Practitioner perspectives about managing Community Treatment Orders (CTOs) in England and the importance of social influences

Abstract

Previous research in England has suggested a medical acceptance of Community Treatment Order (CTO) coercion, but none have explored the importance of social influences on practitioner decision making. A sample of 181 practitioners with Mental Health Act responsibilities completed an online survey. They recorded their perspectives about the influence of medical and social items. Sixteen questionnaire items were subdivided into three operational aspects: discharge, renewal, and recall.

Medical item averages scored significantly higher as influences than social items, (medical items mean = 4.43; social items mean = 3.58; t= -19.38, p=0.001). The influence of separate medical and social factors was evidenced by exploratory factor analysis when related to discharge and renewal, but not for recall, where items divided into factors that resembled 'risk' and 'disengagement'. Participants' scores showed no statistically significant difference for a practitioner's professional allegiance. The findings demonstrate that social influences are a homogeneous influence on managing CTOs, in addition to the higher scoring influence of medical factors.

Keywords

Community Treatment Orders, Social Factors, Practitioner Perspectives

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Background

Community Treatment Orders were introduced in England and Wales by the Mental Health Act 2007 (section 17A) and allow service users subject to a Mental Health Act treatment order to be treated in the community rather than hospital. Their policy aim was to treat as many patients with severe mental health difficulties in the community as possible (Rogers & Pilgrim, 2001). Community Treatment Orders permit the Responsible Clinician (RC) to discharge a detained patient who has been on a hospital treatment order, but treatment in the community can be accompanied with continuing forms of compulsion and coercion. For example, the patient is subject to conditions while on a CTO and can be recalled to hospital by the RC if their treatment is not progressing satisfactorily. The conditions are intended to ensure the patient receives medical treatment and seeks to reduce the risk of harm to self and other persons. If the RC judges that the conditions are not being met, they can recall the patient to hospital.

Mental health legislation in England and Wales also defines the role of the Care Coordinator (CC). This is not defined as a primarily medical or clinical role, although it can be held by a range of health professionals including a psychiatric nurse. Social workers often take this role (Allen, Carr, Linde, & Sewell, 2016). The CC has a duty to be in regular contact with a service user and to plan and coordinate their care. The expectation is that this includes liaising with a range of organizations and professionals and is likely to include reference to social needs, for example, via contacts with organizations that support actions relating to housing and employment or training.

Section 17A specifies the type of conditions that must be observed. The most common condition used is that the patient must take prescribed medication. Section 17E gives the RC the power to recall a service user to hospital for treatment if there is risk to self or others, or a condition has been broken. In such circumstances, a CTO can be revoked, and the previous hospital treatment order reinstated. Also, the RC can renew the CTO beyond its initial six months duration. Section 17C, 20A allows for a further renewal period of 12 months, following an initial renewal of six months.

The Independent Review of the Mental Health Act examined concerns about the policy implementation of CTOs (Wessely, 2018). There was a concern about the large number of orders made, this being greater than what was envisaged when CTOs were first implemented. Also, there was evidence of the excessive use of CTOs for ‘Black’ and ‘Black British’ people. The Independent Review suggested the future modification of legislation to ensure CTOs are used more selectively. This recommendation is influenced by the fact that several research studies have

concluded that CTOs do not universally lead to positive outcomes for service users. Two important studies in England emerged from the Oxford Community Treatment Order Evaluation Trail (OCTET). Burns, et al., (2013) found in a controlled trial that CTOs did not reduce the readmissions of service users to hospital. Likewise, Vergunst, et al., (2017) concluded that over a 48-month period CTO duration was not associated with improved social outcomes. An international research review by Rugkasa (2016: 15) examining a wide range of research studies and designs concluded that: 'there is no evidence of patient benefit from current CTO outcome studies'. This questioning of outcomes is in the context of research that argues practitioners feel under pressure to use CTOs to minimize risk, especially if generic and diverse community mental health services are not readily available (De Ridder, et al., 2016; Haynes & Stroud, 2019).

Previous research into the perspectives of practitioners about CTOs has shown some incremental adjustment of their views over time. The attitudes of psychiatrists to CTOs in England and Wales were first surveyed in 2000, before the implementation of CTOs into law (Crawford, Gibbons, Ellis, & Waters, 2004). This study found that 45% of respondents from a large sample (N=1171) supported a system that would allow for conditions of treatment in the community. In another national survey, soon after CTOs were implemented, Manning, et al, (2011) found that the percentage of psychiatrists agreeing with the use of treatment conditions in CTOs had risen to 60%.

A more recent quantitative study on the views of practitioners (Coyle, et al., 2013) included other mental health professionals, in addition to psychiatrists. This study found some differences between different professional groups about the effects of Mental Health Act bureaucracy and the impact of coercion. In 2016, a quantitative study by De Ridder, et al., designed to follow up and compare with Mannings, et al (2011) examined the perspective of 364 psychiatrists. This repesented a 10% response rate from those contacted online. Therapeutic insight and adherence to treatment were rated as the most important considerations when deciding to discharge a service user, but only 24% of the respondents believed that CTOs helped the development of a therapeutic relationship. Ensuring medication adherence for a length period was seen as the most important influence on deciding if a CTO was likely to work effectively. Comparing the differences between the 2011 and 2016 results, the authors (De Ridder, et al: 123) concluded that:

> 'Clinical factors remain by far the most important in decisions to initiate or discharge a CTO…the key factors were…to ensure contact with professionals, to promote medication adherence…factors in deciding

> when to discharge a CTO have been remarkably stable: development of insight, treatment of adherence, clinical improvement and reduced risk to others and self.'

Previous research about practitioner prespectives on CTOs has also used qualitative, indepth approaches, in addition to the quantitative sampling of questionnaires. For example, Stroud & Banks (2015), found that practitioners acknowledged that the coercion dictated by a CTO could lead to better contact and engagement with service users, although not in all cases.

A Norwegian qualitative research study into the views of practitioners about CTOs found that they perceived the orders as offering important opportunities to ensure ongoing treatment. This was for patients who were perceived as showing little motivation to engage in treatment (Riley, Fagerjord, & Hoyer, 2018). A study in Sweden (Jansson & Fridlund, 2016) explored mental health practitioner's perceptions of their therapeutic relationship with those subject to a CTO and concluded that not all staff approached the importance of forming a therapeutic alliance with the patient in the same way. Different therapeutic styles were evidenced.

Our research takes the previous research further by examining, in particular, the influence of social influences on practitioner perspectives. By social influences, we mean external social circumstances that can influence mental health conditions and the ability to engage with treatment and recover: for example: family and relationship circumstances; employment, vocation and education, and housing circumstances. Research has shown a strong relationship between these kinds of social influences and mental health recovery (Tew, et al., 2012).

Given that CTOs have been implemented in England and Wales and now operated for some years in practice, it is possible to measure in detail the perspectives of the key professionals involved in CTO decision making. The aim of the research was to examine the homogeneity of professional perspectives about the influence of social influences on working with CTOs across the different professionals who specialize in this area of mental health work, and as defined by the legislation.

Methods

Research Questions

To examine and evidence any differences in medical and social influences on practitioner perspectives.

To measure any differences in perspectives, with regard to professional role and allegiance.

An online survey questionnaire was distributed to a population estimated as circa 300 practitioners working with Community Treatment Orders in three Mental Health NHS Trusts in England. The inclusion criteria for being invited to complete the questionnaire was that the practitioners were either a Responsible Clinician (RC) or a Care Coordinator (CC). One hundred and eighty-one responses were received. Sixty-four (35%) were from RCs and 119 (65%) from CCs. This was a response rate of 60%. The largest professional group represented were psychiatric nurses (77/42%), followed by: psychiatrists (54/29%), social workers (31/17%), occupational therapists (7/4%), psychologists (2/1%) and other professional groups (10/5%). The latter included psychotherapists. The largest age group represented was those aged 45 – 54 (76/43%). Forty practitioners (23%) were aged 55 – 64, and 39 (22%) were aged 35 – 44 years. One hundred of the practitioners identified as female (57%) and 76 (43%) as male. Sixty-one respondents (34%) said they had held a professional registration for over 20 years and 77 (43%) had been registered for between 11 and 20 years. This evidences a cohort with considerable professional experience. Only 17 (10%) identified their ethnicity as Black, and 11 as Asian (6%), with the majority (132/74%) identifying as White.

The online survey included question items to measure practitioners' perspectives about key aspects of managing a CTO and used statements to represent likely considerations for professionals when making operational decisions (tables 1 – 3). These statements had been informed by a previous research study (Stroud & Banks, 2015). The design of question items was also informed by consultation with a Research Project Advisory Group that included practitioner and service user representation. The question items were primarily worded to evidence either social influences (like social contact, relationships, and accommodation) or medical influences (like medication and clinical risk). The split of the influences into medical and social question items is shown in tables 1, 2 and 3.

The question items asked practitioners to rate the significance of a given situation that might influence their judgement and decision making in relation to a CTO. These questions were measured using five-point ordinal scales

where practitioners chose from one of the following ranked categories: Not at all significant (1), Slightly significant (2), Quite Significant (3), Very Significant (4), Extremely Significant (5).

The questions were organized into three subgroups reflecting the key legal aspects of decision making when managing a CTO case: discharge, renewal, and recall. There were seven items related to discharge, nine concerned with renewal and six about recall. (The questions are shown in full in tables 1, 2, 3.)

Data analysis was undertaken using IBM Statistical Package for the Social Sciences (SPSS) version 25. In addition to comparing descriptive data for each question item and an overall comparison of the social and medical item scores, it was also possible to measure the degree of consistency across items in each of the three sub-groups using Cronbach's Alpha. An exploratory factor analysis using principal axis factoring and varimax rotation was applied to each sub-group, to see whether there was any evidence for a difference in the scoring of items about medical influences with those about social influences. Exploratory factor analysis is a documented quantitative method for analyzing the similarities and differences between questionnaire items when scoring questions in this way (Thompson, 2004). For example, Clifford, et al., (2002) used exploratory factor analysis in a mental health setting to identify different item sub factors in a generic quality of life measure. Principal axis factoring is the preferred algorithm for measuing factors, this based on its reliability of application, as argued by Strauss, et al.(2012). Varimax is a method available in SPSS for orthogonal rotatation and it seeks to maxmise the interpretability of valid factor loadings.

Results

Tables 1, 2 and 3 shows the descriptive statistics for each question item. The distribution of the item scores tends to be negatively skewed with respondents more likely to see a situation as very significant (4) or extremely significant (5).

Before analyzing the three subgroups of discharge, renewal and recall items the descriptives were compared for all medical items and social items (as indicated in tables 1, 2, 3). It can be observed that the medical items tend towards higher average scores. Social items were marginally less likely to be seen as significant or very significant factors by

participants when compared with how they scored medical aspects (for all items, the social items mean= 3.58, sd=0.55; medical items mean= 4.43, sd = 0.39; t= -19.38, p=0.001).

Practitioner's perspectives on discharge

A bivariate matrix of correlation coefficients was used to explore associations between discharge item scores. The first two discharge items, *good engagement with Mental Health Professionals* (item 1) and *patient has been compliant with taking medication* (item 2) had a score of 0.43 ($p<0.01$), but no significant and substantive correlations > 0.3 with any other discharge items. Nevertheless, all the other discharge items (items 2-7, see table 1 for details) were moderately correlated with each other as pairs, with scores > 0.4 ($p<0.01$). The strongest pairing was *engagement with positive social activities* and *positive relationships with partners*, *families, and friends* (0.71, $p<0.01$). This exploration of the data suggested that the differences in the discharge items might be related to two latent factors, where the first is focused on medical influences, and the second is focused on social influences.

An exploratory factor analysis examined this further. The model satisfied the test of sampling adequacy (Kaiser-Meyer-Olkin = 0.81) Orthogonal rotation confirmed the presence of the two factors 'medical' (items 1 and 2) and 'social' (items 3 – 7) with different scoring patterns for each latent factor (Factor 1, Social = Eigenvalue = 3.00, 42.58 % of variance; Factor 2, Medical = Eigenvalue = 1.03 % of variance = 14.77%). The final factor loadings for each item, after rotation, are shown in table 1.

The resulting two factor scores were computed into two new variables for each respondent (medical score and social score). This was done by calculating factor regression scores for each practitioner. For both factors, there was no statistically significant different in the mean average score for RCs when compared with CCs (Social Factor: Levene's = 0.54, p=0.82; t = -0.03, df=173, p=0.97: Medical Factor: Levene's = 0.27, p=0.60; t = - 0.37 df=173, p=0.71). Similarly, when the three largest professional practitioner groupings were compared (social work, psychiatric nurses, and psychiatrists), one way ANOVAs found no statistically different relationships in mean scores (Social Factor: Levene's = 0.24, p =0.79; F(2,158) = 0.44, p=0.96; Medical Factor: Levene's= 0.74, p=0.93; F (2,158)= 1.22, p=0.30). These non-significant results demonstrate homogeneity in practitioner's perspectives towards discharge across the occupational and professional demographics tested.

Insert table 1 here

Practitioner's perspectives on renewal

A bivariate matrix of correlation coefficients was used to explore associations between renewal item scores. The first two items, *patient is currently unwell,* and *patient does not always accept the need to take medication* had a score of 0.37 ($p<0.01$), but neither of these items have significant correlations with any other renewal items. All the other 7 items, however, had significant correlations >0.2 ($p>0.01$) with the exception of one single pairing. The majority of pairs were correlated >0.3 ($p>0.01$). The exploration of the renewal items suggested at least two latent factors, where the first two item pairing was an indication of medical factors.

An exploratory factor analysis examined this further. The model satisfied the test of sampling adequacy (Kaiser-Meyer-Olkin = 0.76). This identified two factors after orthogonal rotation (Factor 1 [Social] = Eigenvalue = 2.47 % of variance = 27.49; Factor 2 [Medical] = Eigenvalue = 0.91, % of variance = 10.13). As the second factor has an Eigenvalue below 1, it is not considered substantive enough to merit further exploration (Girden & Kabacoff, 2011). The final factor loadings for each item in factor 1 are shown in table 2.

The resulting social factor scores were computed into a new variable using the factor regression scores for each practitioner. There was no statistically significant difference in the mean average score for RCs when compared with CCs (Levene's = 0.26, p=0.60; t = 0.97, df=171, p=0.33: Medical Factor: Levene's = 1.68, p=0.20; t = - 1.97 df=171, p=0.6). When the three largest professional practitioner groupings were compared (social work, psychiatric nurses, and psychiatrists) a one way ANOVA found no statistically significant difference between the scores for the three groups for the Social Factor (Levene's = 0.11, p =0.90; F(2,153) = 2.99, p=0.60).

Insert table 2 here

Practitioner's perspectives on recall

A bivariate matrix of correlation coefficients explored associations between items measuring perspectives on recall (items listed in table 3). The largest correlation in the matrix was between the items about risk: *patient is posing a risk to others* and *patient is posing a risk to themselves* (cor = 0.82, p >0.01). Both these items also had small and significant correlations (cors > 0.35, p> 0.01) with the item *Patient's mental health has deteriorated and they need assessment in hospital.* The next largest correlation in the matrix was between the items: *Patient has disengaged with the community mental health support team* and *Patient has declined to take medication (cor = 0.62 p> 0.01*). This item also had small but significant correlations with the remaining item in the matrix: i.e.: *Concerns about the patient's mental health are expressed by the carer/family/friends* (cors > 0.35, p>0.01). This exploration of the recall items suggests two latent factors. An exploratory factor analysis confirmed the presence of two factors (table 3), but an examination of the separation of the actual items (see table 3) into a first and second factor suggests that they cannot be qualitatively described as medical factors and social factors, due to the resulting alignment of individual items into the two factors. A more appropriate description proposed in table 3 is to describe factor 1 as 'risk items' and factor 2 as 'disengagement items'. The model satisfied the test of sampling adequacy (Kaiser-Meyer-Olkin = 0.68). This identified two factors after orthogonal rotation (Factor 1 [Risk] = Eigenvalue = 1.86, % of variance = 31.08; Factor 2 [Disengagement] = Eigenvalue = 1.59, % of variance = 26.49). The final factor item loadings for each item are shown in table 3.

The resulting two factor scores were computed into two new variables (risk and disengagement) using the factor regression scores for each practitioner. For both factors, there was no statistically significant different in the mean average score for RCs when compared with CCs (Risk: Levene's = 1.16, p=0.28; t = 0.28, df=176, p=0.78: Disengagement Factor: Levene's = 2.37, p=0.12; t = 0.98 df=176, p=0.33).

Similarly, when the three largest professional practitioner groupings were compared, one way ANOVAs found no statistically different relationships in mean scores (Risk Factor: Levene's = 2.24, p =0.11; F (2,158) = 1.24, p=0.29; Disengagement Factor: Levene's= 0.67, p=0.93; F (2,158) = 2.73, p=0.70). These non-significant results demonstrate homogeneity in practitioner's perspectives towards renewal across the occupational and professional demographics tested.

Insert table 3 here

Discussion

The results analysis shows that social items have an important influence on practitioner perspectives. There is no evidence of differences in practitioner perspectives towards the influence of social items being related to their primary Mental Health Act role (RC/CC) or professional grouping. This is evidence of homogeneity of perspectives about the influences of social issues on Mental Health Act decisions and this suggests congruence in the difficult decision-making processes in mental health multidisciplinary teams.

If one expects an interdisciplinary team to be able to reach a shared approach to treatment interventions and plans, this congruence of views implies that the interprofessional approach is functional. If, however, the policy function of interdisciplinary assessment is to encourage a more adversarial approach, for example where the RC has primary responsibility for managing public and service user risks and the CC focuses on arguing the human rights of the service user, homogeneity of perspectives might not be seen as a positive development by service users. Some researchers have noted a blurring of specialist professional roles as a consequence of the implementation of the Mental Health Act, 2007. As a result, they expressed concern that such blurring can erroneously be assumed to benefit service users and their needs when this is not always the situation (Hannigan & Allen, 2011).

The findings in this research study about the very strong influence of medical factors on decision making are similar to De Ridder, et al, 2016, who found that clinical factors were by far the most important influences on discharge decisions, although the definition of clinical in this respect included the psychosocial aspect of the development of patient insight into their own condition. Reduced risk to self and others was also a very important influence on

discharge decisions in their study. That important and seminal research did not include separate measurements for items and factors influencing CTO renewal and recall.

Previous quantitative studies about practitioner perspectives towards CTOs have predominantly sampled from psychiatrists who take the role of the Responsible Medical Officer (RC) under mental health legislation. The exception was (Coyle, et al., 2013) that found some significant differences between psychiatrist and psychiatric nurses about the importance of the availability of psychological therapies, and the burden of bureaucracy imposed by the Mental Health Act. Our study makes an important contribution because it focuses primarily on the influence of social influences on decision making and compares several professional groupings with psychiatrists. This includes the practitioners who more usually take up the role of Care Coordinator (CC). The data analysis showed no significant differences between the perspectives of these practitioner groupings and provides evidence of homogeneity in perspectives towards CTO decision making. Similarly, in our study, all professional groups find social influences an important consideration in mental health act decision making.

When examining the practitioner perspectives on issues that influence recall to hospital there was less evidence of social items being a consistent influence as differentiated from medical items. Rather, the items divided into latent factors that could best be described as risk compared with disengagement. The main difference between these two factors was that items reflecting risk scored very highly, indicating they were seen as predominantly 'very significant' by the majority of practitioners in the sample.

The high scores for the risk factor and its items are important in the context of the recent review of the Mental Health Act and the perceived overuse of CTOs by the review (Wessley, 2018). Practitioners see many users who - despite being subject to a CTO - are at risk to themselves and/or others and who are therefore recalled to hospital (De Ridder, et al., 2016).

Research by Light, et al. (2015) found important differences in how service users and caregivers defined risk when compared to clinicians and mental health review tribunal members, with the former group more likely to put emphasis on 'social adversity' such as material disadvantages. While our research found that practitioners certainly recognize the impact of these social factors, the policy system and its interpretation of the legislation tended to place more emphasis on a clinical definition of risk (broadly similar to Light et al) when considering the coercive return of service users from the community into institutional care.

Similarly, practitioners are cautious to discharge, leading to a tendency to renew orders. Much of this is because of the overall context of a Mental Health system in England and Wales that lacks the general resources to creatively meet diverse needs, including social needs. This explains the over reliance on coercive treatment in the community (Haynes & Stroud, 2019)

Conclusions

Mental health practitioners who took part in this survey scored social items highly alongside medical items. Practitioners showed a keen awareness of the importance of social factors, but the limitations in the resourcing of preventative mental health services and the general condition of society – with its high levels of social isolation and a lack of suitable support, including social housing - encourages the large-scale use of CTOs to protect service users. These social conditions contribute to the current Mental Health policy circumstances in England and the over reliance on compulsory interventions (Wessley, 2018).

The overall message from this research is that mental health practitioners do not work in medical and clinical isolation while ignoring the social environment. They are frequently aware of the constant interaction of the challenging social circumstances that service users face while trying to recover. It seems likely that much of the time they do not feel that they have the resources available to impact these social issues.

While CTO research has not been conclusive about the benefits of CTO outcomes in terms of reduced future hospital admissions and improved social factors, it is not known what would have happened to the many service users who have experienced CTOs in England and Wales since 2011, if CTOs had not been a policy option. This was a period of time after the global financial crisis, when public expenditure on local authority social care and income benefits in these countries was in rapid decline. Therefore, CTO outcome achievements might be researched in the future against the more modest outcomes of reducing self-harm and premature mortality. Substantial improvements in the quality of life of service users are not likely to be made without substantial investment in a wide range of associated social and welfare services.

Compliance with Ethical Standards

Ethical approval was granted by the following ethics and governance committees: University of Brighton; South East Coast and Surrey, NHS (IRAS 196566); and Sussex Partnership Foundation NHS Trust. By completing the survey, all human participants gave consent for their data to be used in this research and the independent ethical approval process approved this as informed consent.

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