



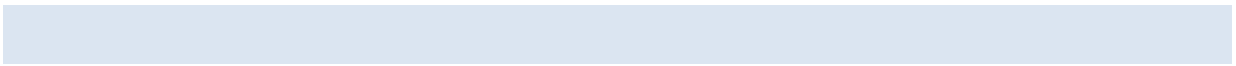






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*engagement*













*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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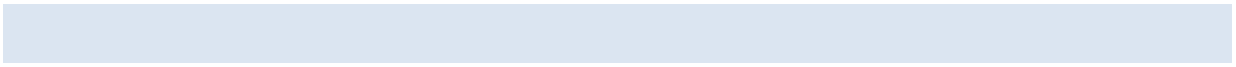
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*See, these are legal issues, and it makes it incumbent on the team as well to provide, by law, certain basic treatments for the patients even when you are restricting their liberty and you are restricting them to do this, you are confining them to 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 understand 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 intention 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 a 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*





Basicall he doesn't belie e that he has a mental health problem ... he was on 300 milligrams [of XXX] at night-time b t he decided that some da s o d take , 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 belie e it or not he s totall a different person, o kno And he doesn't act all belie e it b t he is a completel q ite a different person beca se he s been taking that medication reg larl b t he still doesn't like it and he still arg es abo t it and hich is fair eno gh b t it doesn't matter ho m ch o act all sa Well, a co ple of ears back e o ldn't be able to ha e this con ersation o kno hile e can no (SP3).

So I think he j st needs integrating someho into the comm nit b t its hat to do if o don t see  
an bod else its like old people isn t it The go into a little shell don t the (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 are reporting on Commitment 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 a bit 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).*

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*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 see and here it's been effective and I have sort of seen case notes and talked to Care Coordinators and seen their records here perhaps they're starting to relapse and I see 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 about*









*I mean I think he is a bit of a trial and error case so maybe the 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  
a person is but I can't listen to you because you're not involved and because 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 I  
can't discuss it with you that 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  
had tried to toooooo ill*

*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 thing's initially because of 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 the sort of that as initially and I mean no one's got their heads round it but it's quite complicated at first (AMHP5).*

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*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 about that but I get a sense of that really - perceptions of dangerousness perhaps and we have to be sort of very careful about that (AMHP4).*

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re it's done and decided the 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 it. I know they couldn't 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).





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*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*

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*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 the 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).*



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

*I*





*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 as a bit disastrous it doesn't work with the Trust's Bed Management Policies so we get 48 hours and by that time the bed's given away. That's the other huge difficulty that the Trust Bed Management Policies don't really 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 point 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).*

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*There was a 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).*

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*The more restrictive you make them the less self-reliant they are and the more you're kind of selling people to not be labelled to do that or asking them to do so. 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 because again we've got sort of a high percentage of dual diagnosis - people who it's just not at all 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).*

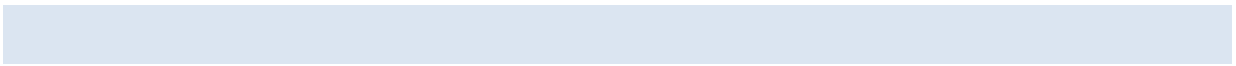
*I don't think it made any difference. We had to go to court, we had to get violent, we had to get police escorts (CC3).*



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  
W*



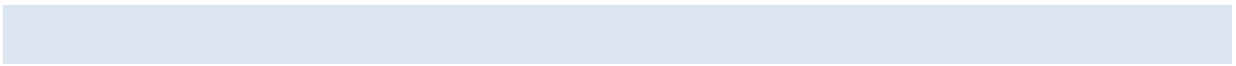












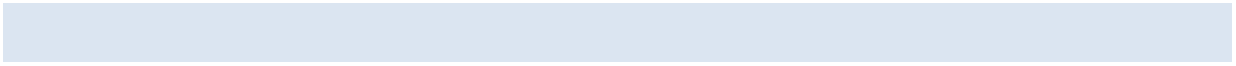


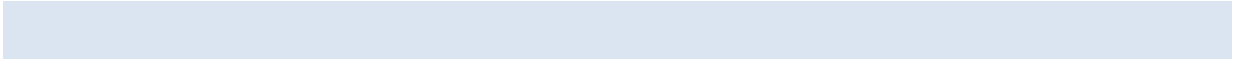
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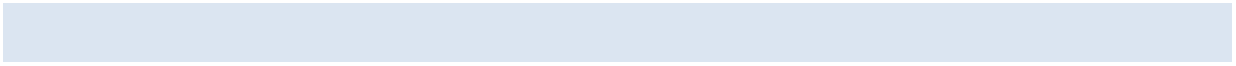
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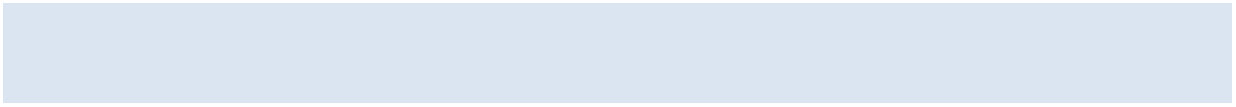






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*If you are happy to take part in an interview, please tick the box below and provide your contact details so a researcher can contact you:*

