe saying "Yes, I'm taking them", when maybe they're not. What I do with people is, with one person in particular, she lives on her own. We go through her medication, through the amount of medication, you've got to make sure it tallies, making sure she picks it up from the pharmacy so I contact the pharmacy to make sure she's coming in when she needs the medication. And yes, in terms of her mental state, she is quite well at the moment - so all the things we need to believe that she's taken her medication (CC15).*

Experiences such as this show that it is still possible to have a Service User on a CTO who is on oral medication. With careful monitoring and a good therapeutic relationship this can prove successful.

## RECALL

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There was some confusion reported by Care Coordinators when it comes to recall to hospital. Some Care Coordinators had found themselves having to deliver the recall letter to the Service User having been delegated by the RC. There had in some instances been much confusion and doubts as to the legal rights that the Care Coordinator had. Reportedly, the police assisting with the recall often lacked the appropriate information. When it comes to a S. 2 or S. 3 sectioning, this would be the remit of the AMHP, so Care Coordinators find themselves in a new position of often having to do the legwork of RCs when it comes to recall, and often deal with highly difficult recall situations. One Care Coordinator comments:

*I guess my biggest bugbear with CTOs is that point of recall. As a nurse I am now expected to lead that process, I deliver the paperwork because often the doctor doesn't do it there and then so I have to deliver the paperwork, informing the person that they have been recalled. If they then refuse to come with us we then have to go to court and get warrants with the aid of the police, and if the person was being assessed under the Mental Health Act either section 3 or 2, an AMHP would be doing that process (CC3).*

In response to the question of whether the CTO made the recall process less traumatic for the Service User, the same Care Coordinator says:

*I don't think it made any difference. We had to go to court, we had to get violent, we had to get police escorts (CC3).*

In some instances when the Service User were residing in a different area, recall was even more complex and roles and responsibilities unclear.

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## SERVICE PROVIDER EXPERIENCES

The records are incomplete in regards to how many Service Users on CTOs within SPFT are living in some form of supported accommodation. However, most of the supported housing projects the researchers were in contact with (both public and private) in the SPFT area had at least one, if not several Service Users living with them who were subject to CTOs. The nine Service Providers interviewed were largely managers of housing projects (one was a social worker) that provide supported housing (with different levels of support) for people with mental health problems who are unable to live independently, located across Brighton, Eastbourne and Worthing.

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## INFORMATION AND UNDERSTANDING OF THE CTO

None of the Service Providers had received any formal training or information about CTOs. They had all sought out their own information, mostly on the internet or by talking to colleagues who were more knowledgeable.

*As soon as it came in I think a lot of us were just interested to see how it would work. So I think a lot of the kind of education and training came from ourselves having an interest (SP6).*

Many Service Providers recognised that they had a limited understanding of the legislative powers and the administrative process of the CTO, but did not necessarily feel this was a problem:

*It's more verbal information, verbal discussions on it ... I know enough to do my job but I don't need to know the ins and outs of all the paperwork involved (SP1).*

However, many felt that it was useful to receive information when a Service User was going to arrive on a CTO. It only appeared to be in rare cases that Service Providers received a copy of the CTO paperwork and it was unclear whether they had a right to see this unless the Service User had consented:

*When they come out of hospital or wherever they will be on a community treatment order, that is all I am told initially and I get an initial assessment from social services so sometimes I don't even see, I don't see the order itself, I don't see the paperwork unless the Service User shares it with me (SP2).*

*We don't have the paperwork for the CTO yet (SP3).*

*We don't see the actual paperwork (SP8).*

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## POSITIVE OPINIONS OF THE CTO

Much like Nearest Relatives, Service Providers were overwhelmingly positive about CTOs:

*I think they're great, I think they are great (SP2).*

Several participants reported they had initially been sceptical when they were first brought in because of views that they were too restrictive and an infringement on Service Users' human rights. However, such reservations seemed to quickly fade into the background when CTOs were found to impact positively on service provision, staff safety concerns and relationship to other services.

*I think when it initially was suggested - my background's in social work and I think when it was initially suggested I thought umm, I was probably a little bit concerned about it being another way of possibly restricting people umm, but I must admit I think it's, personally I think it's a really useful tool (SP6).*

## NEGATIVE EXPERIENCES

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There were relatively few mentions of negative experiences. The only negative experiences mentioned related to multiple recalls of Service Users, so it was felt the CTO wasn't working very well as the Service User had stopped taking the medication. Nearly all recalls were due to stopping medication. However, there were also examples of conditions being breached, which were felt were unhelpfully strict.

*We had a chap who, and they wrote very clearly in there 'must not use cannabis because he'll be returned on a CTO' and he came straight out and he was going back in and in and in and it really didn't work effectively in that respect...it was actually creating, I think, a lot of frustration for that particular person but also it was creating a lot of work and expense for the services too (SP9).*

However, most of the CTOs discussed in this sample had minimal restrictions, only relating to medication and place of residence, and occasionally travel restrictions. In the cases where more specific conditions were used, such as around alcohol and illegal substances these were often not enforced in practice, although the fact that they were on the CTO was mentioned to the Service User as a deterrent, but the Service Provider was aware that they would not be monitored closely or recalled if they were found to have breached those conditions except in cases where this had a direct impact on their mental health.

## VARYING DEGREES OF INVOLVEMENT

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There were varying degrees to which Service Providers were involved in the CTO process including reviews and tribunals. Some said they had a good relationship with the Care Coordinator and consultant for the Service Users residing with them, and that they would be invited to CTO reviews and were well aware of the CTO conditions. Others had not seen the paperwork and were not aware of conditions or routinely invited to review meetings. Whether or not the Service Provider was involved in the CTO process, having a direct telephone number to a named Care Coordinator, for example, was highly valued. Having a more direct relationship with other services was attributed to the CTO framework by several Service Providers, who felt that services were more approachable when the Service User in question was subject to a CTO and there was a greater readiness of response. However, the constraints within the system were recognised and there was still a varying degree to which Service Providers felt they could access information or support from services if they had concerns about the mental health of a Service User resident. Some were not informed or involved in the CTO process, and those who were not involved tended also to be unaware of the specific conditions on the CTOs, had not received any paperwork, and were not invited to accompany the Service User to review meetings. Some felt this was not a problem as they did not view the CTO as their domain:

*Obviously because it's housing we wouldn't, we would have a big part of it but we wouldn't be a major player in that because, you know, only by sort of virtue of the fact that if anything happened then we would have to alert the relevant sort of agencies and stuff like that (SP4).*

However, some would have liked more information, at least to be aware of the conditions on the CTO as this could have a role to play in their support of the Service User day to day:

*Actually informing the Service User, you know, is pretty good but to actually liaise with us is not, from hospital is not... is not very good...It could be better because it's only a phone call really (SP3).*

Some Service Providers were more proactive about being involved in the review process and 'invited themselves' or let the Care Coordinator know they expected to attend:



*We're the people who are going to be working with them on a day to day basis, Care Coordinator may have a limited amount of contact with that person so it's quite, it's really important that we communicate effectively about how this person behaves, what, where the concerns and issues may lie...I'm one for pushing that forward anyway... I will phone Care Coordinators and say, you know, make suggestions and try and arrange meetings (SP6).*

In some cases the relationship between the housing project manager and the services had been cemented and there was regular contact and involvement. In these cases Service Providers tended to be routinely invited to attend any review meetings about the CTOs and these Service Providers also viewed their input as important.

## BACK-UP FROM AND RELATIONSHIP WITH OTHER SERVICES

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Several Service Providers commented that the CTO makes a difference if something goes wrong, that is if the Service User deteriorates or refuses their medication or something else happens that has a negative impact on their mental health:

*There is an intervention that can be sought so that the person doesn't deteriorate too far... from my point of view it is good to get the extra support you need if a Service User is deteriorating (SP1).*

In some cases, Service Providers felt that the CTO made a big impact on their working relationship with other services – in a positive way although some attributed having a more direct relationship with other services to the CTO framework per se. Having a direct telephone number to a CPN was highly valued and several Service Providers mentioned the importance of getting through to other services when something happens 'on a Friday afternoon'. Several Service Providers felt that the speediness of the response from other services if something went wrong was a clear benefit of the CTO:

*You can get support for the Service User quicker (SP1).*

*Rather than having to wait until it gets to, you know, quite a chronic stage it just means that he'll be seen more quickly (SP6).*

This was especially mentioned in relation to forensic teams, which were regarded as well organised and approachable:

*The meetings happen when they say they are going to, if I ring I can ring 24/7 and I will get a response. I mean I haven't tried ringing a consultant psychiatrist at 4 in the morning, I have not needed to but I think I will get a response even then..., whereas when you are working with people who have got a mainstream social worker or community psychiatric nurse, you can wait three days for a return from that call, you don't get that with forensic teams (SP2).*

AOTs on the other hand were often over-stretched, which affected relationships:

*I mean from the forensic side we are always invited, I get email invitations and sometimes written ones as well and we are always kept completely up to speed with what everybody else is thinking about this person, whereas with AOT they are a bit busier, they are a bit more all over the place and so it doesn't always happen (SP8).*

## SAFETY

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There were also instances when Service Providers reported that the CTO framework improved perceptions of safety for staff, as the CTO ensured medication was kept up with and if it was not, professional services could be relied upon to react quickly. In addition, one Service Provider had the understanding that the CTO framework would safeguard his interests as a housing provider in cases of 'bad behaviour' by a Service User holding a tenancy in one of his unsupported properties:



*Because he is on a Community Treatment Order, the risk is reduced for me because I don't have to think about "Well I'm going to be stuck with this guy in a six month tenancy who has wrecked the joint and had a load of mates over and done a lot of drugs, yeah, and nothing is going to happen, there won't be any consequence because it is just the CMHT that's working with him and he's not, there's, they've got no power over him".... If it's just bad behaviour then you are stuck with it whereas when you are on a CTO that is not the case, they can lift people and they do lift people (SP2).*

## RECALL

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Service Providers felt that the CTO made it easier and less distressing for the Service User as there was less waiting and no need for a new mental health assessment. None of the Service Providers thought that the recall had negatively impacted on their relationship afterwards in the cases where the Service User had returned to the housing project, even if the Service Provider had been the person to start the recall process by informing the Care Coordinator of the situation. Some Service Providers commented that it was helpful for them to not be seen as 'the bad guy' as they were not seen to be directly involved in enforcing the CTO.

## SUPPORTING SERVICE USERS

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Service Providers see the Service User day-to-day and appreciate the impact that the CTO has on them. Some have commented that they position themselves on the 'Service User's side' and even that they encourage Service Users to question the CTO and why they need to be on it, or by extension their medication – especially in cases where medication is causing significant side-effects. They also comment about the distress or anxiety Service Users have experienced in relation to reviews, renewals and tribunals, which can be overwhelming.

*One person who was brought in, brought to the tribunal had had because which the CTO had been extended... So it is a lot of paperwork involved in but it feels like a lot but one after another she went to were here and it was only about a month ago and there's another one because of the extension coming up at the end of September... So it's a very short time and she does get anxious about it (SP1).*

## SERVICE USER UNDERSTANDING OF CTOS

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Many Service Providers commented that their resident Service Users on CTOs had poor insight into their own mental health and if they were not on the CTO they would not be taking medication. In this regard the CTO was seen as necessary to keep the Service User from deteriorating and ending up back in hospital:

*I think it is working for her in the fact that she, if she doesn't receive the medication the depot she has no quality of life, no friends, her behaviour and her manner and anger are so overwhelming that she would have to be in a hospital. But also she dislikes having it and I have a feeling that if she, she has stated in fact that if she didn't have to have it she wouldn't, so that's why it, it enables that person to have a proper quality of life, to be able to meet up with friends, go out to cafes, restaurants, enjoy life and we are, she is planning to move on in the next month from here (SP1).*

Many Service Providers spoke of lack of understanding on the part of Service Users, as well as objections and dislike of the CTO:

*From their point of view why do I need it? Why do I need a depot? Why do I need medication? Why do I need to be on this order?... sometimes as housing providers we are the ones that witness the battle that goes on within themselves about why they are on an order that is not what they've asked for basically (SP4).*

However, many Service Providers felt that the CTO was necessary and useful for Service Users who had little understanding of their own need for medication:

*I feel that it's appropriate in this case because of his lack of insight (SP6).*

## CONCLUSION

### SUMMARY OF KEY ISSUES

Below we highlight a number of key tensions in the use of CTOs and related issues identified by this study.

#### WORKING RELATIONSHIPS

This study found that for the most part there tended to be agreement between the professionals around most aspects in relation to the CTO. However, there were some disagreements, particularly between RCs and AMHPs. Some AMHPs for example describe RCs as too risk averse and are unhappy about RCs and Care Coordinators deciding upon the CTO and even informing the Service User before involving AMHP. RCs could be unhappy if AMHPs not in agreement. Some disagreements were also evident around the nature of conditions – whether these should include specific conditions (e.g. around substance misuse) or only more general conditions e.g. around taking medication and attending appointments (also in at least one case disagreements noted between in-patient and out-patient RCs who felt specific conditions set by in-patient RCs were not enforceable, which could cause difficulties). AMHPs tended to argue for general conditions/ least restrictive practice although in one case it was recognised that some control over travel was useful.

#### SERVICE USER INVOLVEMENT

There was concern about raising the issue of the CTO with Service Users on ward rounds – some thought this was not necessarily the best environment as discussions can be rushed and there can be too many professionals involved which can be overwhelming for the Service User. Service Users generally did not consider that they had a great deal, or any, choice concerning the CTO. However, not all were particularly concerned about this and some felt in retrospect that the CTO had made a positive impact on their recovery. Often Service Users were under the impression that if they did not keep to the conditions of the CTO they would be automatically returned to hospital, which amounts to an implied threat. It did not seem to be generally explained to Service Users that they would only be recalled if there was a significant deterioration in their mental health (so taking substances in itself would not be sufficient to recall someone unless this resulted in a fast deterioration in mental health). There is an ethical question about whether increased honesty/ clarity would negate the effectiveness of the CTO in relation to this implied threat of recall as many Service Users admitted they only took medication (at least at first) because they believed they had to in order to stay in the community.

Our results point towards a range of important tensions in the CTO framework. One of these tensions is around the clarity of information given to Service Users and the level of understanding they have of their rights under the CTO and the limits to the powers of the CTO when it comes to medication and recall. Whilst the CTO has been introduced as a way to oversee and administer medication in the community, the principle that medication cannot be given forcibly in the community still stands, and CTOs do not technically include powers to force Service Users to take medication or to recall them if they do not comply. Technically, the only way that a Service User CTO can be recalled to hospital under the power of the CTO is if they require treatment in hospital and if they do not receive this treatment they are likely to be a risk to themselves or others. Therefore, if a Service User refuses to take their medication but their mental health remains relatively stable, this refusal in itself is not enough to recall them to hospital and forcibly administer medication. Whether these principles are followed universally in practice is another matter. However, as far as this study goes, the recalls that were discussed by practitioners were made in cases where they deemed the Service User to be at risk of harm due to a severe deterioration in their mental health.

Often the CTO was considered by the Service User to be a positive choice in comparison with the alternative - i.e. staying in hospital - although one person to some extent preferred being in hospital because he was able to

take oral medication in hospital whereas the condition of his CTO was to have injections. Most Service Users did not recall receiving written information, although staff stated in most cases that this was given to Service Users. Service Users were not always clear about discussions around renewal/ discharge and tended not to be actively involved. One Service User had actively raised the subject of being discharged which had been agreed to, but in most cases there seemed to have been little room for negotiation with Service Users and they were not involved in decisions around conditions either. CTOs were supposed to be for so-called 'revolving door' patients, however, there is some anecdotal evidence that they may, in practice, also be used preventatively. The CQC reports (2011; 2012) state that a significant number (up to a third in 2010/11) of their sample did not have a reported history of non-compliance or disengagement. If CTOs are also used preventatively in some cases, this could go some way towards explaining the higher than expected numbers.

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## FAMILY INVOLVEMENT

Where families were involved they generally tended to be supportive of the CTO and regarded it as a safety net that enabled speedy intervention if their relative's mental health deteriorated. Some staff felt families could be involved to a greater extent where involved with Service Users. Often however Service Users were estranged from family (particularly in Brighton).

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## SUPPORT

The aftercare support was described by most as being the same as for those not on a CTO, although at least one Service User said that the support she received had decreased after being discharged. The CTO may have been a factor in securing supported accommodation for some Service Users. Also the support may be increased in the sense that Service Users were obliged to engage with services as a condition of the CTO. Thus, the level of engagement often tended to be greater. Some Service Users would have liked more therapeutic support. Some staff acknowledged there were resource issues in providing this.

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## RELATIONSHIPS WITH PROFESSIONALS

Relationships with professionals were generally thought to work ok even though there could be tensions at times. These could be particularly evident through the recall process and at tribunals e.g. for RCs who would need to present evidence Service Users may not like to hear or not agree with. However, others felt that the honesty involved in this was important and such tensions should not be avoided.

Service Users often did not like having to take medication and this could cause tension, but in some cases after seeing an improvement in their condition, they accepted that this was necessary and helpful to some extent. Some attended tribunals with one in particular disappointed with the outcome but accepting in retrospect that professionals were "looking out for me". Another Service User had taken the initiative to ask for the CTO to be discharged early and this was agreed. She felt she had a very good relationship with the professionals involved. Most felt that the support they had received from Care Coordinators and support workers (if in supported accommodation) was very good. However, there was likely to have been a positive bias in this respect, particularly owing to the use of Care Coordinators as gatekeepers and the exclusion of some Service Users by Care Coordinators on the grounds that the Service User was not an appropriate participant because they 'lacked insight' etc. or where engagement with services had broken down (so they were limited in their capacity to pass on and/ or fully explain the research study).

Service Users usually attended appointments outside the home. Where Care Coordinators came to the Service User home this tended to be by mutual agreement and did not seem to have caused any tensions or problems.

## INDICATORS FOR GOOD PRACTICE

This section outlines a number of indicators for good practice which emerged from the qualitative data from Service Users and practitioners.

### INFORMATION

There is a need for better information about CTOs in all its aspects and at all levels. Service Users and Nearest Relatives were found to often lack an understanding of CTOs. Information for Service Users was often delivered verbally. Even if this were repeated several times, a user-friendly leaflet with the key points of information about CTOs is needed. This leaflet needs to make clear what the CTO is, why it is used, what its legal powers are in relation to medication and recall and what rights the Service User has under the CTO, including details of their right to advocacy. A similar concise leaflet could be produced for Nearest Relatives.

### ADVOCACY

Many Service Users said they were not aware of their right to advocacy and the IMHA service. A leaflet about the advocacy service should be made available to the Service User on the ward in relation to early discussions about discharge onto a CTO, however this was often not the case. Whilst many AMHPs made sure to inform the Service User of their right to advocacy, there needs to be clear written information as part of a general information leaflet that the Service User can keep and refer to.

### MAKING THE CTO, DECISION-MAKING, SERVICE USER INVOLVEMENT AND WORKING RELATIONSHIPS

There were concerns about the rushed nature of decisions in relation to making the CTO. Many Service Users had poor recall of any discussions, indicating they still may not have been well. Decisions about making the CTO most often happened in ward rounds, which is not an ideal environment as this can be disempowering for the Service User as well as not providing enough time for discussion and planning. The Service User needs to be fully involved in discussions and cognisant that the CTO is being made.

Whilst multidisciplinary teams usually worked well together, some of the AMHPs raised concerns about their professional role not being well understood and being expected to provide a 'rubber stamp' for the CTO. Best practice would be to include the AMHP in any team discussions about a potential discharge onto a CTO as early as possible; this would ensure a focus on social supports also. The Service User should not be informed about going onto a CTO before an AMHP has been involved.

Support from colleagues was found to be a strength in developing good practice in relation to CTOs as few general guidelines are available. More opportunities for exchanging experiences with other practitioners and learning from others would be helpful across the professional roles.

### CONDITIONS

It was generally found that CTOs were most effective when conditions were kept to a minimum and included only the essential stipulations about complying with medication, allowing access to care staff or residing in a specific place if appropriate, and engaging with services. More specific and restrictive conditions (such as those around substance use or restricting people they were allowed to see or places they were allowed to visit, or setting curfews) were commonly found to be difficult to enforce and meaningless when a breach cannot automatically result in a recall to hospital.

## CONCLUDING REMARKS

This study has explored Service User and practitioner experiences of CTOs in the context of the contemporary policy drive towards increasing personalisation of services. Other research, such as the OCTET study (Burns et al., 2013), the CQC reports (2010, 2011, 2012) and the earlier Department of Health systematic review (Churchill et al., 2007) have shown that CTOs are a complex and contentious field. This research has contributed a qualitative exploration of experiences of both working with this new legislation and being subject to it. These experiences have at times stood at odds with previous findings such as the OCTET study (Burns, 2013) in regard to highlighting positive experiences of the CTO.

The research question was ‘what are Service User and practitioner experiences of the use of community treatment orders in an environment of social care policy focused on personalised social cares service provision?’. In summary, the Service Users who took part in the study reported little, or no, choice in being subject to a CTO or the conditions that were set. Many Service Users could not recall clearly being consulted about being made subject to the order or being consulted about the conditions that were part of it. The Service Users who took part in the study commonly reported they did not know what the Independent Mental Health Advocacy (IMHA) service was. There were conflicting responses from the Service Users who took part in this study about CTOs. Most Service Users did not like the CTO. However, a significant proportion of Service Users could appreciate (often in hind-sight) that being subject to the CTO had helped them maintain a greater stability of mental health. Service Users, Nearest Relatives and Service Providers valued the CTO as an assurance of the Service User’s need for care. The study found that CTOs were predominantly medically driven and that there was little focus on social care planning in making the CTO. This is to be regretted, given some Service Users identified social contact as a positive aspect of being an in-patient. However, it was found that medical treatment could provide a platform for greater involvement in social activities in the community.

There were conflicting responses from practitioners, with some concerns from AMHPs and Care Coordinators about the over-use of CTOs and the lack of choice and understanding on the part of Service Users. RCs commonly felt the CTO lacked ‘teeth’ as a legal power and had no significant benefit over Section 17 Leave apart from reduce pressure on hospital beds.

The CTO is a relatively new tool and it is still an evolving practice with many contentions, concerns and ethical questions to resolve. Each of the cohorts interviewed for this study has a different role in it and thus a different perspective on it. This report both draws together the perspectives of the different groups in the ‘emerging themes’ that came through the data as a whole, but also gives space for a discussion of the experiences that are specific to each of the groups, thus a fuller (if complex) picture has emerged.

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**University of Brighton****An Exploration of Service User and Practitioner Experiences of Community Treatment Orders****Participant Information Sheet****(Social care practitioners and Service Providers)**

You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

**What is the purpose of the study?**

Community Treatment Orders (CTOs) were introduced in 2008 in an environment of personalised service provision. Although use of CTOs has exceeded estimates, there is a lack of knowledge around how they are applied and how effective they are. This in-depth, exploratory research, which will be undertaken between July 2011 and February 2013, aims to develop our knowledge of CTOs through exploring Service Users', professional practitioners' and Service Providers' experiences. The study aims to explore good practice in relation to the workings of supervised community treatment, in a context of personalised services.

**Why have I been contacted?**

You have been asked to take part in this research because you are providing social care or a service to a mental health Service User who is currently on a CTO, and who has been referred to this study. The Service User has given written permission for us to contact you and to interview you about their care. We would like to arrange to interview you about your experience of this particular CTO as well as your more general experiences of supervised community treatment.

**Do I have to take part?**

No. It is up to you to decide whether or not to take part. If you do decide to take part you are still free to withdraw at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way in relation to your day to day work.

**What will happen if I take part?**

If you decide to take part in the study a researcher from the University of Brighton will liaise with you to arrange an interview at a time and place convenient to you. We realise your time will be pressured and will seek to cause as little disruption to your work schedule as possible when making interview arrangements. The interview should take no more than an hour. If you agree, the interview will be recorded. At your interview you will be asked to sign a consent form and you will be given a copy of this.

**What are the possible benefits of taking part?**

Though there may be no direct benefit to you from taking part in the research, the project will enable you to share your experiences and views in a way we hope will help to inform and improve practice in relation to supervised community treatment. Learning from this project will be used in the education and continuing professional development for workers in adult social care and mental health services.



### **What are the possible disadvantages and risks of taking part?**

There should be no risks involved. However, this study involves you talking about your current and possibly past practice with Service Users subject to CTOs, which you may find upsetting. Should involvement in the study cause you any distress, you are free to take a break from or stop the interview at any time without giving a reason.

### **Will my taking part in this study be kept confidential?**

Yes. We treat everything you tell us in confidence. Only those employed/ known the university will type up interviews and will be asked to sign a confidentiality form before doing so. We will not share any identifying information with anyone else outside the research team. The only exception to this would be if the researchers were required to contact an appropriate person or authority because something you said indicated you or another person was at risk of harm. Equally, if anything you said indicated that any professional practice was not in keeping with practice requirements and standards, the researchers would be obliged to disclose this to social services. If we write up or present anything about the findings from the interviews your name or details that may identify you will not be used. We will also keep any data relating to you on a password protected computer and any typed interviews in a locked filing cabinet. Your personal and contact details will be kept separately from typed interviews for a period of time after the study and then destroyed.

### **What if something goes wrong?**

Any complaints should be referred to the Dr Julia Stroud (the person coordinating the research) in the first instance; Tel: (01273) 643853 or email: [J.Stroud@brighton.ac.uk](mailto:J.Stroud@brighton.ac.uk). If the matter is unresolved, a further complaint can be made to Professor Phil Haynes (Head of School of Applied Social Science) by telephone: (01273) 643465 or email: [P.Haynes@brighton.ac.uk](mailto:P.Haynes@brighton.ac.uk).

### **What will happen to the results of the research study?**

All participants will receive a summary of findings, and the full findings of the study will be written up in a report and in one or more journal articles. We also aim to develop a practice guide. These will be available via relevant web based organisations and the University of Brighton's Social Science, Policy and Research Centre (SSPARC) website and in paper format if desired. We will also seek to disseminate findings via national and regional networks of practitioners and providers of social care/ social work services and through voluntary organisation networks.

### **Who has reviewed the study?**

This study has been reviewed by the National Institute for Health Research, School of Social Care Research (who are funding the study); University of Brighton, Faculty of Health and Social Science Research Ethics & Governance Committee, National Health Service Research and Development research ethics committees of the Integrated Research Application System (IRAS) and the local authority governance panels for East Sussex, West Sussex and Brighton and Hove, where the study will be taking place.

### **Contact for Further Information**

If you would like any further information or to discuss any of this information, please contact:

**Laura Banks, Research Fellow**, University of Brighton, Falmer, Brighton, BN1 9PH; Tel: (01273) 644599 or email: [L.C.Banks@brighton.ac.uk](mailto:L.C.Banks@brighton.ac.uk).

**Thank you very much for reading this. We hope that you will agree to participate in this study and look forward to hearing from you.**

## APPENDIX B

### INFORMATION LETTER TO CARE COORDINATORS FOR RECRUITMENT OF SERVICE USERS

*Dear [Care Coordinator],*

Re Research Study

#### **An Exploration of Service User and Practitioner Experiences of Community Treatment Orders**

The University of Brighton, in partnership with Sussex Partnership Foundation NHS Trust is carrying out a research study about Community Treatment Orders (CTOs). The study is funded by the National Institute for Health Research, School for Social Care Research: it has received full ethical and governance approval from the NHS and from the University.

The aim of the study is to further our understanding of how CTOs are being used and managed and about the social care supports that Service Users on a CTO can draw on. We are not evaluating the work of individual practitioners but want to understand aspects of the intervention that have been considered helpful in order to influence practice.

We have contacted you because one or more of the Service Users whom you support (who is or was previously on a CTO) has been selected for inclusion in the sample. The details of this Service User has been sent to you by a Sussex Partnership Trust Mental Health Administrator, along with further information from about the project and how you can assist us.

We have enclosed the information sheet and consent form that we would like you to pass on to this Service User. Please ask him or her to read the information and think about whether s/he would like to participate. If s/he would like to take part in an interview please also explain that s/he needs to return the consent form to us in the stamped addressed envelope provided.

If you believe that the Service User who has been selected is currently experiencing an acute phase of mental distress or does not have mental capacity to give informed consent or if there are other issues around passing on the information, please let us know as soon as possible (see contact details below).

Thank you very much indeed for reading this. We are very grateful in advance for your help and co-operation in supporting this important research.

Yours sincerely,

*Laura Banks and Julia Stroud*

School of Applied Social Science

University of Brighton

If you have any queries about the research please contact:

**Julia Stroud** Tel: (01273) 643853 or email: [J.Stroud@brighton.ac.uk](mailto:J.Stroud@brighton.ac.uk) or

Laura Banks Tel: (01273) 644599 or email: [L.C.Banks@brighton.ac.uk](mailto:L.C.Banks@brighton.ac.uk)



**Social Care Practitioner/ Service Provider Participant Consent Form**

**An Exploration of Service User and Practitioner Experiences of Community Treatment Orders (CTOs).**

- I agree to take part in this research.
- The researcher has explained to my satisfaction the purpose of the research and the safeguards for participants.
- I have had the principles of the research and the research process explained to me, I have read the information sheet and I understand it fully.
- I am aware that I will be required to engage in an interview in which I will be asked questions about my experiences of working with/ providing social care services to, Service Users subject to Community Treatment Orders.
- I understand that any confidential information will be seen only by members of the research team and no one else with the exceptions of indications of risk of harm to myself, another, or of practice not in keeping with relevant practice guidelines.
- I understand that I will not be identified personally but that my words may be used as quotes in the report or in any articles written by researchers.
- I consent to the interview being recorded.
- I understand that I am free to withdraw from the research at any time, without giving any reasons.
- I agree that anonymised (not including my name) data collected may be later archived and used by other researchers.

Name (please print): .....

Signed: .....

Date:.....



University of Brighton

**Nearest Relative Participant Consent Form**

**An Exploration of Service User and Practitioner Experiences of Community Treatment Orders (CTOs)**

- I agree to take part in this research study.
- I have read, or been read, the information sheet, and the researcher has explained to my satisfaction the purpose of the study and what my participation will involve.
- I am aware that I will be asked to answer questions about my experiences of my relative's Community Treatment Order (CTO) and answer questions. This may mean talking about things of a personal nature which I may find upsetting.
- I understand that any confidential information will be seen only by the research team unless they are very worried about the safety and well-being of anyone, in which case they may need to speak to an appropriate person about this (e.g. mental health services, GP)
- I understand that I will not be identified personally but that my words may be used as quotes in the report or in any articles written by researchers.
- I agree to the interview being recorded.
- I understand that I am free to withdraw from the research at any time, without giving any reasons.
- I agree that anonymised (not including my name) data collected may be later archived and used by other researchers.

Name (please print): .....

Signed: .....

Date: .....



**An Exploration of Service User and Practitioner Experiences of Community Treatment Orders**

- I agree to take part in this research study.
- I have read, or been read, the information sheet, and the researcher has explained to my satisfaction the purpose of the study and what my participation will involve.
- I am aware that I will be asked to talk about my own experiences of my Community Treatment Order (CTO) and answer questions. This may mean talking about things of a personal nature which I may find upsetting.
- I am aware that the researcher carrying out the interview will be from the University of Brighton, with, if I have requested, a Service User researcher present.
- I understand that any confidential information will be seen only by members of the research team and no one else with the exceptions of indications of risk of harm to myself or another
- I understand that I will not be identified personally but that my words may be used as quotes in the report or in any articles written by researchers.
- I agree to the interview being tape recorded.
- I understand that I am free to withdraw from the research at any time, without giving any reasons.
- I agree that anonymised (not including my name) data collected may be later archived and used by other researchers.

Name (please print): .....

Signed: .....

Date:.....

## APPENDIX F

### PARTICIPANT CONSENT FORM FOR BEING CONTACTED BY A RESEARCHER TO SET UP AN INTERVIEW



**University of Brighton**

#### Participant Consent Form - consent to be contacted by a researcher

##### **An Exploration of Service User and Practitioner Experiences of Community Treatment Orders**

*If you are happy to take part in an interview, please tick the box below and provide your contact details so a researcher can contact you:*

**I agree to a researcher contacting me to arrange an interview. I understand that I will be free to change my mind and decide not to participate at any time, without giving any reasons.....**

☐

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Please tick to indicate which time of day you would you prefer us to telephone you or indicate a specific time you would like us to call you in the space provided:

Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ Specific time: \_\_\_\_\_

Thank you for completing this form. **PLEASE RETURN THIS TO US IN THE STAMPED ADDRESSED ENVELOPE PROVIDED.**

Signed: ..... Date:.....

**University of Brighton****An Exploration of Service User and Practitioner Experiences of Community Treatment Orders****Participant Information Sheet**

You are being invited to take part in a research study. It is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet take part before making your decision about whether or not participate.

**What is the purpose of the study?**

We would like to know more about people's experiences and views of Community Treatment Orders (known as 'CTOs'). For example, we would like to know how much choice people have in making their care plan and about any social support they receive as part of their CTO. We hope that improving our knowledge about CTOs will inform practice in relation to CTO's.

**Why have I been chosen to take part?**

You are being asked to take part in this research because you are currently on a Community Treatment Order. We would like to arrange to talk with you in an interview about your experience of the CTO. We will also be trying to contact other Service Users and practitioners working with people on CTOs.

**Do I have to take part?**

No. It is up to you to decide whether or not to take part in this research. Even if you do decide to take part you are free to leave the research study at any time without giving a reason. This will not affect your treatment in any way.

**What will happen to me if I take part?**

If you decide to take part in this research, someone will meet with you to ask you some questions about your experiences of being on a CTO. Depending on the choice you make, this person will either be a university researcher or a Service User researcher (or could include both). The interview will be informal, like a conversation, and will last between 40-60 minutes. It will take place a social care venue convenient to you. If you agree, we would like to record the interview. At your interview you will be asked to sign a consent form and you will be given a copy of this.

It would also be helpful to the research for us to be able to talk with the people in your care team and Service Providers (e.g. housing, day care) involved in your CTO. We would only talk with people involved with your care and services with your permission: if you wish to take part in an interview yourself but are not comfortable about interviews with any or all members of your care team, please indicate this on the consent form enclosed and we will respect your wishes.

**Will my taking part in this study be kept confidential?**

Yes, we will treat everything you tell us in confidence. Only those employed/known to the university will type up interview recordings, and will be asked to sign a confidentiality form. We will not share any identifying information with anyone else outside the research team. The only exception to this is if we were worried you or someone else was at risk of harm, in which case we would talk to your care co-ordinator about this. If we write up or present anything about the findings from the interviews your name or details that may identify you will not be used. We will also keep any data relating to you on a password protected computer and any typed

interviews in a locked filing cabinet. Your personal and contact details will be kept separately from typed interviews for a period of time after the study and then destroyed.

**What are the possible benefits of taking part?**

The research will give you a chance to share how you feel about your experiences. Although the findings from the research may not affect you directly, we hope that learning from your experiences will help us to understand CTOs better and that this may help to inform how CTOs are used and managed.

**What are the possible disadvantages and risks of taking part?**

There should be no risks involved. However it is possible that in talking about yourself and your experience of your CTO, you may revisit memories you find upsetting. If during the interview you become distressed, you can take a break or end the interview at any time without giving a reason. After the interview, you may wish to seek support via people involved in your care.

**What if something goes wrong?**

If you wish to make a complaint about the research you can contact Julia Stroud in the first instance, as the person co-ordinating the research; Tel (01273) 643853, email: [J.Stroud@brighton.ac.uk](mailto:J.Stroud@brighton.ac.uk). If you are not satisfied with the action taken, you can make a further complaint to Professor Phil Haynes at the University of Brighton by telephone: (01273) 643465 or email: [P.Haynes@brighton.ac.uk](mailto:P.Haynes@brighton.ac.uk).

**What will happen to the results of the research study?**

We will write a report and a summary about what we find in the research we will send you a copy of the summary. We hope also that the results will be published in journals which may be of interest to those involved in the treatment and care of Service Users on CTOs.

**Contacts for Further Information**

If you would like any further information about the study or to talk with someone before deciding whether to take part, please contact:

**Laura Banks, Research Fellow**, University of Brighton, Falmer, Brighton, BN1 9PH. Tel: (01273) 644599 or email: [L.C.Banks@brighton.ac.uk](mailto:L.C.Banks@brighton.ac.uk).

**Ruth Chandler**: Service User & Carer Co-ordinator for research, LEAF (the Lived Experience Advisory Forum) at: Sussex Partnership NHS Foundation Trust, 76–79 Buckingham Road, Brighton, BN1 3RJ. Tel: (01273) 265896 or email: [Ruth.Chandler@sussexpartnership.nhs.uk](mailto:Ruth.Chandler@sussexpartnership.nhs.uk).

Thank you very much indeed for reading this. We hope that you will agree to take part in this study. If so, **please fill in the attached consent form and return this to us in the stamped addressed envelope provided.**