engagement

insight

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

experiential

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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).

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).

the other big thing about the CTO as I've understood it is that they are now allowed to include 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 us, I can ring the CPN and say, 'I'm worried about him', and she goes to see him, and before it was, 'Well I'll

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 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).

There was very little recovery work going on because we 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

I had horrific experien

Basically he doesn't believe that he has a mental health problem ... he was on 300 milligrams [of XXX] at night-time, 'but he'd decided that some days you'd take млл, 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 believe it or not he's totally a different person, you know. And he doesn't actually believe it but he is a completely, quite a different person because he's been taking that medication regularly, but he still doesn't like it and he still argues about it and, which is fair enough but it doesn't matter how much you actually say, 'Well, a couple of years back we wouldn't be able to have this conversation, you know, while we can now' (SP3).

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So I think he just needs integrating somehow into the community but it's what to do … if you don't see anybody else, it's like old people isn't it? They go into a little shell, don't they? (NR3).

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).

No I didn't have a choice which was just as well really as I could have gone off on the same tangent… (SU7).

With the CTO there's a good mixture between freedom and control (SU11).

I don't mind taking the medication. I still would rather not but I have to otherwise I'll go back to hospital (SU20).

[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 (SU4).

These patients who we're putting on Community Treatment Orders, they start to reengage better, they comply

[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).

Where people don't buy into it and don't accept the authority in which it is granted then you 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 when you're on a CTO (RC7).

I phoned up that morning to tell [Care Coordinator] I was going away and so she said 'Oh no, no, no I can't let you do that'. So she just said 'Do what you want', so I went to the airport to go, and there were the police (SU1). 268T/more TBT1 0 0 1 96.624 740.38 Tm 0 Tc[( )5 TJET EMC /P ⁄MCID 3/

I was fine with it. I understand now how it works so, (SU1).

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've, and where it's been effective, and I have sort of seen case notes and talked to Care Coordinators and seen their records where perhaps they're starting to relapse and I've 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 abou

I mean I think he is a bit of a trial and error case so maybe they don't know, perhaps it's all learning all the time, I don't know,... I don't really feel that I fully know exactly what is going on (NR2)

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' (NR1).

When I've known he's going downhill and I have felt that I wasn't really being listened to enough then and I

It hasn't been without trial and error along the way (AMHP5).

When somebody's on a CTO and they agree to come into hospital, that one threw us initially because we thought are we recalling them? Are we revoking them? Or are they going to be an informal patient or are they still detained? You know we sort of, that was initially and I mean now we've got our heads round it but it was quite complicated at first (AMHP5).

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 particular profile of a person. I get a sense that there are more males considered for CTO than females and I'm not quite sure why 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).

review, it's done and dusted, they want to discharge them on a CTO that day and the AMHP is asking all sorts of questions (AMHP4).

It won't work unless they have a good relationship with 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 it's not there, it's not going to work (AMHP2).

Well it's really difficult because if when I choose not to put somebody on a CTO, when I say no, there's quite often quite a lot of anger or resentment in the team around well you know, why couldn't you just do that and they are going to get unwell now, or, and I think without sort of them looking at how we are restricting somebody's liberty here [...] so around kind of the ethical issues (AMHP6).

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

We inherit people who have been on CTOs or who are on CTOs and we take them off because we're able to provide more intensive community support, we're more able to… we feel a bit more secure with therapeutic risk taking and we feel that, I certainly feel that, you know, there is a level of violence in inverted commas in compulsory treatment that, you know, I can't countenance (RC2).

Where a patient has the capacity to consent and is not consenting, then you can't go ahead with the CTO, and that creates the biggest problem sometimes, because they may have the capacity to understand and to decide but they're refusing to be on it, and the legislation is such that we then cannot put them on a CTO and it becomes just impossible to do so.... we had a recent problem when the patient, I thought, needed to be on a CTO, because she was refusing treatment, but I really can't say that she did not have the capacity, she could understand what we were telling her (RC7).

It would be seen as illegal. So that is a bit of a drawback, I think (RC7).

The framework we try and use when we can remember [Laughs] is… one of the AMHPs went on a conference and came back with a

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 they don't count 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).

Out of… was it 19 periods of CTO and 18 patients, all but two of them have got schizophrenia (RC10).

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The chap I've just seen, he doesn't have a post-box in his flat and there's no way of getting into the flat, so we had to send one to him in the post once, and again, that wasn't, it was a bit disastrous, it doesn't work with the Trust's Bed Management Policy cos you get 72 hours, and by that time the bed's given away. That's the other huge difficulty, that the Trust Bed Management Policies don't.. can't deal with 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).

It's a bit of a pedantic palava but easier than sorting out a fresh Mental Health Act assessment that's for sure

Because I'd explained to her beforehand that this was the power that the CTO gave 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 work out for herself that the best thing to do was just to take her medication. She's been absolutely fine for the last 18 months or two years since that happened (RC 9).

There was very little recovery work going on because we 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).

The more restrictive you make them the less useful they are and the more you're kind of selling people up to not be labelled to do what you're asking them to do. So we've, I guess there's been occasions when we've had stuff on there about attending drug and alcohol services for instance or providing drug screens.But even, that, we tend not to do really now because again we've got sort of a high percentage of dual diagnosis - people who it's just not always realistic that they would be able to do that (CC2).

[The Service User] was on oral medication and I couldn't monitor that on a day to day basis so I was having to take her word for it (CC3).

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).

We're the people who are going to be working with them on a day to day basis, Care Coordinator may have a

Because he is on a Community Treatment Order, the risk is reduced for me because I don't have to think about ǻW

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: