University of Brighton

# Social Factors, Care and Community Treatment Orders (CTOs). Service User and Practitioner Perspectives

## A report on preliminary findings from Phase One of the study, January 2017

## Summary


### From the analysis of data on CTOs in England:

- NHS Trusts vary in their use of CTOs.
- NHS trusts' use of the Mental Health Act use varies considerably, in accordance with the size of the population they cover.
- The use of CTOs is also impacted upon by regional and demographic differences.
- The mean average number of CTOs made per Mental Health Trust in England in 2014-15 was 53
- The maximum number of CTOs made by any one Mental Health Trust in IN 2014-2015 was 210
- Sussex has a relatively high number of CTOs compared to its total MHA activity.

### From the analysis statistical data on CTOs in Sussex:

- Data supports the existence of some basic social challenges and difficulties for service users.
- Basic social challenges and difficulties include: homelessness, single status, no occupation - and the CTO population is at quite an advanced stage of life (average age is quite high/middle aged).
- This suggests that by the time someone is placed on a CTO, a lot of their life has not been going well … so, it appears that 'late' intervention will require significant resources and impact to be successful.
- It indicates a fairly major 'social' holistic intervention is needed to aid recovery and bring the person 'back' into society.

### From a survey of 181 practitioners (Responsible Clinicians and Care Co ordinators) in South East England:

- There was considerable similarity between the views of the different professional groups.
- Professionals are cautious about discharge.
- There are good reasons to be cautious when one adds together the medical and social factors reported.
- The survey shows social factors are very much taken into account by professionals alongside medical and risk factors.


## Background

Community Treatment Orders (CTOs) have been available since 2008 for service users who have been on a treatment order (s3, s37). CTOs were introduced to enable services to support and treat service users who refused treatment and assistance and who would deteriorate and be re admitted to hospital – the so called 'revolving door' syndrome. The introduction of CTOs was controversial for human rights reasons and because a systematic review before their implementation provided inconclusive evidence as to their effectiveness (Churchill et al 2007). CTOs have been used extensively. In 2014/5 there were 4,564 people subject to a CTO with 2369 recalls and 3918 revocations or discharges - an increase of 7.9% (HSCIC 2015). A disproportionate number of service users on a CTO are from minority ethnic groups (CQC 2015).

Significant themes in existing research has been the effectiveness of CTOs (e.g. Burns et al 2013; Rugkasa et al 2015) and practitioner and service user experiences (e.g. Coyle et al 2015; Riley et al 2014; Light et al 2014;

Stroud et al 2014; 2015). At present there is a lack of evidence with regards to the social and environmental factors that service users on CTOs experience and to the factors, especially social factors, associated with the discharge and renewal of CTOs and with recall to hospital. The rate of discharge from CTOs is unclear. Gupta, et al (2015) suggest a discharge rate at about 30% and Dye et al (2012) found that in some cases CTOs were allowed to expire rather than be formally discharged.

It is challenging to identify Literature in England and Wales that specifically deals with issues of CTO discharge. Current research, generally, confirms the associations that are known about discharge. DeRidder et al's (2016) recent review restated that the most important factors considered in discharge are clinical factors, adherence and improved insight. There is also evidence (see Churchill et al, 2007; George & Joseph, 2009; Weich et al, 2014) of risk-related considerations in relation to early discharge, e.g. the potential for relapse, that service users feel supported and therefore don't want the CTO to end.

Overall, social factors are not mentioned explicitly in research related to discharge, though some (e.g. DeRidder et al, 2016; Gibbs, 2010; Manning et al, 2011; Romans et al, 2004; Vine et al, 2016) mention social relationships, housing and access to community treatment in terms of what a patient might need *if* discharged. However, these are not discussed in terms of their significance to decisions about discharge and not included in any numerical analysis that rates variables associated with discharge.

Some studies (e.g. Dawson & Mullen, 2008; Manning et al, 2011; Patel, 2008) consider the role of tribunals and service user influence on discharge decisions. In an Australian study (Patel, 2008), statistics on discharge via tribunal were high indicating CTO's may not be being routinely discharged when they should be. In another Australian study, Vine et al (2016) suggest unplanned or abrupt discharge arising from expiry or review board may be associated with worse outcomes.

One study made an association between discharge and ideas of recovery (Simpson et al, 2016) though it was not clear whether these comments were CTO specific. However, it begs the question whether service users on a CTO are having the same opportunities for interventions and support to promote recovery as other service users.

# About the study

This study is concerned with exploring issues relating to the **discharge and renewal of CTOs**: it is focussed particularly what social care factors may be involved in these processes.

It is a **mixed methods** study involving:

- The quantitative analysis of national and regional data on CTOs and of survey data from a survey of 181 RCs and CCs regionally (Phase One).
- The qualitative analysis of data from interviews with Responsible Clinicians, Care Co ordinators and Service users (on a CTO April 2014 to March 2016 )- (Phase Two, Streams 1 and 2).
- A small, qualitative, longitudinal case study with service users (on a CTO made between July & October 2016 ) - and with their care co ordinators and any other person significant in their lives – if they agree. (Phase Two, Stream 3).

**Research Question.** The study seeks to answer the following question:

- What are the factors, particularly social care factors, associated with the discharge or renewal of a Community Treatment Order and with recall to hospital?

**Research Aims.** The study has the following aims:

- To identify and understand the **factors, particularly social care and social environmental factors, associated with the discharge or renewal of a CTO and with recall** to hospital.

- To **identify the social interventions and support** which are provided and to explore whether these are experienced as helpful by service users, in order to inform good practice.
- To explore and understand **whether relationships (personal and professional) or loneliness are influential** in CTOs being renewed or discharged, or there being a recall to hospital.

**Other key features**

- Funded by National Institute for Health Research (NIHR) School for Social Care Research (SSCR).
- Project started 4th April 2016: ends May 2018
- **Project Advisory Group** ( Practitioners; Service Users; Carer; University Staff; Trust Research staff) – input into design and content of survey; interview schedules; data analysis; dissemination and impact
- **Peer Researcher Group** – 7 members – undertake interviews jointly with University research staff if service user participant requests this - peer researchers are also involved in qualitative data analysis and making a dvd about service user involvement in the project

# Statistical Analysis of Data on CTOs in England

## The nature of the data available

- Data on CTOs in England are collected by monthly returns to the Health and Social Care Information Centre (HSCIC) and are published monthly as part of the Mental Health and Learning Disability Minimum Dataset (**MHLDDS**) and **KP90** which is published annually.

- There are significant differences between the two data sets and the CQC (2016) have stated that providers are not consistently making the required returns.

- KP90 includes more detail about CTOs e.g. the section to which the person was subject previously; the number of CTO recalls to hospital; revocations and discharges from a CTO. Type of provider (i.e. NHS/ independent) is identified. Although there is a breakdown by provider of people subject to the MHA, there is no regional breakdown of the use of CTOs. This limits the analysis that can be carried out which would allow us to better understand variations in the way CTOs are used across England

- HSCIC have a Data Access Request Service - an application was submitted for CTO data by provider trust and with demographic breakdown (i.e. age group, gender and ethnicity), which would have enabled us to identify patterns and trends in the use of CTOs

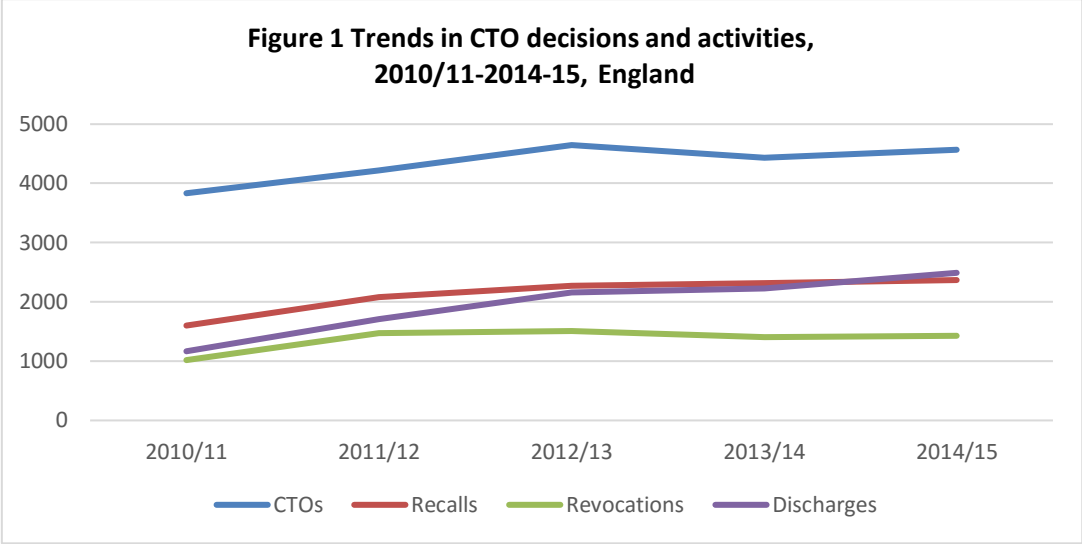
- We could not proceed with the application, however, because the cost, data protection and contractual requirements were prohibitive and it was not clear whether the data we would receive would meet our requirements. Therefore, we used the HSCIC data on CTOs which was in the public domain over Summer 2016; this limited the analysis we were able to undertake

## Analysis of data on CTOs in England

As stated, the preliminary source for these data were the public information held on the Health and Social Care Information Centre (HSCIC) website, reference SSDA 702 and KP90 **www.hscic.gov.uk**

- Ninety five percent (n=4,323) of all CTOs followed a section 3 under the Mental Health Act

- The national trend of activity is that approximately 4,500 CTOs are made each year (n=4, 647 in the peak year 2012-13) (see also **Figure 1**).




***Source:*** *Derived from public information at the Health and Social Care Information Centre (HSCIC). 2015, Table 3, KP90.* [*http://www.hscic.gov.uk*](http://www.hscic.gov.uk)

- CTOs made by Independent/ private hospitals form a very small element of all CTO activity (n=218 in 2013-14).

- **Figure 1** shows that recalls, revocations and discharges have followed a similar trend in the last five years to the making of CTOs, with only a marginal increase in discharge orders above trend in 2014-15.

- There are considerable regional variations in the making of new CTOs in 2014-15. The England population ratio of CTOs is 101 orders per million. The highest regional rate is in London (157 orders per million) and the lowest regional rate is East Midlands (with 69 cases per million).

- South East England has 73 CTO new cases per million in the population.

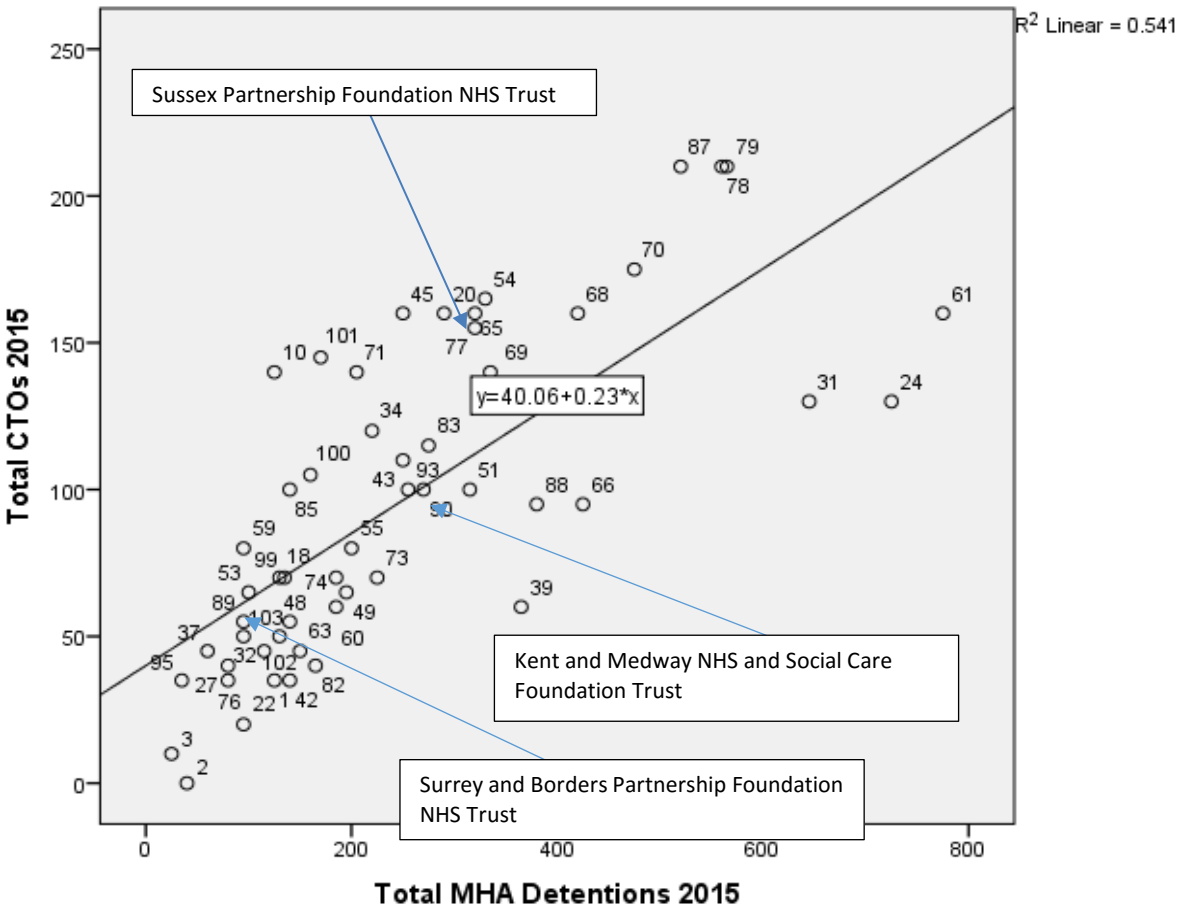
- The South East has the lowest rate of continuing CTO cases per million at 93 per million, where the England ratio is 122 per million.

- When examining differences in Mental Health Act activity in NHS Mental Health Trusts in England there was a moderate national correlation between the number of detentions and CTOs made by a Trust (Pearson = 0.736 p=0.0001).

- However, Trusts vary considerably in their scale of mental health operations and this is reflected in CTO activity. The mean average number of new CTOs per trust was 53 in 2014-15, but this varied between a maximum of 210 and a minimum of 0.

- **Figure 2** shows that Sussex Partnership NHS Trust has a high ratio of CTOs to mental health detention being above the national NHS Trust regression line with 155 new CTOs in 2014-15. Kent and Medway and Surrey and Borders (involved in the survey of practitioners) fit the expected picture for England with their ratio of CTOs to Mental Health Act detentions being on the national regression line.

**Figure 2. The relationship between prevalence of total Mental Health Act Detentions and CTOs, Mental Health NHS Trusts in England, 2015**




***Source***: *Derived from public information at the Health and Social Care Information Centre (HSCIC). 2015.* *http://www.hscic.gov.uk*

- There was no conclusive evidence of NHS trusts converging towards as similar use of CTOs in ratio to other mental health activity.

# Analysis of data on CTOs in Sussex

- A data sample of 340 CTOs was analysed (CTOs made 2013 – 2015)
- Two thirds of all CTOs made are for men (65% n = 221)
- Women subject to a CTO are more likely to be older (mean average age 51, compared to 43 for men)
- The sample was predominantly white British (83% n =282). 17 (5%) were from other white ethnic cultures. 5 (1.5%) orders were to those describing themselves as Black British
- There was no evidence that gender, age or ethnicity affected CTO outcomes.
- A high percentage of these CTOs (77% n=256) recorded their relationship status as single.

- A high percentage recorded their occupational status as unemployed (83% n=210). 9.5% (n= 24) were retired. Only 2% (n = 5) were working full time and 1% (n=3) working part time. Only one person was volunteering.

- While 73% (n=126) perceived they had a mental health disability, 17% perceived that they had no disability. The number of people recording additional disabilities was small. For example, three people had mobility difficulties. It seems likely that there is an under recording of disability status at the point of a CTO commencing.

- The sample reported a diverse range of accommodation circumstances. 14% (n=34) were living in some form of hostel, care home, or supported accommodation, 13% (n=3) were living with family, and 7% (n=17) were homeless.

- In Sussex 94% (n = 319) had been subject to a section 3 order before being subject to a CTO. (England rate is 95%)

## Characteristics of service users subject to one CTO

- Within the sample time period, 272 individuals experienced one CTO only
- The most likely outcome from a service user's experience of one CTO was discharge (39% n = 133)
- CTOs who reported as homeless were less likely to experience discharge when compared to all other accommodation statuses, with only two homeless CTOs eventually being discharged.
- 26% (n = 89) of these CTOs were recalled and revoked: only one was currently subject to recall (where no further decision had been made at the time of the data collection).
- Another 7 % (n =25) of CTOs had come to an end and 23% (n = 77) were ongoing or subjected to renewal.
- Two people subject to CTOs were deceased (ie. less than 1%).
- The average time span of respondents' first CTO was seven months. The maximum time span was 37 months.

## Characteristics of service users subject to a second CTO

- 60 service users experienced a second CTO.
- 32% (19) of these were revoked – a higher proportion to those on a first CTO
- 25% (15) were discharged
- 38% (23) were renewed or still ongoing in first six months
- Average time span of CTO for this cohort was five months
- 1 person was deceased

## Characteristics of service users subject to a third CTO

- 8 service users experienced a third CTO
- Average time span for a third CTO was five months
- Six were revoked
- Two people were deceased

## Note: Demographic information of five deceased service users across the sample.

- 2 women, 3 men
- Average age 57, so older.
- Accommodation – independent. No homeless, one in low level supported accommodation.
- 3 single, two had partners.
- 4 unemployed ( 1 unknown occupational status)

# Analysis of survey data from Responsible Clinicians and Care Co ordinators in Kent, Medway, Surrey and Sussex

- A total of 181 professionals (RCs and Care Co-ordinators) completed a self-completion online questionnaire across Kent and Medway, Surrey and Sussex.
- 64 were responsible clinicians and 119 were care coordinators.
- The largest professional group answering the questionnaire was psychiatric nurses (42% n = 77), followed by psychiatrists (30% n = 54) and social workers (19% n = 35) there were smaller representations from psychologists, occupational therapists and psychotherapists.

## Characteristics of respondents

- **Gender:** 43% (76) male; 57% (100) female
- **Age:** 43% (76) aged 45-54; 23% (40) aged 55-64; 22% (39) aged 35-44
- **Ethnicity:** 70% (122) describe themselves as White/British; 9% (16) as Black African/British. 4% (7) as Asian/British or Indian.
- **Professional Experience:** 34% (61) had over 20 years' experience and 78% of the sample (138) had over 10 years professional experience;

## Discharge

- Twenty five percent (n = 45) agreed when a patient is well and taking medication they should be discharged as soon as possible.

- Thirty nine percent (n=70) were neutral and 36% (n = 66) disagreed.

- There was a lot of similarity between the different professionals about what factors were significant to make a discharge decision.

- There were some small differences for occupational therapists and psychotherapists when compared to the other larger professional groupings. OTs and psychotherapists were more likely to support the discharge of a CTO when a patient was well and taking medication.

- While good engagement with mental health professionals and taking medication were very significant or extremely significant factors when deciding upon discharge, for about 90% of the sample**, social factors** were also often seen as very or extremely significant.

- For example, 'positive relationships' were seen as very or extremely significant for 63% (n = 112) of the sample.

- 'Living in appropriate accommodation' was seen as very or extremely significant for 54% (n = 98).

- 'Engagement with positive social activities' was seen as very or extremely significant for 51% (n=91)

- 'Engagement in meaningful occupation' was seen as very or extremely significant for 41% (n=73)

- 'Engagement with support groups' was seen as very or extremely significant for 28% (n = 51)

## Renewal

- Again, there was a lot of similarity between professionals about what factors were significant when making a decision to renew an order.

- The factors of a 'patient being currently unwell or 'not always accepting their need to take medication' was rated as very significant or extremely significant for making a renewal decision by over 80% of the sample. Psychiatrists were marginally more likely to rate these factors as extremely significant.

- **Social factors** were also a key influence on decisions, for example, with the concern that 'the patient's lifestyle is chaotic and they require considerable support and monitoring', being rated as very or extremely significant by 83% (n = 147).

- A concern that the patient was socially isolated was seen as very significant or extremely significant factor in renewal decisions by 47% (n = 82).

- Use of recreational drugs by the patient was seen as a very significant or extremely significant factor in renewal decisions by 49% (n =88).

## Recall

- Over 99% of professionals stated that risk to self and risk to others were very significant or extremely significant reasons for recalling a CTO.

- In addition, 87% of professionals stated that concerns expressed by carer/family/friends were very significant or extremely significant reasons for recall.

## Key themes that emerged from respondents' free text comments in the survey

- Importance of service user insight (into mental health problems and causes of relapse)
- Abstinence from alcohol and use of illicit substances
- Financial stability (e.g. debts/ benefits 'sorted out')
- Stable personal and professional relationships ('meaningful relationships') – not being alone
- Views of significant others
- Engagement with some kind of activity/ group (from gym membership to membership of a church or religious group)

# Preliminary conclusions

- The use of CTOs under the Mental Health Act is a relatively small proportion of activity when compared to the total picture of all legal activity covered by Mental Health Act.

- Discharge is the most likely outcome of a CTO, indicating some degree of success with CTOs as an intervention, but revocation and renewal activity is also frequent. Recall only to hospital (i.e. for 72 hours) is rare and is more often associated with revocation (and therefore is recorded as the latter).

- Social factors like accommodation problems, relationship difficulties, and recreational drug use have a substantial influence on discharge and renewal decisions. These factors influence decisions only marginally less than issues to do with mental health treatment (compliance with medication), risk to self and others.

- Living alone as a single person, without a meaningful occupation, or as homeless, present major challenges to those subject to CTOs

## Research Team

Dr Julia Stroud, Reader in Social Work, Principal Investigator
Professor Phil Haynes, Professor of Public Policy, Co-Investigator
Dr Ceri Davies, Research Fellow, Co-Investigator
Ms Laura Banks, Research Fellow, Co- Investigator

## For further information please contact:

J.Stroud@brighton.ac.uk

## NIHR SSCR Disclaimer

The study represents independent research funded by the National Institute for Health Research (NIHR) School for Social Care Research (SSCR).
The views expressed are those of the authors and not necessarily those of the NIHR, SSCR, Department of Health, or NHS.

## References

Burns T., Rugkåsa J., Molodynski A., et al. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* 2013; **381:** 1627–33.

CQC (2015). *Monitoring the Mental Health Act in 2013/14,* Newcastle Upon Tyne, Stationery Office.

CQC (2016). *Monitoring the Mental Health Act In 2014/15,* Newcastle Upon Tyne, Stationery Office

Churchill et al (2007). *International experiences of using community treatment orders.* Kings College, London. Available online: http://psychrights.org/research/Digest/OutPtCmmtmnt/UKRptonCTO.pdf (Accessed, October 2016)

Coyle, D., et al. (2013). "Compulsion in the community: mental health professionals' views and experiences of CTOs." *The Psychiatrist* 37(10): 315-321.

Dawson, J., & Mullen, R. (2008). Insight and use of community treatment orders. *Journal of Mental Health*, 17(3), pp269-280

DeRidder, R., Molodynski, A., Manning, C., McCusker, P., & Rugkåsa, J. (2016). Community treatment orders in the UK 5 years on: a repeat national survey of psychiatrists. *BJPsych Bull*, 40(3), pp119-123.

Dye, S., Dannaram, S., Loynes, B., & Dickenson, R. (2012). Supervised community treatment: 2-year follow-up study in Suffolk. *The Psychiatrist Online*, 36(8), pp298-302.

George, M.K. & Joseph, R. (2009). Is this not discrimination? *BJPsych Bulletin*. DOI: 10.1192/pb.33.11.439

Gupta, J., et al. (2015). Application of community treatment orders (CTOs) in adults with intellectual disability and mental disorders. *Advances in mental health and intellectual disabilities*. 9(4). Pp196-205

HSCIC (2015). *Mental Health Bulletin. Annual Statistics 2014-15* http://content.digital.nhs.uk/catalogue/PUB18808/mhb-1415-ann-rep.pdf (Accessed September 2016)

Light, E. et al. (2014). The lived experience of involuntary community treatment: a qualitative study of mental health consumers and carers. Australasian Psychiatry, 22, 345-351.

Manning, C. et al (2011). Community treatment orders in England and Wales: national survey of clinicians' views and use. *The Psychiatrist Online* 2011, 35. pp328-333.

Patel, G. (2008). Community Treatment Orders in Victoria: a clinico-ethical perspective. *Australasian Psychiatry*, 16(5), pp340-343

Romans, S., et al (2004). How mental health clinicians view community treatment orders: a national New Zealand survey. *Australian and New Zealand Journal of Psychiatry*. 38. pp836–841

Rugkåsa, J. & T. Burns (2009). "Community treatment orders." *Psychiatry*, 8(12). pp93-495.

Simpson, A. et al (2016). Cross-national comparative mixed-methods case study of recovery-focused mental health care planning and co-ordination: Collaborative Care Planning Project (COCAPP). *Health services and delivery research.* Volume 4. Issue 5

Stroud, J., Doughty, K ., & Banks, L. (2013). *An exploration of service user and practitioner experiences of community treatment orders.* Project Report. University of Brighton. https://www.brighton.ac.uk/_pdf/research/ssparc/ctos-report.pdf

Stroud J, Banks L. and Doughty K. 2014. *An Exploration of Service User and Practitioner Experiences of Community Treatment Orders.* NIHR, School for Social Care Research: London. http://www.sscr.nihr.ac.uk/PDF/Findings/RF18.pdf

Stroud J, Banks L. and Doughty K. 2015.Community treatment orders: learning from the experiences of service users, practitioners and nearest relatives. *Journal of Mental Health*. 24: 2: 88-29

Vine, R. et al (2016). Mental health service utilisation after a Community Treatment Order (CTO): a comparison between three modes of termination. *Australian and New Zealand Journal of Psychiatry* 50. pp363–370.

Weich, S. et al (2014). Variation in compulsory psychiatric inpatient admission in England: a cross-sectional, multilevel analysis. *Health services and delivery research.* Volume 2. Issue 49