University of Brighton

# NIHR School for Social Care Research

## Research findings

# An exploration of service user and practitioner experiences of Community Treatment Orders

## KEY POINTS FROM THE RESEARCH

■ The CTO was often understood as providing legal recognition of the need for care and to provide structure and containment for the 'right' service user.

■ Care for CTO service users was defined as predominantly medical.

■ Misunderstandings exist over the actual powers and conditions of CTOs.

■ Examples were apparent of person-centred care incorporated into practice. However, this was more evident at review stage than at earlier points in the process.

■ CTOs were perceived as more successful in teams where they were carefully planned over time as an appropriate intervention, rather than where they were made almost as a matter of course, and involved the service user as much as possible.

■ There is a need for improvements in provision of information including details of the service user's right to advocacy services.

This research explored service user and practitioner experiences of Community Treatment Orders (CTOs) in the Sussex Partnership NHS Trust area, within a policy context of person-centred care that aims to provide service users with increased autonomy and choice.

The research aimed to:

• understand how compulsory powers were being used in an environment in which practitioners are encouraged, and service users expect to be consulted, to exercise choice to a greater extent than previously;

• 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; and

• 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 readmission.

## BACKGROUND

CTOs were introduced in 2008 by the Mental Health Act 2007, following protracted public and political concern over the arrangements for the care of the mentally ill in the community. CTOs are only available for service users who have been detained in hospital for treatment (sections 3 or 37 Mental Health Act 1983) and have two mandatory conditions relating to medical examinations, but discretionary conditions can also be made. Once discharged on a CTO, the service user can be recalled to hospital without the need for a further Mental Health Act assessment. The service user's consent to the making of a CTO is not a requirement in law. Clearly, the conceptualisation of CTOs is at odds

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with the precepts of person centred care and this study explored experiences and uses of CTOs in the contradictory policy context of promoting autonomy and choice on one hand, and enforcing compulsion and control on the other.

## FINDINGS

### Quantitative analysis of NHS Trust records of CTOs

Trust records showed 199 new CTOs were made during the study period (July 2011 to December 2012). Just over a quarter (52/26%) of these service users had their CTO discharged, 64 (32%) were revoked, 8 allowed to lapse (4%) and 3 (2%) transferred, while the remaining 71 (36%) were still active, having either been renewed or not yet due for renewal.

The majority of those subject to CTOs were diagnosed with schizophrenia (the most common being paranoid schizophrenia, 53%), or schizoaffective disorder. Apart from the mandatory conditions attached to CTOs, the most common condition specified, evident in a third of cases (65/33%), was around adherence to a prescribed medication regime.

Most service users were male (62%), but the majority (68%) of those aged over 50 were female. The mean average age of service users was 44, with the majority aged between 35 and 59 (56%), almost a third (63/32%) aged under 35 and 22 (12%) aged 60+. CTO service users in the sample were most likely to be single (150/75%), which excludes those who were divorced, separated or widowed (29/15%) and only 20 (10%) were recorded as married, in a civil partnership or cohabiting.

The large majority (185/93%) were recorded as White British, White Other or White Irish, while the remaining 14 (7%) service users were categorised as Black, Asian or Mixed Race. Although national Care Quality Commission (2014) data has indicated an over-representation of service users from ethnic minorities, these statistics reflect the general population of the Sussex Partnership area according to 2011 Census data (in which those categorised as White comprise 94%).

### Key themes from qualitative analysis of interview data, common to all groups interviewed

*A legal recognition of the need for care*

The CTO was found to provide not only a legal framework to support enforced care in the community but a common theme, especially among service users and their relatives, was that the order provided a legal recognition of the service user's need for care. Service users, relatives and service providers often expressed how the CTO's legal requirement to 'check-up' on the service user made a significant difference to the amount of contact the service user had with services. Furthermore, this legal recognition of the need for care was commonly experienced as reassuring, especially if there had been concerns about receiving adequate care in the past.

The specific advantages of recall 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 for re-admission; and (iii) that the service user could come into hospital for 72 hours and thereafter be discharged back into the community under the same CTO.

*Structure and containment for the 'right' service user*

Related to the previous theme, there was also a sense across the groups that the CTO could provide structure and (for some) a reassuring 'safety net'. The 'right' service users were perceived as those who were treatment-resistant prior to being subject to the CTO and often lacked 'insight' into their mental health needs.

However, whether the CTO was successful or not depended on the presence of a range of factors for the service user: (i) the motivation to get well and/or progress to independence; (ii) finding structure and/or legal recognition of need for care reassuring; (iii) respect for legal power and/or regard recall to hospital as a deterrent; vi) 'grudging' acceptance that conditions of the CTO are in own best interest (although this acceptance often came after being on the CTO for some time, with a recognition of greater stability).

The element of control was found to be experienced as a reassuring 'structuring force' that was attributed to a progression towards greater stability in many cases. An understanding of the CTO as a 'contract' could be helpful in containing mental health issues and shifting an element of responsibility away from the individual and on to services. However, some practitioners felt that for the 'wrong' kind of service user, where the CTO is experienced as restrictive and punitive, the CTO can be ineffective and potentially harmful for therapeutic relationships.

*Care defined as predominantly medically driven*

The CTO's primary function was found to be a framework for the administration and monitoring of medical treatment and this medically driven aspect of the CTO far outweighed social care elements, particularly when the CTO was made.

This was reflected in care plans. 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, leading to multiple hospital admissions.

Although, many professionals, nearest relatives and service users themselves (typically retrospectively) conceded medication was a key factor in achieving stable mental health, some felt that the focus on medication took emphasis away from social aspects of care that are also crucial for the long-term success of treatment. However, there were also reports that service users' increased stability, achieved through adherence to medication, provided a 'platform' from which social care supports could be accessed subsequently.

*Misunderstandings surrounding the power and conditions of the CTO*

There was a worrying level of misunderstanding around the actual powers of the CTO and its conditions. This was most apparent among service users, nearest relatives and service providers.

Most notably, service users tended to be 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.

Typically, it did not seem to be have been explained to service users that they would only be recalled following a significant deterioration in their mental health. In fact, service users reported having had little or no information about the CTO and involvement in decisions, particularly in the early stages of the CTO (although some reported more involvement at review stage) and were in some cases unaware of the availability of advocacy services.

Approved Mental Health Professionals (AMHPs), in particular, raised concerns around a lack of clear and appropriate information for service users. Practitioners were often conscious of the dilemma of providing increasing clarity and honesty as this could reduce the effectiveness of the CTO (because of a weakened view of the deterrent of automatic recall).

There was also some ambivalence among practitioners around the appropriate use and purpose of discretionary conditions. These tended to focus on medication and engagement with services. In some cases more specific conditions were attached, for example, around residency, and more controversially around use of substances and travel restrictions.

Across the groups, viewpoints were mixed as to the usefulness of including such specific conditions, with some practitioners expressing concerns around these not constituting least restrictive practice, being difficult to enforce and 'setting service users up to fail'. The service users interviewed, however, had generally complied with these conditions and examples were given of where specific restrictions had proved a helpful aspect of recovery.

## CONCLUSIONS

The study findings suggest CTOs can be effective for the 'right' service user with certain needs and perceptions: for example, to work within clear boundaries. Careful assessment of the service user's perspectives and likely engagement with the CTO framework is therefore essential.

CTOs were perceived as more successful in teams where they were carefully planned over time as an appropriate intervention, rather than where they were made almost as a matter of course. Therefore, the project team recommends that assessments should not be rushed and should involve the service user in decision making as much as possible.

Further, the research indicates a number of specific ways in which CTOs could be better aligned with ethical practice and 'person-centred' care. These include:

- Full involvement of service users in all stages of the process, through open discussion and negotiation, with awareness of how perceptions and level of understanding may fluctuate and impact on compliance with the CTO.

- AMHP involvement as early as possible in any team discussions about the potential making of a CTO (and before discussion with service users).

- Allowing sufficient time for the AMHPs to have face-to-face contact with service users as part of the assessment process.

- Avoiding decision-making around the making of the CTO taking place during a ward round since this can be a disempowering environment for the service user and often fails to provide enough time for discussion.

- Better provision of information including a user friendly leaflet with key points of information about CTOs, clarifying why it is used and what its legal powers are in relation to medication and recall.

- Clear information about Independent Mental Health Advisors (IMHAs) provided to service users while in hospital. As also suggested by the CQC (2013), consideration should also be given to making the IMHA service an opt-out rather than opt-in service.

- Nearest relatives to be involved where appropriate, including provision of clear information through a user friendly, jargon-free leaflet.

- Better information and training on CTOs to be provided to service providers.

**ABOUT THE STUDY**

The study was conducted between July 2011 and December 2012 by members of the Social Science Policy and Research Centre and the School of Applied Social Science at the University of Brighton, in partnership with Sussex Partnership NHS Foundation Trust, which covers East Sussex, West Sussex and Brighton and Hove.

A case study method was used in relation to CTOs in the Trust area and included quantitative analysis of Trust data and semi-structured qualitative interviews with 72 participants including service users, nearest relatives, care coordinators, responsible clinicians, approved mental health professionals and service (accommodation) providers.

The project was conducted with the support of an advisory group consisting of members of all the relevant professional groups as well as members of the Lived Experience Advisory Forum (LEAF) of Sussex Partnership. Peer researchers from LEAF were also involved as co-interviewers. Ethical and governance approval was obtained from NHS Research Authority NRES Committee South East – Surrey, as well as other appropriate bodies.

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- Following least restrictive practice principles, by ensuring any discretionary conditions for CTOs have a clear rationale and include the service users in discussions concerning these.

**REFERENCES**

CQC (2013) *Monitoring the Mental Health Act in 2011/12*, Care Quality Commission, Newcastle upon Tyne.

CQC (2014) *Monitoring the Mental Health Act in 2012/13*, Care Quality Commission, Newcastle upon Tyne.