

MENTAL HEALTH CLINICIANS' PERSPECTIVES ON
WORKING WITH
COMMUNITY TREATMENT ORDERS

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A thesis submitted in partial fulfilment of the requirements of the
University of East London Professional Doctorate in Clinical Psychology

May 2013

ABSTRACT

This research explores the beliefs and experiences of mental health clinicians working with people who are subject to a Community Treatment Order (CTO). Previous research indicates that the effectiveness of CTOs is questionable and there have been debates about the ethics of compulsory community treatment generally. The opinions of stakeholders are therefore important. Previous research with mental health clinicians has predominantly been quantitative and survey-based.

Participants took part in a semi-structured interview which focused on their views about CTOs based on their clinical experiences. A Grounded Theory approach was adopted to collect and analyse the data.

Two core categories were constructed from the data: 'Factors influencing decision-making in the use of a CTO' and 'Impact of decisions'. The first core category contained the subcategories 'Service user characteristics', 'Clinicians' constructions of appropriate care and treatment', 'Clinicians' knowledge', 'Pragmatic and systemic influences' and 'Societal influences'. The second core category contained the subcategories 'Impact on service user', 'Impact on therapeutic relationship', 'Impact on clinician', and 'Impact on service delivery'.

The current research is placed in the context of previous literature. The limitations of the study are described. The clinical and research implications are explored.

ACKNOWLEDGMENTS

Many thanks to the participants for giving their time and interesting insights.

Thanks to Dave Harper, for all his help, support and patience.

Thanks to my parents, for everything.

Thanks to Dave, for all his support and for doing more than his share of household duties and parenting over the past few months.

And thanks to Konrad, for always helping to keep things in perspective.

Word count: 26,832

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1. INTRODUCTION

1.1 Overview

This research is intended to explore the perspectives of mental health clinicians working with people who are subject to a Community Treatment Order (CTO). It will focus specifically on how clinicians talk about negotiating the use of CTOs with regards to how a CTO is implemented, and how they make decisions around recall and discharge. It will also explore what difficulties and dilemmas clinicians say they encounter, both pragmatically and ethically.

'Supervised Community Treatment' was introduced in England and Wales as part of the revised Mental Health Act (MHA) in 2007, coming into force on 3rd November 2008. The legislation is operationalised by making a CTO and has arguably been the most controversial aspect of the substantially amended MHA. The stated purpose of CTOs is to enable mental health services to provide support and treatment in the community to people whose mental health depends upon it, without which they might deteriorate and require hospital admission, often referred to as 'revolving door' service users (NIMHE, 2008a). A CTO can be made after a period of detention and 'treatment' in hospital, i.e. under section 3 of the MHA, and will contain specific conditions such as adherence with prescribed medication. The decision to use a CTO is determined by clinical discretion alone. There are no clinical circumstances in which it is mandatory for a CTO to be used.

In this chapter I aim to place this research in context by examining relevant literature about coercion and compulsion in mental health, specifically relating to CTOs, both from the UK and internationally. I will start by describing the strategies used to find relevant literature. I will then briefly outline some of the debates around terminology used in mental health in order to clarify my own position and the use of terms within this chapter and subsequent chapters. Next, I will place CTOs in context by

providing an overview of historical developments in mental health care generally, with more recent historical developments in England and Wales specifically, and a brief outline of CTO use internationally. I will then discuss the use of informal coercion in mental health before describing types of formal coercion used in the community prior to the introduction of CTOs. I will then outline the changes made to the MHA in 2007, before focussing specifically on CTOs in England and Wales, first describing some of the opposition to them and then describing the particulars of how the legislation is enacted. Next, I will discuss some of the problematic aspects of CTO use in terms of ethical concerns, how their use was underestimated, the impact on the therapeutic relationship, as well as some practical issues in their day-to-day use. I will then outline some of the factors deemed important in decision-making around CTO use. Lastly, I will outline some of the research describing stakeholder views on CTOs, both service users and families, before describing the previous research regarding clinicians' views on and experiences of using CTOs.

1.2 Literature search

A literature search was conducted using the following databases: SAGE journals (1990-2013), Science Direct (1990-2013), PsycINFO (1990-2013), PsycARTICLES (1990-2013), and Google Scholar (1990-2013). The following search terms were used combined with Boolean operators AND/OR: community treatment order; supervised community treatment; outpatient commitment; outpatient civil commitment; involuntary outpatient treatment; and mandatory outpatient treatment. Relevant articles were identified by reviewing abstracts and the article itself if deemed relevant. Searches were conducted for the period 1990-2013 as articles were likely to reflect current patterns in compulsory community treatment as well as providing a recent history of its development. Citation searches were conducted on particularly relevant articles to identify other relevant literature. Google Internet search engine was used to find further information in the public domain, such as policy documents, newspaper articles and position statements.

1.3 Terminology

Most of the literature regarding supervised community treatment utilises language consistent with mainstream discourses about mental health difficulties. These are very much rooted in the dominant medical model which constructs 'mental illnesses' as brain diseases or 'chemical imbalances' which require 'treatment' (Szasz, 2005) that can be seen as parallel to treatment for physical ailments. The word 'treatment' usually refers to psychiatric treatments such as medication or hospital admission and implies a patient who willingly takes the treatment prescribed to them by a doctor, resulting in a cure (Harper, 2008). Therefore, when treatment that is self-evidently beneficial is refused, it can be attributed to a 'lack of insight', often described as being a feature of a mental disorder, particularly when there is a diagnosis of schizophrenia (Mintz et al., 2003).

There are, however, fundamental flaws with this concept. The antipsychiatry movement of the 1960s challenged the notion of the biomedical discourse (Cromby et al., 2013). More recently, clinical psychologists have demonstrated the assumptions underlying the Diagnostic and Statistical Manual (DSM) to be problematic (Boyle, 2002) and criticised biomedical approaches to emotional distress as being simplistic (Johnstone, 2000). Similar criticisms of psychiatric diagnoses have been made by Bentall (2003), while the evidence base of psychiatric medication has also been questioned (Moncrieff, 2008).

With this in mind I will aim to use language that is consistent with a critical approach to understanding mental health difficulties. However, when reviewing the literature and describing what my participants said, I will use their terminology where appropriate whilst also recognising the problematic nature of some of the language used.

When referring to the people who are subject to CTOs or mental health treatment generally, I will use the term 'service user' except when paraphrasing from research

that uses different terminology. This is due to its current common usage in mental health services, although I recognise the problematic nature of this term (Simmons et al., 2010).

1.4 Context of CTO use

I will now give an overview of the historical context of the development of mental health services and legislation and outline the use of CTOs internationally.

1.4.1 Deinstitutionalisation – brief history

To place the use of CTOs in context, I will now describe the process of deinstitutionalisation across Europe and the US, focusing particularly on the UK. The information, where not specifically referenced, is drawn from Molodynski et al. (2010) and Cromby et al. (2013).

In the 19th and early part of the 20th centuries, Europe and the US saw large asylums being built to confine and ‘treat’ those deemed to be mentally ill. Numbers of residents rose rapidly, with rates of admission not being matched by rates of discharge, and by the mid-20th century hospitals were severely overcrowded. The 1950s marked a turning point where asylums were no longer sustainable and the process of deinstitutionalisation began in Europe and the US, with residents slowly being moved into the community. A number of factors contributed to this process, not least because asylums were very expensive to run. There had also been concerns about the quality of the care within the institutions, with a number of high-profile scandals, and increased attention was being given to patient rights. New drugs, such as chlorpromazine, became widely used and were deemed to be effective ‘treatment’, creating optimism that mental ill-health could be cured or, at least, contained (Mitchell, 1993).

In the UK the process of deinstitutionalisation and community care was further accelerated in 1961 by the Conservative Minister for Health, Enoch Powell, who delivered his famous ‘water tower’ speech which outlined the move from hospitals to

outpatient services and urged that psychiatric bed provision be halved in 15 years (Powell, 1961). Another factor that drove the closure of large institutions was the introduction of the welfare state, meaning that people did not need to live in an institution to receive financial support. The development of community psychiatry, day hospitals, and social methods of rehabilitation such as occupational therapy were also contributory factors. In the 1970s and 1980s multidisciplinary community mental health teams (CMHTs) were introduced across the UK which emphasised the importance of continuity of care.

1.4.2 More recent legislation changes in England and Wales

During the 1980s and 1990s, as deinstitutionalisation continued, some politicians and media commentators began to argue that people with psychiatric diagnoses were posing a threat to the general public, leading the then Health Secretary Frank Dobson to announce in 1998 that

“care in the community has failed... [deinstitutionalisation] has left many vulnerable patients to try to cope on their own. Others have been left to become a danger to themselves and a nuisance to others... A small but significant minority have become a danger to the public as well as to themselves” (BBC, 1998).

In the proposed overhaul of mental health legislation and services leading up to the recent changes, a greater emphasis was placed on ‘protecting the public’ from the implied risks posed by people with a ‘mental illness’ (Harper, 2008). This was in the context of a number of high-profile incidents of violence committed by people diagnosed as being mentally ill. The murder of Jonathan Zito in 1992 by Christopher Clunis, a man with a diagnosis of paranoid schizophrenia and a long history of institutional care, led to a public inquiry which was highly critical of the care he had received (Ritchie, 1994). This brought about the introduction of the Care Programme Approach (CPA) which aimed to ensure services were coordinated more effectively, significantly shaping mental health policy and practice in the UK. When Lin and Megan Russel were murdered in 1996 by Michael Stone, a man diagnosed as

having an untreatable antisocial personality disorder, it created a public outcry and enabled the UK government to drive forward legislative reform (Butcher, 2007). The Home Secretary at the time, Jack Straw, clashed with psychiatrists over this issue, saying that it was “time, frankly, that the psychiatric profession seriously examined their own practices and tried to modernise them in a way they have so far failed to do” (Warden, 1998). Laurance (2002) asserts that, as a result, one of the main factors driving the construction and implementation of mental health policy is fear and that this pressure and risk aversiveness from the government is a relatively recent phenomenon.

Anthony Maden, a professor of psychiatry (in Butcher, 2007), stated that risk management is essential in 21st century psychiatry and highlighted that few other specialities in medicine have to predict and manage third party risk. He stated that any risk of harm to an innocent by-stander is unacceptable. This is consistent with commonly-held attitudes towards people with mental health problems who are often believed to be unpredictable and potentially dangerous (Crisp et al., 2000), even to some degree by medical students and doctors (Mukherjee et al., 2002), a view that is reinforced by the media (Philo, 1994). This is despite the relatively small proportion of murders committed by people experiencing mental health difficulties (Taylor & Gunn, 1999) which has actually been falling as a proportion of overall murders over the last 50 years (Povey et al., 2009). Harper (2008) argued that such risk is simply an unfortunate by-product of living in a democratic society and that the concept of risk has become ambiguous in mental health services, as it may also mean risk to professional registration, litigation and so forth. Minimising risk in mental health is often achieved through coercion, both formally and informally, which will be discussed further below.

1.4.3 CTOs internationally

Compulsory community mental health treatment has existed in some areas of the United States since the 1970s and has been established in various forms in countries such as Canada, Australia, New Zealand and Israel (O'Brien *et al.*, 2009).

Several European jurisdictions, including Scotland in 2005, have introduced some form of involuntary community treatment (Manning et al., 2011). This has followed on from patterns of deinstitutionalisation and transitions to community-based mental health care. Compulsory community treatment has often been implemented following high-profile incidents involving people known to mental health services, e.g. 'Kendra's Law' in New York which is named after Kendra Webdale who was pushed in front of a subway train by a man with a diagnosis of schizophrenia (Pataki & Carpinello, 2005). Naming laws in this way emphasises the need for public protection rather than the importance of appropriate mental health treatment (Snow & Austin, 2009).

There are four main types of CTO internationally (Woolley, 2010):

- A person is given conditional leave following an involuntary admission to hospital
- A person meets criteria for hospitalisation but is treated involuntarily in the community
- A person does not meet criteria for hospitalisation but may do if their mental health deteriorates, and a preventative order is instigated
- A person is ordered to accept treatment by a court

These fall into two forms of CTO design – 'least restrictive' and 'preventative' CTOs (Churchill et al., 2007). 'Least restrictive' CTOs are characterised by having the same admission criteria as hospitalisation with the objective of treating a deterioration that has already occurred, while 'preventative' CTOs make it possible to 'treat' service users for the purpose of preventing deterioration that may result in dangerous behaviour. New York is an example of the preventative form, Norway has the rare, least restrictive form, and England and Wales have both forms in the legislation (Sjöström et al., 2011).

The legislation and implementation of involuntary community treatment varies across different countries and even within countries according to jurisdiction. Generally, CTO rates are low in Canada, high in Australia and New Zealand, and varied in the

US (Lawton-Smith, 2005). In the US rates vary from 2 per 100,000 in New York to 26 per 100,000 in Nebraska, while in Australia rates vary from 10 per 100,000 in Western Australia to 55 per 100,000 in Victoria (Lawton-Smith, 2005). A report of the early findings of CTO use in Scotland (Lawton-Smith, 2006) shows significant geographical variations.

1.5 Informal coercion in mental health services

This section describes the use of informal coercion in mental health services which is a common feature of the care provided and is often referred to as 'leverage' or 'treatment pressure' (Zigmond, 2011). An example of informal coercion is a situation where an 'informal' or 'voluntary' patient on an inpatient ward may be aware that they will be sectioned if they decide to leave, thus preventing them from doing so. Similarly, service users may be persuaded to comply in the community through the use of different strategies with increasing amounts of pressure (Szmukler & Appelbaum, 2008). Burns et al. (2011) suggested that coercion, or leverage, is used much more extensively than official figures indicate and Mullen et al. (2006a) suggested that persuasion works by harnessing the symbolic authority of the law. Furthermore, it has been suggested that most psychiatric service users in the UK experience their care as coercive, simply because they know that the powers to compel exist (Richardson, 2007), and that nobody can be considered entirely free in a system where compulsion is possible (Szasz, 2007).

As well as constituting explicit compulsion, CTOs might also be seen as a form of leverage in that the threat of recall is often sufficient to make people comply.

1.6 Formal coercion in mental health services in England and Wales

I will now outline the recent history of formal coercion in mental health services in England and Wales.

Prior to the introduction of CTOs, other legislation existed for the purpose of compelling people to accept treatment in the community.

1.6.1 Leave of Absence (Section 17)

In England and Wales Section 17 leave of absence has been used for many years as a way to provide some containment following discharge. It allows temporary absence from hospital when compulsory inpatient treatment is still deemed necessary, and is often used as a stepping stone to discharge (Woolley, 2010). It can only be granted by the Responsible Clinician (RC) (previously Responsible Medical Officer) and may have conditions attached for therapeutic and risk management purposes (Brookes & Brindle, 2010). Section 17 leave can be revoked by the RC if it is deemed necessary for the service user's health or safety, or for the protection of others, notice of which must be served in writing (Brookes & Brindle, 2010). It has been stated that Section 17 leave has sometimes been used as a 'long leash' that allows service users to be treated in the community while retaining the power to recall to hospital if necessary (Hewitt, 2003). In this sense it has, in the past and perhaps still, occasionally been used similarly to how a CTO might be used.

1.6.2 Supervised Discharge (Section 25)

In 1996 supervised discharge (section 25) was introduced and could be used to compel patients to attend appointments and live in a certain place but did not require them to accept medical treatment (Molodynski et al., 2010). It was described as a "paper tiger" for giving the illusion of supervision without providing compulsory adherence to treatment (Holloway, 1996) and was accused of being politically motivated rather than clinically useful (Eastman, 1995).

1.6.3 Guardianship (Section 7)

Guardianship (section 7) is to ensure that a service user receives appropriate care outside of hospital if it cannot be provided voluntarily (Brookes & Brindle, 2010). The guardian might be a person authorised by the local authority, or the local authority themselves, and may decide where someone should live, who can visit, and what the service used might require in terms of treatment and activity. It is largely used for people with cognitive impairment, such as those with a learning disability or dementia diagnosis.

1.7 The Mental Health Act 2007

The next step in the evolution of compulsory community treatment was introduced as part of significant changes to the MHA 1983.

The MHA 2007 is an Act of Parliament in the United Kingdom which amended the MHA 1983 and Mental Capacity Act (2005). It applies to people in England and Wales and most of the changes were implemented in November 2008. The main amendments were as follows:

- A broader definition of 'mental disorder' and the removal of most exclusions from the coverage of the MHA 1983
- The 'treatability test' was replaced by an 'appropriate treatment test' for longer-term compulsory detention
- The introduction of new safeguards with regards to the provision for advocacy, and displacing and appointing Nearest Relatives
- The roles of Approved Social Worker and Responsible Medical Officer were replaced by Approved Mental Health Practitioner (AMHP) and Responsible Clinician (RC) which are open to a wider range of professionals
- Supervised community treatment was made possible through the use of Community Treatment Orders (CTOs), which will be described in greater detail below.

Supervised Discharge (Section 25) ceased to exist. Guardianship (Section 7) remains. Leave of absence (Section 17) also remains but clinicians must consider using a CTO instead when granting leave for more than seven consecutive days (DoH, 2008a).

1.8 Community Treatment Orders in England and Wales

CTOs were first proposed in England and Wales in 1988 by the Royal College of Psychiatrists who, five years later, drew up a proposal for 'Community Supervision

Orders' which are very similar to the current legislation (Royal College of Psychiatrists, 1993). They were not implemented at the time as the Department of Health saw them as incompatible with Article 5 of the European Convention in Human Rights (Eastman, 1997).

The rationale for the introduction of CTOs was to provide care for 'revolving door' service users, those deemed 'difficult-to-treat' whose mental health deteriorates in the community, leading to repeated hospital admissions. CTOs were introduced to allow this group to be 'treated' assertively in the community, thus avoiding the often traumatic experience of being brought into hospital. The Mental Health Act Code of Practice (DoH, 2008a) states that the purpose of the CTO is to provide an alternative to compulsory hospital treatment and to provide a framework for care to be provided in the community while allowing for quick recall to hospital if necessary.

I will now outline some of the opposition to the proposed introduction of CTOs before describing how they work in practice.

1.8.1 Opposition and debate

There was a great deal of opposition to the introduction of CTOs among professional and service user groups (Crawford, 2000; Mental Health Alliance, 2005). There were concerns that CTOs would result in more coercive measures and paternalism at the expense of service users' rights to choice and autonomy, that they may be overused, and misused as a way of controlling 'difficult' service users, particularly those from ethnic minority backgrounds. MIND (1998) described the proposed legislation as a further erosion of civil liberties for mental health service users which are otherwise inherent in our legal system. There were also concerns that the community services provided alongside the CTO would be inadequately resourced (Mental Health Alliance, 2005).

When the legislation was passed the Mental Health Alliance, a coalition of organisations working towards fair mental health legislation, expressed regret that the government had missed the opportunity to create a modern and humane Mental

Health Act. Andy Bell, the chair of the Alliance said that the government had “failed to heed the evidence about risks of significant over-use of community treatment orders and the excessive powers the Bill gives to clinicians [...] it treats people with mental-health problems as second class citizens by allowing treatment to be imposed on those who are able to make rational decisions for themselves” (Butcher, 2007). Others, however, argued that CTOs only constituted a minor amendment to previous law and practice (e.g. Gledhill, 2007).

1.8.2 Particulars of CTOs in England and Wales

This section describes when a CTO might be considered, what conditions might be put in place, and what circumstances might lead to a recall of the CTO and, lastly, a discharge from the CTO.

1.8.2.1 *Criteria for CTO*

A CTO can only be made for an individual who is detained in hospital for treatment (i.e. sections 3 or 37 of the MHA) at the point of discharge. This is different to Scotland where they can be introduced *de novo* (Lawton-Smith, 2006). The CTO must be agreed by the RC and an AMHP.

A guide for practitioners produced by the National Institute of Mental Health in England outlined the criteria to be met as follows (NIMHE, 2008a):

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment.
- The treatment must be necessary for the patient’s health or safety, or for the safety of others
- Appropriate treatment can be provided without the patient needing to be detained in hospital.
- It is necessary for the RC to be able to recall the patient to hospital.
- Appropriate medical treatment is available for the patient.

The Mental Health Act Code of Practice (DoH, 2008a) states that, although formal consent from the service user is not necessary, it is important that they are prepared to co-operate with the proposed treatment.

1.8.2.2 CTO conditions

Outlining, and agreeing to, the conditions of the CTO are a vital part of developing the care plan and should involve the service user as well as their family and other professionals involved. The two mandatory conditions are that the patient must make themselves available to be assessed (i) for the purpose of possible renewal of the CTO and (ii) by the Second Opinion Appointed Doctor (SOAD) to confirm treatment (NIMHE, 2008a). The CTO can contain further conditions for the service user to adhere to, such as an agreed amount of contact with their mental health team and compliance with prescribed medication but these must be specific and must be designed to either ensure the patient receives medical treatment, to prevent risk of harm to the patient's health or safety, or to protect others (NIMHE, 2008a). Conditions should restrict an individual's life as little as possible, or might otherwise be deemed to breach human rights legislation (Bindman et al., 2003). In practice, the person would need to accept the CTO and agree to the conditions (NIMHE, 2008a), which they may do as a means of being discharged from hospital more quickly (Brookes & Bindle, 2010). Once in place, the non-mandatory conditions of the CTO can be changed by the RC without the involvement of the AMHP, although it is deemed good practice to make such decisions in the context of appropriate care planning (Brookes & Brindle, 2010).

1.8.2.3 Recall and revocation

The RC has sole responsibility to recall someone on a CTO and is able to do so without consultation if necessary, but will be likely to consult with other professionals, family and the service user themselves. The power of recall must be sufficiently justified by the risks arising from the person's 'mental disorder', which may include risks to their well-being, vulnerability, neglect and harm to self or others (NIMHE, 2008a). Failing to comply with a condition is not in itself enough to justify

recall but the RC can take such non-compliance into account when considering if recall is necessary (NIMHE, 2008a). However, if the failure to comply means immediate risk of harm to the patient or others, then the patient can be recalled (NIMHE, 2008a).

The RC must provide written notice to the service user outlining the reasons for the recall, to be delivered either by hand, in which case the recall takes immediate effect, or by post, when the recall takes effect the day after it was delivered (Brookes & Bindle, 2010). The service user is brought to hospital by the police or by ambulance depending on the circumstances.

The service user is recalled to hospital for an assessment period of up to 72 hours after which the CTO must continue in the community or be revoked. In some instances recall may be solely to administer medication. Both the RC and the AMHP must agree for the CTO to be revoked, resulting in the service user once again being detained under their original section (usually section 3), effectively ending the CTO and resulting in an automatic referral to a mental health review tribunal (NIMHE, 2008a).

1.8.2.4 Renewal and discharge

A CTO initially lasts six months and can then be renewed for another six months, subsequently being reviewed annually. They are renewed by the RC following consultation with at least one other involved professional and with the agreement of an AMHP.

Service users may be discharged from the CTO by the RC, by hospital managers or by a mental health review tribunal. The Nearest Relative can also apply for discharge. They should be discharged as soon as the criteria are no longer met (NIMHE, 2008a).

1.9 Problematic aspects of CTOs

This section describes some of the more problematic features of CTOs discussed in the literature, such as the evidence base, ethical issues, how their use was underestimated in England and Wales, and some practical difficulties encountered in their use.

1.9.1 Evidence base

The effectiveness of CTOs is a particularly contentious issue, with difficulties in both establishing criteria for their success as well as isolating elements of their use from generic input from mental health services (Romans et al., 2004). It has been suggested that, where positive findings have been reported, it has not been possible to attribute the benefits to the CTO or to a generally higher level of service provision (Lawton-Smith et al., 2008). Due to the substantial variations in legislation and implementation of CTO across and within countries, it is difficult to meaningfully compare and combine research findings about them. A review of mental health legislation and rates of detention across Europe found enormous variability despite similar detention criteria, leading the authors to conclude that detention rates are primarily influenced by professionals' attitudes and ethics, socio-demographic variables and public perceptions of risk (Zinkler & Priebe, 2002). This is also likely to be true of CTO use.

It seems that the most important reason cited by stakeholders for the use of CTOs is to prevent involuntary hospitalisation where possible (Churchill et al., 2007).

Comparative studies, however, looking at CTO patients and matched controls found that CTOs did not lead to reduced use of health services (Preston et al., 2002) or number of hospital admissions (Kisely et al., 2004). Moreover, it has been suggested that hospitalisation is a poor outcome measure by which to measure success as some patients may benefit from spending more time in hospital and because it does not necessarily reflect patient well-being (O'Reilly, 2004). Patients on CTOs have been found to have greater outpatient contact with mental health services than controls (Preston et al., 2002) which has been used as an outcome measure, but

this is not surprising if they are compelled to attend appointments . Other reasons for 'success' in mental health care may be regression to the mean, other treatment, and change in social circumstances (Kisely & Campbell, 2006), making it difficult to isolate the influence of the CTO.

Two randomised controlled trials (RCTs) in the US found no statistically significant differences in the number of hospital admissions or medication compliance between patients on a court-ordered CTO or those receiving standard care (Swartz et al., 1999; Steadman et al., 2001). *Post hoc* analysis in the Swartz et al. (1999) study, however, found that service users kept on a CTO for over six months and offered high levels of support were significantly less likely to require hospital admission, leading the authors to conclude that CTOs could be effective when they represented a reciprocal commitment by community services to provide sustained and intensive treatment to service users (Swartz et al., 1999). The use of *post hoc* analysis has been criticised as introducing potential biases. Steadman et al. (2001) found no significant differences on other outcomes such as arrests, homelessness and quality of life as measured by standardised instruments. Both RCTs excluded patients with a history of violence from randomisation which limits the generalisability of the findings as this is an oft-cited reason for placing someone on a CTO, and selection bias was further compounded by high dropout rates by the 1 year follow up. The Cochrane review (Kisely et al., 2005) of the two RCTs, concluded that compulsory community treatment results in no significant differences in service use, social functioning or quality of life compared with standard care and that “there is no strong evidence to support the claims made for compulsory community treatment that make it so attractive to legislators” (p10). It stated that it would require 85 CTOs to avert one readmission to hospital, 27 to avoid one incidence of homelessness and 238 to prevent one arrest.

A systematic and independent review of CTOs was conducted on behalf of the Department of Health in 2007 and considered the findings of 72 studies conducted in six countries over the previous 30 years. It concluded that there is a lack of

evidence to suggest that CTOs are associated with any positive outcomes (Churchill et al., 2007).

The Oxford community treatment order evaluation trial (OCTET) aimed to address the uncertainty around CTOs' utility (Burns et al., 2009) and have recently published the results of their RCT (Burns et al., 2013). They investigated whether CTOs reduce hospital admission when compared with Section 17 leave in two groups receiving equivalent levels of clinical contact with different lengths of compulsory supervision. During the 12-month follow-up period they found that CTOs did not reduce the rate of hospital readmission for service users with psychosis and concluded that the curtailment of personal liberty through the use of a CTO is, therefore, not justified.

1.9.2 Ethical concerns

For UK psychiatrists, decisions about whether to use a CTO are more determined by clinical reasons than ethical concerns (Manning et al., 2011), however it is nevertheless important to consider the ethical issues that are relevant to CTO use.

CTOs are based on the assumption that society has an obligation to care for those who cannot care for themselves and lack the insight to accept medical treatment willingly, as well as protecting the public from individuals who potentially pose a risk. The philosophical basis of the legislation is to provide service users with care and treatment that places the least restrictions on their freedom and interferes least with their rights and dignity, with due regard to the safety of themselves and others. However there are a number of counter-arguments for their use on ethical grounds, which I will now describe.

1.9.2.1 Human rights

The Human Rights Act 1998 is UK statute, enacting most of the European Convention of Human Rights into UK law and outlining the fundamental rights that all people are entitled to (Khurmi & Curtice, 2010). It is enforceable by courts and tribunals, including mental health tribunals, which are obliged to interpret the MHA

1983 consistently with the Human Rights Act, thereby bringing human rights to the core of both legal and health systems (DoH, 2008b).

CTOs could be seen to have some positive effects on service users in terms of human rights, in that they might be deemed to help vulnerable people regain their rights through treatment in the community and provide a 'least restrictive' alternative to hospitalisation (Khurmi & Curtice, 2010), thereby helping someone maintain their autonomy and family life (Kinderman & Tai, 2008). Similarly, Munetz and Frese (2001) suggested that compulsion may be consistent with the 'recovery model' as long as the treatment is adequately resourced. However CTOs might also have significant negative impact on a person's human rights and, therefore, their well-being if the CTOs are used inappropriately (Khurmi & Curtice, 2010). Khurmi and Curtice (2010) argued that striking a balance between restricting a person's rights and improving their quality of life can be assisted by using a proportionality approach to human rights issues, and that the Human Rights Act and the amendments to the MHA 1983 provide adequate legal safeguards.

Articles 3, 5 and 8 of the Human Rights Act are particularly relevant to service users subject to CTOs. Article 3 states that people should not be subjected to degrading treatment, with the exemption of when it is deemed necessary. Arguably, being placed on a CTO might be considered degrading, however what is considered *necessary* by mental health services can be rather broad. Article 5 concerns the deprivation of liberty, with a clause addressing the lawful detention of 'persons with unsound mind'. Although this term is not defined, it is in some ways equivalent to being diagnosed with a 'real' mental 'illness' (Kinderman & Tai, 2008), which, as noted above, is a problematic construct that continues to be seen as entirely valid within the legislation. Article 8 addresses the right to private and family life without interference by public authority, however the exemptions to this include when there are concerns about public safety, which the CTO is essentially designed to address. These Articles, therefore, do not seem to provide any significant additional safeguards than those already offered to detained service users. Khurmi and Curtice

(2010) stated that CTO legislation appears to be compliant with the Human Rights Act, although they concluded that this may be tested in future by influential case law (Khurmi & Curtice, 2010).

1.9.2.2 Balancing autonomy and paternalism

Paternalism is behaviour that limits someone's liberty or autonomy, with the aim of doing good or avoiding harm, while autonomy is the freedom to make decisions for oneself. Lawton-Smith (2008) argued that public risk is at the top of the political agenda where introducing CTOs is concerned and that professional paternalism has been prioritised above patient autonomy which contradicts government efforts to increase patient choice within the NHS. Setting autonomy against paternalism is particularly problematic when a service user is deemed to have capacity (Lawton-Smith, 2006), and gives further powers to health professionals to monitor service users and to judge what is normal and deviant (Foucault, 1995). An important aspect of autonomy is being able to make decisions, regardless of whether other people deem them to be appropriate or not. Patel (2008) argued that CTOs impede the developmental process of learning and growing through experiencing adverse consequences for one's actions. How autonomy and paternalism are balanced depends on the fundamental question of whether society has a 'parens patriae' obligation to care for citizens who cannot care for themselves (O'Reilly, 2004).

1.9.2.3 Mental capacity

Mental capacity is defined as the ability to make one's own decisions, which adults are presumed to possess under common law unless there is an "an impairment of, or a disturbance in the functioning of, the mind or brain" (Mental Capacity Act, 2005). In an early draft of the legislation reform in the UK, it was suggested that capacity principles should be applied (Richardson, 1999), however these were not accepted by the UK government due to concerns about being able to provide prolonged and consistent treatment to people with severe but fluctuating mental disorders who pose significant risks to others (DoH, 2005). Around the same time, Moncrieff and Smyth (1999) argued that CTOs would lead to curtailments of basic human rights for people

who were managing to live in the community, had not committed a crime, and who were deemed to be sufficiently competent to marry, vote and enter into business contracts, i.e. people who are deemed to have capacity. Similarly, the mental health charity, MIND, during the discussions around the reform of the MHA, argued to make mental health law congruent with common law principles, which makes decisions for non-consensual medical treatment purely on incapacity to consent (MIND, 1998). It is only possible to give general health treatment against someone's will in very specific circumstances, such as having a dangerously infectious disease that could kill other people (Cromby et al., 2013).

Much of the debate about an individual's capacity centres around their ability to make decisions about their treatment (Munetz et al., 2003). There is often an assumption of irrationality, or even of lacking capacity, if a service user refuses psychiatric care such as medication. This is linked with the concept of 'lacking insight'. In the 2010 Care Quality Commission report, 55% of service users on a CTO were described as having 'insight' (CQC, 2010) which makes it somewhat unclear why a CTO was necessary.

Establishing whether a service user has capacity is problematic in itself. Szasz (2005) argued that *in principle* mental health patients are considered competent (until proven otherwise), however *in practice* they are regularly treated as if incompetent. He goes on to argue that competence and incompetence, like innocence and guilt, are "*attributions, not attributes, judgments, not facts*" (p79). He argues that, like 'mental illness' and 'dangerousness', there are no objective criteria. If a person is deemed incapacitous, 'best interest' frameworks come into play, however what a mental health professional deems to be in someone's best interest, such as high doses of anti-psychotic medication, may be at odds with what the person would choose for themselves, even at a time when they have capacity.

The issue of capacity is treated differently across different jurisdictions. In the US and some parts of Europe, the tendency is to apply the same principles to mental

health care than to other forms of medical care, i.e. only incompetent, or incapacitous, patients may be treated without their consent (Dawson, 2006). This reflects the centrality of the principles of autonomy and competency in health care ethics (Dawson, 2006). The main practical implication of this principle in a mental health context is that it is not permitted to give a person psychiatric treatment against their will if they regain capacity, something which needs to be assessed regularly. Dawson (2006) suggested that using this approach would significantly reduce CTO use, but may lead to greater use of the criminal justice system as an alternative mechanism of social control. Dawson and Szmukler (2006) argued that a single legislative scheme that governed both physical illnesses and 'mental illnesses' based on capacity principles would have a number of advantages, such as reducing discrimination against those deemed to have a mental disorder and permitting earlier intervention as it would be possible to intervene as soon as the service user lacked capacity to determine treatment, whether or not there was an immediate threat of harm.

In the reforms of mental health legislation in Scotland in 2005, a test of 'significantly impaired capacity' was implemented to determine whether someone can consent to treatment for a mental disorder, governing both detention and treatment decisions. Its language is flexible enough to allow for fluctuations in mental state, and a person who is deemed to lack capacity much of the time could be considered to have impaired capacity overall, allowing them to be treated without their consent (Dawson, 2006). However the test acknowledges the important role of capacity principles with regards to consenting to treatment, and to some extent responds to the suggestion that mental health law is discriminatory towards those with mental health difficulties when compared to the principles applied to all other forms of medical care (Dawson, 2006).

1.9.2.4 Principle of reciprocity

Eastman (1994) argued that the protection of society does not justify detention, and the 'principle of reciprocity' requires that curtailment of civil liberties must be

compensated for by the provision of high-quality services. It is questionable whether this has been achieved in jurisdictions that have introduced CTOs, particularly in the UK as they were introduced at a time when, if anything, mental health budgets were being curtailed. It is also possible that well-resourced, appropriate mental health services with assertive outreach principles would displace the need for CTOs altogether.

1.9.3 Underestimation of use

While CTOs were introduced largely to stop the phenomena of 'revolving-door' service users, recurring hospitalisation is not a necessary requirement to be placed on an order (Lawton-Smith *et al.*, 2008) and, in fact, the Care Quality Commission (2010) found that 30% of the service users in their sample did not have a reported history of disengagement or non-compliance, suggesting that CTOs are being used beyond the group of service users for which they were primarily introduced. During their first full year of use (2009/10), 4,107 CTOs were put in place (CQC, 2010). In 2010/11, the number dropped slightly to 3,606 (CQC, 2011) before rising again to 4,220 in 2011/12 (CQC, 2012). These numbers are significantly higher than the 400-600 annual number predicted by the Department of Health (Lawton-Smith, 2010). This may be reflective of an estimate that was far too low to begin with, but nevertheless highlights the need for caution to avoid rising numbers of CTOs.

1.9.4 Impact on therapeutic relationship

It seems almost unavoidable for a CTO to have some impact on the therapeutic relationship between staff and service users. Patel (2008) argued that a CTO places the case manager in a dual role of both supervisor of involuntary treatment and collaborator in care, a contradiction which is often resolved in the patient's mind by seeing them as primarily acting in the interest of the mental health system. This may reflect the clinician's perspective that their main role is that of enforcer, negating their rapport- and engagement-building skills. Revoking a CTO can be seen as inconsistent with assertive care that relies on carefully-constructed therapeutic relationships and can thus become anti-therapeutic (McIvor, 1998). However, O'Reilly (2004) suggested that patients placed on CTOs have often previously disengaged from services, so it is more appropriate to compare having a

relationship, however strained, with having none at all, rather than comparing a 'good' and a 'bad' relationship.

1.9.5 When to discharge

Dawson et al. (2003) raised the clinical dilemma of, when a service user on a longer-term CTO avoids readmission to hospital, whether the CTO should be considered *successful* or *unnecessary*. If it is deemed successful and the service user's mental health remains stable, it could be argued that the service user should be discharged, however it could also be argued that the CTO is necessary and should be continued. If a CTO is deemed unnecessary it is thereby rendered as being overly coercive. The longer the CTO is extended and the service user does not require readmission to hospital, the more successful it might be deemed to be on the one hand, and the more unnecessary on the other hand. Particular concerns remain around discharge from CTOs and the potential 'lobster pot' effect whereby it is easy to get onto a CTO but very difficult to get off one (Rugkåsa & Burns, 2009). MacPherson et al. (2010) similarly highlighted this issue of what constitutes a 'successful' CTO and at what stage the CTO should be terminated.

1.9.6 Disjointed care

Another difficulty with CTO implementation in England and Wales reflects changes in the organisation of mental health services since the legislation was drafted. There is an increasing split between inpatient and outpatient services with Consultants working in either inpatient or community services rather than in geographic sectors, resulting in the inpatient RC making the decision to place someone on a CTO while the outpatient RC is expected to use the Order in the community. There is no legal requirement for a community RC to be involved in the decision to use a CTO or what conditions should be applied (Brookes & Brindle, 2010). The MHA Commission (2009) (now Care Quality Commission(CQC)) highlighted this issue in their initial report following the legislation change as something requiring on-going monitoring given its effects on continuity of care as well as the planning and negotiating of CTOs, and highlighted the same issue in the 2009-2010 report (CQC, 2010).

1.10 Factors driving decision-making in the use of CTOs

In order to understand what determines whether a CTO is used, it is important to consider the factors that drive decision-making for clinicians.

The legal power to use a CTO allows for clinical discretion which has resulted in substantial variability between and within jurisdictions. Dawson (2007) suggested that there are several factors that influence clinical decision-making:

- The legal structure around CTOs
- The structure and quality of the community mental health services available
- Considerations about the impact of coercion on the therapeutic relationship
- The expectations of third parties around the use of CTOs, including carers and other agencies such as the criminal justice system
- Past patterns of involuntary community care
- The consensus of liability of clinicians for the conduct of patients in the community

Clinicians reportedly use a CTO when the overall picture favours that option within a complex network of influences, which may impact rapidly on the rate of CTO use in a particular jurisdiction without any change in the law (Dawson, 2007). Similarly, when a CTO is in place and the conditions have been violated, the power to recall is optional rather than mandatory, leading to widely varying practices (Burns & Dawson, 2009). Despite giving some ideas about what influences the use of CTOs generally, this research does not clearly outline what drives the specific decisions made 'on the ground' within a specific jurisdiction.

Dawson and Mullen (2008) studied the reasons for using CTOs in 42 cases in New Zealand by interviewing service users, their carers and clinicians. They concluded that lack of insight was an important indicator due to the perceived link with compliance with prescribed medication. There was also a common perception that service users would gain insight during sustained treatment on a CTO. However,

recovering insight was not necessarily deemed to be an indicator for discharge from the CTO if there were ongoing risks of harm, and of sudden deterioration.

The factors deemed most important in deciding to use a CTO among UK psychiatrists were 'promoting medication adherence', 'protecting patients from the consequences of relapse', and 'ensuring contact with health professionals' (Manning et al., 2011). Qualitative comments showed a wide range of opinions, with some describing CTOs as 'ethically acceptable' and providing the 'best possible care', while others described them as 'bureaucratic', a 'waste of time' and 'unethical' (p332). The same respondents believed that CTOs were more likely to have been introduced due to public pressure than because of convincing research evidence.

1.10.1 Service user characteristics

Particular service user characteristics are frequently cited in the literature as making a CTO more or less likely to be implemented.

The Churchill report, which combined the findings of different studies across various countries and jurisdictions, concluded that there is considerable agreement among clinicians about which service users might be suitable for a CTO:

“There is remarkable consistency in the characteristics of patients on CTOs across jurisdictions in very different cultural and geographic settings... typically males, around 40 years of age, with a long history of mental illness, previous admissions, suffering from schizophrenia-like or serious affective illness, and likely to be displaying psychotic symptoms at the time of the CTO. Criminal offences and violence are not dominant features amongst CTO patients” (Churchill et al., 2007, p109).

The majority were single and living alone.

Service user characteristics may, therefore, be one of the most significant factors for clinicians when making decisions related to CTOs.

1.11 Stakeholder views

Given the lack of conclusive evidence supporting or opposing the use of CTOs, it is important to consider the opinions of the people who are directly affected by their use – service users themselves and their families. In the absence of universally-agreed criteria by which to judge the effectiveness of CTOs, the views of clinicians are central to the ongoing discussion of whether CTOs are useful. This section summarises some of the literature on the views of different stakeholders.

1.11.1 Service users' and families' views

A number of studies have looked at the views and experiences of service users and families regarding compulsory community treatment. An Australian report of focus groups consisting of 30 service users on CTOs and interviews with 18 professionals found that service users were generally dissatisfied, and both groups tended to regard CTOs as stigmatising and disempowering (Brophy & Ring, 2004).

Conversely, a survey in New Zealand found that service users generally viewed their CTO positively, describing improved mental health, sense of security and access to services (Gibbs et al., 2005). However they also described a loss of control, increased stigma and feeling coerced into adhering to medication which impacted on their relationships with health professionals. A US study found that service users tended to be unhappy with their CTO at first, but that a majority acknowledged the benefits of the intensive services they received as a result of the CTO (Pataki & Carpinello, 2005). Another study in the same jurisdiction found that service users found aspects of their care coercive, regardless of whether they were subject to a CTO (Swartz et al., 2009). In a Canadian study service users reported that they experienced coercion due to the CTO but that it also provided necessary structure (O'Reilly et al., 2006).

Families seem more likely to identify benefits than service users. In O'Reilly et al.'s (2006) study, family members tended to see the orders as a necessary way of controlling the chaos caused by the service user's limited insight. Similarly, in New Zealand, qualitative interviews with families found that they reported benefits for the

service user and themselves, improved family relationships, and better relations with the clinical team (Mullen et al., 2006b).

1.11.2 Staff views

Quantitative surveys of professionals' attitudes to CTOs have been conducted in New Zealand and Canada, where CTOs are well-established. The New Zealand survey (Romans *et al.*, 2004) of psychiatrists and community mental health professionals found that most clinicians were in favour of such powers, while a small minority would prefer to work without them. They indicated that the three most significant mechanisms by which CTOs work are: compliance with medication, providing a clear signal to patients that they have a 'major mental illness' and ensuring a greater period of stability. When considering factors that may discourage the use of CTOs, concern for patients' civil liberties and the degree of coercion were most significant, although none were considered very important. Respondents felt that using a CTO impacted on the therapeutic relationship, with 42% believing it to be helpful and 31% believing it to be a hindrance. While it is worth noting that, of the 284 respondents, 202 (71%) were psychiatrists, the other mental health professionals rated the same items as being most important, albeit in a slightly different order. Of the 55 psychiatrists who identified themselves as British-trained (at a time when CTOs did not exist in Britain) 42 (76%) said they preferred working in a system with CTOs. This is comparable with the 74% of New Zealand-trained psychiatrists who were in favour of working with CTOs. Similarly, a survey of 50 psychiatrists in Saskatchewan, Canada found that 62% of respondents were satisfied or extremely satisfied with the effect of CTOs on patient care, while 10% were dissatisfied or extremely dissatisfied (O'Reilly et al., 2000).

In investigating the experiences of Maori service users using qualitative interviews in Otago, New Zealand, Gibbs et al. (2004) found that the mental health professionals involved consistently said that the main purpose of the CTO was to ensure the ongoing provision of mental health services to service users who would otherwise refuse medication or assistance. They said that the CTO provided the framework in

which service users could acknowledge their 'illness', and ensure compliance with medication and arranged appointments.

Mullen et al. (2006a) found that, in qualitative interviews about dilemmas faced while using a CTO, clinicians experienced dilemmas such as balancing the adverse consequences of the CTO with perceived benefits, weighting up the impact on the therapeutic relationship, feeling uncertain about the CTOs efficacy, and the dilemma of when to discharge. The authors concluded by providing recommendations for clinicians in how to manage these dilemmas, such as tailoring the CTO to the individual, using the powers of the CTO with great discretion and actively using the power of discharge.

1.11.2.1 Staff views in England and Wales

In 2000 a postal survey was sent to consultant psychiatrists in England and Wales when the changes to the Mental Health Act were being debated (Crawford et al., 2000). Of 1171 respondents, 46% were in favour of involuntary community treatment, 35% were against and 19% were unsure.

Manning and colleagues (2011) sent a postal survey to members of the Royal College of Psychiatrists in England and Wales in the 12-18 months after the introduction of CTOs. It mirrored the previous New Zealand research (Romans et al., 2004) and achieved an overall response rate of 29%. In this sample, 60% were in favour of a system that included CTOs. Similarly, a recent Mental Health Alliance survey emailed to 9,297 Royal College of Psychiatrists members found that, of the 533 respondents, 61% thought that Supervised Community Treatment powers were useful while only 14% thought they had not been useful (25% did not know) (Lawton-Smith, 2010). The extremely low response rate (6%), however, limits any meaningful interpretation.

In Manning et al.'s (2011) study, when deciding whether to discharge a patient from a CTO, the three factors considered most important were 'development of insight',

'clinical improvement' and 'adherence to treatment'. The mechanisms considered most important in how CTOs work were 'ensuring medication adherence for a lengthy period during which other changes can occur', 'ensuring a greater period of stability' and 'signalling to the patient that they have a serious mental health problem which needs active management'. When rating potential factors that might discourage clinicians using CTOs the three most important factors clustered close together – 'concerns for the person's civil liberties', 'the administrative burden', and 'the degree of coercion involved'. When asked about factors which might have influenced the introduction of CTOs in England and Wales, the top three were 'to enforce better community services and follow-up for those at risk', 'a response to public pressure (in respect to acts of violence committed by individuals with mental illness)', and 'a result of procedural evolution' in terms of mental health law.

While being a thorough and extensive survey in terms of the questions asked, the results of the Manning et al. (2011) research are nevertheless reflective of the forced-choice responses dictated by the authors. The survey was also only sent to psychiatrists, thereby not representing the views of other mental health clinicians.

1.12 Current study

This research will use semi-structured interviews to explore how clinicians who have worked with someone subject to a CTO talk about their experiences of the new legislation. It will aim to elucidate how clinicians talk about negotiating the use of CTOs and what difficulties they encounter, both pragmatically and ethically.

Although there has been some qualitative research with mental health clinicians regarding CTOs (Mullen et al., 2006a; Dawson & Mullen., 2008), this has focussed predominantly on their views about CTOs more generally rather than how clinicians talk about making practical decisions in specific clinical circumstances . The New Zealand research cited above was conducted in a mental health system where CTOs were well-established. It is therefore particularly interesting to explore the

experiences of clinicians where the legislation is established but still relatively new, allowing them to make direct comparisons between the previous and current systems. To my knowledge there has not been any published UK-based qualitative research. An increased understanding of clinicians' experiences may help to guide the use of CTOs and the subsequent care provided.

1.13 Research questions:

- How do mental health clinicians talk about negotiating their work with service users subject to a CTO?
- In what circumstances do clinicians consider CTOs useful?
- What difficulties do clinicians describe about the use of CTOs, both ethically and practically?

2. METHOD

2.1 Chapter overview

This chapter will outline the rationale for adopting a qualitative approach for this research and, specifically, for using grounded theory as the method of data analysis. It will also give details of the nature of the participants and the procedures involved in collecting and analysing the data.

2.2 Overview of approach

2.2.1 Qualitative

A qualitative approach was deemed most appropriate for investigating clinicians' experiences of using CTOs as it enabled an open and flexible approach to data collection and analysis. Given that previous research investigating staff experiences of CTOs has been largely quantitative and survey-based, it seemed particularly important to adopt a qualitative approach in order to obtain a richer account of the processes and experiences involved.

2.2.2 Semi-structured interview

Interviews are directed conversations which facilitate in-depth explorations of a particular topic (Rubin & Rubin, 1995). While they may not reflect an everyday experience, most people recognise and accept the format. Interviews fit well with a grounded theory approach as they allow the researcher to maintain control over the construction of data while remaining flexible to what the participants want to say about their experiences.

2.2.3 Grounded theory

Grounded theory was originally developed by two sociologists, Glaser and Strauss (1967), who wanted to investigate social processes and found that traditional quantitative hypothesis-testing restricted theory generation and relevance. This led them to develop a method that 'grounded' the research in the data itself, rather than relying on analytic constructs or categories from pre-existing theories (Willig, 2008). Through the process of continual sampling and comparative analysis, theories are

developed that directly related to the raw data. 'Grounded theory' refers both to the *method* of category identification and integration, and to the *theory* as the end-product of the process (Willig, 2008).

Grounded theory has evolved into a number of versions adopting different epistemological positions, from more positivist forms to constructivist versions (Charmaz, 2006). The original versions of grounded theory purported that theories 'emerged' from the data as if entirely separate from the researcher (Glaser & Strauss, 1967) whereas more recent versions view the construction of theory as interactional and subjective (Charmaz, 2006). The method used in grounded theory has nevertheless remained fairly consistent and provides clear strategies for data collection and analysis in order to construct a theory of social or psychological processes that is very much *grounded* in the data through continual sampling and comparative analysis.

Grounded theory is suited to a wide range of open-ended research questions that focus on processes and meanings within a particular context. Charmaz (2006) proposed that grounded theory should be seen to offer researchers a set of principles and heuristic devices that can be flexibly adapted according to their individual research needs rather than providing formulaic rules to follow.

Grounded theory seemed appropriate for the current research for a number of reasons. The flexible, data-driven approach to analysis and framework for developing a theory seemed ideal due to the paucity of qualitative research about clinicians' experiences of working with people subject to a CTO. It enables a rich level of data analysis without relying on predetermined categories of interest. Grounded theory's focus on social processes seemed relevant to how staff talk about their experiences of working with people under CTOs, specifically how they negotiate complex decision-making and ethical dilemmas.

In order to develop a grounded theory, researchers use a number of key strategies (Willig, 2008):

- Systematic coding in order to identify categories of data that share central features.
- Constant comparative analysis to identify similarities and differences between emerging categories, in order for categories to be refined so that they capture all instances of variation.
- Use of memo-writing to document connections across the data and the researcher's emergent ideas, interpretations and decision-making throughout the analysis.
- Theoretical sampling which involves collecting further data in light of categories that are emerging in order to challenge or elaborate on them.

A grounded theory is considered complete when no new categories are identified by carrying out theoretical sampling until 'theoretical saturation' is achieved (Willig, 2008). The aim of the analysis is completeness of the theory rather than generalisability, however the process of theoretical saturation is theoretically infinite as it is always possible to find new perspectives (Glaser & Strauss, 1967). The full version of grounded theory involves the researcher collecting some data, exploring the data through initial coding, creating tentative links between categories and then collecting further data informed by the emerging theory (Willig, 2008). This process helps to ensure that theoretical saturation is being approached.

It is possible to conduct an abbreviated version of grounded theory whereby grounded theory principles are applied to data that has already been collected. Data is analysed following the principles of coding and constant comparative analysis, however theoretical sensitivity, theoretical saturation and negative case analysis can only be implemented within the existing data rather than returning to the field to collect further data (Willig, 2008). Willig (2008) suggests that many important aspects of grounded theory methods are missing in this version but that the quality

can be enhanced through the use of line-by-line coding, as it enables a depth of analysis to compensate for the lack of breadth.

2.2.4 Other methods considered

Other methods considered included Thematic Analysis (TA) and Interpretative Phenomenological Analysis (IPA). TA identifies and analyses patterns of meaning in a particular phenomenon by drawing out themes in order to summarise unstructured data, the end result of which includes affective, cognitive, and symbolic dimensions (Joffe, 2012). It is usually carried out using a critical realist epistemology (Joffe, 2012). IPA focuses on how people make sense of experiences through the use of phenomenological interpretative processes, usually exploring meanings around a topic that personally matters to the participants (Larkin and Thompson, 2012). As the current study focuses on clinicians talking about an aspect of their working lives adopting a social constructionist epistemology, these approaches did not seem suitable. Grounded Theory is designed to construct a theory that describes and conceptualises how social structures, situations and relationships influence patterns of behaviour, interactions and interpretations and is often used in areas of research that are under-defined (Tweed & Charmaz, 2012), making it an appropriate approach for this research topic.

2.3 Epistemological and personal reflexivity

Charmaz (2006) asserted that researchers and participants, far from being objective arbitrators of an underlying direct reality, approach research with certain assumptions and knowledge which impact upon the process and Willig (2008) stated that simply by identifying and labelling a research question researchers impose their own assumptions. Charmaz (2006) proposed that researchers should embrace this as a way of developing ideas. Remaining aware of such influences is of primary importance to researcher reflexivity and allows for a more transparent research process, thus enhancing the quality of the research overall. As grounded theory has evolved since its inception and is no longer regarded as a unitary approach, it is possible to use the same method while holding different epistemological positions

(e.g. Madill et al., 2000) and it is therefore vital for researchers to make their epistemological positions explicit.

My epistemological position is defined as relativist social constructionist (Harper, 2012). Researchers adopting this position subscribe to the position that it is not possible to comment on the nature of reality as one cannot be in direct contact with it. In analysing data they therefore focus on what people say without going beyond the text to interpret it, concentrating on the transcripts of talk rather than abstract entities such as thoughts and feelings, and recognise that multiple interpretations of the data are possible. Adopting this epistemological position allows me to remain aware that certain positivist constructs, such as 'illness', 'insight' and 'treatment', exist and are negotiated within a social context rather than being fixed, unchanging entities. Charmaz (2006) states that, in a social constructionist version of Grounded Theory, the theory and researcher are inherently connected, making researcher reflexivity particularly important to ensure awareness of one's own starting assumptions.

It therefore seems important to describe something about myself for the sake of transparency. I am a 30 year old white British woman training to be a clinical psychologist. Prior to training (and prior to the introduction of CTOs in the UK) I worked in two Early Intervention in Psychosis teams in London, firstly as a research assistant and subsequently as a care coordinator to a caseload of approximately ten service users. I therefore have an appreciation of the anxiety provoked when service users engage in 'risky' behaviour and why mental health clinicians may consider using additional powers when they are available. This position is, however, at odds with my belief that mental health services should aim to be as least coercive as possible, with service user rights to autonomy and self-determination being paramount. I have not worked with a service user subject to a CTO in the UK, but worked with one service user subject to a CTO in New Zealand while I was a support worker there a number of years ago. This gives me some limited personal insight into how someone subject to CTO might experience the process.

I have attempted to remain as reflexive as possible throughout the processes of interviewing and analysing the data. Discussions with my supervisor and with peers helped me to remain aware of the influence of my own ideas on the research in all its stages, as did using a reflective diary. Using memos helped me to reflect on my own position and ideas throughout the research process, as well as allowing me to 'track' my research decisions.

2.4 Ethics

Ethical approval was obtained from the University of East London School of Psychology Ethics Committee (Appendix 1). It was felt that the interviews were unlikely to cause distress as, while mental health clinicians might feel strongly about the subject matter, they would nevertheless be able to maintain some professional distance as were not talking about something relating to their own personal lives, unless they knew somebody personally who was subject to a CTO (which none reported). Had any distress arisen I felt confident to manage this with skills gained from my clinical psychology training.

2.5 Participants

Participants were qualified mental health clinicians who had roles relating to the Mental Health Act or were care coordinators, and who had worked with at least one person subject to a Community Treatment Order. I decided to exclude psychologists as I felt their relationship with service users may be fundamentally different to those in other professions in that participating in psychology sessions, arguably, needs to be voluntary whereas having a relationship with your care coordinator or psychiatrist is, to a degree, compulsory for people subject to a CTO. The sample composition could be seen to reflect the professionals who might be directly involved with a service user around the time a CTO is implemented, and is more generally reflective of a multidisciplinary team (MDT) in community mental health services.

Eight participants were recruited, the details of which are below. This number reflects the time constraints on the study. Guest et al. (2006), in their research on data saturation and variability, found that saturation occurred within the first twelve interviews, but that basic elements of their themes were present after six interviews. While recruiting more participants would have added to the current research, it is possible that theoretical saturation was beginning to be reached.

Participant	Gender	Profession	Age band
1	M	CPN (care coordinator)	35-44
2	F	OT (care coordinator)	25-34
3	M	Psychiatrist	25-34
4	F	CPN (care coordinator)	25-34
5	F	Consultant Psychiatrist	55-64
6	F	AMHP (social worker)	25-34
7	M	AMHP (social worker)	45-54
8	F	Consultant Psychiatrist	45-54

Table 1 – Participant demographics

2.6 Recruitment procedure

Participants were recruited using a ‘snowballing’ method, drawing on personal contacts within mental health services. I spoke to previous work colleagues and asked them to circulate the Participant Information Sheet (see Appendix 2) among people they thought might be interested within their teams. One participant was recruited through my supervisor. Participants 1 and 2 worked within the same team, as did Participants 3, 4 and 5. Participants 6, 7 and 8 all worked in different teams. The workplaces of the participants are within three different mental health Trusts in London. As grounded theory aims to develop a theory that is complete rather than being concerned with generalisability, this method of recruitment did not appear to pose major limitations.

When someone expressed interest in participating, they were asked to email me with a convenient time and place. All of the interviews were conducted face-to-face in the places of work of the participants, with managerial permission.

2.7 Interview schedule and data collection

I developed a semi-structured interview schedule (see Appendix 3) for the purpose of the current research. It was developed with the aim of exploring mental health clinicians' experiences of working with people subject to a CTO from a day-to-day, practical perspective as well as elucidating their personal beliefs about the legislation in terms of its clinical utility, its impact on mental health services generally and any ethical dilemmas faced. There were a few main questions and prompts, and I aimed to make questions open-ended to allow the interview to be tailored to individual participants.

When initially approached and again when confirming the interviews via email, participants were sent the participant information sheet. Prior to the interview, participants were given another opportunity to read the information sheet and asked if they had any questions. Participants were then asked to sign the consent form. Interviews were between 27 and 43 minutes long and were recorded on a digital recording device. The interviews were transcribed within a week of each interview using an adapted version of the transcription conventions described by Banister et al. (1994) (see Appendix 4 for summary of conventions). Any identifying information was removed.

2.8 Data analysis

Due to time constraints, I was only able to transcribe each interview before conducting the next. This allowed me to be familiar with the ideas expressed, thus influencing the questions asked in subsequent interviews, e.g. I asked Participants 7

and 8 about their criteria for deeming a CTO 'successful' based on comments made by Participant 6. This can be seen as an attempt to incorporate the principles of the full version of grounded theory as advocated by Charmaz (2006), however the process was inherently less thorough. The limitations of using this abbreviated method of grounded theory will be considered further in my Discussion.

The analysis started by reading sequentially through the transcripts in order to re-familiarise myself with the data. I recorded any ideas or reflections in memos. I aimed to adopt Charmaz's (2006, p.49) 'code for coding', which includes remaining open, staying close to the data, preserving action and keeping codes simple and precise. I used gerunds in the coding process where possible in order to preserve action and sequence, as recommended by Charmaz (2006). I started using line-by-line coding during the initial stage of analysis, which Willig (2008) considers particularly important in abbreviated versions of grounded theory. This involved developing short summaries of the ideas expressed in each line of the transcript in order to 'open up' the data (Charmaz, 2006) (see Appendix 5 for example).

I then moved on to focused coding (see Appendix 6 for example), which Charmaz (2006) describes as the second major phase in coding whereby larger quantities of data can be synthesized and explained. The most significant or frequent earlier codes were examined to determine their adequacy and whether they made the most analytic sense to form categories within the data. Relevant quotes were extracted. While focussed codes are descriptive and remain close to the data they can be thought of as low-level categories. As Tweed and Charmaz (2012) suggested that focused codes should integrate lower level codes into meaningful units, I attempted to construct focused codes that would transcend and thereby encompass individual descriptions and interviews.

Writing memos throughout the process of data collection and analysis helped me to remain reflexive as well as develop ideas. Charmaz (2006) highlighted the importance of memos in the creation of a grounded theory, assisting the researcher

in developing focused codes into categories, developing links between categories and comparing data at all levels of the coding process. She also suggested that they are a useful way of alerting the researcher to their own preconceived ideas. Memos may be regarded as the 'audit trail' of grounded theory, enabling the recording of the analysis as it happens (Tweed & Charmaz, 2012). Willig (2008) asserted that memos help justify analytic decisions and directions, including how coding evolves and how categories are integrated into a theory (see Appendix 7 for examples).

Charmaz (2006) proposed that following the development of preliminary categories, researchers should collect further data through the use of theoretical sampling which involves sampling new data in order to develop or refine the emerging grounded theory after tentative analytic categories have been created. Ideally this process continues until theoretical saturation is reached. This was not possible in the abbreviated version of grounded theory adopted due to time constraints. Instead I re-read the transcripts searching for exceptions to and examples and elaborations of categories.

2.9 Criteria for evaluating qualitative research

There has been extensive debate about whether and to what extent qualitative research can be evaluated. The criteria used to evaluate quantitative research, such as reliability, validity and generalisability cannot be meaningfully applied to qualitative research which is concerned with meaning in context (Willig, 2008). There has also been some debate about whether criteria should be specific to the research method or whether it is possible to have broad criteria for evaluating qualitative research more generally, resulting in a number of different sets of criteria being constructed (Spencer & Ritchie, 2012). Spencer and Ritchie (2012) have identified some recurring principles that underpin different conceptualisations of what is deemed quality research – these are the *contribution* of the research, the *credibility* it holds and the *rigour* of its conduct, which will be considered further here.

Contribution refers to the value of the research and the relevance it holds, whether this is to clinical practice, to theory or to the lives of individuals. It should aim to enhance existing understanding of the subject matter, whether this is by generating new hypotheses, identifying processes or developing analytic concepts (Spencer and Ritchie, 2012). Spencer and Ritchie (2012) summarise the debate about whether qualitative research can be deemed to have relevance beyond the participants or context of a particular study. One school of thought is that qualitative research can offer *inferential* generalisation from one setting to another (Lincoln & Guba, 1985), another is that it can provide *theoretical* generalisation by constructing analytical concepts that can be applied more widely (Strauss & Corbin, 1998), another is that it can provide *representational* generalisation where the findings can be inferred from the study population to the parent population from where it was chosen (Lewis & Ritchie, 2003). Another school of thought is that wider inference is not possible using qualitative research (e.g. Schwandt, 1997). This study explores clinicians' experiences when working with people subject to CTOs which may offer new insights into their working practices and, to some extent, generalisability to other clinicians, thereby holding wider clinical significance. This will be considered further in the Discussion chapter.

Credibility refers to the plausibility of the claims made by the research as well as how these claims have come to be made (Spencer & Ritchie, 2012). It is concerned with methodological validity and interpretive validity, the former referring to the rigour of the research process and the latter referring to how convincingly a claim is made and supported by evidence. Credibility may be demonstrated in ways such as including extracts of raw data and providing descriptive accounts of how data has been categorised (Spencer & Ritchie, 2012). This chapter has described the processes involved in carrying out this research, with examples of raw data and research decisions in the Appendices.

Rigour is synonymous with methodological validity, and is concerned with the appropriateness of research decisions, the dependability of evidence and whether

research has been conducted safely (Spencer & Ritchie, 2012). This includes researcher reflexivity whereby the researchers describe the research process and assess the impact of their own role, values and theoretical orientation on the research process (Spencer & Ritchie, 2012). It also includes the appropriateness of the methods used, how thoroughly the analysis was carried out, whether ethical issues have been sufficiently considered, and whether research decisions and reflections during the research process have been carefully documented. This chapter has described the decisions behind the methodology and data analysis, how ethical issues have been addressed, and has considered researcher reflexivity. The 'audit trail' of the research process is partially presented in the Appendices.

The issues of contribution, credibility and rigour will be discussed further in the Discussion chapter.

3. ANALYSIS

In this chapter I will outline the grounded theory model developed from the interview data, and provide descriptions of the categories with quotes from the participants to illustrate.

In addition to the model and explored later in this chapter are descriptions of some of the discursive devices used by clinicians to explain and justify their beliefs and actions relating to CTO use.

In order to provide further context, I will list the types of conditions talked about that clinicians have experienced as being part of a CTO:

- Compliance with psychiatric medication
- Attending appointments with their care coordinator and psychiatrist
- Living at a particular residence, e.g. supported accommodation
- Abstaining from illicit drugs

3.1 The factors influencing decision-making in the use of CTOs and the impact of these decisions: A grounded theory

This section outlines the constructed model (see Figure 1), which contains two core categories: 'Factors influencing decision-making in the use of a CTO' and 'Impact of decision-making'. The categories reflect the questions asked during the interviews and, therefore, my interest in how clinicians make decisions in relation to placing service users on CTOs, recalling them to hospital and renewing CTOs, and the impact that these decisions might have.

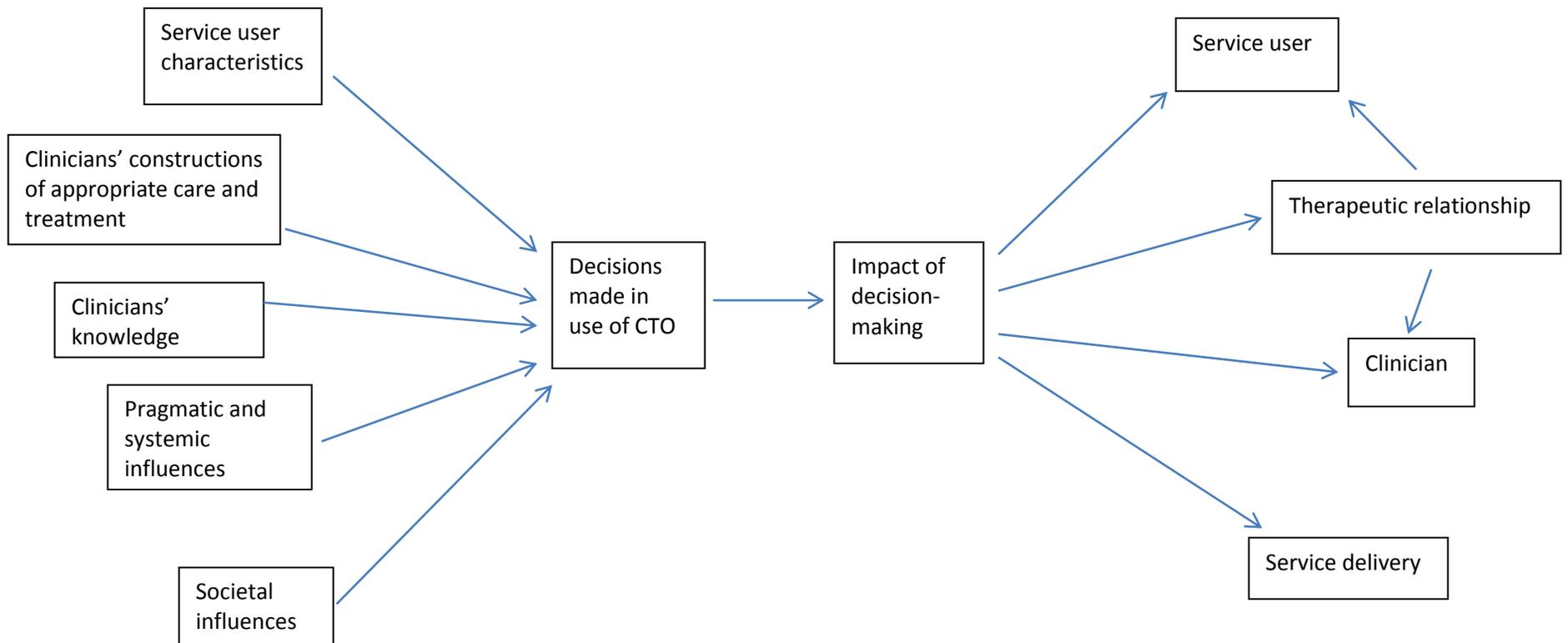
The two core categories 'Factors influencing decision-making in the use of a CTO' and 'Impact of decisions' are chronologically separate in that the former describes factors that exist prior to any decisions about a specific service user taking place, whereas the latter describes the consequences of the decisions made. However, the factors driving decision-making and impact of the decision-making processes are

actually more cyclical than can be demonstrated in the model. The categories described in the 'decision-making' core category influence the categories in the 'impact' core category independently of the actual decisions made about a particular service user with regards to a CTO, for example the service user's personal characteristics will influence how they view their mental health care irrespective of the details of their CTO. Similarly, the categories in the 'impact' core category may influence categories in the 'decision-making' core category, for example the impact of the CTO on a particular therapeutic relationship may influence a clinician's decision-making in future.

Figure 1: Grounded theory model – The factors influencing decision-making in the use of CTOs and the impact of these decisions

Category 1: Factors influencing decision-making

Category 2: Impact of decisions



Categories	Sub-categories	Focused codes
Factors influencing decision-making	Service user characteristics	<i>Social circumstances of service user</i>
	Clinicians' constructions of appropriate care and treatment	<i>Balancing care and coercion 'He wasn't taking medication' – medication as treatment</i>
	Clinicians' knowledge	<i>'Very little training' – the role of staff training</i>
	Pragmatic and systemic influences	<i>'Variations in practice' 'Pressure to discharge' – hospital bed shortages 'Cover your own back' – protective practice among clinicians</i>
	Societal influences	<i>Whose responsibility is it? 'Racism'</i>
Impact of decisions	Service user	<i>Mental health Response to CTO Feeling confused about the CTO Emotional impact Impact on notions of 'personal responsibility'</i>
	Therapeutic relationship	
	Clinician	<i>Becoming 'lazy' as a clinician</i>
	Service delivery	<i>Disjointed care Improving services? 'Whip him in again quickly'</i>

Table 2 – Categories, sub-categories and focused codes

3.2 Category 1: Factors influencing decision-making in the use of a CTO

This category describes participants' explanatory frameworks for why certain service users are placed on CTOs, reflecting on the different factors they describe as influencing the decision-making process. These factors can broadly be described as 'Service user characteristics', 'Clinicians' constructions of appropriate care and treatment', 'Clinicians' knowledge', 'Pragmatic and systemic influences' and 'Societal influences', which have become subcategories and all of which were developed using data from two or more interviews (underlined titles). Some subcategories are further broken down using focused codes (italicised titles). Subcategories and focused codes are summarised and illustrated using extracts from participants' interviews. Extracts are labelled by Participant Number and their profession in order to provide context for their quotes. Text written in bold print indicates my speech.

3.2.1 Service user characteristics

There were a number of service user characteristics that were consistently highlighted as making the use of a CTO more likely. Most participants made reference to multiple hospital admissions as a reason to consider a CTO, e.g. "the number of admissions to hospital, so the revolving door nature of the illness" (P5, Consultant Psychiatrist). Non-compliance with prescribed psychiatric medication was highlighted as a significant factor by all participants:

P4 (care coordinator): ... he's agreed to oral [medication] but we are very concerned about his compliance

P5 (Consultant Psychiatrist): ...And then there's obviously the big issue of compliance with medication

The use of illicit drugs was highlighted by Participant 2 (care coordinator) and Participant 6 (AMHP) as a factor in someone's mental health deteriorating and, thus, deciding to use a CTO:

P6 (AMHP): ... so he would become unwell very quickly from smoking cannabis usually, even when taking medication...

Participants 3 (Psychiatrist) and Participant 5 (Consultant Psychiatrist) raised psychiatric diagnosis as important:

P5 (Consultant Psychiatrist): ...it's probably mostly schizophrenia or schizophrenic type illnesses...

Being considered a risk to others was a consistent reason cited for placing a service user on CTO, even among participants who were more critical of their use generally:

P6 (AMHP): the real revolving door high risk service users ... and the kind of more forensic-type service users, more when it's a risk to other people I think it can be suitable and appropriate

Some participants talked about CTOs being useful for service who might be considered 'vulnerable', i.e. a risk to themselves such as through self-neglect, but without posing a risk to others. When asked who CTOs might be useful for, Participant 1 (care coordinator) highlighted people who

"don't hurt themselves, they don't cause too much distress, they just sort of bumble along in a confused state".

He went on to explain:

P1 (care coordinator): ... maybe certain clients wouldn't end up being placed on CTOs because they're not coming to the attention of emergency services or their risk behaviour is not deemed to be that high. Obviously I think that's a shame if it means they're not actually progressing...

P4 (care coordinator): ...when he relapses it's more about vulnerability (.) because he starts behaving quite bizarrely, taking off his clothes in public, barking like a dog, just really bizarre behaviour

Some participants reported that they do not support the use of CTOs for people who do not seem to pose a threat to others:

P6 (AMHP): ...I don't think that you need to have the power of recall just for self-neglect, I think that could be a Mental Health Act assessment could be arranged around that unless somebody is at death's door I don't think that's appropriate to recall them if they don't look after themselves well

P8 (Consultant Psychiatrist): ...I think people should be able to do things that mean that they end up back in hospital, especially if y'know they're not harming anyone...

The perceived presence or absence of 'insight' was highlighted by many participants, providing justification for a CTO and in explaining when someone might be ready to be discharged from a CTO:

P1 (care coordinator): ... with psychosis often comes a lack of insight and awareness into their illness, their behaviour, the consequences of being unwell because they don't think they are

P2 (care coordinator): ... [the CTO is] hopefully just for a short term to keep that person well and while they're well to help develop their insight

P5 (Consultant Psychiatrist): ... if they had good insight and capacity obviously you would take them off [the CTO]

Some participants described characteristics that seemed to make a CTO more effective, which included responding well to boundaries and a tendency to acquiesce:

P1 (care coordinator): ...he thinks very black-and-white and so although I think CTOs wouldn't work for some people who are just "I don't care do what you like I'm not going to take this treatment or adhere to these conditions" he was actually somebody who seemed to respond to having those conditions in place even though he doesn't necessarily agree or wasn't that happy

P4 (care coordinator): ...I find that he responds better to boundaries and conditions being in place for him

P7 (AMHP): ...I think the general profile is someone who you think at some level is likely to go along with it but there may be some doubts, I suppose the sort of person who is acquiescent to treatment rather than completely fully on board with it, if someone was completely insightful, completely.. on every aspect of their treatment it would seem I think quite difficult to justify putting them on a Community Treatment Order

Social circumstances of service user

Participant 6 (AMHP) said that if a service user lacks a supportive network of friends or family who might voice their concerns about a deterioration in mental health, a CTO might be seen as providing a safeguard:

P6 (AMHP): ...if somebody gets unwell and then there's nobody that can help get them into hospital or be in contact it's a way of getting hold of them and getting them in...

But she also said that this makes a service user more vulnerable to being placed on a CTO for inappropriate reasons:

P6 (AMHP): ...the people that are more subject to CTOs have less of the, have less of the safeguards of the role of Nearest Relative or people advocating for them if they don't have families or support then who do they have saying "hang on a minute that is completely unacceptable, you know that's not appropriate for the person"

Service user characteristics were talked about as an important aspect of decision-making throughout all of the interviews. How these compare to other research findings of the 'typical' CTO service user will be discussed further in the Discussion chapter.

3.2.2 Clinicians' constructions of appropriate care and treatment

Clinicians' descriptions of their own personal beliefs about when it is ethical to intervene and what constitutes appropriate treatment appeared to have an influence on their decision-making regarding CTOs.

3.2.2.1 Balancing care and coercion

Ethical dilemmas were discussed both spontaneously and in response to specific questions, with varying ideas about how to balance care with coercion. Participants 1 and 2 in particular talked about the importance of providing care to people they felt needed it outweighed the service users' right to refuse contact with mental health services:

P1 (care coordinator): ...the reason I think I'm a real advocate for [CTOs] generally isn't because I like restricting people, it's that I genuinely feel that that it's the only way to go in terms of treating them assertively not just with medication but I guess forcing them at some level to engage with services and to talk to people

P1 (care coordinator): ...people would argue it's taking away people's basic human rights (.) I suppose I've been programmed to see the importance of following people up to try and improve their quality of life really

P2 (care coordinator): ... it's helping the more vulnerable people from getting more vulnerable when they're unwell

Different clinicians seemed to hold an idiosyncratic position of where the right balance between coercion and care sits. Participant 4 (care coordinator) said that she would not want to use a CTO for everybody because "it takes a person's rights away" and she highlighted the tension between "the recovery model versus the CTO and the mental health act", a dilemma that she portrayed as on-going.

Participant 6 (AMHP) described her initial reaction to the introduction of CTOs as thinking it was "a really sad further extension of social control", a belief which she said has been confirmed by observing and experiencing the legislation in practice. She proposed that care coordinators have stressful jobs which may limit their ability to see the ethically problematic aspects:

P6 (AMHP): ...people whose stressful daily care-coordinating lives might see it as a good opportunity, might have less of the options for thinking about the negative side of things

Participant 8 (Consultant Psychiatrist) described similar concerns about whether CTO use can be considered ethical, stating that "their convenience has obscured their ethical, their very worrying ethical implications". She stated that the legislation is surreptitiously being used as a form of social control:

P8 (Consultant Psychiatrist): ...we are using this health legislation actually as y'know social control legislation, actually as a way of containing risk but we're not doing it explicitly

Participant 5 (Consultant Psychiatrist) reported having few misgivings about their use on ethical grounds generally and stated that dilemmas can be minimised by being collaborative with the service user:

P5 (Consultant Psychiatrist): ...I suppose the only ethical dilemma you might experience is about the patient's will and where do you place that in the hierarchy of the decision making. And I as far as possible will incorporate that into the decision making

It is difficult to elucidate what influences a clinician's standpoint in relation to ethical issues regarding CTO use. It is likely to be influenced by their professional background, experiences in mental health, political position generally, and is also likely to be fluid rather than fixed.

3.2.2.2 *'He wasn't taking medication' – medication as treatment*

The belief that psychiatric medication constitutes appropriate and effective treatment for service users appears to be implicit and assumed in most of the interviews, which is very much reflective of the dominant medical discourse in mental health professions, for example:

P2 (care coordinator): ... the medication [non-]compliance with my guys links into their quick deterioration and high vulnerability

P4 (care coordinator): ...he told me he wasn't taking medication and shortly after that he had a major relapse

P5 (Consultant Psychiatrist): ...it is better to keep the patient well for as long as possible [...] and get them treated quickly to prevent the kind of cognitive decline that you get

Participant 8 was the only participant to explicitly reject the view that psychiatric medication constitutes treatment of mental health difficulties:

P8 (Consultant Psychiatrist): ...I think [CTOs are] premised on the idea that drug treatment solves the problem, that drug treatment makes people better, erm when of course we know that it doesn't, what it's doing is just suppressing people and just replacing the schizophrenia with a drugged down zombified state

P8: ...if people are very disturbed and you give them some drugs and they get better and they say "oh thank goodness, these have made me better, I'll carry on taking them", that's treatment. But if they get better and they say "these are absolutely awful, I'd rather be mad" it's not treatment is it

She stated that not taking medication outside of hospital should be deemed an acceptable choice:

P8: ...To make a choice that you'd rather live an undrugged life and have relapses it seems to me is a perfectly rational choice

When a clinician holds the belief that medication is directly responsible for someone's 'wellness' and that a CTO might increase someone's medication compliance, it becomes clearer why they might see a CTO as a valuable clinical tool.

The issue of whether medication can be considered treatment will be explored further in the Discussion chapter.

3.2.3 Clinicians' knowledge

A clinician's knowledge of the legislation appears to have an impact on their decision-making.

When asked about the implementation process and the amount of training staff received on CTOs, Participant 5 (Consultant Psychiatrist) said there had been "some training at the beginning" and that it was "adequate" whereas most participants said that training had been insufficient, and linked this to difficulties both ethically and practically:

P2 (care coordinator): ...I think sometimes the doctors who write them don't seem to understand them particularly well, I've had that experience before, and then the recall has been murky

P4 (care coordinator): ...there is no formal training for people using the CTOs do you know what I mean, it's just 'okay, read a few lines' and that's it and people think they've got the hang of it and but it's y'know you're impacting on someone's life so it's important to get the right training for it, I think it should be mandatory before it's used

P6 (AMHP): ...I don't think that even some Consultants and certainly not a lot of care coordinators are able to explain what a CTO is, I know it's the responsibility of the hospital as well to provide information but I would question the knowledge of the nurses

P7 (AMHP): ...doctors - variable, I think some are pretty good, some maybe aren't quite as clued up as us, but I think generally now everybody's pretty much there, it was a bit shaky at the start but I think it's generally ok now

Participant 6 (AMHP) said that lack of training also contributes to tribunal panels suggesting CTOs when they are not necessary, leading the clinician to having to justify why they are not using one:

P6 (AMHP): ...and I hope that tribunals can get a bit more training on when they're appropriate so they stop suggesting them

The limited training could explain some of the confusion that appears to exist about when it is appropriate to recall someone. Participant 4 (care coordinator) said she believed professionals were vulnerable to litigation if they did not prevent a person's mental health relapse by recalling them to hospital:

P4 (care coordinator): ...He's doing quite well but he's not taking the medication and because that's one of the conditions of the CTO we have to recall [...] **<I thought that you can't recall someone just on the basis of them not taking their medication, that they have to become unwell>**
Umm Dr. X is under the impression that he can, we can be sued if we don't prevent his relapse, y'know so technically we have to prevent the relapse...

Some participants said that it is lawful to recall someone if they do not adhere to the conditions set in the CTO, such as medication compliance, even if there is no accompanying mental deterioration:

P8 (Consultant Psychiatrist): ...it is like an ASBO, if you don't abide by your conditions you can be recalled, it might be deemed to be better practice to wait until someone's deteriorating but it's not, the letter of the law is that someone can be recalled

I asked Participant 6 (AMHP) where this confusion might come from, which she attributed to lack of training:

P6 (AMHP): ...people think that because it's a Community Treatment Order that you have to have your treatment in the community and if you don't you go back into hospital but that's because there's lack of training about the fact that it also has to be that they meet the criteria in that there's evidence of deterioration in their mental state and that there's a need for them to be recalled to hospital and not just because they missed medication

Another issue related to the paucity of training is what types of conditions are typically written into a CTO and how they are written. Participant 6 (AMHP) stated that conditions need to be precise, realistic and as unrestrictive to people's lives as possible:

P6 (AMHP): ...the amount of times that I've had to sit down and explain that in a court of law if you want to say that somebody has breached their conditions you need to be clear about what the condition is and that's a big thing for the doctors, not realising that the conditions have to have a real logic that's about ensuring medical treatment and managing risk, that they have to be as less restrictive as possible. When doctors put in there not to smoke cannabis for people who have no intention of stopping you have to sit down and think 'well, you know, what else? To have three nutritional meals a day or be in bed by nine o'clock', some ridiculous things that people are not going to stick to that might be logically good for their mental health but they are completely inappropriate

Participant 8 (Consultant Psychiatrist) similarly stated that some of the conditions she has witnessed around substance misuse are "pretty ridiculous" and "not enforceable".

The limited amount of compulsory training staff receive prior to using a CTO is a surprising finding and will be discussed further in the Discussion chapter.

3.2.4 Pragmatic and systemic influences

Participants described wider influences within mental health services that influence decision-making around CTOs.

3.2.4.1 *'Variations in practice'*

One factor that was described as influencing decision-making is divergent opinions both within and between services that lead to differences in how individuals and teams might respond to a particular set of clinical circumstances:

P2 (care coordinator): ...there are some people in the team who are very much against them and don't think they are effective so I think there is variability

P3 (Psychiatrist): ...I've seen a bit of variation in practice, some people have a very low threshold for if someone misses a depot one time, a few times, they get recalled and other times you see that the team has been very reluctant to do it and things have gone round in circles for a while

Participant 6 (AMHP) highlighted that the power held by different people in a team affects how much weight their opinion has on decisions:

P6 (AMHP): ...these are hierarchical medical teams nowadays where you don't argue with the doctor or you wouldn't give an opposing view [...] the way that the doctors are now more involved in management means that people would just go along with it so there was far less questioning of their appropriateness

There may also be differences of opinion between the inpatient and community team, with the inpatient Consultant ultimately making the decision:

P2 (care coordinator): ...we've within our team we've had the idea that this person would benefit from a CTO and the inpatient Consultant has discharged them and not to put them on a CTO [...] and that can cause some frustrations really

Participant 8 (Consultant Psychiatrist) also talked about negotiating differences of opinion with the inpatient Consultant:

P8 (Consultant Psychiatrist): ...usually it's actually the inpatient Consultant who initiates the Order on my behalf which is quite bizarre that it can work like that [...] I usually raise objections and sometimes erm it's decided that it's not necessary, occasionally I've got into quite big arguments with inpatient Consultants about it

The variability in practice reflects the fact that using a CTO, alongside many decisions in mental health practice generally, are led by clinical judgment and guidelines rather than prescriptive rules, allowing a great deal of scope for interpretation between individuals and within teams.

3.2.4.2 *'Pressure to discharge' – hospital bed shortages*

Participants also raised pragmatic issues that make it more likely for a service user to be placed on a CTO. One factor raised was the pressure on hospital beds, making it likely that inpatient Consultants discharge service users earlier than they would prefer to knowing that they can recall them if necessary:

P5 (Consultant Psychiatrist): ...because of the changes in health care systems which means that patients are discharged much earlier than they would have been in the past I think that the CTO is being used as a degree of containment in the community, and also because of the short stays in hospital the patient is less likely to be completely well when they are discharged so

they are more likely to relapse, leading to the revolving door patient in the first place

It is suggested that use a CTO makes it easier to discharge someone from hospital:

P8 (Consultant Psychiatrist): ...Inpatient Consultants are at the moment under great pressure to discharge people and it is definitely easier for them to discharge people on a Community Treatment Order

Reducing the time service users spend in hospital through use of a CTO is often portrayed as being primarily for the benefit of the service user themselves, however there are also financial incentives to discharging people from hospital sooner which clinicians, particularly inpatient Consultants, are having to be very mindful of.

3.2.4.3 *'Cover your own back' – protective practice among clinicians*

The issue of risk management was pertinent throughout the interviews, which was talked about with reference to protecting the service user themselves and the people around them, but there was also a sense that clinicians need to be seen to be managing risk appropriately for their own professional standing. Participants talked about CTOs being part of the repertoire of things a clinician might use to show that they are doing their job correctly:

P2 (care coordinator): ...there's the sense of 'cover your own back' which sounds terrible but you document everything...

P3 (Psychiatrist): ...I've seen people practice according to errrr whatever poses the least risk and are extremely risk averse and perhaps that might cause [staff] to be very keen to go on to a CTO

P4 (care coordinator): ...I think it's about people protecting their own backs and making sure again to be seen doing the right things than it is about the client

P6 (AMHP): ...somebody being on a CTO reduces teams' anxieties

P6 (AMHP): ...so I think it's about the risk averse culture and I think it's about people (.) protective practice or perhaps even defensive practice

P 7 (AMHP): ...I suppose from a Responsible Clinician's point of view the temptation would be to put them on a Community Treatment Order, at least if something goes wrong to avoid the question 'did you consider putting them on a Community Treatment Order?'

Participant 8 stated that their mere existence compels clinicians to use them, which is further reinforced by other clinicians regularly implementing them:

P8 (Consultant Psychiatrist): ...now that CTOs exist, it's very difficult not to use them, y'know now they exist you have to use them to protect yourself because if you weren't using them you would be criticised

P8 (Consultant Psychiatrist): ... you become vulnerable as a professional, you become I think more vulnerable to accusations of medical negligence if you're not using this legislation and especially if everyone else is using it

Participant 6 said that it becomes even more difficult when tribunals suggest the use of a CTO, leaving a clinician having to defend their decision not to:

P6 (AMHP): ...tribunals suggesting it for people and then you have to explain why you haven't done it when it shouldn't be that you explain why you haven't

done it you should have to really strongly justify why you do extend that control into people's daily lives

Participant 1 extended this concern about being criticised more widely to the media and gave an example of when a service user he care coordinated went missing with the service user's young niece, causing great concern amongst the family:

P1 (care coordinator): ...situations get blown out of proportion by the media and you know there's no doubt fears (.) certainly I'd been in a situation not that long ago where ..[describes incident].. my thought was 'shit this is going to be on the front page of the newspaper'

But some clinicians, while acknowledging risk management for the sake of the professional, nevertheless talked about placing greater emphasis on care for the service user:

P1 (care coordinator): ...clearly there is an element of covering your own arse but hopefully it's thinking about other people's safety not just your registration, it's about the client ultimately

P3 (Psychiatrist) ...so I would say it is mainly for the patient, mainly for the patient's benefit really rather than it just being about risk aversion because there are plenty, plenty, plenty of risky patients in the community that are being managed with a lot of input without being on a CTO

P5 (Consultant Psychiatrist): ...I don't think that I ever put a patient on CTO necessarily to manage risk all for my own erm (.) benefit

Participant 2 (care coordinator) described risk management as the “crux of everything we do”, and it seems the risks considered are not only in relation to harm to the service user themselves or people around them, but also in relation to the

clinician in terms their professional role. This is linked with wider discourses about who is responsible when a mental health service user behaves in a 'risky' way, which is considered further below.

3.2.5 Societal influences

Wider societal influences on decision-making around CTOs were also described by some participants.

3.2.5.1 Whose responsibility is it?

Participants 6 and 8 highlighted the wider issue of controlling those deemed to be dangerous, and who is responsible when things go wrong:

P6 (AMHP): ...it's about the fact that when things do go wrong in mental health those who are held up as responsible are usually not the individual or their partner or family or friends or their communities, it's the mental health professionals who are involved

P8 (Consultant Psychiatrist): ...[CTOs are] there to protect the public, undoubtedly that is their ultimate aim <yeah> it's to control anti-social elements

They indicated that being held responsible for somebody else's behaviour might make it more likely for clinicians to err on the side of caution and initiate a CTO.

3.2.5.2 'Racism'

Participant 6 was the only participant to highlight the disproportionate numbers of black males on CTO, saying this is due to racism and stereotyping:

P6 (AMHP): ...we know stereotypes around black males in particular presenting a risk, I think that's partly why there's more black males who are subject of CTOs in my experience [...] I think statistically there's more males

than females and that there's a higher proportion of black people than other groups and I do think that's totally about racism and stereotypes about men and about black people

This issue will be explored further in the Discussion chapter.

3.3 Category 2: Impact of decision-making

This category describes the impact of the decisions made regarding CTO use. The outcomes participants talked about have been subcategorised into 'Impact on service user', 'Impact on therapeutic relationship', 'Impact on clinician', and 'Impact on service delivery'.

3.3.1 Impact on service user

3.3.1.1 Mental health

Some participants described the CTO as having a positive influence on a service user's mental health. Participants 1 and 2 in particular seemed to suggest that a CTO provides a framework within which a service user's mental health might improve by providing stability and an opportunity to increase their insight:

P1 (care coordinator): ...I think the longer someone is on one (.) we're able to see improvements in their mental health, their social functioning, their well-being and their progress

P2 (care coordinator): ...I would hope that over time they would (.) see a connection between not taking medication, getting unwell, going into hospital

A CTO is described as having a direct positive impact on a person's well-being and understanding of their own difficulties.

3.3.1.2 *Response to CTO*

Participants described a wide variety of service user responses to being placed on a CTO:

P3 (Psychiatrist): ...Some welcomed it, a few didn't like it, the majority seemed to be pretty ambivalent about it

Some service users are described as welcoming the CTO, and as agreeing to it as a means of getting out of hospital sooner, while some are described as accepting it despite not completely agreeing with it:

P2 (care coordinator): ...He's a bit bemused to be honest [laughs] because he is just, I think he's just doing it to humour us really, I mean I don't think he acknowledges (.) the seriousness of his condition

Participants described some service users as seeing their CTO as a form of protection or 'safety net' if their mental health started to deteriorate:

P3 (Psychiatrist): ...a few people felt a degree of protection about it knowing that if they did relapse and if their own insight was impaired that there was an extra safeguard that would hopefully be able to get them treated earlier

P7 (AMHP): ...I think [he] in some ways welcomed it, it made everything feel a little bit safer with that element of containment

Participant 7 described most service users he works with in forensics as not minding being placed on a CTO and believes this is due to the greater restrictions that have been placed on them previously:

P7 (AMHP): ...within the forensic setting erm, generally not too negatively. I think it's probably because of the context that most of the other people on the

ward are already on 37/41s so in a sense being on a CTO is a lesser restriction

Some service users, on the other hand, are described as being ambivalent towards or disagreeing with the CTO:

P2 (care coordinator): ...But I have said to him I think it's a good idea and he'll sit there and tolerate that and listen and say "okay fair enough", on things like that we've agreed to disagree

P3 (Psychiatrist): ...I think a lot of patients saw [the CTO] as a [...] symbol of their reliance on services and the fact that they are never going to escape them

Participant 3 then went on to attribute a service user not wanting to have contact with mental health services to a "lack of insight into their illness". This appears to be a common explanation for a service user's disengagement from services or non-compliance with psychiatric medication, which will be discussed further in the Discussion chapter.

3.3.1.3 *Feeling confused about the CTO*

A number of participants questioned whether service users fully understand what a CTO means for them in terms of specific conditions as well as overall implications:

P1 (care coordinator): ...when you talk about discharged from hospital the word 'discharge' suggests they are discharged from everything so I think there has been confusion

P6 (AMHP): ...somebody at some point hasn't explained that even if you stick with all the conditions if there are concerns about your mental health or risk then you can be recalled and that's been a frequent issue is that people on

CTOs seem to think it's kind of a set of rules that if you stick to you don't have to go into hospital but that's not the case, you can be recalled if there are any concerns about your mental health deterioration or risk even if you stuck to them...

This confusion is both attributed to the service user's mental health and to the lack of appropriate information provided. Participant 4 (care coordinator) said that the process of explaining a CTO to a service user should be formalised further in order to check their understanding:

P4 (care coordinator): ...anyone that's placing the client on a CTO [...] should have sat with the person and explained it to them and the person signs something to say they've understood their rights, yeah

Participant 5 said that service users demonstrate their understanding by disengaging with services or by challenging the CTO through tribunals:

P5 (Consultant Psychiatrist): ...Well I think they must [understand] because they've gone for tribunals and they've gone for running away so I think they must do at some level understand it

The ethical implications of service users not fully understanding their CTOs will be discussed further in the Discussion chapter.

3.3.1.4 *Emotional impact*

Some participants speculated about the emotional impact being on a CTO might have on someone, although Participant 2 admitted that she had not given it a great deal of thought:

P1 (care coordinator): ...I completely understand that erm that people feel disempowered

P2 (care coordinator): ...it's interesting to be asked what do your clients think about it because I guess I hadn't really given that much consideration before and I should probably spend a bit more time talking to them about it

Participant 8 expressed concern about a lack of consideration by mental health professionals and society generally of what it might feel like for someone to be placed on a CTO:

P8 (Consultant Psychiatrist): ...I think we as in health professionals and also as in society have not really thought through how absolutely dreadful it must be to have recovered from an episode of illness and find that your life is still controlled, that you are not able to make choices about what substances go into your body

P8 (Consultant Psychiatrist): ...The sort of people who are happy with them are the sort of people who have generally been in services for a long time, I really worry about the younger people who are increasingly getting put on them for whom it must just be such a frightening experience

She suggested that the emotional impact of being placed on a CTO is not given enough weight when making the decisions.

3.3.1.5 *Impact on notions of 'personal responsibility'*

Participants 4, 6 and 8 talked about the impact a CTO might have on a person's beliefs about their own personal responsibility:

P4 (care coordinator): ...it feels like we're going back in the asylum days and giving patients less control of their own illnesses and they have less autonomy in the community

P6 (AMHP): ...you come with a coercive stance within the first three years then I think you can ruin people's attitudes towards mental health services and their ideas around choice and personal responsibility

P8 (Consultant Psychiatrist): ...I think you can argue (.) that it takes responsibility away from them, instead of actually saying 'no you shouldn't behave like that' we're saying 'ok this is part of your illness'

They seem to be saying that service users should hold responsibility for their own decisions whether those decisions might be deemed positive or ill-advised.

3.3.2 Impact on therapeutic relationship

The impact of the CTO on the relationship between the service user and mental health services is a pertinent issue.

Participants 3 and 4 said that service users might engage with services more if on a CTO but that this was perhaps at a more superficial level than if there were no compulsion:

P3 (Psychiatrist): ...certainly the presence of the CTO and the knowledge that they could be recalled was enough to compel people to engage with the team and accept medication

P4 (care coordinator): ...you feel like people are forced to come and do it, do you know what I mean, it's not, 'ok they're gaining anything out of any therapy that you're doing with them', it's just they're forced to come and engage

Some participants expressed concerns about the negative impact a CTO might have on their therapeutic relationship with a service user:

P4 (care coordinator): ...it changes my role in a way where I think previously I had a really good relationship with him but now he sees me as a person who's going to take him back into hospital

P8 (Consultant Psychiatrist): ...People who I've previously had a good relationship with, I've felt that there are risk issues that I've needed to accept the suggestion that they go a CTO, and I've found it difficult to re-establish a good relationship with them in that situation <In what way?> Well they don't trust you anymore

Participant 3 talked about using the CTO to keep the inpatient and community staff separate in the service users' mind in order to preserve the therapeutic relationship between the service user and community team:

P3 (Psychiatrist): ...when I worked in inpatient we were happy to be the bad guys in order to I suppose we were maintaining the false dichotomy in the patient's mind that we were the medicators and the community team had a more balanced view when in actual fact we usually acted in agreement

Some participants, however, said that it is possible to maintain a positive therapeutic relationship in spite of the CTO:

P1 (care coordinator): ...from my point of view, I haven't felt like it's made the relationship worse I think it's given as I said before hopefully a period of stability for the person's mental health which y'know then you can build on in terms of having a hopefully more meaningful relationship working together

P8 (Consultant Psychiatrist): ...I think there are ways around it and there are ways of people having good therapeutic relationships and continuing that on a CTO

Participant 5 said it is possible to maintain a positive therapeutic relationship and described how she achieves this:

P5 (Consultant Psychiatrist): ...sometimes I might say to a patient “well lets meet halfway”. I try very hard to be collaborative

She seemed to suggest that a central aspect of maintaining the therapeutic relationship is to respond appropriately to the service user’s concerns, e.g. regarding medication dose.

3.3.3 Impact on clinician

Participants talked about the influence that CTOs have on clinical practice, and some talked about the impact CTOs have on themselves. Participant 4 talked about the CTO affecting her view of herself as a clinician:

P4 (care coordinator): ...you do feel like a prison guard with a key as in y’know “come on, you behave” or a teacher

3.3.3.1 Becoming ‘lazy’ as a clinician

Some clinicians expressed concerns that CTOs might be used as a substitute for therapeutic skills:

P4 (care coordinator): ...if you have for example a caseload of 23 people and you have 10 clients on a CTO then you are not really doing, you're not really doing the leg work, all the clients are coming to you because they have to, d’you know what I mean, so I think I've found that a lot of professionals did, have abused the CTO

P5 (Consultant Psychiatrist): ...[some clinicians] will see it as a tool to manage risk, they will see it as a tool to manage poor compliance, it was seen as a tool to manage their non-engagement

P6 (AMHP): ...I think you can become lazy with a CTO ... you might be more inclined to focus your therapeutic skills on other people who aren't on a CTO

They portrayed CTOs as having the potential to become a shortcut in encouraging service users to engage with mental health services.

3.3.4 Impact on service delivery

3.3.4.1 Disjointed care

Participant 5 (Consultant Psychiatrist) highlighted the difficulty of the CTO being implemented by the inpatient Consultant, while it is the community team who are then responsible for the person's care:

P5 (Consultant Psychiatrist): ... there is the thing that the CTO, it is a different Consultant who usually puts the patient on a CTO to the Consultant who looks after the patient in the community which is often confusing (.) it is a little bit disjointed

3.3.4.2 Improving services?

Participant 7 said that a CTO can improve the experience for a service user in that it provides an added safeguard for mental health services to provide a good service:

P7 (AMHP): ...I suppose there's an element that it places an obligation on the treating team as well, for that person, to keep that person, providing intensity of support for that person

P7 (AMHP): ...it's a bit of a two-way process – these are the expectations we'd have on you in the community and we think these things would be useful to keep you well and also it provides some obligation on us to continue to provide the service and to keep that support open for you

But Participant 6 said that a CTO can effectively force someone into receiving a service which does not correspond with their worldview, either for personal or cultural reasons:

P6 (AMHP): ...what if you have a really annoying care coordinator? What if they don't understand either your culture or your attitude to mental health or your experiences?

P6 (AMHP): ...if you have all white workers or if you have a team that's based on an Anglo-centric model of how mental health care is with a Western ethology around mental health, that's not inclusive

3.3.4.3 *'Whip him in again quickly'*

Some participants highlighted that a CTO makes some of the processes of bringing someone into hospital easier, for example Participant 2 (care coordinator) said that a CTO was introduced to enable the team to “whip [the service user] in again quickly” as soon as there were suspicions of a deterioration. This was also reported by Participant 4:

P4 (care coordinator): ...I think it's smoother, the transition between community and inpatient because I think prior to that it was very difficult to get someone who was really unwell into hospital

Participant 6 (AMPH) agreed that recalling someone on a CTO is easier than arranging a Mental Health Act Assessment, however she said that the difficulties in the process should be addressed rather than using a CTO almost as a shortcut:

P6 (AMHP): ...[a Mental Health Act assessment is] an arduous process yes but then the focus should be done sorting out the process and not making this

new law where you can have one doctor recall the person to hospital because they haven't been seen and they are a bit worried and they haven't been able to assess them so yes I would agree that [CTOs] are helpful when the process of arranging a Mental Health Act assessment is arduous but the reason why it's arduous is because there's not enough money, there are not enough people, the systems are inept...

There are other practical processes which appear to be made easier by having a CTO in place, which may increase staff motivations about using them. For example, Participant 4 highlighted that a CTO allows the police to do a welfare check of someone at their home if services are concerned about them, while Participant 7 stated that one "incentive" for using a CTO relates to the "complexities of section 117 aftercare" funding if a service user is placed outside of their original borough.

4. DISCUSSION

This chapter will discuss the analysis in relation to the research questions and previous literature. The quality of the research and limitations will be described. The implications of the present study will be explored, both in terms of further research and utility for clinical practice.

4.1 Research questions

4.1.1 How do mental health clinicians talk about negotiating their work with service users subject to a CTO?

How mental health clinicians talk about negotiating their work with service users subject to a CTO appears to be influenced by personal beliefs, interpersonal factors with the service user themselves as well as wider systemic issues.

In negotiating the experience of working with someone subject to a CTO, clinicians appeared to be informed by their own ethical standpoint, with their stated beliefs around the balance between care and coercion clearly woven throughout their narratives. Some participants seemed to suggest that it is their duty to intervene when someone is deemed to be mentally ill, even if that person is not harming anyone else. This is reflective of a wider discourse of the providing care within health professions and of a caring society generally, for example O'Reilly (2006) states that "most of us believe that a caring society has a responsibility to look after individuals who are unable to care for themselves" (p686). On the other hand, some participants said that service users should be allowed to behave in a way that might not be deemed wise by others, even if that means they are at some point readmitted to hospital. Participants 6 (AMHP) and 8 (Consultant Psychiatrist) said they believed CTOs were being used as a form of social control. This reflects Mclvor's (1998) concerns about the implications of CTOs for civil liberties and about the potential for CTOs to be used as an 'easy option' to control difficult behaviour or people unwilling to comply with treatment plans. Geller et al. (2006) argued that society requires coercion in order to ensure people adhere to laws and social norms with the aim of

maintaining social order but Foucault (1995) questioned whether it is acceptable that health professionals are given powers which allows them to determine what should be considered 'normal' or 'deviant'.

Participants described having to renegotiate their relationships with service users in the context of the CTO and a process of balancing their own beliefs with the views of the service user to reach decisions that were deemed acceptable to both parties. Some described the CTO as changing the dynamics of the relationship, for example Participant 4 (care coordinator) said it made her feel like a "prison guard" or "teacher" and Participant 8 (Consultant Psychiatrist) said that a CTO has made it difficult to re-establish a good therapeutic relationship because the service user can lose trust in the clinician. Other participants, however, said that a CTO did not necessarily have to change the therapeutic relationship and some said it had a positive influence as it provided a structured framework and time in which to build a relationship. Despite the fundamentally coercive nature of the legislation, some participants still talked about being 'collaborative' as far as possible (e.g. P5, Consultant Psychiatrist) in order to reconcile the differences of opinion between clinician and service user, while Participants 1 and 2 (care coordinators) talked about 'agreeing to disagree' with service users who did not think they needed to be on a CTO, almost giving the impression of an equal relationship. This, however, might be seen as somewhat tokenistic given the inherent power imbalance between service users and professionals, where professionals might consider the service user's views, but not be led by them.

Participants also described having to negotiate wider systemic influences in the process of working with someone subject to a CTO. They talked about the influence of the varying opinions of other professionals both between and within teams, and the impact that this has on decisions around a CTO: whether one should be implemented, whether someone should be recalled and whether someone should be discharged from their CTO altogether. Participant 6 (AMHP) highlighted the hierarchical nature of MDTs, with psychiatrists being more involved in management.

This is an issue if a clinician disagrees with the views of the RC but, due to the team dynamics, finds it difficult to voice their opinion. O'Reilly (2004) suggested that differences of opinion reflect different philosophical perspectives of individuals and groups who share a common concern for the well-being of those experiencing mental health difficulties, however it tends to be the most powerful whose opinions carry the most weight.

In the interviews some participants appeared to minimise or justify using CTOs, which they did in a number of ways. Participant 1 (care coordinator) constructed the use of CTOs as assertive treatment rather than being a fundamental deprivation of someone's liberty. Many participants provided examples of service users' extreme behaviour which seemed to serve the function of demonstrating why a CTO was necessary. Participant 2 seemed to adopt a strategy of using language that minimised the appearance of coercion, such as saying medication "concordance" rather than "compliance" as she said this sounds "less coercive", and saying "whip him in again quickly" to describe the often traumatic experience of admitting someone to hospital. She said she had not given much thought to how her service users experience being under a CTO, which may reflect a denial of their experience as a coping strategy for herself. In her "stressful care-coordinating daily [life]" (P6, AMHP), it might be easier not to think about the more ethically challenging aspects of using a CTO. These strategies could be seen as developing defences in order to avoid the anxieties aroused (Menzies-Lyth, 1960) by the often difficult nature of the job of working with people who have severe mental health difficulties. Rose (1996) argued that mental health professionals are caught up in a culture of blame where they are held culpable for any unfortunate event, placing political expectations upon them. In this context it is understandable that the development of some defences may be necessary.

How clinicians make decisions related to CTOs can be connected with broader theories about how behaviour is linked with beliefs, such as the Theory of Planned Behaviour (Ajzen, 1991). In this model the determinants of a person's behavioural

intention are their 'attitude' towards carrying out the behaviour, their 'subjective norm' associated with the behaviour, and their 'perceived control'. In relation to utilising CTOs, a clinician's 'attitude' might be seen to constitute beliefs around whether a CTO leads to increased adherence to medication and contact with a mental health team, and whether or not these variables then lead to better outcomes overall for the service user and, perhaps, for themselves as clinicians. A clinician's 'subjective norm' might be seen as their understanding of other people's attitudes towards CTOs, with particular emphasis on significant others in the wider system, such as other team members within the MDT. Their 'perceived control' may be seen as the perceived ease or difficulty with which different aspects of the CTO (e.g. recall) can be implemented, and whether this will assist in the overall goal of keeping service users 'well'.

In the NHS there is a drive towards shared decision-making between clinicians and patients (Coulter & Collins, 2011). Clinical expertise has been said to consist of a combination of a patient's clinical state, a patient's personal preferences and actions, and the research evidence (Haynes et al., 2002). These concepts, however, primarily relate to physical health with the assumption that the patient has the capacity to make decisions about their own health. This is at odds with the general approach to people with mental health diagnoses, particularly at the more severe end of the spectrum such as people who might be considered for a CTO, who are often assumed to lack the capacity to make decisions relating to their mental health.

4.1.2 In what circumstances do clinicians consider CTOs useful?

Participants described a number of circumstances in which a CTO might be useful. Many were in relation to the characteristics of individual service users, as well as their social circumstances, such as a lack of a supportive family. Multiple hospital admissions, non-compliance with medication and a perception of high risk were most talked about as reasons for implementing a CTO. The presence of experiences deemed psychotic were also mentioned by some participants. This is, to some extent, consistent with Churchill et al.'s (2007) description of CTO service users as

being “typically males, around 40 years of age, with a long history of mental illness, previous admissions, suffering from schizophrenia-like or serious affective illness, and likely to be displaying psychotic symptoms at the time of the CTO” (p109). Responding well to having boundaries put in place, and a tendency to acquiesce were also characteristics that were described as being consistent with a successful CTO, which corresponds with Pinfold et al.’s (2001) notion of ‘persuading the persuadable’, where some level of compliance is necessary for compulsory community treatment to be successful.

Many participants linked the need for a CTO with a service user’s non-compliance with psychiatric medication, which they attributed as the reason for relapses. In mental health, medication is often seen as the quickest, cheapest and most effective form of treatment however its efficacy has been shown to be questionable (Moncrieff, 2008). Zigmond (2011) argues that people may not want to take psychotropic medications as they cause obesity, diabetes, impotence, lethargy and other adverse effects, and questions whether it is proper practice in medicine to coerce people to accept treatment which they perceive to be worse than the original affliction. This raises the question of whether it is ethical to enforce medication in the community through the use of a CTO.

Non-compliance with medication was connected with a service user’s lack of insight into their mental health difficulties by most participants. The CTO was portrayed as a useful way of ensuring medication compliance in the absence of insight, as well as providing a framework within which insight might develop. The notion of insight and mental illness being connected is pervasive in mental health services and the literature. Lack of insight has even been suggested to have a neurological basis in schizophrenia (e.g. Mysore et al., 2007). When a service user does not want to take their prescribed medication, this is often interpreted as being due to a lack of insight (e.g. Trauer & Sachs, 2000). O’Reilly (2006) argued that “[CTOs] can greatly improve the lives of many patients whose illness has robbed them of the ability to understand that they need treatment” (p687), while Dawson & Mullen (2008)

described service users who view their CTO as an “insurance policy” as having “good insight” (p272). Given the potential adverse effects of psychotropic medications, the idea that lack of compliance is ‘irrational’ is somewhat problematic. The concept of insight is also problematic. Szasz (2005) argued that a person deemed to be mentally ill immediately loses the right to protest against this judgment, as insisting they are sane is interpreted as evidence for their insanity. Similarly, Bentall (2003) asserts that the problem with deeming service users with psychosis to lack insight is that “it assumes that psychologists and psychiatrists are privileged possessors of a correct theory of psychosis” (p496) and denigrates service users’ own understanding of their difficulties which may be equally valid. Perhaps, rather than focusing on the presence or absence of ‘insight’ there should be greater attention to an individual’s capacity, or competence, which will be discussed further in the Clinical Implications section below.

A number of participants talked about a CTO as being useful in terms of being able to bring a service user into hospital quickly if necessary, which they contrasted with the long-winded process of organising a MHA assessment. Participant 6 (AMHP), however, said that it is the bureaucratic systems around MHA assessments that are “inept” and should be improved, and that a CTO should not be used purely as a way of short-cutting the process of bringing someone into hospital.

Dawson (2006) concluded his examination of CTO use in different jurisdictions by saying that the critical factor of whether CTOs are used is the clinicians’ perceptions of the balance of their advantage. In forming these opinions clinicians draw upon beliefs about the CTO’s utility, administrative burden, adequacy of community service, and the impact of the CTO on the therapeutic relationship, as well as concerns about their liability for the service user under the CTO. This seems to be reflected in the narratives of the participants.

4.1.3 What difficulties do clinicians encounter in the use of CTOs, both ethically and practically?

Clinicians described a number of difficulties in the use of CTOs which are challenging from both an ethical and practice perspective. Even among participants who were more positive about CTOs generally, there seemed to be a need to negotiate the balance between providing appropriate care and not curtailing a service user's liberty unnecessarily, such as Participant 5's (Consultant Psychiatrist) description of discharging someone from a CTO when they regain "good insight and capacity".

A lack of understanding of the legislation was highlighted as an issue, both for service users and other clinicians. Some participants described service users as being confused about what the CTO means in terms of what rights they have, what conditions they are meant to adhere to, and what circumstances might result in a recall to hospital. Participant 4 (care coordinator) said there should be a formalised way of checking that service users have understood their rights. Similarly, a lack of understanding among clinicians was talked about by some participants, which has created difficulties about when it is appropriate to recall a service user and about professional roles, i.e. who has responsibility for doing what. The CQC (2012) has raised concerns regarding understanding of the legislation, specifically that a person on a CTO should not be treated with medication against their will unless they are recalled to hospital, and that a non-compliance of medication in itself is not sufficient reason to recall someone.

The NIMHE produced a workbook to support training in the amended MHA (NIMHE, 2008b) which includes clinical scenarios, activities and self-assessment, however it is unclear to what extent this has been used in training for the majority of clinicians utilising CTOs, and the participants seemed to have had very little specific training in the legislation and best practice guidelines around CTOs. Manning et al. (2011) concluded their article about UK psychiatrists' views on CTOs by saying "the practical, legal and ethical issues surrounding the use of coercion and compulsion in community psychiatry should be introduced into postgraduate training schemes and

continuing professional development” (Manning et al., 2011, p332) which begs the question why this is not currently the case. This is connected with Eastman’s (1994) argument that the principle of reciprocity extends to psychiatrists having adequate knowledge of the law.

Most participants talked about the dilemma of needing to be seen to be managing risk for the sake of their professional registration, although most of these described it as a peripheral issue in the use of a CTO. Whether the use of unwarranted CTOs might cause difficulties for their registration was not raised by any participants. Participants 6 (AMHP) and 8 (Consultant Psychiatrist) placed more emphasis on the need for protective practice as an explanation for why CTOs are used, with Participant 6 describing “anxious, risk-averse teams” and Participant 8 highlighting the possibility of being accused of “medical negligence” if a service user engages in ‘risky’ behaviour. The concerns that clinicians might have are understandable, given that mental health staff are often criticised if a service user harms themselves or someone else, and sometimes very publicly (Ritchie, 1994). Szasz (2005) argued that if a psychiatric patient behaves in a ‘socially deviant’ way by, for example, killing themselves or someone else then they might be considered incompetent for this reason alone, meaning their psychiatrist is at risk of being deemed negligent for failing to fulfil their duty of care. This is connected with the wider issue of who is responsible when incidents happen. Participant 6 (AMHP) said “when things do go wrong in mental health those who are held up as responsible are usually not the individual or their partner or family or friends or their communities, it’s the mental health professionals who are involved”. This reflects Harper’s (2008) argument that the discourse of ‘health’ is used as an explanatory framework for someone’s difficulties, rather than recognising it as a social and political problem, and Laurance’s (2002) assertion that the fear of being blamed is a significant driving force in mental health services.

The issue of judging the effectiveness of a CTO did not fit within the grounded theory model but is nevertheless an interesting subject to arise from the data. When it is

appropriate to discharge someone from a CTO was highlighted as problematic by Participants 6 (AMHP) and 8 (Consultant Psychiatrist), as service user's stability might be interpreted as a sign that the CTO has been successful and should therefore be ended, or that the CTO has been necessary and should therefore continue:

P6 (AMHP): ...how do you judge the effectiveness of it? One school of thought is that if the need for recall has been justified so if you have had to recall the person even if only once in the six months but if you've had to use that then that's justified to continue with it because it shows that it has been effective. Other people say it's effective in that people are sticking to the boundaries of it and therefore it's effective because they had stayed out of hospital but there is no clarity on that in the Act, there is no clarity on that in the code of practice and there's no consensus among even AMHPs who are doing it or Consultants or teams and I don't know, and that's something that's a real quandary for me

This reflects Dawson et al.'s (2003) dilemma of, when a service user on a longer-term CTO avoids readmission to hospital, whether the CTO should be considered *successful* or *unnecessary*. Similarly concerns have been raised about the potential 'lobster pot' effect whereby it is easy to get onto a CTO but very difficult to get off one (Rugkåsa & Burns, 2009).

4.2 Other findings

There are other important findings, not directly linked to the research questions, which nevertheless seem important to address.

Some participants said that a CTO can make a clinician "lazy" and be used as a shortcut to make service users engage with them. This is reflected by Brophy and McDermott (2003) who suggested that CTOs may have the effect of deskilling

clinicians in that they become a substitute for “highly skilled and resource intensive” interventions (p87).

Participant 6 (AMHP) expressed concerns that CTOs were being used disproportionately for black males which is reflected in the latest CQC report (2012). Black people remain overrepresented in mental health services and the criminal justice system generally (Browne, 2009). Evans et al. (2010), in their report of the first six months of CTO use in Birmingham and Solihull, found disproportionately high rates of black and minority ethnic groups on CTOs. The authors suggested that possible reasons for this include social or economic deprivation, differences in help-seeking behaviour, culturally-determined understanding of mental health and “biases in assessment of risk and dangerousness” (p332). It seems that the stereotype of ‘big, black and dangerous’ (Prins, 1993) remains deeply entrenched in mental health services and society generally (Wacquant, 2005).

4.3 Evaluation of the research

The extent to which qualitative research can be evaluated, and by which criteria, is somewhat contentious (Spencer & Ritchie, 2012). I have drawn upon the broad principles described by Spencer and Ritchie (2012) in evaluating this research - the *contribution* of the research, the *credibility* it holds and the *rigour* of its conduct.

4.3.1 Contribution

This research contributes to the knowledge base by elucidating the decision-making processes described by clinicians in relation to the use of CTOs, as well as their perceptions of the impact CTOs have. This is useful as the legislation and guidelines for clinicians regarding CTO use may not always be the only factors in how decisions are made. This research is novel in that it describes how clinicians’ account for the influence of their own beliefs and wider systemic factors on the process. This has been achieved by using qualitative methodology which allowed clinicians to talk about what they see as influencing decision-making from their own

professional experiences. To my knowledge it is, as yet, the only UK-based qualitative research investigating staff experiences of CTOs.

Previous research investigating staff experiences has been largely quantitative and survey-based, with little attention to the broader circumstances that influence decision-making, such as perceptions of team dynamics and protective practice among clinicians. A number of important clinical implications arose from the data, outlined below. While the small numbers of participants used in qualitative research limits generalisability beyond the sample, it is possible that the findings can be seen to be, to some degree, representative of mental health clinicians' experiences more generally (Lewis & Ritchie, 2003). The participants not only talked about their own individual experiences, but described more widely the opinions and practices they had observed among their colleagues, suggesting that the grounded theory model may, to some extent, represent the experiences of a larger group of people. Yin (1994) proposes that case studies provide theoretical insights which may be generalisable. He distinguishes between *analytic generalisation* and *statistical generalisation*, the former of which may be used to expand and generalise theories. In this sense the current research can be seen as being analytically generalisable.

4.3.2 Credibility

Credibility refers to the plausibility of the claims made by the research and how these claims have come to be made (Spencer & Ritchie, 2012). It can be demonstrated by being transparent about the research process, such as including extracts of raw data and providing descriptive accounts of how data has been categorised (Spencer & Ritchie, 2012). Examples of line-by-line and focused coding of the raw data, and of two memos which demonstrate how data has been categorised, have been included in the Appendices. Following the construction of the grounded theory, I went back through the transcripts to ensure that all the data could be accounted for within the model. Much of the data is reflected in previous literature, as well as findings from the CQC reports regarding clinical practice, adding to the plausibility of the claims.

4.3.3 Rigour

Rigour refers to the appropriateness of research decisions, whether the research method was followed, the dependability of evidence and whether research has been conducted safely, including ethical decisions (Spencer & Ritchie, 2012). It also refers to researcher reflexivity which will be described further below. The 'audit trail' of the research process is partially presented in the Appendices to demonstrate how decisions were made during the process and the thoroughness with which the analysis was conducted. Due to the participants being mental health clinicians themselves, the ethical challenges were arguably less complex than they might have been if the participants had been, for example, service users where there was a more obvious power differential or where my role as a clinician might have needed to be prioritised at times. None of the participants appeared to find the process of being interviewed distressing and some said that it had been interesting to have an opportunity to think about their own position relating to CTOs.

4.4 Researcher reflection

4.4.1 Epistemological reflexivity

Epistemological reflexivity refers to how the assumptions behind the design of the study, both data collection and analysis, have constructed the data and the findings (Willig, 2008).

There was a clear tension between my social constructionist epistemology and most of the participants' realist epistemology where they drew on medical discourses to explain and validate their positions. A researcher with a more realist epistemology themselves may have interpreted the data differently and seen a clearer link between 'mental illness', 'lack of insight', non-compliance with medication and, therefore, the need for coercion in the form of a CTO.

Using a different method of analysis, such as Discourse Analysis, would again have led to different interpretations of the data. Paying closer attention to *how* participants

were talking rather than *what* they were talking about would have allowed for deeper insights into how clinicians construct their roles in the context of making and utilising CTOs.

Using a different method of data collection would have yielded different findings. It would have been interesting to record naturally-occurring speech, such as an MDT meeting, in order to observe how CTOs are talked about on a day-to-day basis rather than being led by my own agenda (Potter & Hepburn, 2005). Conducting a focus group with mental health clinicians may have been an interesting middle ground, whereby I could have some influence on the direction of the discussion but for the most part allow participants to construct their experiences among themselves.

4.4.2 Personal reflexivity

Personal reflexivity refers to the ways in which our own values and experience have shaped the research (Willig, 2008). It is possible that my role as a trainee clinical psychologist influenced responses given by participants and that they might have deduced that I was approaching the topic from a critical perspective, however I tried to minimise the effect of this by asking questions that were relatively neutral and open.

Given my past role as a care coordinator, I found that I could empathise with the position of wanting to help service users whose mental health difficulties were debilitating and of trying to find different ways of keeping people engaged with the service. The anxieties around risk management felt mostly justified given the culture of mental health services which, from my experience, centres very much around defensive practice. It is understandable that clinicians might want a CTO in place in order to speed up the arduous process of admitting someone to hospital if necessary, as well as just being able to show that they have done all they can as a professional to manage risk if anything should be wrong. I found myself wondering

whether my views about CTOs would be different if I were still working 'at the coalface' of mental health.

I found that my opinion of participants who held the more positivist, unquestioning, views regarding CTOs was slightly negative following the interviews (recorded in a reflective diary). In some cases my opinion softened following transcription, where I was able to understand more of the context behind their views, such as a genuine belief that vulnerable people deserve to be cared for. However, for two participants in particular, who seemed to subscribe to the medical model in a wholly uncritical way, I found that my annoyance remained. I am almost certain that this annoyance was not conveyed during the interviews themselves, as my questions and their answers carried on in quite a neutral way. It is nevertheless important to recognise the impact that my position with regards to CTO use will have had on the questions asked, what participants said, and how I interpreted the data.

4.5 Limitations

Using semi-structured interviews as my method of data collection has its limitations. Although interviews have a familiar format for most people, they cannot be considered naturally-occurring speech as participants' responses are very much directed by the interviewer's questions and, therefore, their own agenda and beliefs (Potter & Hepburn, 2005). In the current research, the final grounded theory model could be seen to be an interaction between my own interests in how decisions are made relating to CTOs and the participants own constructions of their experiences.

A larger number of participants would have generated further data and potentially impacted on the grounded theory model. Larger numbers in each occupational group may have shown some general differences in how CTOs are viewed between professions. It would have been interesting to interview AMHPs who were from different occupational backgrounds, as the two participants who were AMHPs were both Social Workers.

Due to time constraints, an abbreviated version of grounded theory was adopted, whereby all the data was collected prior to analysis. Despite employing strategies to enhance the quality of the research, such as using line-by-line coding (Willig, 2008), the criticisms of abbreviated versions still apply. Future research in this area would benefit from the use of the full version of grounded theory.

4.6 Research implications

How staff negotiate working with service users subject to a CTO would benefit from further research. While this investigation has helped to elucidate what processes are involved in making decisions pertaining to CTOs, it would be useful to explore this further in order to understand why CTO use has continued to increase since they were introduced. Particular attention to how clinicians manage their anxiety around 'risky' service users and how they weigh this up with positive risk-taking would be interesting, as would doing more interviews with people from the same profession and then comparing the results between professions.

The discursive devices used by participants were of particular interest, helping to demonstrate how they construct their experiences and explain their own involvement in CTO use, however this was largely beyond the scope of the present study. Using methodology such as Conversation Analysis or Discourse Analysis would be a useful way of exploring this further, perhaps by analysing 'naturally-occurring' conversations, such as MDT discussions about a service user's CTO, or a tribunal hearing regarding a CTO.

4.7 Clinical implications

A number of significant implications for clinical practice arose from this research.

Implications for team practice and policy

The paucity of staff training was described by many of the participants. Considering the power that a CTO wields over someone else's life, it seems vital that the people using that power have a comprehensive knowledge of the legislation. Every clinician involved in using a CTO should attend mandatory training with annual 'refresher' training to keep up-to-date with any amendments or case law as part of their registration requirements.

Two participants raised the issue of capacity, believing that service users should not be forced into engaging with mental health services or taking medication if they have capacity. Perhaps the legislation should be limited to those deemed unable to make valid capacitous decisions, similar to the wording used in the Mental Health (Care and Treatment) (Scotland) Act (2003).

It seems that tribunals sometimes propose the use of a CTO which then requires the clinician to defend their decision not to use one. As tribunals are meant to provide legal representation and independent advocacy for the service user (Kinderman & Tai, 2008), it seems inappropriate that they should be suggesting them.

Whether service users fully understand the implications of a CTO is questionable, with one participant saying that the process of explaining a CTO to a service user should be formalised further in order to check their understanding. This is connected with the idea of capacity. One way of checking service users' understanding might be through an informal test, where the service user has to explain their rights back to the clinician assessing their understanding.

Some participants said that CTOs are being overused and for the wrong people. Despite CTOs being implemented in England and Wales for 'revolving door' service users, they are in actual fact being used for people that do not fit this picture (CQC, 2010). In some jurisdictions, such as Ontario and Saskatchewan, there are specific criteria of the amount of time someone must have spent in hospital in order to qualify

for a CTO (Dawson, 2006). Similar criteria provide some safeguards for CTOs being used inappropriately.

When asked about future directions for CTO legislation, one participant said that it would be useful to be able to “treat in the community” as this may help to avoid recalling people to hospital whereas other participants did not appear to share this view. Forcing medication using restraint in the community is not currently permitted in any jurisdiction, even in New Zealand which arguably contains the most explicit treatment powers (Dawson, 2006). Dawson (2006) suggested that administering medication by force in a community setting would always be contrary to a person’s human rights. However, it is worth noting that there has been an increase in the number of clinicians in favour of CTOs (Manning et al., 2011) compared with a survey carried out by Crawford et al. (2000) prior to CTOs being introduced in the UK. As Participant 8 (Consultant Psychiatrist) pointed out, once legislation comes into effect it becomes “less worrying” and becomes difficult not to use. Whether this would also be the case if it became legal to administer medication forcibly in the community is possible, despite clinicians’ current objections. It is therefore imperative that any further legislation reform is considered carefully, with its ethical implications thoroughly deliberated.

One participant raised the concern of whether teams and, specifically, RCs will be able to supervise an ever-increasing number of people on CTOs and whether this will reduce their effectiveness. Eastman (1994) argued that the “principle of reciprocity” means that restrictions of civil liberties must be matched by the provision of high quality services, something he reports is sought after in some American states to the extent that a detainable person may be discharged purely due to lack of appropriate services. He also argued that supervised discharge orders (the predecessor to CTOs) have little effect other than concentrating resources on a small number of patients. CTOs should not be used as a substitute for high quality, well-funded services that are easily accessible and collaborative, which service users actually might want to engage with.

Implications for clinical psychologists

While clinical psychologists may not be directly involved in the day-to-day use of CTOs (unless they train to become an AMHP or a Responsible Clinician), they nevertheless have an important role to play in helping MDTs to consider whether a CTO may be useful for a particular person. Given that participants talked about a number of factors that might influence whether a CTO is used aside from the service user's personal characteristics and circumstances, a clinical psychologist might help clinicians to consider the influences of their own ethical position, anxieties around risk issues and wider systemic factors using a formal staff consultation model or more informally within MDT meetings. Given that clinical psychologists may also work with service users subject to a CTO in a therapeutic capacity, it seems important that they are aware of the complex issues involved themselves.

4.8 Conclusion

CTOs have become an established part of mental health legislation in England and Wales, however their use remains controversial. CTOs have been portrayed as a less restrictive alternative to hospitalisation (e.g. Hiday, 2003; Pinfold & Bindman, 2001) and as ensuring the provision of adequate care in the community (Churchill et al., 2007). It is also a common argument that coercion, particular around medication compliance, is in the service user's best interests. However in law, 'best interest' authority can only be used if the individual lacks capacity to make decisions (Zigmond, 2011), and this is not currently considered when making a CTO.

Professor Tom Burns, who led the OCTET trial (Burns et al., 2013) and once strongly supported the introduction of CTOs, very recently said:

"The evidence is now strong that the use of CTOs does not confer early patient benefits despite substantial curtailment of individual freedoms ... Their current high usage should be urgently reviewed. I think there should be a moratorium on their use at least for a year or so while we think through how

we can improve on the quality of evidence we've got. If we can't do that I think it really is unjustified to continue to use them." (Manning, 2013)

It would have been interesting to be able to ask participants what they made of the findings of the OCTET trial, which were published after the interviews were completed, and what impact the findings might have on their clinical practice. It will be interesting to see the impact, if any, this research has on CTO policy, guidelines and use in England and Wales and, perhaps also, internationally. While the findings of the OCTET trial are highly significant, whether reducing hospital admission should be the primary indicator of success for CTOs is debatable, as discussed in greater detail in the Introduction chapter. Kisely (2006) argued that staff opinion about the utility of CTOs should be seen as 'Level 3 evidence' (with Level 1 evidence being RCTs and Level 2 being well-designed, non-RCTs). In the absence of universally-agreed criteria for measuring the success of CTOs, perhaps the views of the people who are directly involved in their use, namely clinicians, families and service users themselves, should be elevated as being of greater importance.

CTOs were primarily introduced in order to minimise risks posed to the public by people with mental health problems, however the literature suggests that CTOs do not necessarily reduce these risk. Patel (2008) argued that CTOs draw out the controlling rather than the compassionate aspects of the self, both individually and collectively, which can lead to the tendency of perceiving the client as having less human value and that "CTOs operate as a paper straightjacket... staff are placed in reductionist, paternal roles that undermine a more holistic collaborative stance and creative struggle to find novel approaches" (p342). Without any conclusive evidence for their effectiveness, it is difficult to continue justifying this "paper straightjacket". Failings within community care might well be attributed to under-funded and poorly organised services in the context of entrenched social problems and inequalities, and CTOs cannot and should not be used to try to 'fix' these problems.

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Appendix 1 – Letter confirming UEL ethical approval

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology



Doctoral Degree in Clinical Psychology Direct Fax: 0208 223 4967

June 2011

Name of Student	Anna Chalmers-Brown
Title of Research Project	Mental health clinicians' experiences of working with clients under a Community Treatment Order

To Whom It May Concern:

This is to confirm that the above named student is conducting research as part of the requirements for the Professional Doctorate in Clinical Psychology. The Ethics Committee of the School of Psychology, University of East London has approved their proposal and they are, therefore, covered by the University's indemnity insurance policy. This policy should normally cover for any untoward event provided that the experimental programme has been approved by the Ethics Committee prior to its commencement. The University does not offer "no fault" cover, so in the event of untoward event leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the above named is a student of UEL the University will act as the sponsor of their research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Kenneth Gannon PhD
Research Director

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Appendix 2 – Participant information sheet

PARTICIPANT INFORMATION SHEET

Mental health clinicians' experiences of working with clients under a Community Treatment Order

What is the purpose of the research?

Community Treatment Orders (CTOs) were implemented in England and Wales in November 2008 in line with the revised Mental Health Act (2007). Compulsory community treatment has existed in a number of other countries, including Australia and the United States, for some time however evidence for its effectiveness remains inconclusive. It is, therefore, useful to find out the experiences of those who are directly involved in using CTOs in their everyday work – mental health clinicians. The research aims to assess the perceived usefulness as well as the potential difficulties of utilising CTOs, and to gain some insight into which service users CTOs are helpful for and who they are unhelpful for.

Why am I being asked to participate?

You have been given this information as you are involved with the care of a service user who is subject to a CTO.

Do I have to take part?

Participation is entirely voluntary. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen if I decide to participate?

You will be asked to participate in an interview which will ask you about your experiences of working with service users who are subject to a CTO. The interviewer is a trainee clinical psychologist who does not have any involvement in the mental health team where you work. The interview should take no more than 60 minutes and there will be a space at the end for any questions or comments that you might have. The interview will take place in a location convenient for you.

Possible benefits of taking part

Finding out about staff experiences of using CTOs will provide an invaluable insight into how they are employed in day-to-day practice. The research will help to elucidate the useful aspects of the revised mental health legislation pertaining to compulsory community treatment, as well as examining its limitations. It also aims to explore how clinicians manage to negotiate their relationships with service users in the context of compulsory care. The findings may have important implications for clinical practice.

Possible risks of taking part

It is unlikely but possible that you may find certain aspects of the CTO process difficult or distressing to talk about. There will be time both during and at the end of the interview to ensure that you have an opportunity to discuss any problems.

Confidentiality

Interviews will be recorded using an audio recorder and transcribed verbatim. Recorded data will be saved onto a password protected computer and will not have any identifying information attached to the file. The recording will be transcribed by the interviewer. All transcriptions will be anonymous and any information which could potentially identify you will be changed.

What happens to the data?

The interview transcripts will be analysed by the interviewer. Some direct quotes from what you say in the interview may be used to illustrate the data. Quotes will be used in a sensitive and confidential manner with any possible identifying information being removed or changed. The findings will be submitted by the interviewer as their thesis for their clinical psychology doctorate training. It is likely that the findings from this service evaluation will also be written up for publication within an academic journal.

Data will be stored for up to five years on a password-protected computer to which only the researcher has access. Consent forms will be stored in a locked drawer to which only the researcher has access, and will be stored separately to any material relating to the interviews themselves.

Right to withdrawal

Participation is voluntary and you are free to withdraw from the research at any time without having to give a reason.

Who has reviewed the study?

The study has been reviewed by academic staff within the Clinical Psychology department at the University of East London. It has also been looked at by the Ethics Committee at the University of East London (details below).

Further information and contact details

If you have any questions about this research either before or after you consent to participate, please contact the interviewer directly: Anna Chalmers-Brown (anna.chalmers-brown@nhs.net).

Phone: (University of East London, Doctorate in Clinical Psychology office): 0208 223 4174/4567

Many thanks for your time and consideration

UNIVERSITY OF EAST LONDON

Stratford Campus

Water Lane, London E15 4LZ

University Research Ethics Committee

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact the Secretary of the University Research Ethics Committee, Ms Debbie Dada, Admissions and Ethics Officer, Graduate School, University of East London, Docklands Campus, London E16 2RD (Tel 020 8223 2976, Email: d.dada@uel.ac.uk)

The Principal Investigator

Anna Chalmers-Brown

Clinical Psychology Department

020 8223 4174

Appendix 3 – Interview schedule

Thank you for agreeing to take part in this research project. The interview will last up to 60 minutes and there will be time at the end for a debriefing or for any questions you might have. I am interested in your experiences of working with clients who are subject to a Community Treatment Order. I will start by asking you about specific information about clients you have worked with or are currently working with who are under a CTO. Following on from the specific questions I will ask you some more general questions about your experiences and views on CTOs.

So to start...

- Can you tell me how many clients you have worked with who have been subject to a CTO? In what capacity were you working with them? Are you currently working with anyone under a CTO?
- What has been your experience of working with service users who are under a CTO?
 - How has it been explained to them? Their reactions?

Prompts:

- How did you find the transition to a system where CTOs are used?
 - What were your initial thoughts about the new legislation?
 - Were there any initial difficulties?
 - Any ongoing problems?
- Do you think CTOs are a useful clinical tool?
 - Why/why not?
 - Who do they seem more useful for? Why?
- Are there any positive or negative effects of using CTOs, e.g. on the therapeutic relationship?
 - How do you manage this?
- Have you experienced any ethical dilemmas relating to the use of CTOs?
- Can you tell me a bit about your understanding of why CTOs were introduced in the first place?
 - Do you think they are fulfilling their aims?
 - Why do you think CTOs are being used so much more than the government predicted?
 - The DoH predicted 400-600 per year, whereas 4,107 were put in place in their first full year of use (Lawton-Smith, 2010)
- What did you think of CTOs when they were first introduced, and how does that compare to how you view them now?
- What long-term changes have CTOs made on the mental health system?
 - How has their use evolved? Room for improvement?
- How are decisions made about who goes on a CTO? Typical service user?

Added for interviews 7 and 8: when do you know that a CTO has been effective? What are the criteria for success?

Appendix 4 – Transcription conventions

Adapted from Bannister, Burman, Parker, Taylor & Tindall (1994):

Symbol	Explanation
(.)	Pause
[inaudible]	Inaudible piece of transcript
[laughs]	Indicates laughter of participant
<u>Emphasis</u>	Underlined speech indicates word(s) spoken with more emphasis
[...]	Indicates some speech has been removed – no more than 40 words
<>	Brief interruption by other speaker
[]	Square brackets indicate description rather than participant's speech, i.e. to contextualize what is being said

Appendix 5 – example of line-by-line coding (from Interview 1)

As a ... it's difficult to come up with general rules but what kind of people do you think CTOs work for and where are they less useful?

Interestingly I think erm people who erm don't cause too much concern because of their behaviour when they're unwell might end up being a sort of neglected really in terms of (.) well they don't hurt anyone, they don't hurt themselves, they don't cause too much distress, they just sort of bumble along in a confused state. Maybe there aren't carers around voicing their concerns so maybe certain clients wouldn't end up being placed on CTOs because they're not coming to the attention of emergency services or their risk behaviour is not deemed to be that high (.) obviously I think that's a shame if it means they're not actually progressing you know being productive in their life and functioning in a meaningful way then I'd be tempted to be assertive yeah. Erm so I imagine that more often than not people on community treatment orders are going to be ones who have got a forensic history already and that (.) yeah are violent or particularly aggressive towards staff and others, family, neighbours, whatever (.) and certainly deteriorate relatively quickly so that the idea of being able to recall into hospital, having that power of a CTO is deemed necessary

So it sounds like in some instances it's quite a useful tool if things start to deteriorate?

Yeah I mean people I think outside of the system expect services to be able to organise for someone to be assessed under the mental health act and taken into hospital quite quickly but in reality obviously we are very much at the mercy of the pressure that is on the police (.) yeah that would be occasions where someone might be able to be assessed on the mental health act and taken to hospital without police involvement but I imagine that that would be pretty rare...

Describing who useful for

Not causing concern

Neglecting self

Not hurting others/self

Not causing distress, 'bumbling' along confused

Absence of carers

Avoiding attention of services

Expressing sadness if person not functioning

Justifying assertiveness

Predicting CTO use

- Forensics
- Violence
- Quick deterioration
- Needing to recall quickly

Describing outsider expectations of MHA assessments

Contrasting with reality

Being at the mercy of the police

Mostly requiring police to take SUs to hospital

Appendix 6 – example of focused coding (from Interview 6)

...my main concern at the time and still now is around the impact that compulsory treatment has on the therapeutic relationship and ideas of kind of responsibility and recovery being self-defined and people being responsible for themselves, personal responsibility, it can admonish personal responsibility and be overly restrictive so initially I was very anti, then when I did the AMHP course my views were more confirmed and I looked into some of the research around their effectiveness and where the idea came from and the Australian studies and for the very fact that there is very little evidence that they do work and that they are helpful and that in this risk averse culture the way that teams work I could see that they were going to be taken up more than they were originally thought but I know that the research has shown that they have been taken up much more than was ever expected and I think that probably in the majority of times they are being used inappropriately

And why do you think they are being used a lot more than was predicted?

I think they.. somebody being on a CTO reduces teams' anxieties, they see it as an effective way to quickly dash somebody back into hospital when they've had difficulties in the past with people having.. organising Mental Health Act assessments quickly enough so I think it's about the risk averse culture and I think it's about people.. protective practice or perhaps even defensive practice, so one thing I've noticed is that tribunals are recommending that the team consider CTOs even when the person is maybe on their second or third admission so they are not the revolving door service user that these were meant to be for...

Feeling concerned about impact on therapeutic relationship

CTOs admonishing personal responsibility

Predicting protective practice

Witnessing protective practice

Tribunals recommending CTOs

CTOs being used inappropriately

Appendix 7 – example memos

Memo - written 30th March 2013

Balancing care and coercion – focused code/category?

There seems to be a continuum – human rights at one end, intervening at all costs at other end. Participants sit at different points on the continuum. This is linked to tensions between CTOs and recovery/EIS models.

P1 puts treatment and ‘wellness’ as absolute priority, superseding right to choose whether receive mental health input. There seems to be an idea of the ‘greater good’, whereby ethical concerns are demoted against overall aim of treatment compliance, insight developments, wellness etc. Grounded in a belief that there is a *duty* to help people with mental health problems whether they want it or not, including those who do not pose a risk to others but might be deemed ‘vulnerable’. His beliefs seem to come from a genuine wish to heal, rescue, help others and coerciveness is justified due to overall aims.

P8 believes that people should be allowed to make own decisions, even if unwise – at the human rights end. She talks about CTOs being used as a form of social control and believes that treatment is only treatment if the person wants it, finds it useful. P6 holds similar views and makes good point that care coordinators don’t have the time and space to think about ethical issues in their stressful daily jobs.

When does the end justify the means? Even if the end were reliably positive, would it justify means?

Memo - written 30th April 2013

‘Clinician’s beliefs and knowledge’ was one subcategory, which seemed appropriate as it was located within the clinician. However it seems to make more sense to separate issues pertaining to knowledge relating to staff training, from more philosophical/ethical standpoints on the role of medication and the balance between providing care and coercion.

Knowledge can in some ways be seen as externally influenced, in that it is very much reflective of what training has been available to staff.

Ideas around medication and care/coercion feel more internal and are perhaps linked to their fundamental understanding/construction of what constitutes a mental health problem and how best to deal with it. Also linked to professional background, i.e. medical model vs. more social model of madness. Medication as treatment is linked with this. A subcategory might encompass these ideas - ?constructions of care and treatment.