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

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In collaboration with Sussex Partnership NHS Foundation Trust, LEAF, Brighton and Hove City Council, East Sussex County Council and West Sussex County Council
Outline

- CTOs – the law and policy context
- The research study
- Findings
  - Key emergent themes from all groups interviewed
NIHR SCCR Funding of the research

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The views expressed in this presentation are those of the authors and not necessarily those of the NIHR School for Social Care Research or the Department of Health, NIHR or NHS
Community Treatment Orders s17A MHA 1983

Available from 3 November 2008, when MHA 2007 amendments to Act became effective

The legal power
S17(A) (1) A detained patient admitted for treatment (s3/ 37)

a ‘compulsory treatment order’
Community Treatment Orders s17A MHA 1983

(4) The RC may not make a CTO unless -
(a) In his opinion the relevant criteria are met, and
(b) An AMHP states in writing –
   (i) That he agrees with that opinion; and
   (ii) That it is appropriate to make the order

(5) The relevant criteria are –
(a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
(b) It is necessary for his health or safety of for the protection of other persons that he should receive such treatment;
(c) Subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in hospital;
(d) It is necessary that the RC should be able to exercise the power under s17E below to recall the patient to hospital and
(e) Appropriate medical treatment is available for him
(6) In determining whether the criterion in subsection (5)(d) above is met, the RC shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient’s condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).
Community Treatment Orders s17A MHA 1983

s17B (1) A CTO shall specify **conditions** to which the patient is to be subject while the order remains in force.

S17 B(2) . . . the order may specify conditions only if the RC, with the agreement of the AMHP . . . Thinks them necessary for **one or more** of the following purposes –

(a) Ensuring that the patient receives **medical treatment**;
(b) Preventing **risk of harm** to the patient's health or safety;
(c) Protecting other persons

s 17(3) **Mandatory** conditions
Community Treatment Orders s17A MHA 1983

Duration – 6 months, s20A

Power of Recall by RC – s17E

(a) The patient requires medical treatment in hospital for his mental disorder and

(b) There would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose
Para. 25.2

The purpose of SCT is to allow suitable patients to be **safely treated in the community** rather than under detention in hospital, and to provide a way to help **prevent relapse and any harm – to the patient and others** – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and **to promote recovery**

Para. 25.6

The decision as to whether SCT is the right option go any patient is taken by the RC and requires the agreement of an AMHP. SCT may be used only if it would not be possible to achieve the desired objectives for the patient without it. **Consultation at an early stage with the patient and those involved in the patient’s care will be important.**
Wider Health and Social Care Policy

Personalisation – choice and control over own care – for example,

- Direct payments

- Health and Social Care Act 2012 (effective 1.4.13)
  ‘Greater voice for patients’

‘A key part of patient empowerment is to offer increased choice about their care’

Caring for our future: reforming care and support. White Paper 2012

‘The primary objective of the White Paper is to improve outcomes for individuals, enabling people to maintain independence, health and wellbeing. We believe that proposals aimed at enhancing diversity of service provision and **improving user choice** will also offer positive opportunities for independent and civil society organisations’.


**Care Bill 2013**  http://www.officialdocuments.gov.uk/document/cm86/8627/8627.pdf
Conclusions— little conclusive evidence to demonstrate that Supervised Community Treatment was either effective or ineffective

Churchill R. et al 2007

*International experiences of using community treatment orders*

London, DH
OCTET
RCT

336 patients to be discharged from hospital on either a CTO (167 patients) or s17 Leave (169 patients)

At 12 months the number of patients readmitted did not differ between the 2 groups (36%)

Conclusion:
‘In well co-ordinated mh services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. **We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty**’

Professionals’ experiences of CTOs

Survey of all mh professionals in adult CMHTs and AMHPs in 2 NHS trusts - 288 surveys completed

- Some of the key findings

- 83% Psychiatrists and 67% non psychiatric mh professionals were in favour of CTOs

- Decision making re CTOs was overwhelmingly clinically orientated for all professional groups

- Belief that CTO could improve development of therapeutic relationships over time with continued treatment

- Belief that benefits of CTO outweighed any coercive impact on patient (74% of psychiatrists – 50% of other mh professionals)

- Nurses – concerned inadequate access to psychological therapies could undermine effectiveness of CTO

- Psychiatrists concerned with burden of bureaucracy

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

- Case study method – mixed methods **exploratory research strategy**
  SPT area suitable as ‘case’ – range of demographics


- Semi structured interviews for qualitative analysis with service users, nearest relatives, and professionals and service providers

- Thematic qualitative data analysis

- **Project advisory group** (all relevant professionals, service providers and service users)

- Study period – **July 2011 – Dec 2012**
Researchers

University researchers and peer researchers from LEAF

- Lived Experience Advisory Forum (LEAF) of Sussex Partnership Foundation NHS Trust were part of the Project Advisory Group and took part in the interviews with service users as peer-researchers.

- Provided with preparatory training for conducting service user interviews together with university research staff.

- 9 interviews with SUs were carried out with a peer-researcher.
Research Aims

1. To understand how compulsory powers are being used in an environment in which practitioners are encouraged and Service Users expect to be consulted and to exercise choice to a greater extent than previously.

2. To understand what social care supports can be drawn on and whether these are affected by being provided in the context of the use of compulsory powers.

3. To explore Service Users’ and practitioners’ experiences of CTOs and identify good practice in relation to assessment for, and management of, CTOs which maximises Service User participation, minimises risk to self and others and reduces the likelihood of hospital re admission.
Ethics and Governance Approval

University of Brighton, Faculty of Health and Social Science
Research Ethics and Governance Committee (sponsors of the research)

NHS Research Authority NRES SE Coast - Surrey

Sussex Partnership NHS Foundation Trust

Brighton and Hove City Council

East Sussex County Council

West Sussex County Council

*Focus of discussions and concerns from NRES and UoB* . . .
<table>
<thead>
<tr>
<th>Participants</th>
<th>Number</th>
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<tr>
<td>Service users</td>
<td>21</td>
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<tr>
<td>Nearest Relatives</td>
<td>7</td>
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<tr>
<td>Care-Coordinators</td>
<td>15</td>
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<td>Responsible Clinicians</td>
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<tr>
<td>Approved Mental Health Professionals</td>
<td>9</td>
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<tr>
<td>Service Providers (housing)</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
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Service user recruitment

- Challenge of engagement with ‘difficult to reach group’
- Accessed Care Co –ordinators of service users on CTO via Trust Research Officer: Care Co ordinators asked to pass on info about study to service user
- Service user asked to fill in one page form - give contact details and state they are willing to take part in research and return form to University researchers
- 243 service users in sample – minus those not contacted because CC deemed they were not well enough (68) and those interviewed (21) – **gives service use response rate of 12%**
- Working through the Research Officer and CCs as ‘gate keepers’ meant it was difficult to manage and monitor the recruitment of service users
- Lack of certainty about how many service users actually received the invitation letter
FINDINGS - Statistics

June 2010- June 2011
- 138 new CTOs were made
- 61 CTOs were discharged
- 36 were recalled to hospital
- 22 were revoked
- 115 CTOs were renewed

July 2011 – December 2012
- 199 new CTOs were made
- 52 CTOs were discharged (26%)
- 31 CTOs were renewed in the time period (15.5%)
- 64 CTOs were revoked (32%)
- 8 CTOs lapsed
- 62 service users who had their CTO made during this period were recalled to hospital (31%)
Headlines from statistics

Gender and age
Majority of those receiving a CTO were male – and over 40 - but the majority in the older age groups (over 51) were female

Relationship status
Those subject to a CTO likely to be single

Ethnicity
Majority recorded as ‘white British’. BME service users were a small minority (9% July 2010 – June 2011: 9.5% July 2011 – Dec 2012) BUT an over representation of minority ethnic groups compared to those in general population of study area
Headlines from statistics

**Diagnosis**
Schizophrenia or schizoaffective disorder - most common diagnosis paranoid schizophrenia. 7%- 10% bipolar disorder

**Housing**
Incomplete data e.g. ‘not specified’

**Employment**
Incomplete data – but where available most ‘unemployed’ - 73% - 80.8%

**Conditions**
Apart from mandatory conditions, most conditions related to taking medication; keeping in contact with professionals/ allowing professionals to visit at home (24% and 23%); 18% condition to reside at a particular address; 2% to adhere to care plan.

In 2011-12 sample, 32.6% had NO extra conditions attached – move towards specifying less conditions (e.g. re drugs and alcohol) – reflective of HRA concerns
Findings from qualitative analysis of data

Key emergent themes from ALL groups interviewed
(Service users, NRs, RCs, CCs, AMHPs, Service Providers)

- The CTO provides a legal recognition of the need for care
- Care is defined predominantly as medical
- CTO provides a structure and containment for the ‘right’ service user
- Ambivalence/ misperceptions surrounding the power and conditions of the CTO
CTO provides a legal recognition of the need for care

- CTO not only provided the legal framework for enforced care in the community but many – especially service users and nearest relatives – felt that the order extended recognition of the service user’s need for care i.e. there is an experiential value, especially for service users and relatives.

- I’m on my own. I need someone like a social worker to come and drop off my medication, a doctor to come . . . to see me, to make sure I’m alright. I’ve got no one. People like me need things like that (Service User 1).

- The CTOs legal framework of care CTO can be experienced as reassuring and as a ‘safety-net’ in case of deterioration, but most significantly it can be regarded as an assurance that care will be provided and it will be speedy.
CTO provides a legal recognition of the need for care

A nearest relative’s comment –

- *So this order allows him to be asked, or whoever, to get him admitted much more quickly without all the fuss as soon as he stops taking his tablets, so it’s like a security blanket really to make sure if he were to stop taking them* (NR 4).

- Service users generally said that their relationship with services and practitioners had not changed since they had been subject to the CTO, BUT, some SUs worried about the withdrawal of the containing, structuring and monitoring aspects of the order would affect their mental health in negative ways, and that without the CTO in place to facilitate monitoring and speeding up the admission process they may be allowed to deteriorate.
CTO provides a legal recognition of the need for care

This theme was also present in interviews with practitioners –

- ... my experience is that most of the families are actually saying ‘don’t discharge him or her from CTO’ because they think that... we have to have that support really (RC 1)

- ... since the community treatment order came in, it gives you a framework to work with and the patient knows their rights and their limitations and we know the same and so we work within a system (RC 1)

- ... There is no point having a CTO which allows you to recall someone if you as a care coordinator never see the person. So I think it does make them more active really (AMHP 2).
CTO provides a legal recognition of the need for care

... 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 ... 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)
CTO provides a legal recognition of the need for care

Service Providers -

- There is an intervention that can be sought so that the person doesn’t deteriorate too far...from my point of view it is good to get the extra support you need if a client is deteriorating [...] you can get support for the client 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 is defined predominantly as medical

The CTO’s primary function is as a framework for administering and monitoring medical treatment and it was found that the medically driven aspect of the CTO outweighed social care elements at the point at which it was made.

- ... the way I understand it, it’s a way to ensure you take your medication (SU 16).

- I came to be on a community treatment order because I was refusing to take medication and so they put me on that so I couldn’t refuse it (SU 8).
Care is defined predominantly as medical

- Many Service Users spoke about their dislike of medication and negative side-effects:

- *I had horrific experiences with the medication to start with. I used to have full on near death experiences when I first started taking it. So the dose they gave me was way too much and I used to have like, feel like I was going to cripple and be hallucinating and really like strong experiences from it and I hated the medication and then they lowered the dose* (SU 2)

- Even though the relationship Service Users had to their medication was often one of difficulty or at best ambivalence, a significant portion of the Service Users who took part in the study could identify in retrospect a positive outcome from the medication, in many cases related to more stable mental health.
Care is defined predominantly as medical ‘Grudging acceptance’ by service users . . .

- I feel much better from having been taking the medication even though it wasn’t agreeing with me at first it seems to have settled down. So that’s probably the only good thing that’s come of it, it’s simplified my energy a lot (SU 2)

- You don’t have to be locked up in hospital all the time because, I would know this from past experience, if you stop taking medication every time that you’re out of hospital, you’re just going to go straight back in again. So the truth of the matter is some people actually physically do need medication all the time and the CTO is the perfect thing for them [...] I like taking medication now; I see the benefits of taking medication (SU 3)
Care is defined predominantly as medical

Social Support -

- The CTO initially is medically driven and primarily used for the purpose of administering medical treatment in the community and care-plans reflected this.

- None of the service providers interviewed made mention of social support services – even if these were actually provided – as being part of the CTO framework for treatment.

BUT
Care is defined predominantly as medical

The CTO with its medically focused conditions was seen to provide a platform on to which social rehabilitation could be built.

. . . . it is the final piece in a bio-psychosocial jigsaw for some people and what it usually is is that it, it forces them to take their medication and that’s not a bio-reductionist statement, it gives them an excuse to take their medication, which gives them the ability to engage with a psychological and social care package. (RC 2).
But a missed opportunity for social care planning?

- Some Service Users found that the level of interpersonal contact/support diminished once discharged into the community on the CTO, compared to while in hospital when there had been more opportunities to speak to staff, even in just a social capacity.

- I mean that’s the key one really, being able to communicate with someone. I mean in [hospital] you’ve got a whole host of people who will sit down, have a cup of tea and talk with you but out here it’s different [...] I’ve had several meetings here where we’ve gone into the first five minutes and I think you can tell that they don’t want to talk anymore and instead you have to rush, rush, rush, rush (SU 8).
CTO provides a structure and containment for the ‘right’ service user

- All groups felt the CTO’s legal requirement to ‘check up’ on the SU made a big difference to the amount of contact the SU had with services.
- Participants reported the CTO could work to provide stability and (for some) a reassuring ‘safety net’, backing up positive decisions and empowering professional relationships as a result.
- The legal aspect was seen to work as a motivating factor for the ‘right’ service user:

  I see it much as a sort of external locus of control or something or, you know, ‘I don’t want to take my medication or see my CPN but I have to’ (RC 2).

Links to preceding themes
CTO provides a structure and containment for the ‘right’ service user

The ‘right’ service users were often seen as those who were treatment resistant prior to the CTO and often had little or no ‘insight’ into their own mental health. However, whether the CTO was successful or not depended on a range of other, individual, factors:

- Motivation to get well and/or progress to independence;
- Find structure and/or legal recognition of need for care reassuring;
- Respect for legal power and/or regard recall to hospital as a deterrent;
- (Grudging) acceptance that conditions of the CTO are in own best interest (although this often came after being on the CTO for some time and recognising s/he is more stable as a result).
CTO provides a structure and containment for the ‘right’ service user

- No I didn’t have a choice which was just as well really as I could have gone off on the same tangent.” (SU 7).

- . . . The restrictions I suppose of not being able to, to come off it if I want to but it’s for my own good you know? Yeah, it’s for my own good (SU 1)

- With the CTO there’s a good mixture between freedom and control (SU 11).

- I don’t mind taking the medication. I still would rather not but I have to otherwise I’ll go back to hospital (SU 20).

- [the CTO was used] to keep me in check and to make sure that I didn’t stray off the path. And now I’m off the CTO and officially off my section, I was on the CTO for about four, five months (SU 4).
CTO provides a structure and containment for the ‘right’ service user

Service providers often reported that the CTO provided a structure and a sense of control –

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

- . . .it certainly works well with people who lack insight into their mental illness and certainly when they start feeling better they start wanting to stop taking their medication. So I think it’s, it’s really a potentially very, very useful tool. (SP6).
CTO provides a structure and containment for the ‘right’ service user

Many mentioned the service user needed to regard the legal power of the CTO as a motivating factor, respecting the authority of the CTO, viewing it as either a deterrent or as a reassuring ‘structuring force’.

- **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** (AMHP 2)

- **Like one patient says ‘oh I know I won’t take my depot if I’m not on CTO but I’ll take it because I am on CTO’** (RC 5).

- **CTOs in my experience have worked for some patients and have not worked for the others. They have usually worked for patients who are more compliant, really, in my opinion** (RC 7).
CTO provides a structure and containment for the ‘right’ service user

CTOs do not work for all . . .

- Where people don’t buy into it and don’t accept the authority in which it is granted then you can recall them, you can try to enforce it but it doesn’t, it’s not therapeutic, it’s not building their relationship of trust and moving towards engagement at all or effective treatment (CC 6).

- For service users that have little understanding or little knowledge of the process and no agreement with the process it’s, it’s going to be difficult to make it work (CC 14).
Ambivalence misperceptions around the power of the CTO and its conditions

- A level of ambivalence / misperceptions around the actual power of the CTO and its conditions was found in all groups.

- Many service users and nearest relatives (and service providers) had a perception that the CTO had powers which did not correspond with reality.

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

**Interviewer**

*Do you think they [patient and family] understood what it was about?*

*No. I really don’t, because I think if people really understand what it’s about they would recognise that it doesn’t have any teeth at all [...] The daughter of the [patient] did get it but she knew that what the system was effectively doing was tricking her mother into thinking that we could compel her to have medication (RC9)*
Ambivalence around the power of the CTO and its conditions

- *It seems that it probably does keep them, a few of the patients, in check and more compliant, some of them, because they think the CTO is some huge thing and this can happen or that can happen when you’re on a CTO* (RC 7).

- Ethical issues re. the CTO being seen as essentially dependent on service users’ poor understanding or actual misunderstanding of a CTOs powers
Ambivalence around the power of the CTO and its conditions

- Often SUs were under the impression that if they did not keep to the conditions of the CTO they would be automatically returned to hospital.
- *I don’t mind taking the medication. I still would rather not but I have to otherwise I’ll go back to hospital (SU 20).*
- *… they said to me the CTO is this, this is the A-Z, you must comply with this or you’ll back in here, in [the Unit]*

**Interviewer** – *Did you have any say in the conditions? No, that’s policy (SU 2).*

**Interviewer**: *Did you feel you had any choice really about it? No choice [....] No I had no choice whatsoever because basically if you refuse then they call the police in and pin you down and jab you    . . . and it gets quite nasty I think. (SU1)*
Ambivalence around the power of the CTO and its conditions

- It did not seem to be explained to SUs that they would only be recalled if there was a significant deterioration in their mental health.

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

  ...there is no investment in explaining it clearly (AMHP 2).
Indicators for good practice

Information giving

- There is a need for better information about CTOs in all its aspects.
- Service users and Nearest Relatives were found to often have a poor or lacking understanding of CTOs.
- Information for service users was often delivered verbally and even if this was repeated several times, a user-friendly leaflet with the key points of information about CTOs is needed that service users can refer back to.
- 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.
Decision-making about the CTO and service-user involvement in this

- There were concerns about the rushed nature of decisions in relation to making the CTO. Many service users had very poor recall of any discussions, indicating they still may not have been well.

- Decisions about making the CTO most often happened in ward rounds, which is not an ideal environment as this can be disempowering for the service user as well as not providing enough time for discussion, negotiation and planning.

- The service user needs to be fully involved in discussions and cognisant that the CTO is being made.

- *For Service Users that have little understanding or little knowledge of the process and no agreement with the process it’s, it’s going to be difficult to make it work (CC 14).*
Decision-making about the CTO and service-user involvement in this

Advocacy

- Many service users said they were not aware of their right to advocacy and the IMHA service.

- A leaflet about the advocacy service should be made available to the service user on the ward in relation to early discussions about discharge onto a CTO, however this was often not the case.

- Whilst many AMHPs made sure to inform the service user of their right to advocacy, there needs to be clear written information as part of a general information leaflet that the service user can keep and refer to.
Working relationships

- Multidisciplinary teams were reported to usually work well together; some AMHPs raised concerns about their professional role not being well understood and being expected to provide a ‘rubber stamp’ for the CTO.

- Best practice would be to include the AMHP early in any discussions about a potential discharge on to a CTO; this would ensure a focus on social perspectives also. The service user should not be informed about going on to a CTO before an AMHP has been involved.

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

- It was generally reported that CTOs were most effective when conditions were kept to a minimum and included only the essential stipulations about complying with medication, allowing access to care staff or residing in a specific place if appropriate, and engaging with services.

- More specific and restrictive conditions, such as those around substance use or restricting service users socially or geographically, or setting curfews or financial allowances, were commonly found to infringe human rights and be difficult to enforce.

- Many additional conditions are in effect meaningless as a breach cannot automatically result in recall to hospital.
Conclusion

... in terms of the Service Users that most benefit, those who have had lots of admissions to hospital and are likely to be admitted again but have a certain level of understanding of their mental health issues, are able to reflect on the circumstance that brought them to hospital, maybe when they’re well, less when they’re unwell but there’s a beginning of understanding and sort of collaboration with services (AMHP 4).

Full Report
http://www.brighton.ac.uk/sass/news/2013/131014-cto.php