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The CTO was often understood as providing legal recognition of the need for care and to provide structure and containment for the ‘right’ service user.

Care for CTO service users was defined as predominantly medical.

Misunderstandings exist over the actual powers and conditions of CTOs.

Examples were apparent of person-centred care incorporated into practice. However, this was more evident at review stage than at earlier points in the process.

CTOs were perceived as more successful in teams where they were carefully planned over time as an appropriate intervention, rather than where they were made almost as a matter of course, and involved the service user as much as possible.

There is a need for improvements in provision of information including details of the service user’s right to advocacy services.

CTOs were introduced in 2008 by the Mental Health Act 2007, following protracted public and political concern over the arrangements for the care of the mentally ill in the community. CTOs
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with the precepts of person centred care and this study explored experiences and uses of CTOs in the contradictory policy context of promoting autonomy and choice on one hand, and enforcing compulsion and control on the other.

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Trust records showed 199 new CTOs were made during the study period (July 2011 to December 2012). Just over a quarter (52/26%) of these service users had their CTO discharged, 64 (32%) were revoked, 8 allowed to lapse (4%) and 3 (2%) transferred, while the remaining 71 (36%) were still active, having either been renewed or not yet due for renewal.

The majority of those subject to CTOs were diagnosed with schizophrenia (the most common being paranoid schizophrenia, 53%), or schizoaffective disorder. Apart from the mandatory conditions attached to CTOs, the most common condition specified, evident in a third of cases (65/33%), was around adherence to a prescribed medication regime.

Most service users were male (62%), but the majority (68%) of those aged over 50 were female. The mean average age of service users was 44, with the majority aged between 35 and 59 (56%), almost a third (63/32%) aged under 35 and 22 (12%) aged 60+. CTO service users in the sample were most likely to be single (150/75%), which excludes those who were divorced, separated or widowed (29/15%) and only 20 (10%) were recorded as married, in a civil partnership or cohabiting.

The large majority (185/93%) were recorded as White British, White Other or White Irish, while the remaining 14 (7%) service users were categorised as Black, Asian or Mixed Race. Although national Care Quality Commission (2014) data has indicated an over-representation of service users from ethnic minorities, these statistics reflect the general population of the Sussex Partnership area according to 2011 Census data (in which those categorised as White comprise 94%).

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The CTO was found to provide not only a legal framework to support enforced care in the community but a common theme, especially among service users and their relatives, was that the order provided a legal recognition of the service user's need for care. Service users, relatives and service providers often expressed how the CTO's legal requirement to 'check-up' on the service user made a significant difference to the amount of contact the service user had with services. Furthermore, this legal recognition of the need for care was commonly experienced as reassuring, especially if there had been concerns about receiving adequate care in the past.

The specific advantages of recall to hospital under the CTO was felt to be: (i) the speed with which recall could be issued; (ii) that a new Mental Health Act assessment was not needed for re-admission; and (iii) that the service user could come into hospital for 72 hours and thereafter be discharged back into the community under the same CTO.

Related to the previous theme, there was also a sense across the groups that the CTO could provide structure and (for some) a reassuring 'safety net'. The 'right' service users were perceived as those who were treatment-resistant prior to being subject to the CTO and often lacked 'insight' into their mental health needs.

However, whether the CTO was successful or not depended on the presence of a range of factors for the service user: (i) the motivation to get well and/or progress to independence; (ii) finding structure and/or legal recognition of need for care reassuring; (iii) respect for legal power and/or regard recall to hospital as a deterrent; vi) 'grudging' acceptance that conditions of the CTO are in own best interest (although this acceptance often came after being on the CTO for some time, with a recognition of greater stability).

The element of control was found to be experienced as a reassuring ‘structuring force’ that was attributed to a progression towards greater stability in many cases. An understanding of the CTO as a ‘contract’ could be helpful in containing mental health issues and shifting an element of responsibility away from the individual and on to services. However, some practitioners felt that for the ‘wrong’ kind of service user, where the CTO is experienced as restrictive and punitive, the CTO can be ineffective and potentially harmful for therapeutic relationships.

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