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Perceptions to Care, (Education) and Treatment Reviews (C(E)TRs) of Mental Health Clinicians Working with Adults with Intellectual Disability in England: A Cross-Sectional Study

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ABSTRACT

Introduction: Care (Education) and Treatment Reviews (C(E)TR) are meetings to review individualized needs of people with intellectual disabilities (PwID) at risk of or currently undergoing psychiatric hospitalization. We aimed to understand C(E)TR impact and effectiveness from professionals working with PwID.
Methods: An online mixed-methodology survey which included 34 questions (either Likert or free text) was shared with networks including relevant professionals. Quantitative data are presented descriptively. Thematic analysis was conducted on free-text responses.
Results: Of 66 people representing multiple intellectual disability teams across the UK, 67% found the C(E)TR process useful, 35% felt C(E)TRs made a difference to their clinical care, while 36% felt it did not. Thematic analysis showed four overarching themesj: processes and structures, recommendations, accountability, and statutory vs. advisory. Word missing after advisory?
Conclusion: Clinicians find C(E)TRs useful for their practice but remain concerned about significant clinical risks and service issues beyond their control which C(E)TRs fail to identify.

KEYWORDS
Psychiatric inpatient; mental health; learning disability; segregation; challenging behavior

Introduction

Across England, there is an increased focus on the transition for people with intellectual disabilities out of inpatient hospital settings into community

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services (Burrows et al., 2023; Lennard et al., 2020; Niven et al., 2020; Shankar 2023). According to the World Health Organisation, the transition should be supported through adequate allocation of resources to develop community service infrastructure (World Health Organization, 2011). The aims are to reduce the number of people in mental health inpatient settings but also to ensure safe, high-quality care (Health and Social Care Committee, 2022).

In England, this was spotlighted following the institutional abuse experienced by people with intellectual disabilities at Winterbourne View Hospital in 2011. Transforming Care captures the governmental response to this incident (Department of Health, 2012). The initiative aims to improve community services and reduce discharge times, and to avoid unnecessary inpatient admissions for people with intellectual disabilities (Department of Health, 2012). The Transforming Care agenda, along with The Winterbourne View Concordat, set national targets for people with intellectual disability who were inappropriately placed within inpatient settings to be discharged into community provisions by 2014 (Department of Health, 2012).

The concordat set to work with stakeholders and aimed to meet 63 transforming care commitments, with one central commitment of moving into the community anyone with an intellectual disability and challenging behavior who does not need to be in a hospital setting (Department of Health, 2012). Data in 2015 found that, despite progress on most of the commitments the government had set itself, hospital placements or new admissions were not greatly reduced (National Audit Office, 2015). In fact, many patients with intellectual disability still did not have a plan to move into community settings (National Audit Office, 2015). A national plan setting targets to move 35–50% of people with intellectual disability into community support settings by March 2019 was enforced shortly after, involving as its centerpiece the Care (Education) and Treatment Review (C(E)TR) (NHS England, Association of Directors of Adult Social Services & Local Government Association, 2015)

The C(E)TR process was developed in 2015, after evidenced lengthy admissions and delayed discharges of people with intellectual disabilities (NHS England, Association of Directors of Adult Social Services & Local Government Association, 2015). It is based on human-rights based approach (HRBA) principles, emphasizing service-user inclusion and a more collaborative approach to care (Greenhill & Whitehead, 2011). C(E)TRs are meetings of a panel (including commissioners, an independent clinical expert, and a person with lived experience) who meet with professionals involved in the care of an individual with intellectual disabilities who is either at risk of admission or already in an inpatient setting, to review personalized care and treatment needs of the person and discuss the appropriateness of inpatient care with the panel and the patient's family (NHS England, 2023; NHS England, Association of Directors of Adult Social Services & Local Government Association, 2015)

Community C(E)TRs are initiated for people who are seen to be at risk of needing hospital admission, to ensure that admissions are necessary and to consider community-based alternatives (NHS England, 2020). If eventually admitted, after 6 weeks, a review C(E)TR should be conducted if they are yet to be discharged (NHS England, 2020). When a community C(E)TR has not been conducted, a post-admission review is conducted within 28 days of admission. Review C(E)TRs are conducted every 6 months (for those in nonsecure settings) or every 12 months for inpatients in secure settings. Review C(E)TRs aim to ensure admission is appropriate, identify reasons for continued inpatient care and barriers to discharge; and discharge preparation and planning. A pre-discharge C(E)TR is then held to identify advocacy needs and to plan discharge and follow-up in the community (NHS England, 2023).

In 2020, NHS Digital published data on inpatients who have had a C(E)TR (NHS England, 2020). Of patients eligible for a C(E)TR, 78% in nonsecure wards had received one C(E)TR, and 66% of patients in secure settings. According to the Health and Social Committee, over 80% of community C(E)TRs lead to a decision to not admit a person to the hospital (Murdoch & Banks, 2021).

However, there is limited data regarding the C(E)TR process and how it has supported discharges, nor outlining how patients who did not receive a C(E)TR were supported (Langdon et al., 2023). National data show 53% of inpatients have had a length of stay greater than two years (NHS England, 2024). The reduction of admission post Transforming Care implementation has been around 5% (Langdon et al., 2023). The C(E)TR policy has been criticized for not considering patients who present with complex needs, leading to minimal impact of the C(E)TR process for this group (Langdon et al., 2023; Taylor, 2021).

Evidence is limited regarding the current opinions of clinicians who work with people with intellectual disabilities on the role and impact of C(E)TRs. As such, our study aims to investigate this.

Method

Materials

STROBE guidelines for reporting cross-sectional studies were used to design and report the study (supplementary information 1). CA 34-item questionnaire was developed which included questions on demographic data, work experience, experience of C(E)TRs, and views about the proposed changes to the C(E)TR process (supplementary information 2). Response options included multiple choice, matrix questions with Likert scales, ranking questions, and free text boxes. The questionnaire was hosted online on Google Forms.

Table 1. Survey results of respondents.

Q1. Select your role from the following list	
Psychiatrist	20 (30%)
Psychologist	19 (28.8%) (including 1 psychotherapist)
Nurse	13 (19.7%)
Occupational Therapist	5 (7.6%)
Speech and Language Therapist	3 (4.6%)
Social Worker	5 (7.6%)
Other	1
Q2. If you are a psychiatrist, please select your grade from the following list:	
Consultant	16
Specialty Doctor/SAS	4
Higher trainee	0
Others	1 (CT)
Q3. In which Region are you currently based?	*N* = 65 (%) Here and throughout article, including tables, please confirm: *N* or *n*
East of England	16 (24.62%)
Southwest	14 (21.54%)
Northwest	8 (12.31%)
London	8 (12.31%)
West Midlands	8 (12.31%)
Southeast	7 (10.77%)
East Midlands	3 (4.62)
Others	Eastern(1)
Q4. How many years have you worked in mental health?	*N* = 65(%)
0-5 years	9 (13.85%)
6–10 years	5 (7.69%)
11–15 years	13 (20%)
16–20 years	15 (23.08%)
21–25 years	12 (18.46%)
26–30 years	5 (7.69%)
31–35 years	2 (3.08%)
36–40 years	3 (4.62%)
More than 40 years	1 (1.54%)
Q5. In which of the following settings do you work? Please select all that apply.	
Outpatient/ Community	32
Specialist Inpatient Service	31
Specialist Secure Service	32
General Hospital/ Secondary Care/ Liaison	2
Others	Criminal Justice system (1); Transforming care team (1); mainstream female forensic inpatient unit (1); Learning disabilities (1); Care pathway management of service users in out-of-area hospitals, specialist forensic outreach and liaison service (1); Forensic services (1); Primary care/community (1); Community intensive support team and inpatient ANT service (1) and Tier 4 CAMHS ID Service(1)
Q6. If you work in an inpatient setting, what category best describes your unit? Please select all that apply.	
Specialist ID Adult Assessment and Treatment Unit	17
Open/Locked Rehabilitation	10

(*Continued*)

Table 1. (Continued).

Q1. Select your role from the following list	
Low Secure	20
Medium Secure	19
High Secure	1
Not Applicable	8
Q7. In which sector do you work? Select all that apply	
NHS	56
Independent	8
Third Sector/ Charitable	1
Q8. How many beds allocated for patients with intellectual disability does your unit contain?	
0	6
1–10	23
11–20	12
21–30	3
31–40	2
41–50	2
>50	1
Others (0 for LD. But 12 ASD beds)	1
Q9. Over the last 24 months, how many patients have been discharged from your service?	
0	5
1–5	23
6–10	6
11–15	2
< 5	*1*
I have now left the unit but I can give you a rough idea in 2022 was about 3 patients	*1*
Many	*1*
N/A (n/a)	*3*
N/A (have been in community in last 24 months)	*1*
N/A – community based	*1*
Unsure	*1*
My service is outpatients. Many have been discharged	*1*
28 with LD/A	*1*
None from our secure MSU beds, lots from the other parts of my job	*1*
Unsure10?	*1*
10+	*1*
Approx 10	*1*
No response	15
Q10. Which of the following types of CTR have you attended over the last 24 months? Please select all that apply (*n* = 66)	
Pre-admission CTR	26 (39.4%)
Post-admission CTR	56 (84.8%)
CTR for delayed discharge	42 (63.6%)
None of the above	3 (4.5%)

All	Most	Some	None	N/A

(*Continued*)

Table 1. (Continued).

Q1. Select your role from the following list					
Q11. 11. How many of your patients have had a CTR in the last 24 months? (*N* = 65)	27(41.5%)	14 (21.5%)	22 (33.8%)	0	2 (3.1%)
Q12. Of the patients who had CTRs, how many:					
Were clinically ready for discharge and have a current discharge plan? (*N* = 64)	4 (62.5%)	11 (17.2%)	41 (64.1%)	7 (10.9%)	1 (1.6%)
Were clinically ready for discharge but were marked as delayed discharge or delayed transfer of care? (*N* = 63)	3 (47.6%)	10 (15.9%)	36 (57.1%)	12 (19.0%)	2 (3.2)
Have a current person-centered care plan? (*N* = 65)	42 (64.6%)	14 (21.5%)	8 (12.3%)	0	1 (1.5%)
Have had a communication assessment? (where indicated) (*N* = 65)	30 (46.2%)	23 (35.4%)	8 (12.3%)	3 (46.2%)	1 (1.5%)
Have a current Health Action Plan? (*N* = 63)	36 (57.1%)	13 (20.6%)	8 (12.7%)	1 (1.6%)	5 (7.9%)
Have a current PBS plan? (*N* = 64)	39(60.9%)	19 (29.7%)	6 (9.4%)	0	0
Have a current Risk Assessment and Management Plan? (*N* = 64)	57 (89.1%)	5 (7.8%)	2 (3.1%)	0	0
Have had a skills assessment/Care Act assessment? e.g. literacy, numeracy, budgeting, travel. (*N* = 64)	21 (32.8%)	22 (34.4%)	15 (23.4%)	4 (6.3%)	2 (3.1%)
Have had a swallowing assessment? (where indicated in high risk groups) (*N* = 66)	24 (36.4%)	17 (26.6%)	12 (18.8%)	4 (6.3%)	9 (14.1%)
Have a community discharge coordinator? (*N* = 65)	21 (32.3%)	16 (24.6%)	23 (35.4%)	3 (4.6%)	2 (3.1%)
Have had an Autism assessment (where indicated)? (*N* = 63)	31 (49.2%)	13 (20.6%)	15 (23.8%)	1 (1.6%)	3 (4.8%)
Have had an ADHD assessment (where indicated))? (*N* = 64)	27 (42.2%)	7 (10.9%)	22 (34.4%)	1 (1.6%)	7 (10.9%)

(*Continued*)

Table 1. (Continued).

Q1. Select your role from the following list						
	All		Most	Some	None	
Q13. Among your patients who had CTRs, at the time of admission, which of these were the presenting concerns?						
Challenging Behaviour ($N = 63$)	29 (46.0%)		23 (36.5%)	11 (17.5%)	0	
Offending Behaviour ($N = 58$)	23 (39.7%)		15 (25.9%)	16 (27.6%)	4 (6.9%)	
Serious Mental Illness (e.g., bipolar, psychosis, mood disorders.) ($N = 60$)	12 (20%)		15 (25%)	31 (51.7%)	2 (3.3%)	
Physical health illness (including epilepsy, dementia) ($N = 59$)	6 (10.2%)		6 (10.2%)	41 (69.5%)	6 (10.2%)	
Social care issues ($N = 62$)	18 (29.0%)		25 (40.3%)	15 (24.2%)	4 (6.5%)	
	Up to 1 Hour	2 hours	3 hours	4 hours	5 hours	>5 hours
Q14. In general, how long do you spend attending a CTR? ($N = 65$)	15 (23.1%)	34 (52.3%)	9 (13.8%)	3 (4.6%)	0	4 (6.2)
	All		Most	Some	None	
Q15. Of the CTRs attended over the past 24 months, how many of these were led by the responsible commissioner? ($N = 65$)	21 (32.3%)		18 (27.7%)	15 (23.1%)	11 (16.9%)	
16. Of those CTRs attended, which professionals were usually present? (roughly more than 75% of the time) $N = 65$						
Psychiatrist	61 (93.8%)					
Nurse	64 (98.5%)					
Psychologist	53 (81.5%)					
Occupational Therapist	52 (80%)					
Speech and Language Therapist	27 (41.5%)					
Physiotherapist	4 (6.2%)					
Social Worker	50 (76.9%)					
Pharmacist	3 (4.6%)					
Family member	40 (61.5%)					
Others	Intensive Support Team and ICB Commissioner, 1(1.5%); Locality SW, 1(1.5%); Positive partnership team (PPT, part of SLDS), 1(1.5%); NHS England, 1(1.5%); Associate Specialist, 1(1.5%); Teacher, 1(1.5%).					
	Always		Often	Sometimes	Rarely	Never
Q17. How many of the following CTR actions were covered during reviews that you have attended?						
Key Areas of Concern ($N = 62$)	35 (56.5%)		20 (32.3%)	6 (9.7%)	0	1 (1.6%)
Does the person need to be in Hospital? ($N = 63$)	41 (65.1%)		16 (25.4%)	4 (6.3%)	1	1 (1.6%)

(*Continued*)

Table 1. (Continued).

Q1. Select your role from the following list					
Is the person receiving the right care and treatment? (*N* = 63)	47 (74.6%)	10 (15.9%)	4 (6.3%)	0	1 (6.3%)
Is care person-centred? (*N* = 63)	40 (63.5%)	16 (25.4%)	3 (4.8%)	4 (6.3%)	0
Are the Person's health needs known and met? (*N* = 63)	43 (68.3%)	14 (2.2%)	6 (9.5%)	0	0
Is medication being used appropriately? (*N* = 62)	39 (61.9%)	15 (24.2%)	4 (6.3%)	4 (6.3%)	0
Are there clear, safe, and positive approaches to risk? (*N* = 62)	31 (50%)	21 (33.9%)	8 (12.9%)	2 (3.2%)	0
Are any autism needs being met? (*N* = 62)	37 (59.7%)	15 (24.2%)	7 (11.3%)	1 (1.6%)	2 (3.2%)
Is there active planning for the future and discharge? (*N* = 62)	39 (62.9%)	17 (27.4%)	3 (4.8%)	2 (3.2%)	1 (1.6%)
Are families and/or carers involved? (*N* = 62)	38 (61.3%)	15 (24.2%)	6 (9.7%)	3 (4.8)	0
Are the Person's rights upheld? (*N* = 62)	36 (58.1%)	18 (29%)	4 (6.3%)	1 (1.6%)	3 (4.8%)
Q19. Which of the following account for delayed discharges? (defined in this study as 6 weeks post-completion of treatment and agreement by all parties)					
No placement profile/ community assessment done (*N* = 57)	2 (3.5%)	14 (24.6%)	13 (22.8%)	18 (31.6%)	10 (17.5%)
No placement options available with preferred option agreed (*N* = 59)	13 (22%)	32 (54.2%)	8 (13.6%)	4 (6.8%)	2 (3.4%)
Placement Funding disputes (*N* = 59)	0	15 (25.4%)	22 (37.3%)	17 (28.8%)	5 (8.5%)
No agreed community clinical responsibility. (*N* = 58)	1 (1.7%)	11 (19%)	16 (27.6%)	20 (34.5)	10 (17.2%)
No agreed social care responsibility (*N* = 58)	0	12 (20.7%)	16 (27.6)	21 (36.2%)	9 (15.5%)
Q21. In your opinion, what are the top 3 benefits of CTRs? (*N* = 62)					
Checking adequacy of care and treatment.	41 (66.1.%)				

(*Continued*)

Table 1. (Continued).

Q1. Select your role from the following list					
Enhanced collaborative working with the community team.	16 (25.8%)				
Experts by experience working in partnership with the MDT	15 (24.2%)				
Experts by experience having the opportunity to ask focused/ relevant Questions	18 (29%)				
Checking Quality of reports	8 (12.9%)				
Discussing Legal framework	10 (16.1%)				
Facilitating the discharge pathway.	27 (43.5%)				
Integrated multi-professional assessment, diagnosis, and formulation.	16 (25.8%)				
Others	I don't think they benefit **(1;1.6%);** Areas are already covered by usual good care, clinical governance, strong collaborative relationships with commissioner and care coordinators **(1;1.6%);** Advising on Local Care Needs **(1;1.6%);** supporting development of clinical treatment pathways **(1;1.6%);** offer other ideas **(1;1.6%);** clarifying and reviewing care pathways **(1;1.6%);** seems to be questioned by individuals that left a service and drag back from retirement **(1;1.6%);** Pulling together multiple agencies to make planning more seamless **(1;1.6%);** Support for team through CTR recommendations and generally receiving feedback that the team are heading in the right direction and have done or are planning to do everything possible (**1;1.6%);** Personally i dont think they made much difference to whether the pace of discharge changed **(1;1.6%);** Commissioners required to take an active part improves stalemate situations **(1;1.6%);** At present the way it is done it is pointless exercise most of the time **(1;1.6%);** Ensuring there is a focussed plan toward a less restricted future **(1;1.6%);** None of the above **(1;1.6%);**				
	Always	Often	Sometimes	Rarely	Never
Q22. Overall, have you found CTRs useful? *N* = 65					
	5 (7.7%)	15 (23.1%)	29 (44.6%)	11(16.9%)	5(7.7%)
Q23. In your opinion, do CTR panels have the appropriate specialist expertise present? *N* = 64					
	8 (12.5%)	20 (31.3%)	28 (43.8%)	6 (9.4%)	2 (3.1%)
Q24. Regarding experts by experience, in your opinion					
How much is their experience valued in CTRs? *N* = 64	14 (21.9%)	24 (37.5%)	22 (34.4%)	4 (6.3%)	0
Do their contributions add to the CTR process? *N* = 62	14 (22.6%)	17 (27.4%)	24 (38.7%)	7 (11.3%)	0
Q25. In your opinion, is it necessary to have a psychiatrist as a panel member? *N* = 65					
	19 (29.2%)	10 (15.4%)	20 (30.8%)	14 (21.5%)	2 (3.1%)
	Yes		No	Not Sure	
Q26. Have CTRs made a difference to your clinical care? *N* = 65					
	23 (35.4%)		24 (36.9%)	18 (27.7%)	
Q27. What impact have CTRs had on your workload?					
	No Change	Minimally	Averagely	Significantly	Overwhelmingly

(*Continued*)

Table 1. (Continued).

Q1. Select your role from the following list					
Increased workload $N = 63$	4 (6.3%)	10 (15.9%)	22 (34.9%)	23 (36.5%)	4 (6.3%)
Decreased workload $N = 45$	36 (80%)	8 (17.8%)	0	1 (2.2%)	0
	Yes		No	Other	
Q31. Would you support CTRs be coming a statutory and enforceable process? $N = 63$	30 (47.6%)		32 (50.8%)	Please see my reply to question 30 (1;1.6%)	
	Very likely	Likely	Neutral	Not likely	Very unlikely
Q33. How strongly would you recommend CTRs?	12 (18.5%)	24 (36.9%)	14 (21.5%)	7 (10.8%)	8 (12.3%)

Ethics and Governance

The Health Research Authority tool confirmed ethical approval was not required for this project, as it met service evaluation criteria (Supplementary information 3). The RCPsych ID faculty inpatient group supported the survey and had some of its members as part of the project team. The project team updated the RCPsych ID faculty inpatient group on a regular basis and the group wwas supportive of the process and in helping to disseminate the survey.

All participants were advised at the start of the study that participation was voluntary and informed consent would be implicit and presumed if the survey was submitted. If they chose to participate, data would be pooled, anonymized, and analyzed. Intention to disseminate by publication was stated. No participant identifier data wwere collected. Further, participation involved a professional participant group for which consent was implicit by participation.

Procedure and Participants

The questionnaire survey link was shared via e-mail with all the RADIANT group members(https://www.hpft.nhs.uk/information-and-resources/radiant-research-in-developmental-neuropsychiatry/). RADIANT is a developmental disability–focused clinical research network in England. At this time, there were around 800 people on the mailing list including clinicians, academics, patients, carers, and community leaders. This approach aimed to attract multidisciplinary professionals working within intellectual disability settings. Responses were collected in September 2023, with periodic reminder e-mails sent.

Analysis

Quantitative data were analyzed statistically, and free-text answers were analyzed thematically (Braun & Clarke, 2006). The themes were verified by two researchers (JP and PT). Quotations from respondents have been included where deemed relevant and have only been edited for spelling and grammar, without changing the context of the original text.

Results

A total of 66 people responded, representing multiple intellectual disability teams across the UK. Approximately 30% of responders were medical staff, either as psychiatric consultants, staff-grade doctors, or core trainees. Most responders (70%) were nonmedical professionals forming the multidisciplinary team. A total of 85% of respondents were working in the National Health Service and respondents worked in varied settings including inpatient, community, and forensic settings. Other demographic information about participants is provided in Table 1.

Quantitative Analysis

C(E)TR Expertise

Regarding which professionals were present at a C(E)TR meeting (e.g., >75% of the time), 64 (97%) respondents reported nursing professionals were present, 61 (92%) said there were psychiatrists present, 53 (80%) mentioned psychologists, 52 (79%) noted occupational therapists, 50 (76%) said social workers, 27 (41%) reported speech and language therapists, and 40 (61%) had family in attendance.

Types of C(E)TR

In total, 26 (40%) of respondents attended preadmission C(E)TRs, 61 (92%) attended post-admission C(E)TR and 42 (64%) had C(E)TR for delayed discharges.

Concerning length of C(E)TRs, 21% reported C(E)TRs to be up to 1 hour long, 49% being 2 hours long, 20% being 3 hours long, 4% being 4 hours long, and 6% being more than 5 hours long. In total, the majority (31%) of respondents had a responsible commissioner lead the C(E)TR, 27% had a responsible commissioner lead the C(E)TR most of the time, 23% some of the time, 17% none of the time, and 1% left blank.

Assessment and Plans

Most respondents (86%) stated that all their patients had a current risk assessment and management plan. About 90% of participants reported

Table 2. Comments to open text questions.

Any additional comments about CTR actions covered during reviews?
<NL>1.These are all areas covered by general good practice and CTPs. 2.I think CTRs should be more integrated within existing MDT/CPA reviews and believe they often fail to consider context and statutory obligations, i.e., s37/41 status. I also think more medical representation would be helpful. 3.If the case is complicated by family engagement or safeguarding issues the board generally keeps to CTR key lines of enquiry and actions. 4.CTR panels only ask formulaic questions often not based on a thorough review of the patients care prior to the CTR. 5.Generally, CTR dose not necessarily add any new unmet needs for the patients. 6.Sometimes the CTR process can feel a bit redundant if we are doing everything feasible that we can be doing! Also in secure services, sometimes people are likely to have very long periods in hospital so it might be that the CTR's are not as useful in this situation. 7.Some actions appear to be a "tick list" recommendation, and even when the actions have been in place, they still come out in the recommendations. This gives a "copy and paste" appearance to some CTR actions. Actions are sometimes assigned to professionals not present, leading to dispute about the suitability for them to complete the action, and so no progress. Sometimes actions have no rationale, for the how and why they are being recommended, and so they are not followed up. Staff turnover means that actions taken up in good faith, are completed and forgotten once staff move on, or not completed. It appears difficult at times to see actions adopted and reflected in care plans. 8.Focus was on who will fund or how others should do the funding. Actual care for the patient was often in the backseat. 9.Sometimes actions are not relevant, e.g., asking for an assessment or piece of work to be done that has already been done or is not felt to be currently relevant/ethical, etc. This sometimes links to which professionals are able to attend CTR, and at times, lack of clinical knowledge by CTR panel. 10.I was the RC for a 12-bedd ASD specialist locked rehab unit for 3 years until last October Some patients had mild LD but almost all the patients had other enduring mental disorders. All the patients were detained under S3 or 37/41. We had CTR for most of the patients every 6 months. CTR panel members who attend the CTRs most of the time had knowledge regarding care pathways of LD and ASD but overall knowledge to understand other care needs coming from risks and comorbid mental disorders were very poor. Panel embers have reputedly demonstrated poor understanding and knowledge of <BL>- Other endearing mental health issues and the treatment, and importance of after care to manage them effectively following discharge. – Poor knowledge regarding reoffending risks and need for good level of security following discharge to prevent reoffence. - Poor knowledge of medications that are prescribed for mental and physical health, e.g., I was asked to stop Carbamazepine which was prescribed for epilepsy for a patient as the panel member who was on the panel at clinical expert capacity as he had heard Carbamazepine can cause blindness (which was not true). There are many examples like this, the panel making recommendations which are not inline with evidence base practice and unsafe. – Had poor knowledge of MHA and the difference between the MHA and MCA. I was once asked why the patient is on S3 after having a lengthy discussion regarding his acute psychotic state and treatment resistant nature of the illness. – Limited knowledge regarding forensic sections. – Panel members were rude on many occasions as they struggled to understand some of the information provided.</BL> 11.They have no teeth. they are not a lever for change with the ICB, They are never followed up by anyone but the inpatient team and so are ineffective. 12.I have found that CTR's can be very negative and unrealistic about Community LD team actions. Some examples given were requests for an LD nurse to administer medication to a patient at 8 pm every evening for 4 weeks. Not within working hours or remit of the team and an unrealistic request. Sometimes the importance attached to autism assessments appears invalid when it won't affect patient care decision making. sometimes there is little commendation for the work being completed by excellent groups of staff. 13.More communication regarding feedback and actions. 14.Sometimes slots can feel too short with too many professionals at once in a short space of time. 15.Often covering what work is being done to risk test and seek to reduce level of restrictions. 16.N/A 17.plans for transitions and what may be needed. 18.Sometimes feel unrealistic and out of our hands. Can feel like negative and deflating experience. Sometimes is like an inspection and not a supportive process. 19.Please note that I work in a CAMHS service so some questions might not be appropriate.</NL>

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
Have there been any other reasons for delayed discharges in your experience?
<NL>
No
Absence of community placements. There is a need for new methods of commissioning informed by assessments of health and risk needs.
lack of understanding around the limitations of community resources and the difficulties in placing some people
n/a- no delayed discharges
In all cases in the inpatient setting, people have lived there for more than 20 years and can't be discharged until a placement and a provider have been identified. This is happening but has been slow progress.
Patient for out of area placement
MoJ related or placement/out of area needs.
Usually the barrier to discharge is lack of available placements. Lack of breath of placement types and skill mix of care providers.
The tendering process (usually sequentially excluding placements that do not meet the placement spec before finally settling on what MDT consider the only viable option)) by some local authorities takes a disproportionate amount of time.
Often local authorities delay and stall by arguing funding to such degrees that places are lost
Sometimes a disputed best interest agreement with family can delay discharge planning
Parents being uncertain about whether they can cope with taking their family member home.
A lack of community options but primarily community providers and services unprepared and unwilling to manage the level of risk of service users who commissioners are forcing to be discharged when often not clinically ready
lack of suitable accommodation
significant court of protection delays
Court of protection delays.
Most patients were admitted following placement breakdown due to unmet environmental and social support need. Therefore it is harder to source package of care in the community that can meet these needs.
Lack of robust and sustainable providers. Lack of appropriate housing. Lack of social care involvement in planning/engaging in discharge planning.
DOLS
Biggest issue is appropriate placement 1 person DD for over 18 months now. Lack of bespoke placements with appropriately skilled staff and a process that the LA follow even when its clear that a more bespoke placement is needed.
Huge delays with the Court of Protection
Difficulties due to people having capacity regarding care and support needs, yet needing restrictive packages of care amounting to DoLS, and so being unable to be discharged. There are also difficulties in these cases getting people discharged to a "nominal bed," in cases where long term s17 has been used, therefore the double funding of inpatient and community services.
Engagement from placement provider in transition work, specifically training staff appropriately and allowing them time to get to know the patient.
No suitable community providers; no suitable housing options; disagreements over funding (e.g. whether NHS or social care funded)
Limited knowledge of the CTR panel especially the the clinical experts regarding treatment and care needs for mental disorder in addition to LD and LSD and limited knowledge on how to manage the risks in the community.
CTR panel seems to be more concentrating on tick boxing tasks rather than looking at the patient holistically. Limited knowledge could be one of the main reasons.
I strongly believe Clinical experts should be either nurses with MH background/or doctors. Even LD nurses have a very limited understanding of other enduring mental disorders and the MHA. Some seemed as they don't have actual hands on experience in managing patients but only have read policies and procedures. Therefore the main task of the CTR of looking at the patient's care holistically is missed often.
no community provision and no accountability for this.
Delay in allocating SW, care act assessment, lack of suitable placements
Delay to works on new homes that require adaptationsPpeople on long-term extended section 17 leave awaiting application and processing of court of protection application for DOLS
Difficulties with securing sufficient staffing for an identified placement.
Delays in actions being completed as part of transition plans, court of protection applications, awaiting MOJ decisions
Lack of suitable placements in area
Poor quality, unprofessional social care provider
No suitable placements available</NL>
What is your opinion of the CTR process?

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
It was something hat held out promise. However people who carry it out do not have the adequate knowledge or training. Their ignorance of legal issues is breath taking. It has become an exercise in mouthing platitudes that make no difference to facilitating a patient's discharge.
It is helpful.
Duplicates many aspects of existing care pathway. Helpful when you need to encourage further engagement from an important stakeholder (e.g., social care).
unhelpful, unrealistic and generally too many.
For a community team the process is resource intensive and a tick box exercise which doesn't typically help with complex issues pre admission and when in crisis. A huge amount of work is needed to get the notes and information to the panel at a time when I would prefer to be undertaking direct face to face work to keep my patient out of hospital.
AfterwardsWe usually get a shopping list of tasks to complete but no extra resource and no acknowledgment of the exceptional hard work which community colleagues have been doing to try to keep no only this patient but all of our patients out of hospital. Often the recommendations are not grounded in reality of the area in which I worke.g., patient's extended family would benefit from a house or social worker to help the family go on holiday when there is no funding available for this.
I feel that the medical voice and necessity to prescribe medications for evidence- based interventions is often not recognized.
Whilst commissioning is present, the large issues such as there not being suitable supported living placements are heard but not acted on.
Increasingly useful
It is overlap and duplication of existing processes. Meetings attended have cause service user distress as they found the panel anxiety provoking, invalidating and upsetting. Recommendations were generic and inappropriate to the individual which caused the service user confusion and stress.
They can be useful for the individual, most often in support for the discharge process but the organization of them and expected timescales is wanting – they are often arranged at short notice and create additional work for the in-patient team in terms of hosting and attendance as well as using scarce space in in-patient units.
It can be a useful process to ensure that people get the right care and to ensure they are not kept in hospital longer than necessary. It can also be useful to avoid a hospital admission.
Its positive and support the physical presence for ICBs to maintain communication and visibility with their patients and the service
I think this is bureaucracy in place of actual needs. I would use the cost of such a process on adequate placements and expertise embedded within teams.
Cumbersome and time consuming with overall little benefit to patient care for many cases.
am always disappointed by their lack of ability to facilitate discharge.
A good family expert by experience can be helpful in cases where families have unreasonable expectations or safeguarding issues re family exist as it endorses the staff actions and helps staff morale.
They are quite good at holding social services to account and driving home the message when someone has been in receipt of inadequate care previously leading to the admission.
Sadly this still doesn't readily translate to enhanced social care going forward.
External scrutiny does help support the need for accurate note keeping.
positive, collaborative approach to getting enhanced perspectives on patient care
Limited power to change the things which need changing; that is to source appropriate placements for individuals with very complex needs as those placements currently do not exist in the community.
Comments and feedback is often based on a snapshot of the person without knowing the person in detail in the way that the clinical team know them.
The CTRs can be a repeat of reviews completed with CPA meetings and weekly MDT meetings, thus duplicating and repeating discussion.
Children's CTRs were happening 3 monthly; due to the pace of change for some young people with complex needs this is too quick. It is also too quick when one considers the time it is taking to source appropriate placements when these do not currently exist in the community.
Sometimes feels like another tick box exercise. Most of the issues covered in CTRs are discussed in regular MDT and CPA meetings

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
Poor. I have observed the process since the beginning as occurring in thirds. Firstly they were conducted aggressively and in an inappropriate and overly hostile manner. Secondly they were more collaborative and effective. Now they are ineffective and unhelpful, with clinical teams asking for help to discharge people and not help is provided. Panel members are regularly unprepared and poorly informed and ask formulaic questions and make formulaic unhelpful recommendations.
The principles behind CTRs are very important, but at present CTRs are not fit for purpose. They can be helpful in terms of ensuring that appropriate documentation and plans are in place, and as a vehicle to get certain things agreed (e.g. commitment to actions from ICBs/community services). However, in my experience (and I have attended a lot of CTRs both within our local inpatient services and nationally) CTR panels very rarely have the experience and skills to be able to really understand, and take a balanced view of, service users' needs, especially when there are issues with regards risk to others or complex legal issues. Frequently, risk to others gets overlooked (particularly when it is care staff being harmed), and sometimes members of CTR panels have unhelpfully rigid views, for example that hospital admissions for people with learning disabilities and autistic people are always harmful and never appropriate in any circumstances. I have had experience of CTRs making recommendations that would be entirely unrealistic, that would be dangerous to others (e.g. to support sexual interests that are linked to harm to others), and that are illegal (e.g. insisting on the service user having leave when this is not legally possible). Sometimes they are so unnecessarily adversarial that they have a significant impact on the morale of staff teams working with complex individuals, which can impact on the quality of the care they provide. I am aware from multiple colleagues that one reason that "mainstream" secure services are often extremely reluctant to admit individuals with learning disabilities and autistic people who need inpatient secure care because of these issues with CTRs. Sadly, although CTRs have the potential to be extremely helpful, it is rare that they are helpful in my experience, and therefore they are often very time consuming exercises with little benefit.
Useful
I think the philosophy of CTRs is really important – to ensure people are receiving the right care and treatment in hospital and are not being unnecessarily kept in hospital longer than they need to be. However, i think there are some problems with the execution as detailed below
The CTR process could be better to help support the service user and professionals. It is useful having the panel in to review the care that is being received but the panel can be inconstant service user to service user. Sometimes the focus of the review does not match the needs of the service user and the misguided focus of the meetings can mean that important topics are not being discussed. Also, it is clear that the panel do not have a full knowledge of the service user and what is important to them, not being able to gather all of this information from the mountain of paper work they are required to review in a short amount of time before meeting them.
Also, many actions are not suitable to do within the setting and require more risk related thought and planning. It appears that the panel are unaware of the structures and policies in place before making suitable recommendations and what is able to be achieved.
I think it is an important process that I would want to happen if I had a loved one in hospital with LD/autism. However it does also place a huge demand on the time of the MDT, both in meeting with the panel on the day and in the collation and sending of documents ahead of time.
Can be helpful, can be unhelpful. CTR's tend to have the stand point view that "hospital is bad." I have experienced CTR's where the panel has made unlawful recommendations. I have found CTR's helpful in cases where there's been dispute around what hospital treatment is required, or how that could be best provided, or where there been commissioning disputes elsewhere. The bit CTR's seem to have difficulty in assisting is where there's complicated forensic risk that is being successfully managed in a hospital environment (i.e. the individual isn't committing further offenses) but sometimes it's difficult for this to be replicated in a community setting. I think it's helpful that the CTR process takes an overview approach, but at times I've felt the panels haven't been suitably qualified or experienced in the areas which they are assessing. It can turn into buzz term bingo. For example I know it will be raised whether someone has had the following (regardless if it's actually clinically indicated). Have they had a life plan? Do they have a SALT assessment? Have they been assessed for autism? Do they have a pen picture? etc.
Potential to improve collaborative working with social care.
I have mixed opinions. CTR needs clear leadership and oversight by ICBs – cannot be an "add on role"
I generally think they are a helpful process, with the point being to ensure we are doing the best we can for our service users, particularly when there might be differences of opinion within the MDT.
I think CTR's are helpful when you have some professionals who do not have the level of understanding of autism that they should and this is an opportunity to ensure that this is followed up on.

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
My experience is that some professionals (often psychiatrists) see them as not helpful because this involves them having to account to external scrutiny about their practice and they then can miss opportunities to get the help for service users because they see them as being adversarial rather than supportive and it can cause them to be defensive!
Should be flexible to meet needs of the Service user.
I like the principles of it, however sometimes they can feel judgmental to MDT (some have described it as feeling pass or fail) especially for those with autism on mainstream wards and wouldn't use PBS (but would formulate a PC care plan maybe by using TIC instead but because it doesn't have PBS at the top that's not considered. I'm not convinced the new CTR paperwork is very patient centered either. It can be a really effective tool at times or a paper ticking exercise at others
The aims of CTRs are often good, but the way they occur in real life can be unhelpful. Panel members sometimes have fixed views and do not listen to the service user, family or professionals. Some service users have been distressed, disappointed and unsettled by the process, how they are spoken to by panel members, and what is said.
I think they are helpful, although sometimes the panel have not looked through all the documents in time, or have asked for these at the last minute. This means that recommendations can sometimes lack the full picture. In addition, sometimes recommendations don't consider the bigger picture of a wider hospital (with legal frameworks, other service users, lack of regular staff etc.)
Helps to gain a thorough multidisciplinary oversight of the entire process keeping the patient at the center.
There appears to be variations in the CTRs that I have attended, which appears to be led by the panel, and so in my experience having attended them over the last 6 years. It has been very positive of late to see inpatient teams acting on recommendations of CTR panels, and so working toward discharge, whereas previously this would not be considered.
Positive to receive feedback however the process is lengthy and sometimes seems unnecessary for all professionals to spend the entire time with the panel.
good agenda, discussions with MDT and experts by experience, fresh views
Mixed. Some CTRs are helpful, particularly pre-admission ones, to get all agencies together in "one" place. Some panels, for in-hospital CTRs especially, can either be too aggressive ("all hospitals are bad") or nitpicking (examining paperwork in minute detail when the overall standard of care and treatment is good). The appropriateness of some Experts By Experience is also mixed, particularly when CTRs are held in secure hospitals.
Somewhat useful, to make commissioning more accountable.
Usually pretty poorly organized, last minute, chair rarely knows much about the person, suggestions made are usually what has happened already/been tried already. Especially with complex cases – too difficult to go over everything and get new ideas in a couple of hours. Find service users don't usually engage that well or don't really understand what the purpose is.
Useful when it is non-blaming, collaborative and well prepared for, e. g., reports read in good time, etc. Family often not in attendance. possible placements and community teams often not in attendance. sometimes expertise is lacking by panel. sometimes requests to clinical team feel tokenistic and not based on literature/evidence, e .g., expectation that every patient has a PBS even if no challenging behavior.
My workload increased after CTR recommendation due to time taken to point out how inappropriate and how recommendations are not inline with the safe medical practice and evidence base practice.
It should be statutory and have follow-up, accountability, and have consequences. All my patients have been fit for discharge for some time and although we do complete the actions, there are no checks consequences if we didn't as there is no accountability.
I wish they would help move discharges on quicker.
They can become very adversarial. Some actions are not valid and reflect lack of understanding of comorbid conditions such as mental illness and PD. Formulaic recommendations without giving due consideration to primary diagnosis
Unnecessarily bureaucratic and prolonged. often unnecessarily critical. often unnecessary overall—patients with mild ID and/or autism without specialist needs, being managed in mainstream services for other serious mental disorders.
CTR should not be used when the person has a significant mental health diagnosis and they require short term admission to mainstream mental health admission units to stabilize and return to their own home.

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
Overall it has never helped to facilitate a discharge when I have needed this for my patients, whilst simultaneously increasing my workload and that of my colleagues.
In essence it's a positive process
The principles and process itself is very useful. However, the quality of the CTR can vary significantly, depending on the knowledge and skills of the panel. Often there can be an over-focus on documentation (which can result in an over-whelming amount of actions which are all paperwork focused), which I feel can often miss the point and can become documentation focused rather than patient-focused.
The CTR process has been somewhat helpful in terms of putting some pressure on professionals to progress with the discharge pathway.
In the hospital I work at, we have a variety of patients with LD and autism needs.
Some are more straightforward (e.g. autism and psychotic illness), so the framework of the CTR panels maps on very easily to their care.
Other's are more complex, e.g. patients with autism, LD, PD, psychosis, with high self-harm levels. This can be very challenging and if the panel don't have sufficient experience in a range of presentations (e.g. working with self-harm/PD) there can often be a pressure to over-simplify the person's care in line with an LD or autism model (when the treating team are of the opinion that a PD approach with adaptations for autism is most beneficial). This can often result in us receiving a lot of criticism in CTR panels for not being sufficiently in line with an LD/autism approach.
Nearly every time I attend a CTR panel, there is a new type of documentation requested. There doesn't seem to be a clear list of core documentation. Also, the views around how the documentation should be formatted varies (e.g. in one CTR, a care plan is criticized for being too long and in another, for being to short. . .)
We also sometimes get requests to add lots of information in but also shorten the document!
Although it's great that families are involved (and this is usually a very positive thing), sometimes it's not (for example, when there is a known history of family being abusive/exploitative). I would expect that a CTR panel could consider all these factors. However, we have had experiences where a (known to be exploitative) family member, criticized us heavily, and despite our evidence against the claims, it was evident in the recommendations that every concern the family member raised was taken on as a formal recommendation. The family member has a history of using the patient to sue mental health services and it was very evident that she was using the CTR recommendations for these purposes.
Very valuable
We tend to use them to try and prevent admission and they can be helpful for this
Potentially useful especially with regard to checking on general health care
works well most of the time
The meetings are typically booked at short notice and there can be (understandable) frustration on the part of the panel when MDT members are not available due to being unable to rearrange preexisting commitments.
There are often times where unrealistic recommendations are made without an apparent clear understanding of the full nature of an individual's needs.
We have numerous CTR meetings regarding patients who are significantly delayed in their discharge and have the same conversations each time about the challenges with finding an appropriate placement, but without the CTR being able to provide any additional support in sourcing appropriate placements as they do not currently exist.
The quality is dependent on the panel chairing. Additionally; it is sometimes difficult to see the difference between CPA and CTR. Also when recommendations are shared regarding ASD specific pathways; it is difficult to fulfill these actions when there is not specific options of local services; to fulfill. There have been occasions where recommendations based on unfounded research have been made by experts by experience and medication; which have turned into actions- this has caused grave concern to doctors previously.
It assists to get an inpatient journey back on track and in the community it can be helpful toassist to look at provider accountability particularly for those commissioned via TCP
In my opinion, the CTR process within our acute A&T service has done very little to hasten the discharge process when a preadmission placement breakdown has occurred. The barriers to discharge have been the identification of a suitable placement and has taken the usual course of time to identify with no hastening of the process through the CTR process.
The CTR meetings take up a lot of staff time to collate and submit documents. Much of the day is spent ensuring a check list of documents are there with some scrutiny of them. In my opinion it is another bureaucratic process which does not influence the outcome or timescale of a patient's stay in hospital.
i think it should be reviewed and held and chaired by the community learning disability team. Unsure of the clinical comprise of the ICB

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
Essential. Valuable
CTRs are complete waste of time and resources.
usually well organized but only being on 1 day does affect the opportunity for some important people, in the persons care, to attend due to annual leave or it just being there day off.
An unsupportive and negative process.
Not always patient specific e.g. comments about other patients feedback about the ward.
A huge use of resources, professional time and room bookings etc.
Could be really useful if it was more of a supportive process. . . time for case reflection and discussion.
Sometimes it is helpful to reviewing progress and the future plans for the patient, not always useful though. Takes the MDT away from clinical work
It is variable.
In your opinion, how can CTRs be enhanced?
(A) For CTR panel members: Set standards for training and competencies (similar to what an MHRT panel member should have). (B)Once that is done, such panels can be considered statutory, on par with MHRTs. (C) That means they will have more powers, but also be more accountable including through the judicial process.
not sure
where there are difficulties finding placement due to resources/risk etc having more in the hope this might change things just takes up more of everyone's time
Ensuring that the panel have access to the clinical notes directly rather than the clinical team having to collate and share large quantities of documentation.
More psychiatrists on panels challenging the treating team
The process seems more relevant if the are concerns or complaints that a service user's needs aren't being met. It feels like a duplication of the usual CPA process.
By not holding them for patients on 45A until they are approaching tariff, by educating panels about the particular needs of people under Part 3 of the MHA and advising them that recommendations about transfers etc are often not appropriate/possible. Revisiting CTRs for convicted people generally – need for them, frequency.
It would be a more pleasant experience if panel members focused on the positives as well as pointing out what is wrong. Some panels do this but not all of them. Some of them it feels like an attack on the service and they're not interested in hearing about the positive work that goes on because that should be happening, which is true but it would be nice if this was acknowledged so that MDTs don't feel "under attack."
Do not need to be a full day
See above
Preserve the preadmission LAEP system and make it compulsory for social services to attend and upward recording of failures in social care packages.
Rather than making CTRs routine and compulsory for all patients, ask inpatient services to select which cases they would like to bring to CTR for reasons such as:
difficult relationship with family, entrenched position with social services, delayed transfer of care, lack of clinical progress, patients requesting external scrutiny,
And CTRs to have direct upward reporting over barriers to discharge.
make the outcomes legally binding, as per MHA proposals
Combine them with the existing CPA timetable to avoid repetition.
To be less frequent.
I think it should be scrapped
Panel members should be clinicians relevant to the service area. They should be better prepared and informed and selected with relevant skills to the service user under review. CTRs as applied to forensic services have failed.
Improved recruitment processes and better training for CTR panels. A shift in focus to supporting services working with this client group (while challenging them when appropriate) rather than taking a fixed adversarial position.

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
(A)Being aware of the service remit and that the purpose of hospital admission is not to investigate every possible problem/do a full health MOT (B)Meeting the person so they have a sense of what is achievable when making recommendations e.g., based on their level of cognitive ability (C)Respecting the clinical opinions of professionals working with individuals on a daily basis for several months/years (D)Having a realistic appraisal of the currently challenges faced by NHS staff working in underfunded and understaffed systems
Have regular members of the panel visiting the hospital. This will enable them to become familiar with the team and service user.
Maybe have the paperwork to review before the meeting takes place so they aren't rushing before meeting the service user. if not have the paper work, they should contact the team to discuss risk and communication needs beforehand, maybe have a quick overview of the case.
They should have some knowledge of the setting before coming in and the restrictions that may be in place. This could better inform their actions and make them more possible to achieve.
Panels need better training to make them better at assessing and bench marking. For example the panels need to be able to determine what treatment options would be clinically indicated for the individual at the heart of the CTR. They then need to be able to determine whether the treatment provided is likely up to scratch. For example its common for the group I work with for the questions of "has autism been considered?" to be asked. This seems to be more common if the expert by experience has autism or a family member etc. Even in cases where autism has been fully assessed, the person found not to have autism we have been given recommendations to reassess for autism. Particularly in the case of forensic risk I think it would be helpful to engage the Ministry of Justice in the CTR process. The MoJ can often be viewed in a negative light due to some of the restrictions they impose on some service users, however the reason for that process (i.e. risk to the public) can be lost in that narrative.
Collaborative working with Social care and potential care providers
Be more solution focused – with barriers – have more collective ownership – agree actions and people responsible before report is generated.
I think if CTR's had perhaps more sway with other agencies – e.g., social care etc, sometimes recommendations are made which are outside of our scope and when the recommendations get passed on it does not seem to make a huge difference
We are often limited by the MOJ in the care we can provide and if CTR's had more impact on this area it would be helpful! e.g., we have a SU who will require leave, but the MOJ are consistently refusing despite risk being mitigated and reduced due to the perception of her case in the media.
I think perhaps having different types of CTR might be helpful instead of a full CTR perhaps interim CTR's such as in the case of service users who have long detention periods due to legal requirements
They should have a clear focus and ALL should meet this
Training, especially around forensics and what the sections mean. Having paperwork that is easier to fill in and for the person being discussed to be able to read. tools for supporting inpatient services in one spot to be able to find examples of communication plans or a grab sheet/reasonable adjustment info. A way of sharing tools (some services have been asked to do a RA passport for police custody and there isn't one. Making sure goals are achievable (no use a E by E stating the person should be going to the community when they have just been recalled on a 37/41 for setting a fire a month ago as the MoJ will not agree)
Appropriate training, monitoring and codes of conduct for panel members.
More consistent consideration of all the documentation
Having the same CTR panel reviewing/carrying out the next CTR? This may give a better understanding of the case and a clearer view on progress. Having the Case Manager chair their caseload may be beneficial? I see a mixture of attitudes to CTRs, from RCs calling them "toothless," and so unwilling to act if recommendations are outside of their current opinions on pathways. However, Q31 addresses this.
More streamlined for professionals attending
SLTs and OT, Dieticians, Physiotherapists must be present according to specific need, only nurses and social workers by background attend
Making commissioners accountable for the process.
Address above issues.

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
CTRs are important only if the panel consists of adequately skilled professionals. This is not the case most of the time. I think in the NW CTR panel members are provided by a private company which is not effective.
statutory footing
variety on the panel, more power to get external colleagues involved i.e. community MH/LD services and to follow up on agreed actions
Having relevant expertise for patients primary diagnosis. Also, understanding the difference in systems in non LD services where patients primary problems are due to mental illness. For example a non specialist service may use physical health care plans as opposed to health action plans for various reasons and this should be explored.
exclude patients in mainstream services with mild ID/autism who do not have specialist needs. Streamline the process and coordinate with CPA process to avoid additional workload and meetings.
The overwhelming feedback I have is that the Chair is often negative and not looking at any positives. I think the chair needs to consider the impact of their words and actions. When the local lead chairs we have a mush more positive and enhancing experience for the patient.
CTR panelists themselves should take charge of chasing up external stakeholders and responsible professionals to get on with discharge planning and hold them to account. At present, all that CTR panels do is come in, confirm that a patient needs to move on when we already know this, and then do nothing while we continue to have to push for discharge ourselves, waving CTR reports at external professionals who simply do not react to those CTR reports. CTR panels offer no practical support in terms of discharge. They seem to believe that their disapproval alone gets things done. It does not.
In my experience, some of the actions are not monitored beyond the CTR meeting. Individual professionals completing actions but having barriers to completion or progression because other services not following through/completing actions.
(A)Less documentation focused. (more quality of life focused) (B)A definitive list of documentation and some clarity around expected length/formatting. (C)If with a complex patient with a number of diagnoses: either the panel members should have the relevant skills or should be explicit about their gaps in knowledge and work with the treating team. (D)Panels being more savvy around family input.
Clearer agenda
Build in stronger clinical challenge
increase number of expert by experience panel members available, panel member's being able to do ad hock turning up at hospitals to meet with patients and staff without prior knowledge of them coming
For panel members to visit the ward and read paperwork prior to meeting with professionals so they have an understanding of the environment and patient beforehand. For recommendations to be realistic. For there to be recognition of the huge amount of good work that goes on with supporting patients, and not to focus just on what isn't happening.
Clearer purpose that does not cross over with other multi-professional meetings.
Having a standardized set of paperwork providers complete and then the documents supplied to panel could be the evidence for this to help with getting through the paperwork
If there is a meaningful clinical discussion of the care and treatment with appropriately qualified professionals and commissioners taken on more responsibility to influence the discharge process.
it should ensure that there is best practice and a critical eye of the proposed plan listening to the person and significant others
Face to face
They should not, they should be scrapped altogether.
as above(can do most people on one day but catch up with the od one or two people involve seperatly)#
Less "us and you;" Less power trip; More realistic and positive
Have the commissioner for the patient present at each CTR
Chairs need to be neutral, listen to experts, listen to family

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
If CTRs are made mandatory, what safeguards would you want in place?'
recommendations are mutually discussed not imposed
It diminishes the role of the MDT and the Responsible Clinician as well as the Hospital Managers and the Tribunal Process, in some ways. They run the risk of being an additional MDT. The MDT should be able to override decisions with justification.
Not to get blamed for delays
Consideration to be given to the impact on the service users. Recommendations from the CTRs to be based on individual assessment, formulation, treatment needs and personalized care.
I would support a move toward making recommendations for discharge enforceable in terms of compelling agencies to work together more effectively to facilitate discharge.
Frequency set and included for Scotland patients
These need to be advisory only with plenty of scope to diverge if required.
That all their actions are not made mandatory as the expectations of the CTR/actions are unreasonable of NHS resource and I would not want our service to be liable for failings of the wider NHS. Also, some of the panel members still have fixed ideas of their own which are not relevant or appropriate
That the clinical of the judgment of the team who know the person is considered valid and reliable. The snapshot assessment that is made in a day cannot account for the comprehensive understanding that the team have of the person and there may be very strong clinical reasons for not following a recommendation from a CTR. If they become mandatory, the clinical judgment of the team runs the risk of being overruled/undermined.
A psychiatrist on the panel, assurance of viable community provisions
This is a scandalous concept. Poorly informed external people offering legally binding recommendations potentially contradicting professionals based on limited review. There would need to be a review process and panels would need to be legally accountable for their errors or risks resulting from their legally enforced recommendations. Clinicians need legal protection if they refuse to follow such poor recommendations.
Adequate experience and skills of the panel. See Q30
See above
The actions would need to be achievable, with a full knowledge of risk/the setting and service user. The service user's opinions and if they didn't want to have one then they shouldn't have one. More efficient and relevant questions and information gathering. They should also take into account any other disorders present and not just their autism and have a full knowledge of mental health illnesses and physical issues that could impact their care.
I would have concerns about CTR recommendations being enforceable. Most panel members are knowledgeable and give helpful recommendations, however sometimes they do not fully understand the presentation, vulnerabilities and risks posed by some of our very complex service users and as such they occasionally make recommendations that the hospital care team feel would increase risk or be counter productive for the service user's care and treatment.
Improved training for panels. I also think panels need to have specific training and experience that's relevant to the service user or setting in which the CTR is taking place.
That actions are achievable. CTR needs clear leadership and oversight by ICBs – cannot be an "add on role." CTRS cannot be delayed or not set up simply because a person doesn't have capacity to have a CTR and cannot consent.
certain staff need to attend
I wouldn't at this time as I see a lot of recommendations from ICB and other areas that are not SMART recommendations. This is likely to scare providers and commissioners off from using CTRs (I have seen people agree and then refuse after discussion with their MDT). If there are clear objectives that could be mandatory and some not plus training for panels about what is available and making goals smart (particularly achievable) i might change my mind.
A requirement that all recommendations made by panels are in line with UK law, and that panels are accountable for their recommendations.
I would want there to be appropriate opportunities for discussion of recommendations i.e. for the team to dispute these

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
That there are knowledgeable and experienced panel members. I answered "sometimes" to having a psychiatrist on the panel, however on reflection this may be necessary, due to there sometimes being the case that an inpatient consultant psychiatrist may not value the clinical opinion of a non-consultant psychiatrist. This is rare, but it does happen, and working with different services across England and Wales there are many cases where this is still the case.
not sure
For the recommendations to be enforceable, the panels need to enhance their knowledge of what's practically and legally possible.
Commissioners to be attending, Psychology and other AMP's all required to attend/present report and be equally accountable.
timescales for submitting and reviewing reports, minimum number of team present, relevant experience of panel, expert by experience expectations addressed based on clinical context, and recognition that clinical team are working with patients that have been referred to by commissioner – so commissioner taking some continued responsibility in terms of how appropriate referral was, what was key treatment request and staying on track with this
Thee panel consists of adequately skilled professionals. CTR panel should understand that the recommendations are legally binding therefore evidence base and patient centered recommendations should be provided for the clinical teams to carryout. it should not be a tick boxing exercise
audit and quality checks. legal expertise. human rights review as part of the process.
Panel should have lived experience ideally someone with LD and/or Autism if possible and a carer/parent, more range in other panel members – why are they always nurses?
Define their remit- it is too broad. Unlike a tribunal with a very narrow focus, CTRs can overreach and disempower those closet to the patient
allocated time and resources
for reasons associated with LD and autism rather than for diagnosed mental health issues
CTR panels them selves ought to chase up those external professionals who are responsible for getting discharge placements identified, funding agreed etc.
Continuing to invite people from the whole system of support. Monitoring actions from CTR.
High quality clinical membership on panel
the amount of hours needed from the MDT to participate and community MDT must be funded for and able to replace with real time people and hours each time.
Scope for clinicians to be able to give a clinical rationale for why certain recommendations were not enacted and for this to be discussed and respected where someone's safety is not put at risk.
Additional resource and support to enable an effective process; and to adhere to proposed actions. A clear purpose and expectation; including the service user's voice but understanding the clinical picture to support in professional decision making for onward appropriate care planning.
That they are in the persons best interest at that time and not process driven decision
The appropriate accountability assigned to recommended courses of action i.e local authority and health commissioning for placement.
Transparency
The should not be made mandatory.
Realistic recommendations. Accountability for the community teams
Sufficient workforce. Skilled chairs, local authority involvement
Any final comments/feedback/suggestions for improvement of future CTRs?

(*Continued*)

Table 2. (Continued).

Any additional comments about CTR actions covered during reviews?
no
CTRs are helpful if process is working toward successful discharge pathways
I would also recommend a consultation be completed with service users who have been through the process.
In my opinion CTRs are ineffective and bureaucratic processes which add little to effective clinical care.
Made the points above.
Whilst a level of scrutiny in care is required; CTRs have become unwieldy and time-consuming in inpatient settings that are already under a significant amount of time pressure and without adequate resource in the community to discharge to, no amount of CTRs is going to speed up the discharge process.
CTRs very often feel like a tick box exercise although they are great opportunities to discuss with experts by experience and ensure physical health needs are met. However most patients remain in hospital because of failure of social care.
The only benefit is having external review of clinical care, however this is only effective if the panels are competent and fully informed. Which unfortunately in my experience they have not been.
As above, the principles of CTRS are very important, and I think they have the potential to be extremely helpful and to help protect vulnerable service users. However, at present they are seen as a panacea, when they are often not helpful and sometimes actively problematic. There needs to be much better recruitment and training for CTR panel members. Experts by experience also need to be much better supported – they need to be matched to CTRs, and the particular areas that they focus on, so that this falls within their expertise and experience.
CTR's can at times feel like a stick to beat hospitals and professionals. I have felt vilified in CTR processes previously, particularly if I've expressed a forensic risk couldn't be safely managed in the community but that treatment in hospital seems to have yielded limited benefits, thus viewed by the panel as a barrier to discharge, to the extent on more than one occasion I have seriously considered leaving my profession.
They need to come from a collaborative approach rather than judgmental approach for MDT to see the benefits rather than focus on the amount of work it takes and feeling its just for them to be criticized.
We have clinicians from mainstream wards citing that a key reason they won't offer beds to people with LD or autism is because of their previous negative experiences with CTRs. Examples include panel members appearing to believe there must be hidden abuse by hospital staff and being accusatory toward hospital staff, lectures from panel members on how bad all hospitals are, hugely unrealistic demands on hospital services, and occasionally very unsettled and distressed service users after CTRs.
Whilst there is literature delivered pre-CTR, I think it could be helpful to have an online e-learning style presentation to promote the CTR process. Perhaps highlighting what is important for the AT cohort, what is looked for, using case studies showing how good care can succeed, and so help services have a head start on catering for this patient group.
Also I think it can be helpful for other professionals, who are not part on the inpatient MDT, to meet separately to the MDT. Being outside of the inpatient MDT, but meeting the panel alongside the inpatient MDT, can make it difficult to have an opportunity to provide feedback.
May sound silly, but the Excel format that CTR reports use, are no the most user friendly and difficult to access.
recognize that SLTs can brief the panel, specifically experts by experience how not to ask leading questions for LD and Mental Health service users
There should be people at national and regional level overseeing the quality of CTRs and they should be taking necessary actions when concerns are raised. I have raised my concerns with the regionally and to my knowledge I didn't even receive a feedback.
please see above
See above.
They are unable to fully serve their purpose when there are insufficient community placements to move people on to.
No
Encourage a collaborative approach with the MDT
thankyou for doing the research
Completely unnecessary and useless.
Sometimes is helpful and collaborative, but not always. Depends on the panel. Can feel like an inspection and focused on negatives, </NL>

Table 3. Recommendations.

- To ensure that all C(E)TR panel members are adequately trained for the various patients and situations they will meet, e.g., C(E)TR panel, to consist of a suitably experienced ID psychiatrist, local commissioner(s), and the expert by experience/carer to have some experience of inpatient care.Please edit for grammar and clarity
- C(E)TR panel to be familiar with local area and resources. To be knowledgeable in relevant legal frameworks, including forensic sections of the MHA (inpatient)
- For Mental Health Review Tribunals to consider the recommendations of C(E)TRs when reviewing detentions.
- C(E)TRs should not be legislated since their effectiveness depends on external agents and factors not subject to sanction under the MHA.
- Clearer lines of responsibility for setting up a C(E)TR meeting within the new ICB structure (community)
- Clear timeframe for urgent community C(E)TRs
- Appeals/arbitration process for inpatient C(E)TRs

person-centered care, and PBS plans were reported to be present for all or most patients. Conversely, less than 40% of participants reported swallowing assessments to be present for all their patients.

Discharge Processes

Of the respondents, 32% reported that all of their patients had a community discharge coordinator, 26% most patients, 33% some patients, and the rest either no patients, not applicable, or left blank. Please clarify sentence; doesn't make sense. Most respondents (55%) had patients who were clinically ready for discharge but were marked as delayed discharge or delayed transfer. When asked if patients were clinically ready for discharge and had a current discharge plan, the majority (62%) reported this to be present for some of the time.

C(E)TR Actions

When looking at actions during C(E)TRs, 65% of respondents replied that the person's health needs are known and met all the time, and patient-centered care was reported as being met 6. Most respondents felt that the patient was always receiving the right care and treatment (71%, and 62% responded that the patient had always needed to be in the hospital.

Following this, 55% of respondents felt that the person's rights were always upheld, 58% said that family and carers were always involved, and 59% said there was always active planning for the future and discharge. When looking at autism needs, 56% respondents felt that autism needs were always met. Furthermore, 47% of respondents felt that there are always clear, safe and positive approaches to risk, and 59% respondents felt medication was always used optimally.

Reasons for Delayed Discharge

There were wide-ranging responses regarding the reasons for delayed discharge, with 42% of respondents feeling there was often or sometimes no agreed-upon social-care responsibility, while 33% of respondents felt there was rarely no agreed-upon social care responsibility. Participants felt a that lack of agreed-upon community responsibility was the cause, with 42% of respondents selecting always, often, or sometimes, and 47% selecting rarely or never. Please clarify: Over half (56%) of respondents said there were often or sometimes placement funding disputes, while 82% of respondents felt there were always, often, or sometimes no placement options available with preferred options agreed. In total, 45% of respondents said therewere always, often, or sometimes no placement profile or community needs assessment completed, while 42% responded to that question as either rarely or never.

Usefulness of C(E)TRs

The respondents felt that C(E)TRs were useful clinically always (44%), often (23%), sometimes (7%), rarely (17%), or never (8%).

Experts by Experience

In total, 48% of respondents felt that expert by experience contributions add to the C(E)TR process always, most of the time or often, with 36% rating sometimes, and 11% rarely.

Benefits and Future Directions of the C(E)TR Process

Regarding the main benefits of the C(E)TR process, the majority (62%) felt this was to check adequacy of care and treatment, 41% responded it facilitates the discharge pathway; 27% felt that experts by experience had an opportunity to ask questions; 24% felt it was integrated into multi-professional assessment, diagnosis, and formulation; and 24% felt it was because of enhanced collaborative working with the community team. A further 23% felt the main benefit was that experts by experience can work in partnership with the multidisciplinary team, and 15% felt it facilitated discussions around legal frameworks of care. One respondent said they do not think the C(E)TR process provides benefit. Regarding if C(E)TRs have made a difference to their clinical care, 35% replied yes, 36% no, 27% not sure, and 2% left the answer blank. Concerning how likely people are to recommend C(E)TRs, 18% said very likely, 36% said likely, 21% remained neutral, 11% said not likely, 12% said very unlikely, and 2% left blank. On whether C(E)TRs should become statutory/enforceable, 45% replied yes, 48% no, 5% left the question blank, and one respondent referred to their free-text answer.

Qualitative Analysis

Table 2 provides all the comments received for the open text responses. There were four overarching themes: processes and structures, recommendations, accountability. and statutory vs. advisory.

Processes and Structures

Across the free-text questions, there were responses relating to the flexibility and rigidity within C(E)TR processes and structures. For example, some participants referred to the C(E)TR questions as "formulaic" and not reflective of the comprehensive discussions held within the meeting, whereas other participants expressed that C(E)TR quality "depended on the knowledge and experience of the panel members," highlighting inconsistences in panel recruitment processes.

A sense of rigidity was discussed regarding the requests for C(E)TRs within patient care. Participants reported that the C(E)TR did not appear to be based on clinical need but on recommendations for reducing and preventing hospital admissions for people with intellectual disabilities. In contrast, some participants expressed the need for more rigidity in the rationale for completing C(E)TRs, suggesting that they should only be used for people with more severe intellectual disabilities. Although the rigidity and flexibility of C(E)TRs proved at times useful in assessing whether the individuals were receiving appropriate and adequate care, participants noted that the current process is not sustainable.

Recruiting panel members under a flexible set of criteria highlighted significant concerns among professionals within inpatient and community services. Participants revealed disparity in the panel's experiences and knowledge base. Participants also discussed how processes secondary to the C(E)TR, such as court-of-protection proceedings or deprivations-of-liberty applications, can be problematic and may delay an individual's discharge. Participants recommended changes to the C(E)TR processes and structures, to allow for greater flexibility or rigidity when required.

Recommendations

Participants reported that the C(E)TR panel's recommendations appeared to lack a person-centered approach and did not reflect the content of discussions held in the meeting. Some participants expressed concerns that panel recommendations did not reflect evidence-based practice and could potentially put the patient at risk of harm. Participants noted that some recommendations showed a lack of understanding of the processes and systems within health and social care services, such as legal frameworks. Others observed that the recommendations sometimes failed to acknowledge the excellent work completed by the team of professionals supporting the individuals.

Recommendations also seemed unachievable to the professionals supporting individuals with intellectual disabilities. The majority of participants suggested that increased training and the use of accessible documents, either requested for review or as a recommendation, could improve the quality of the recommendations going forward.

Accountability

Most participants expressed concerns about an overall lack of accountability in implementing C(E)TR panel recommendations. They argued that these are neither followed up nor enforceable, which can lead to professionals failing to implement them in full. Participants also noted that hospitals are often reluctant to admit people with intellectual disabilities due to the staff negative past experiences with C(E)TR panels.

Some participants argued that C(E)TR panels should be held accountable if their recommendations are unlawful or harmful to an individual's care. At the same time, they advocated that professionals should have some protection if they choose not to implement C(E)TR recommendations if they believe could negatively impact the individual. Although C(E)TRs highlight the significant challenges in finding and commissioning local provisions and accommodations, there appears to be no escalation of these concerns within the process, which limits the potential for broader impact. Some participants acknowledged the positive aspects of C(E)TRs, particularly in holding professionals, such as commissioning staff, accountable for their roles in the person's hospital admission, or the risk of such admission. Suggestions were made to involve the C(E)TR panels beyond the C(E)TR meeting process, by inviting them onto the ward, and supporting them in gaining a better understanding and firsthand experience of the community or inpatient infrastructure.

Statutory vs Advisory

Throughout the qualitative data set, there was an ongoing debate about whether C(E)TRs should be mandatory or remain as best practice with advisory recommendations. The majority of participants advocated against making C(E)TRs mandatory, unless appropriate safeguards are implemented. A small minority of participants expressed a desire for recommendations to be mandatory, believing that this would facilitate better coordinated discharges and improve the overall quality of care for individuals with intellectual disabilities.

Discussion

To our knowledge, this study is the first to describe the views of mental health practitioners on C(E)TRs. Most of the respondents were nonmedical members of the multidisciplinary team. Respondents perceive that C(E)TRs are often

well attended by MDT professionals, in line with NHS England (2023) guidance for C(E)TRs (NHS England, 2023). Most participants valued the input provided by experts by experience. This was expected given the growing promotion of experts by experience in intellectual disability services and generally in health care (Anderson & Bigby, 2023; Bradley, 2015; Castro et al., 2019; Chester et al., 2019; Hollins, 2019). Also, most people considered C(E)TRs useful due to the external oversight they provide for patient care. As such, this provision of independent scrutiny will support good clinical care for both clinicians and especially commissioners (Wood & Hollins, 2023).

In this study, most participants felt patients were receiving the right care, which was person centered. Their health needs were met and, often, key areas of concerns were covered. This is in keeping with findings from a systematic review (Melvin et al., 2022), which showed an association between admission and reduction in psychiatric symptoms. This suggests that the C(E)TR had few insights to offer around ongoing clinical care per se. For those categorized as delayed discharges, various reasons were cited, especially the lack of placement options and funding issues. Delayed discharge rates have been reported at between 17.5% to 55% for people with intellectual disabilities (Devapriam et al., 2014; Melvin et al., 2022). Studies have found that intellectual disability itself was not a predictor of length of stay, but those with intellectual disabilities were more likely to be discharged back to the same community placement they were admitted from (Abraham et al., 2022; Lohrer et al., 2002). Length of stay in services is often used as a proxy for quality of care received (Brasel et al., 2007; Lingsma et al., 2018). But as highlighted here, many factors often contribute to this. In forensic settings, long stays are related to similar sociodemographic, clinical, and forensic variables for inpatients with and without intellectual disabilities (Chester et al., 2018). Other factors include societal attitude toward risk, length of treatment, treatment response, and availability of appropriate discharge options (Devapriam et al., 2014). Fear of risk taking, lack of appropriate community provisions, and other staff-related factors have also been highlighted (Oxley et al., 2013). This highlights the specific role (or lack of it) of C(E)TRs in supporting or facilitating discharges, especially as this could sit outside the locus of control of clinical teams. It might be that C(E)TRs ensure consistency by using evidence-based tools and models to evaluate, describe, and recommend best practice (Painter et al., 2023; Tripp et al., 2024).

Concerning the proposed changes to the C(E)TR framework and making C(E)TR recommendations statutory, views of psychiatrists were polarized, as it has been with the MHA (Tromans et al., 2023, 2024). One view is that providing statutory backing to the C(E)TR process could facilitate community rather than inpatient care for people with intellectual disabilities (HM Government, 2021). Nevertheless, providing statutory footing to C(E)TR recommendations is likely to fail if wider clinical and systemic issues are not addressed (Langdon et al., 2023; Tromans et al., 2024). With little or no

evidence of the efficacy of the C(E)TR process (NHS England, 2023), other objections against providing a statutory basis to C(E)TRs include additional costs to the taxpayer, the lack of trained and appropriately experienced assessors, and the lack of an appeals process.

Compared with the general population, the presentation of people with intellectual disabilities is often a complex mix of neurodevelopmental disorders, mental illnesses, challenging behavior, and psychosocial disadvantage (Cooper et al., 2007; McCarthy et al., 2023). A robust period of assessment with multidisciplinary input and treatment is often needed (Alexander et al., 2011; McCarthy et al., 2023). Hospital stays thus will be determined by the complexity of the individual presentation and other factors, such as availability of community provisions, social care input, and involvement of community teams (Hassiotis et al., 2015). NHS digital data highlighted that while inpatient numbers reduced between December 2013 and March 2021, the rate was below the Transforming Care target of 35–50%. Simultaneously, the availability of community support for people with intellectual disabilities was reduced (Langdon et al., 2023). This inadequate community care support is a contributory factor in the failure of C(E)TRs to significantly impact the number of delayed discharges. Previous studies have identified that wider systemic and cultural issues in community teams affect their ability to cater to the needs of people with intellectual disabilities (Clare et al., 2017; Slevin et al., 2008).

Limitations

One limitation is the possibility of positive responding, a response bias due to the design of the research. Perhaps more importantly, individuals commented on how their service conducts C(E)TRs rather than a specific focus on the C(E)TR quality of individual patients. In addition, possibly multiple personnel from the same service may have responded. Patient and family carer opinions were not sought within this survey. These factors affect the generalizability of this study.

Recommendations and Conclusion

Considering the findings of professionals represented in the survey, our recommendations are provided in Table 3.

Most clinicians (77%) found C(E)TRs somewhat useful, but only 35% felt it impacted their work. Opinion was equally divided on proposed statutory changes, with caution and monitoring recommended if implemented. Concerns included unaddressed clinical risks, poor evidence of effectiveness, added taxpayer costs, unqualified assessors, and no appeals process. Further research is needed to evaluate C(E)TR quality and effectiveness. A greater

investment in robust community intellectual disability services is more likely to improve transition from inpatient services (Burrows et al., 2023) than making C(E)TRs statutory. Inpatient care and treatment, if hurriedly truncated due to philosophical, or legal imperatives rather than clinical needs understood in a person-centered manner, can lead to inappropriate discharges without sufficient resources to care for the patient. This poses significant risks of harm to the patients, staff, and members of the community (Oxley et al., 2013; Taylor et al., 2017).

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Author Contributions

All authors satisfy the ICMJE guidance by substantially contributing to the design, analysis and interpretation of the work, drafting of the manuscript, final approval of the manuscript and all agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work is appropriately investigated and resolved.

Data Statement

The data supporting the study findings are available from the corresponding author on reasonable request.

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