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ORIGINAL ARTICLE

## Community treatment orders: learning from experiences of service users, practitioners and nearest relatives

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### Abstract

**Background:** The effectiveness of Community Treatment Orders (CTOs) has been examined previously. However, few studies have explored the significance of service user and practitioner understandings.

**Aims:** The study explored the experiences of service users, practitioners and nearest relatives, to identify key factors and good practice in relation to CTOs.

**Method:** A study of CTOs in a mental health NHS Trust in Southern England, including 72 semi-structured interviews, analysed thematically.

**Results:** CTOs were perceived as helpful in certain circumstances for the “right” service user. Factors influencing effectiveness included recognition of the containing elements of the CTO, a respect for its legal authority and an acceptance of conditions.

**Conclusions:** The perceptions of service users have an important role in determining the value and potential effectiveness of CTOs. A consideration of these issues should be integral to the process of assessing whether a CTO is appropriate in individual cases.

### Keywords

Community treatment orders, community mental health, compulsory treatment, coercion

### History

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### Introduction

CTOs were introduced in England and Wales in 2008 despite an inconclusive evidence base and ethical concerns (Jethwa & Galappathie, 2008; Lawton-Smith et al., 2008). A few studies have found positive outcomes associated with compulsory community treatment (Awara et al., 2013; Hiday & Scheid-Cook, 1991; Swartz et al., 1999). However, as systematic reviews by Swartz & Swanson (2004) and Churchill et al. (2007, p. 16) have suggested, efficacy has tended to be considered limited to certain conditions or to particular groups of service users. Systematic reviews by Kisely & Campbell (2011) and Maughan et al. (2014) found little evidence of positive effects. Perhaps most notably, the recent “OCTET” randomised control trial included in both these reviews, found no evidence that CTOs impacted on readmission rates (Burns et al., 2013). Questions have been raised, however, over this study’s design which focused on a specific group of patients (CQC, 2014, p. 19; Curtis, 2014). Uncertainty also remains about longer term impacts, although these are to be addressed in a follow-up study (OCTET, 2014). The need for qualitative research to contextualise such findings is clear, as the OCTET study recognised (Canvin et al., 2014).

Several surveys have been undertaken to investigate practitioner perspectives, including Crawford et al. (2000),

Manning et al. (2011) and Coyle et al. (2013). The earlier study found a minority of psychiatrists (46%) in favour of CTOs, whilst later studies reported an increase, with Coyle et al. (2013) finding 83% of psychiatrists and 67% of non-psychiatric staff to be in favour. However, despite the current policy focus on person-centred care, choice and autonomy, there has to date been little qualitative research on service user and practitioner experiences of CTOs and how social support may be involved. Most studies have been small scale and focused on users (and sometimes carers) with no comparison of practitioner perspectives (Fahy et al., 2013; Gault, 2009; Ridley & Hunter, 2013; Riley et al., 2014). Studies which have explored a clinician’s perspective include the work by Gibbs et al. (2005) in New Zealand, and more recently the qualitative OCTET study in the UK (Canvin et al., 2014), the findings of which are similar to those reported here.

The research reported took place in a mental health NHS Trust in Southern England between July 2011 and February 2013. Uniquely, this research explored the experiences of service users, care coordinators, responsible clinicians (RCs), approved mental health professionals (AMHPs), service providers and nearest relatives, with the aim of identifying significant issues and good practice in relation to CTOs. In this paper, we present key findings and discuss how the perceived efficacy of CTOs may be influenced by the perceptions of service users.

### Methods

Between January and December 2012, the researchers carried out 72 semi-structured interviews as detailed in Table 1.

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Table 1. Recruitment and response rates by participant type.

| Participant type  | Sample timeframe (CTO start date) | Population (No.) | Sample (No.) | Recruited (No.) | Response rate (%) |
|-------------------|-----------------------------------|------------------|--------------|-----------------|-------------------|
| Service users     | Nov 2008–Aug 2012                 | 242              | 174          | 21              | 12.1              |
| Practitioners     | Nov 2008–April 2012               | 155              | 86           | 35              | 40.7              |
| Nearest relatives | July 2010–June 2011               | 45               | 45           | 7               | 15.6              |
| Service providers | N/A                               | Unknown          | 18           | 9               | 50.0              |
| Total             | –                                 | –                | 391          | 72              | 18.4              |

Interviews were recorded, transcribed, thematically coded, and analysed. Ethical and governance approval was obtained from appropriate bodies.

This research was a study of one particular NHS Trust and since evidence shows considerable variation in the use of CTOs between Trusts (CQC, 2013, p. 78), caution should be applied to making wider generalisations. The replication of this study in other areas is recommended. Nevertheless, the breadth of participation and depth of qualitative inquiry allows for a useful discussion of common, emergent themes.

### Recruitment, sampling and response rates

Table 1 details the total population (i.e. the number of individuals on or supporting CTOs in the Trust within the specified timeframe), the sample (i.e. the number of people who were selected to be invited to participate), numbers recruited and response rates. In order to protect confidentiality, care coordinators were asked to pass information to service users on behalf of the researchers. Using care coordinators as gate-keepers was considered the best route to recruitment for ethical reasons, since they were felt best placed to make an informed judgment about whether the service user was currently well enough to take part. However, this meant that we could not confirm information was distributed to all service users and, therefore, the actual response rate may be inaccurate. There may also have been some positive bias in recruitment towards those who had a good relationship with their care coordinator. This should be taken into account.

All nearest relatives falling within the designated time period, whose details were held by the Trust, were contacted by Trust administrators. Contact details were only received by the researchers following consent. Initially, all practitioners on the lists provided (supporting those starting a CTO since October 2011) were contacted directly by the researchers, following which a purposive sample was taken of other care coordinators working with those on CTOs prior to this date, with the aim of ensuring maximum variation in relation to professional roles, teams and geographical locations. Finally, a list of service (accommodation) providers was identified by the Project Advisory Group and these were contacted by the researchers.

### Participant characteristics

Despite recruitment challenges, those interviewed represented a range of participants from across the Trust area, attached to different teams (assertive outreach, community mental health, early intervention services and forensic). Professionals included care coordinators (16), responsible clinicians (10)

and AMHPs (9). Nearest relatives included five women and two men. Service users included those from the youngest (18–25) to the oldest age group (over 70) with a mean age of 36. Diagnoses included schizophrenia, schizoaffective disorder and bipolar affective disorder. Twelve (57%) of the interviewees were on a CTO at the time of interview, whilst for the remaining nine (43%) it had been discharged. The gender profile constitutes one third (33%) female, which is a similar to the sampling frame (39%). Those from an ethnic minority (i.e. classified as other than “White British”) (19%) are well represented in comparison with the overall population (18%).

### Key themes

In the data analysis, four common key themes emerged. These were:

- A CTO provides a legal recognition of the need for care;
- A CTO provides a structure and containment for the ‘right’ user;
- Care is defined as predominantly medical;
- There are misunderstandings surrounding the power and conditions of the CTO.

It is beyond the scope of this article to discuss each of these themes in depth. The primary focus is upon the first two. Ethical issues are explored briefly, but the full findings including further discussion of the misunderstandings of the power of CTOs are presented elsewhere (Stroud et al., 2013).

### Structure and support as reassurance

An emergent theme across all groups was that the CTO was seen to provide a valuable “safety net”. This was in terms of the stability and containment associated with the legal recognition of the need for care and support. As one clinician stated, “... 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”. The CTO was considered useful also in providing formal, written boundaries. Another RC described a CTO as:

A bit like an agreement that provides boundaries. And boundaries... are very containing to somebody who suffers from psychosis... So, you refuse to come to your appointment, we take you to hospital, make sure that you get your injection: not a big deal... I think that in itself has a calming effect...

Some practitioners considered this sense of structure was useful for certain users, but not all. As one AMHP stated, CTOs were most appropriate for “people who would benefit

from a sense of structure, they know that things will kick into place quickly if they get unwell”. For service users, the structure of the CTO could provide reassurance that someone was monitoring their condition and that support would be provided swiftly if required. One participant, for example, spoke of how the CTO was used “to keep me in check and to make sure that I didn’t stray off the path”.

Although, under s117 of the Mental Health Act, support should be provided according to need, service users tended to equate the CTO with receiving higher levels of support and hence were often keen to stay on it. This was the case for one young man, for example, who described the CTO as a guarantee of support and monitoring (which he felt had been lacking in the past, leading to isolation and deterioration in his mental health):

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

Some practitioners conceded that the legal recognition for care associated with the CTO placed an onus on practitioners to provide greater opportunities for engagement. One AMHP stated, “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”. In fact, the conditions attached to CTOs may surpass definitions of need that would otherwise determine levels of support provided. One clinician explained:

It makes it incumbent on the team . . . to provide, by law, certain basic treatments for the patients . . . 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.

The reassurance of a safety-net was an important factor for family members and accommodation providers who often saw themselves placed at the “front line” of care provision, feeling unsupported by services. Nearest relatives spoke of how they felt better consulted under the CTO system. One mother described:

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

Relatives and service providers felt reassured by the regular support provided to the service user and the compulsion to take medication. In particular, there was an appreciation of having clear contacts to call and that an emergency appointment could be triggered. The capacity for quick recall

was also considered a benefit of the CTO. One service provider spoke of how he had described this to a patient in hospital:

I’d more or less said it to him, “Look this is really about your care in a sense and this is about, you know, if you come back to us, if you have a CTO, you can go back to hospital immediately. Whereas, you know, generally in admission you could be waiting days on end, they might not have a bed available”.

## Respect for the authority of the legal framework

Practitioners expressed how for a CTO to “work”, service users needed to agree with the CTO process and respect its legal authority. Examples were given of cases in which compliance with medication was believed to have increased. Some service users described how the CTO gave them extra motivation, primarily related to a desire to avoid re-hospitalisation. One described how “I suppose it’s sort of made me sit up and think ‘yep you have to do this otherwise you’ll end up back in hospital within a month’ . . . It’s given me impetus to carry on”. Another interviewee, who was also keen to avoid returning to hospital, spoke of how the CTO influenced her to adhere to treatment and engage with services, even at times when she was feeling unwell or unmotivated:

There were some times when I . . . was feeling more paranoid and the voices were worse, then I didn’t want to come in, but having that . . . CTO in place sort of gave me the motivation of ‘if I don’t go and get it [medication] I will end up in hospital’.

However, where respect for the authority of the CTO was absent, practitioners felt the CTO was unlikely to achieve any positive impact. One care coordinator argued “where people don’t buy into it and don’t accept the authority . . . then you can recall them, you can try to enforce it but . . . it’s not therapeutic, it’s not building their relationship of trust”. Another explained:

[The CTO is] unhelpful with service users who just aren’t going to accept that anyone has a right to tell them what to do with their life, whether it’s a new law, an old law, my law or somebody else’s is irrelevant. People who don’t have the cognitive function to understand the process and they are just lost in their delusions and distress, we try it with these people and sometimes occasionally it does work, but most often we are just trying because we haven’t got anything else to offer.

The issue of service users needing to accept the authority of the CTO raised ethical concerns, with a sense of unease among practitioners (particularly AMHPs) that legal powers were weaker than presented. Service users often believed, mistakenly, that to break a condition would automatically result in recall. There was a lack of incentive for practitioners to ensure users were fully informed, lest respect for the CTO was eroded.

## Acceptance and understanding of conditions

Although conditions tended not to be perceived positively, service users who benefitted from being on a CTO expressed an understanding and “grudging” acceptance that they were in their best interests. Service users reported a difficult relationship with medication, but often agreed that compliance had been beneficial, enabling them to remain living in the community. One participant stated, “I don’t mind taking the medication. I still would rather not, but I have to otherwise I’ll go back to hospital”. However, such acceptance sometimes came retrospectively following a period of stability. As one service user explained:

You need to...agree on the terms of the doctors and in turn you get your freedom instead of going in and out of hospital all the time, which takes time, a bit of a while to get used to the medication and understand that and realise that medication helps. It takes a long time, a very long time, to understand that but I believe that everyone who wants to get on with their lives will see a Community Treatment Order as a beneficial thing.

Since developing such an understanding took time, this poses challenges of how to take this into account at the initial assessment. Many practitioners felt that before a CTO is made, the service user needs to have some insight into their condition. One AMHP described:

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.

## Discussion

Whilst some quantitative studies have raised doubts about the effectiveness of CTOs, this qualitative study enabled an exploration of some of the subtleties of experience and highlights how CTOs can be useful in certain circumstances. Similar to Canvin et al. (2014), we found that experiences of CTOs and legal interpretations affecting practice are diverse. However, the common themes discussed above support findings by Gibbs et al. (2005), that CTOs can be considered most useful with those accepting their authority, but potentially counter-productive for those antagonised by it. Although CTOs have been presented as having more “teeth” than legislative provisions such as Guardianship (which was not commonly used and was felt to lack sufficient powers) (Davies, 2002; Grant, 1992), our study highlights how, in fact, CTO powers also have limitations.

Any apparent benefits of compulsory treatment are difficult to separate from other factors (Canvin et al., 2014), in particular, the higher levels of support associated with it (Phelan et al., 2010; Swartz et al., 1999). Indeed, it has been argued that enhanced support would negate the necessity for a

legal power (Allen & Smith, 2001). However, like Swartz & Swanson (2004), we found the CTO often enabled an increase in support. This was owing to the associated legal obligations on the part of practitioners and the increased motivation of service users to engage and comply with medication, thereby providing a stable platform from which to access social support. In the context of constrained resources, questions remain, however, about how this may affect service users who are not on a CTO, who have similar mental health conditions and may be at risk of not having their needs prioritised. Concern remains also about the ethics of service users misunderstanding the powers of CTOs and professionals’ views that these misperceptions support the efficacy of CTOs.

To conclude, our findings suggest CTOs can be effective for the ‘right’ service user with certain needs and perceptions; for example, to work within clear boundaries. We support the argument that CTOs may be used beneficially with a restricted group of “revolving door” patients for whom other options have been unsuccessful (Curtis, 2014; Lawton-Smith et al., 2008). Data from our study suggests CTOs were more successful when they were a carefully planned intervention, rather than where they were made almost as a matter of course. Therefore, we recommend that assessments should not be rushed and should involve the service user as much as possible, as well as nearest relatives where appropriate. In particular, the decision making process should take account of how service users’ particular needs and perceptions may impact upon a CTO providing a useful framework to support recovery.

## Declaration of interest

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## References

- Allen M, Smith VF. (2001). Opening pandora’s box: The practical and legal dangers of involuntary outpatient commitment. *Psychiatr Serv*, 52, 342–6.
- Awara MA, Jaffar K, Roberts P. (2013). Effectiveness of the community treatment order in streamlining psychiatric services. *J Ment Health*, 22, 191–7.
- Burns T, Rugkasa J, Molodynski A, et al. (2013). Community treatment orders for patients with psychosis (octet): A randomised controlled trial. *Lancet*, 381, 1627–33.
- Canvin K, Rugkasa J, Sinclair J, Burns T. (2014). Patient, psychiatrist and family carer experiences of community treatment orders: Qualitative study. *Social Psychiatry Psychiatr Epidemiol*, 49, 1873–82.
- Churchill R, Owen G, Singh S, Hotopf M. (2007). International experiences of using community treatment orders. London: Department of Health.
- Coyle D, Macpherson R, Foy C, et al. (2013). Compulsion in the community: Mental health professionals’ views and experiences of CTOs. *Psychiatrist*, 37, 315–21.
- CQC. (2013). Monitoring the mental health act in 2011/12. Newcastle upon Tyne: Care Quality Commission.
- CQC. (2014). Monitoring the mental health act in 2012/13. Newcastle upon Tyne: Care Quality Commission.
- Crawford MJ, Hopkins W, Henderson C. (2000). Concerns over reform of the Mental Health Act. *Br J Psychiatry*, 177, 563.

- Curtis D. (2014). OCTET does not demonstrate a lack of effectiveness for community treatment orders. *Psychiatr Bull*, 38, 36–9.
- Davies S. (2002). Compulsory treatment in the community: Current legal powers. *Adv Psychiatr Treat*, 8, 180–8.
- Fahy GM, Javaid, S, Best J. (2013). Supervised community treatment: Patient perspectives in two merseyside mental health teams. *Mental Health Rev J*, 18, 157–64.
- Gault I. (2009). Service-user and carer perspectives on compliance and compulsory treatment in community mental health services. *Health Social Care Commun*, 17, 504–13.
- Gibbs A, Dawson J, Ansley C, Mullen R. (2005). How patients in New Zealand view Community Treatment Orders. *J Ment Health*, 14, 357–68.
- Grant W. (1992). Guardianship Orders: A review of their use under the 1983 Mental Health Act. *Medical Science Law*, 32, 319–24.
- Hiday VA, Scheid-Cook TL. (1991). Outpatient commitment for 'revolving door' patients: Compliance and treatment. *J Nerv Mental Dis*, 179, 83–8.
- Jethwa K, Galappathie N. (2008). Community treatment orders. *BMJ*, 337, a613.
- Kisely SR, Campbell LA. (2014). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Syst Rev*, 12, CD004408.
- Lawton-Smith S, Dawson J, Burns T. (2008). Community treatment orders are not a good thing. *Br J Psychiatry*, 193, 96–100.
- Manning C, Molodynski A, Rugkåsa J, et al. (2011). Community treatment orders in England and Wales: National survey of clinicians' views and use. *Psychiatrist*, 35, 328–33.
- Maughan D, Molodynski A, Rugkåsa J, Burns T. (2014). A systematic review of the effect of community treatment orders on service use. *Social Psychiatry Psychiatr Epidemiol*, 49, 651–63.
- OCTET. (2014). Octet II. Available from: <http://www.psych.ox.ac.uk/research/social-psychiatry-group/current-research-projects/octet-ii> [last accessed 12 May 2014].
- Phelan J, Sinkewicz M, Castille D, et al. (2010). Effectiveness and outcomes of assisted outpatient treatment in New York state. *Psychiatr Serv*, 61, 137–43.
- Ridley J, Hunter S. (2013). Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (care & treatment) (Scotland) Act 2003. *Health Social Care Commun*, 21, 509–18.
- Riley H, Høyer G, Lorem GF. (2014). 'When coercion moves into your home' – A qualitative study of patient experiences with Outpatient Commitment in Norway. *Health Social Care Commun*, 22, 506–14.
- Stroud J, Doughty K, Banks L. (2013). An exploration of service user and practitioner experiences of community treatment orders. Brighton: University of Brighton.
- Swartz MS, Swanson J. (2004). Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: What's in the data? *Can J Psychiatry*, 49, 585–91.
- Swartz MS, Swanson JW, Wagner HR, et al. (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *Am J Psychiatry*, 156, 1968–75.