

There are 5,365 service users subject to a Community Treatment Order (CTO) in England (CQC 2015) and they are in a unique position, since they can have conditions about their care imposed upon them. Being on a CTO identifies these service users as being most 'in need' of services and of potential protection. This study investigated

Service users were generally pragmatic about CTOs, seeing them as a way out of hospital: for some they offered stability, supportive relationships and wide ranging social activities. Loneliness was minimally reported by those interviewed.

Both care co ordinators and service users reported positive and supportive relationships which had developed in the context of CTOs. These can be seen as an important social intervention which may not have developed but for the CTO: they appear an essential component of making a CTO work well.

In terms of resources, practitioners expressed concern about bed availability for recalls and reducing community resources generally. Some felt CTOs could be made



Unlike national statistics, where Black or Black British service users were found to be nine times more likely to be given a CTO than a white person (NHS Digital 2017) , this sample was predominantly white British (83% n =282), reflecting the local demography. 17 (5%) were from other white ethnic cultures. 5 (1.5%) orders were to those describing themselves as Black British.

The service user – care co ordinator relationship was seen as being important. Practitioners described working in a 'relational model' ( ) and efforts were described at building collaborative relationships. It was felt that engagement with the co ordinator/ care team could be understood as an important social intervention, which militated against isolation.

Social interventions/ support were not routinely conditions of a CTO, but were rather part of associated care plans, about which service users had choice, in contrast to the conditions of the CTO. Accounts were given of the considerable attempts to engage service users with support and social interventions, with the extent and nature of these being dependent on how well the service user was engaged with the care team. Compliance with medication, risk and the development of insight were again major themes and it was felt that CTOs could provide a platform from which service users could access support/ engage in social activities.

Engagement or not in support or activities was discussed as providing evidence for potential discharge, renewal or recall ( ). Negative social factors which might be influential included, living in an environment where alcohol and drugs were easily available, withdrawal from personal and professional relationships, insecure/ changing accommodation. Nearly half of practitioners felt that the views of relatives/ carers were a significant factor in making decisions about CTOs.

Practitioners considered being on a CTO could affect the service user's sense of self or identity, although it was difficult to separate this from the stigma of their mental health diagnosis. There was also a feeling that being on a CTO could affect the service user's agency and sense of control (

acceptance and benefit was reported ('...'). The CTO could assist with having to take medication ('...'). Service users reported insight into the need for medication, mostly linked to difficult behaviour ('...'). There were references to increasing maturity, which enabled service users to manage their illness and taking medication. It is as though service users were describing a journey ('...'). All described a belief that they would be recalled to hospital if they did not take their medication.

Service users reported knowing their CTO had a condition to take medication, but most did not know the other conditions. They did not report great understanding of, or involvement in, the management of their CTO or care plan

Doctors were seen as important because of making decisions on medication. Feedback on review tribunals was not generally positive, with service users feeling they were 'talked about' and that their opinion was not asked for, nor heard; this was reported more widely also for other meetings/ reviews.

For service users, social activities provided a structure to their time and chance to meet other people. Activities (e.g. meditation, participation in faith groups, volunteering; bingo, fishing, sport) were not always organised as part of the CTO/ associated care plan, but by the service user themselves. Limited engagement in part time employment/ college courses was reported, but transition to paid employment was difficult because of needing to earn enough to live on. Relationships with family and friends were significant and had been re kindled since being on the CTO: contacts in supported housing/ residential care were important to people who were on their own. Only one person reported they did '...'. There were only limited accounts of being isolated or lonely and those few also described a lot of social activities. It seems that these individuals were reporting being emotionally lonely and would like to have a partner.

Attitudes to the CTO were pragmatic ('...')

care option between detention and treatment in hospital and voluntary treatment in the community. Use of CTOs is high, and renewals and revocations correspondingly so. Greater understanding of the reasons for these is important. It is also important to debate whether recall to hospital should define whether a CTO is successful or not. Notwithstanding this, intensive community resources and support are needed. Processes and responsibilities for recall and the availability of psychiatric beds require review.

Data from service users and practitioners provide strong evidence that the working relationship between the Care Co ordinator (and mental health team) and a service user is of key importance. This engagement can be understood as an important social intervention, providing support and militating against isolation. The stability which emerges for the service user provides a platform from which to access social activities and recovery. In an environment where the forms and processes in social care often predominate, this relationship can be understood as a key message for mental health care.

Practitioners described considerable efforts to support service users and engage them in social activities; service users also described wide ranging activities, many of which they had organised themselves. While compliance with medication and risk remained a dominant discourse for both practitioners and service users in relation to CTOs, social factors were found to be influences in decision making, providing evidence for and against discharge, renewal and recall.

Service users were pragmatic about CTOs but were negative about medication; however, paradoxical views were expressed, with attitudes toward medication changing. It is as though service users were describing a journey ('  
'). Service users wanted more opportunities to discuss medication, the CTO and also more attention needs to be paid in practice to their involvement in the formal processes associated with the CTO (care planning, reviews and tribunals).

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