Bar chart showing the number of people on SCT by age and gende

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# CONTEXT

This research study investigates Service User and practitioner experiences of Community Treatment orders (CTOs) within a climate of person

# RESULTS

# QUANTITATIVE DATA

A statistical analysis of Trust records from the year before the study commenced (July 2010 June 2011) and

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

of S 17 Leave were

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 1865-1863/246.difference 10041) and 262271cd Brogene 24/2(1 0 0] (It )-3(b)-4(y)-4q)-2(e)4(ca-2(tia)-3f434)

### 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

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 involv 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 deteriorates or refuses their medication or something else happens that has a negative impact on the Service User mental health. Several Service Providers mentioned importance of that the focus on medication took emphasis away from social aspects of care that are also crucial for the long-term success of treatment.

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.

### INDICATORS FOR GOOD PRACTICE

A number of indicators for good practice have emerged in the 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 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

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

Whilst multidisciplinary teams

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

(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 w

## APPROVED CLINICIANS AND

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

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 *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

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

compulsion within the defined legal context set out in the MHA 1983 was often seen to be accompanied by constraints on everyday actions th

removed any obligation on professionals to discuss, consult or negotiate matters of crucial personal 2000 p.13).

The introduction of CTOs was preceded by lengthy debate about compulsory powers of treatment outside enable services to provide support and treatment to

those in need who would otherwise refuse it, deteriorate and return to hospital as a r 2010 p. d to the change in mental health service provision, with community based care and treatment the preferred option alongside that 4% of all mental health patients surveyed (n.1371) were on a CTO. Evidence also suggests that th

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

The OCTET study chose readmission to hospital as their primary outcome because CTOs have arguably been

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

### 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 (ASVs, 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 dear 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 hat was described by Service Users in Barnes et al.

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 B (2000) study found that compulsory detention in hospital could have a serious adverse impact on S

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.

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 provheTBT1 0gs69 453.79 Tm[iapT8-4(h)-4(e)4aTBT1 0gs69 453.79.1 287.33 688.4

oveumbers of intervies in tota fore-3(ach)-5(.)] TJETBT1 0 0 1 463041 153.79 Tm[(p)-4(ar)-2(ticip)-3(an)-ted ru

# INTERVIEWS

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

PARTICIPANTS

## 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.

### 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).

### 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

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

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. Snoe 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.

# 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

## DURING THE STUDY PERIOD JULY 2011 TO DECEMBER 2012

NUMBERS OF CTOS ISSUED AND OUTCOMES

During the period of the study (July 2011 December 2012) CT)8 59583 s7.1 w Tm[(Dere9JET14()5(cadb)-16(q. /F3 U)-8(nBTike)31

# ETHNICITY

and a further 6% recorded as

experienced as reassuring; especially if there ha

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 dear difference to their care and their own opportunity, as a Nearest Relative, to be listened to by members of their xperience of her son being placed on the order:

the other big thing abo t the CTO as I e nderstood it is that the are no allo ed to incl de 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 s I can ring the CPN and sa I m orried abo t him and she goes to see him and before it as Well I II 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 relative relationships may be strained, severed or absent.

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. Smilarly to Nearest Relatives, Service Providers commented that the CTO enabled a speedy intervention in the case of deterioration of the Service User

# Service User without causing undue stress and anxiety at time of recall, and from the perspective of ensuring staff safety.

There is an inter-ention that can be so ght 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 as er little reco er ork going on beca se e 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

Medication is often a contentious issue and the Service User with side-effects and their subjective asses

Several Service Providers reported that Service User commonly evidenced by a belief that they did not need medication which resulted in reluctance or unwillingness to take medication. It was particularly 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.

Basicall he doesn t belie e that he has a mental health problem ... he was on 300 milligrams [of XXX] at nighttime b the decided that some das o d take , 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 belie e it or not he s totall a different person, o kno And he doesn t act all belie e it b the is a completel q ite a different person beca se he s been taking that medication reg larl b the still doesn t like it and he still arg es abo t it and hich is fair eno gh b t it doesn t matter ho m ch o act all sa Well, a co ple of ears back e o ldn t be able to ha e this con ersation o kno hile e can no (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 8.3 580.18 Tm[(s)5() >50/19A017D >60/200m]/Type/Pagination >BDC -5(s)5(p)-16(e)/4(ct 8.3)

So I think he j st needs integrating someho into the comm nit b tits hat to do if o don t see an bod else it s like old people isn tit The go into a little shell don t the (NR3).

# 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 that e a choice hich as j stas ell reall as I co Id 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 mit rebet een 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 o Id rather not b t I ha e to other ise I II go back to hospital (SU20).

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

[The CTO as sed to keep me in check and to make s re that I didn t stra off the path And no I m off the CTO and officially off my section, I was on the CTO for about four, five months (SU4).

Smilarly, dinicians 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 ho e rep tting on Comm nit Treatment Orders, they start to reengage better, they comply

# 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).

# Service User, the CTO is ineffective and

## potentially harmful for therapeutic relationships. One Care Coordinator says:

Where people don t b into it and don t accept the a thorit in hich it is granted then o can recall them

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 hen o 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

### CONDITIONS

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

 I phoned up that morning to tell [Care Coordinator] I as going a a and so she said Oh no, no no I can t let

 you do that So she j st said Do hat o ant so I went to the airport to go, and there were the police

 (SU1).
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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 as fine ith it I nderstand no ho it orks 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 e and here it s been effectie and I have sort of seen case notes and talked to Care Coordinators and seen their records here perhaps the restarting to relapse and I e 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

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

#### The same Nearest Relative goes on to comment:

I mean I think he is a bit of a trial and error case so mabe the don t kno perhaps it s all learning all the time I don t kno ... I don t reall feel that I fully know exactly what is going on (NR2)

I now have a voice which I didn that e before it as Well you can let me know what you think about how or son is bit I can t listen to o or e not in olled and bilatorial or can tibe I miclocking and taking do n what you resaling in michead and I microring it bit I can t do an thing becase of that o said and e can t disciss it ho hat e old do either nor can e go to him and do an thing it he becomes so ill that he sign 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 e kno n he s going do nhill and I ha e felt that I as n t reall being listened to enough then and I had tried to toooo ill

#### It hasn t been itho t 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 somebod s on a CTO and the agree to come into hospital that one thre sinitial beca se e thought are we recalling them? Are we revoking them? Or are they going to be an informal patient or are they still detained Yo kno e sort of that as initial and I mean no e e got or heads ro nd it b t it as 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

AMHPs regarded the necessary skill set to do their job to include awareness of Service User

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 partic lar profile of a person I get a sense that there are more males considered for CTO than females and I m not q ites re h 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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re ie it s done and d sted the ant to discharge them on a CTO that da 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 on t ork nless the ha e a good relationship ith 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 its not there its not going to ork (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 reall diffic It beca se if hen I choose not to p t somebod on a CTO hen I sa no there s q ite often q ite a lot of anger or resentment in the team aro nd ell o kno h co ldn t o j st do that and they are going to get unwell now, or, and I think without sort of them looking at how we are restricting somebod s libert 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

taken a step backwards since the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al twit wgng.95 Tm[(e)4(step 2010) al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-4(p)t ua-5(e)4( o)-5019A011E>90gg1 0 0 al the introduction of 54 Tm[(p)-5019A011E>90g10 al the introduction of 54 Tm[(p)-5019A011E>90g10 al the

### CONDITIONS

# 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 s

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

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

et up to handle high-risk and high-need cases. Not all RCs were as happy to work with compulsion unless deemed absolutely necessary:

W

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

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 the don t co nt 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,

### TYPES OF DIAGNOSES AND TYPES OF SERVICE USERS

# 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:

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# 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 e j st seen he doesn t ha e a post-bo in his flat and there s no a of getting into the flat so e had to send one to him in the post once and again that as n t it as a bit disastro s it doesn t ork ith the Tr st s Bed Management Polic cos o get ho rs and b that time the bed s gi en a a That s the other h ge diffic It that the Tr st Bed Management Policies don t can t deal ith 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 pala a b t easier than sorting o t a fresh Mental Health Act assessment that s for s re (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:

Beca se I d e plained to her beforehand that this as the po er that the CTO ga e 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 ork o t for herself that the best thing to do as j st to take her medication She s been absol tel fine for the last 18 months or two years since that happened (RC 9).

### DISCHARGE

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.

### CARE COORDINATOR

### THERAPEUTIC RELATIONSHIPS

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 OPN 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 C

# 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 as er little reco er ork going on beca se e 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

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

The more restrictie o make them the less sef I the are and the more o rekind of selling people p to not be labelled to do hat o reasking them to do So e e I g ess there s been occasions hen e e had stuff on there about attending drug and alcohol services for instance or providing drug screens. But even, that, e tend not to do reall no beca se again e e got sort of a high percentage of dual diagnosis - people who it s j st not al a s 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 as on oral medication and I co Idn t monitor that on a da to da basis so I as ha ing 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

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.

SERVICE PROVIDER EXPERIENCES

We re the people ho are going to be orking ith them on a da to da basis, Care Coordinator may have a

Because he is on a Community Treatment Order, the risk is red ced for me beca se I don t ha e to think abo t W

## 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 ROs and AMHPs. Some AMHPs for example describe ROs as too risk averse and are unhappy about ROs and Care Coordinators deciding upon the CTO and even informing the Service User before involving AMHP. ROs 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-pat9(e)4(ag1550.15 Tm3BT1 0 c9e)-7(s)n

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

# INDICATORS FOR GOOD PRACTICE

This section outlines a number of indicators for good practice which emerged from

PARTICIPANT INFORMATION SHEET FOR PRACTITIONERS AND SERVICE PROVIDERS

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.

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.

Any complaints should be referred to the Dr Julia Stroud (the person coordinating the research) in the first instance; Tel: (01273) 643853 or email: <u>JStroud@brighton.ac.uk</u>. 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: <u>P.Haynes@brighton.ac.uk</u>.

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 B

(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.

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.

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

University of Brighton, Falmer, Brighton, BN1 9PH; Tel: (01273) 644599 or

email: LC.Banks@brighton.ac.uk.

SOCIAL CARE PRACTITIONER/ SERVICE PROVIDER PARTICIPANT CONSENT FORM

## NEAREST RELATIVE PARTICIPANT CONSENT FORM

- 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 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.
- ٠

#### SERVICE USER PARTICIPANT CONSENT FORM

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): .....

Sgned: .....

Date:....

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

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:

Name:	<u> </u>
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:
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## PARTICIPANT INFORMATION SHEET FOR SERVICE USERS

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.