

**The ties that bind?
The practice of supervised community treatment in English
mental health services**

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Abstract

The treatment and control of individuals with severe mental health difficulties in the community has long been positioned as a problem in need of a solution. This thesis investigates one recently introduced 'solution' in English mental health services - community treatment orders (CTOs) - enacted under the Mental Health Act (2007). CTOs work by imposing conditions on how service users live in the community, as well as allowing for them to be recalled for treatment in hospital if they fail to meet these conditions, and/or they are deemed to be a risk to themselves or others. Their introduction has brought with it debate on the ethical implications of extending compulsory treatment into the community, with opinion on their use strongly divided. This thesis aims to get beyond such dichotomous positioning to uncover the potentially multiple and complex ways CTOs are conceptualised, interpreted and used by practitioners and service users, and with what consequences. An ethnographic approach is taken to explore 'inside' CTO practice within two Mental Health Trusts, through observations of everyday CTO processes, interviews with practitioners and service users, and document analysis of policy and practice-related sources. In this way a dual analysis is formed which gives a generative explanation of the pathways a CTO might take, and describes how service users and practitioners experience and respond to CTOs as a compulsory intervention. This analysis is guided and deepened by a combined critical realist-governmentality framework, which informs an understanding of *why* it is CTOs unfold as they do, and *how* they regulate conduct and encourage self-regulation through assemblages of coercive, disciplinary and reflexive forms of power. As will be shown, a number of distinctive conclusions can be drawn about CTO policy and practice relating to: the gaps and continuities between policy theorisation, practice-level conceptualisation and CTOs in action; the constituting power of agency and interaction alongside institutional and cultural factors in shaping various CTO outcomes; the complex and often ambiguous reactions of practitioners and service users to CTO ends and means as connected to ethical self-work; and the mixed, sometimes unexpected and unintended consequences of CTO use.

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Author's Declaration

The work presented here is my own and has been produced independently by me, with funding support from a University of York postgraduate teaching scholarship. Appropriate credit has been given in the thesis where reference has been made to the work of others.

This work has not previously been presented for an award at this, or any other university. Versions of the material presented in this thesis have been published elsewhere, with details as follows:

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Introduction

The treatment and control of individuals with severe mental health difficulties in the community has long been positioned as a problem in need of a solution. This thesis investigates one recently introduced ‘solution’ in English mental health services - community treatment orders (CTOs), enacted under the Mental Health Act (2007). Despite their longevity and persistent spread across different jurisdictions, CTOs remain a controversial and much debated addition to the landscape of community mental health. Modern mental health services, both in the community and in hospital, have always contained elements of compulsion and coercion which can be seen as forming a continuum, from informal persuasion through to formally mandated hospital treatment (Monahan et al, 2001). However, a distinction can be made between the undefined and discretionary use of treatment pressure in the community and the legislatively defined role of CTOs. As Churchill et al (2007, 20, emphasis in original) state, CTOs are qualitatively different from what has gone before in the countries where they have been implemented because they, “enforce community treatment *outside (and independently) of the hospital*, contain specific mechanisms for *enforcement and/or revocation* and are authorised by *statute*”.

This essentially means that CTOs give mental health professionals the power to impose conditions on how service users live in the community, particularly in regards to medical treatment, and provide a mechanism for hospitalisation and treatment enforcement if these conditions are not met or if the service user’s mental health has deteriorated to the extent that they are deemed to be a risk to their own health and safety or that of others. Opinion on CTOs is strongly divided, with opponents arguing that an extension of compulsion into the community results in an unnecessary and stigmatising focus on risk, a loss of liberty and rights for service users, and the neglect of alternative, less coercive methods of engagement (Brophy and McDermott, 2003, Geller et al, 2006, Pilgrim, 2007). Conversely, supporters of CTOs argue that they help to engage service users who are hard to reach and/or considered a risk, facilitate community-based care, reduce rates and length of compulsory hospitalisation, encourage better treatment, improve clinical outcomes and promote recovery

(Lawton-Smith, Dawson and Burns, 2008, Munetz and Frese, 2001, O'Reilly, 2006).

As these two positions demonstrate, the reason why CTOs continue to be fertile ground for dispute is because they act as a crucible for enduring tensions within the field of mental health policy and practice. CTOs have expanded the boundaries of legally mandated compulsion in mental health, and in doing so, have galvanised debates on where the balance should be struck between rights or risk, and freedom or coercion for individuals within the mental health system. In this sense, although the CTO is premised on distinctive historical and cultural contingencies, it also brings into sharp focus the longstanding moral and ethical balancing acts that frame the treatment (in the broadest sense of the word) of individuals diagnosed with severe mental health difficulties. My position, based at least partly on practice experience as a social worker, is that negotiating these kinds of tensions as they manifest in practice dilemmas is rarely straightforward. My practice background has in recent years been in youth offending, working with young people who have committed offences of various kinds. As an area of practice which holds a constant tension between welfare and justice, youth justice brings similar dilemmas to the care/control debate intrinsic to mental health practice. It seems to me that this debate is even sharper in mental health however, as the behavioural aspect of youth offending which calls for control mechanisms is not necessarily present in the same way. Hence, although I have not practiced in a mental health setting, I nevertheless have a long-standing interest in mental health practice, based on a fascination with the varying explanatory models that are put forward for the experiences of individuals who suffer severe mental distress, and the ensuing and often conflicting approaches to dealing with such distress. CTOs provide an ideal exemplar to investigate how such debates, models and approaches play out in mental health policy and practice, given the issues they raise.

Consequently, I came to this thesis with the view that to move beyond the current relatively polarised debates on CTOs, a study which takes account of the potential complexity of their practice would bring a new and valuable perspective to the existing body of CTO research and more generally, to the use

of compulsion in mental health services. My aim therefore is to get underneath the surface of the contested claims made about CTOs: to understand the thought behind their introduction; to expose the mechanics of how they work; to explore why and in what ways they are used; and to illuminate what the experiential and ethical implications of their use are for the individuals who are placed on them and for the practitioners who implement them. Through doing so, I hope to provide a distinctively theorised and methodologically realised account of a noteworthy phenomenon in community mental health, which is of value both in terms of application and theory generation.

In the rest of this introduction I set the scene for the thesis, firstly by describing how the CTO regime works in England. This will provide a ‘reference guide’ to help navigate the more in-depth discussion of CTO practice in the rest of the thesis. I then briefly sketch out the development of the interconnected empirical and theoretical rationales for the thesis, and the subsequent research questions which arise from these rationales. I finish the introduction with a short description of how the thesis is structured.

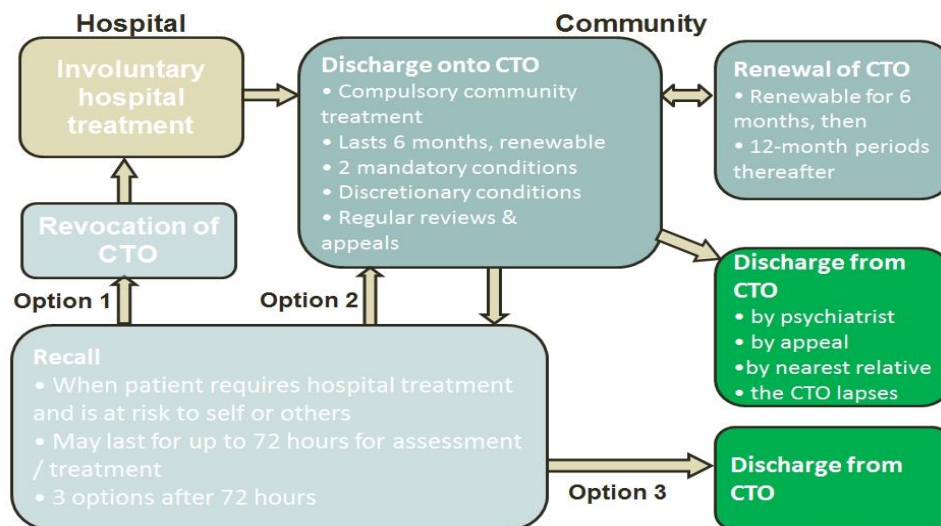
CTOs in England

CTOs are present in a number of forms in different countries around the world. It is worth noting here that because of this, they go under a variety of nomenclatures which differ from country to country and indeed from jurisdiction to jurisdiction. For example, they can be referred to as ‘outpatient commitment laws’, ‘mandated community treatment’ or ‘community compulsory treatment orders’ among other given names. For the sake of clarity, I have mostly retained ‘community treatment order’ and ‘CTO’ throughout the thesis, even when referring to other countries, unless it is necessary to do otherwise. I explain in Chapter Four the international background to the evolution of CTOs in mental health services, including how that background has influenced the development of different CTO regimes. For now, I focus in a very straightforward way on how the CTO works in England¹.

¹ I should note here that the Mental Health Act (2007) and the introduction of CTOs within that Act, applies to England and Wales. For brevity, and also because my fieldwork only takes place in England, I simply refer to England throughout the thesis. Scotland has a separate provision – Compulsory Community

CTOs in their current form resulted from a broader reform programme begun in 1998, in which the Mental Health Act (1983) was eventually amended by the Mental Health Act (2007), and are an example of what is called a ‘preventative’ CTO (Churchill et al, 2007). This means that they have different criteria – a lower legal threshold - than for compulsory hospitalisation. The function of the preventative CTO therefore is to *prevent* mental health deterioration before it occurs rather than *reacting* to deterioration that has already occurred. Preventative CTOs tend to be aimed at particular groups of service users, especially those who have been described as ‘revolving door patients’, meaning they regularly stop their medication and experience relapse, leading to continuous movement between hospital and the community. The large majority of individuals placed on CTOs have been given a primary diagnosis of a psychosis-related disorder, and are on anti-psychotic medication (Churchill et al, 2007), which the CTO is intended to ensure they adhere to. I now describe the CTO process with regards to imposition of the CTO; procedures once the CTO is in place; and renewal or discharge of the CTO. *Figure One* gives a diagrammatic overview of this description.

Figure 1: A diagram of the CTO process



(Adapted courtesy of Kryisia Canvin and Jorun Rugkasa from the OCTET study, University of Oxford)

Treatment Orders –introduced under the Mental Health (Care and Treatment) (Scotland) Act 2003, which I discuss in Chapter Four. Northern Ireland operates under the Mental Health Order 1986 (NI) and has no equivalent of CTOs, although there are moves towards reformation of the legal framework (O’Hare et al, 2013).

Process and criteria for imposition of the CTO

CTOs can only be applied immediately following compulsory hospitalisation for treatment under Sections 3 or 37 of the Mental Health Act (1983). When a service user is in hospital, the inpatient team will decide (usually in collaboration with the service user's community team) whether a CTO is the most appropriate option on discharge, rather than simply discharging the service user to voluntary status in the community. The practice guidance suggests that the potential for a CTO should be discussed as soon as the service user is admitted to hospital, in order to allow for proper planning, consultation and preparation (NIMHE, 2008). The inpatient psychiatrist makes the formal application for the CTO, with an Approved Mental Health Professional (AMHP) providing the second opinion. The AMHP must approve the decision for the CTO to go ahead, and the psychiatrist cannot simply seek the opinion of another AMHP if a disagreement occurs. Although CTOs are described as a "kind of contract" with service users in the guidance for their use (NIMHE, 2008, 17), and it is recommended that agreement on the CTO is reached with the service user, they do not *have* to consent to the imposition of the CTO. The criteria for a CTO are outlined below:

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment.
- It is necessary for the patient's health or safety, or for the safety of other persons, that the patient should receive such treatment.
- Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital.
- It is necessary that the responsible clinician should be able to exercise the power...to recall the patient to hospital.
- Appropriate medical treatment is available for the patient.

(NIMHE, 2008, 11)

Process and procedures once the CTO is in place

When a CTO is imposed, the psychiatrist again with the agreement of the AMHP, attaches specific conditions to the CTO to which the service user will be made subject. These usually include reference to complying with medication, and maintaining engagement with the care coordinator and psychiatrist.

Although psychiatrists have been advised to keep conditions to a minimum (NIMHE, 2008), they can cover any area which is deemed to prevent risk of harm or ensure that the service user receives medical treatment. Consequently, conditions might also include abstention from drug or alcohol use, to reside at a certain address, or other 'lifestyle' conditions. In addition, two mandatory conditions always apply, which combined effectively mean the service user must make themselves available for medical examination when necessary.

Once back in the community on a CTO, the service user can be recalled by their psychiatrist to hospital or an outpatient clinic for assessment and treatment for a period of up to 72 hours. The criteria for recall are as follows:

- The patient needs to receive treatment in hospital; and
- There would be a risk of harm to the patient's or others health and safety if they were not recalled.

(NIMHE, 2008, 33)

It should be noted that there is not a requirement for the service user to be seen and assessed before recall is decided upon. The guidance is clear however that a service user breaching a condition is not enough in itself to trigger their recall (NIMHE, 2008). In these circumstances, recall can only be carried out if the psychiatrist believes that failure to comply with a condition means an immediate risk of harm is deemed likely. Conversely, if the service user is still compliant with the conditions but their mental health has deteriorated to the point that they meet the criteria for recall, then they can also be recalled. It is important to note that whilst the service user does not have to consent to the CTO, they *do* have to consent to the medical treatment given under the CTO whilst in the community. If they do not consent to medical treatment, or withdraw their consent at any point, then enforced treatment in the community is not allowed. The psychiatrist

has to decide whether this refusal of medical treatment constitutes an immediate risk of harm and whether recall to hospital for enforced treatment is therefore necessary. Recall should not be used regularly and a service user can still be admitted to hospital voluntarily even when they are under the CTO. When the service user is told they are to be recalled they are encouraged to make their own way to hospital or attend with a member of the community team. If they refuse to attend hospital the ambulance and police service can be called upon to take them there.

Once a service user has been recalled, the psychiatrist has three options after the 72 hour recall period has ended. They can:

- Revoke the CTO with the agreement of an AMHP, which means the service user reverts back to compulsory hospitalisation and treatment under Section 3 or 37. This happens if the service user is deemed to be significantly unwell, and to meet the criteria for Sections 3/37.
- Discharge the service user into the community back on the CTO. This would happen if the service user has been assessed and treated adequately within the 72 hour period, and is deemed stable and low-risk enough to be discharged.
- Discharge the service user into the community with no CTO in place. This is unlikely to happen, but may occur if it is believed that the CTO is no longer appropriate.

Process and criteria for ending or extending a CTO

CTOs initially run for a period of six months. They can then be renewed for a further six months, and then for a year at a time. If CTOs are renewed at the end of each six month/year period, they can run indefinitely. Discharge from the CTO may take a number of routes:

- The psychiatrist can choose to discharge at any time during the CTO (in practice this usually happens at a mandatory review shortly before the CTO is due to expire, where a decision is made whether to renew or discharge the CTO).

- The CTO can expire automatically at the end of the six month/year period (although this is not usual practice, as it would mean a review has not taken place).
- The Nearest Relative can apply for discharge (again, not typical and can be overturned by the psychiatrist).
- The CTO can be discharged on appeal at a Managers' Hearing or Tribunal².

Typically then, the decision to discharge or renew a CTO is made at the mandatory review attended by the psychiatrist, the AMHP, the care coordinator, the service user, and their carer if applicable. In order to discharge the CTO, the psychiatrist has to believe that the service user no longer meets the criteria for the CTO. If the CTO is renewed at this review, the decision is made subject to legal scrutiny through appeal, where it is decided whether the renewal was appropriate.

The foundations for a study of CTO practice

I have described in a very functional way how CTOs work and the legal framework for their use, which will be referred to at various points throughout the thesis. I now turn to the various rationales I draw on in the thesis, and how together they form the basis for the guiding research questions I use to investigate CTOs, beginning with a summary of how the thesis adds to the current body of CTO research.

A relatively significant body of international research on CTOs has built up over the last thirty years, much of it based on experimental research designs and aimed at ascertaining whether CTOs are effective in relation to a defined set of outcomes, particularly reduction in hospitalisation rates. Such research has yielded an equivocal picture of CTO effectiveness, with little agreement on the conclusions to be reached (Kiseley et al, 2007, Swanson and Swartz, 2014). Consequently it appears that these studies have contributed to the further

² I explain Managers' Hearings and Tribunals in more detail in Chapter Nine, when I discuss the appeals process.

embedding of the dichotomous positions that exist on CTOs. There are broader questions that can be asked about this research agenda, namely that it takes a very particular view of CTO outcomes, which does not account for plurality in terms of the relative value of such outcomes or indeed, the various implications that might arise from CTO use as a complex policy programme. However, whilst there have been a small number of exploratory studies of stakeholder perspectives on CTOs, there has been little in the way of studies of everyday CTO practice which may help account for such plurality in CTO use. A generative, practice-oriented narrative of change through the CTO process would help develop an understanding of how and why CTOs are used, the range of potential consequences they can lead to, and how these consequences are shaped, interpreted and experienced by service users and practitioners. Through taking such an approach a dual analysis can be formed; one which both *explains* the paths a CTO might take inclusive of stakeholder influence, and *describes* the ways that the CTO affects those who are made subject to it and who implement it.

In order to undertake such an analysis I employ both critical realism and governmentality as theoretical guides. A critical realist view of causality can be understood as generative and explanatory in nature, entailing the investigation of context and causal mechanisms. Given my stance towards CTOs as necessitating an investigation which does not take a strong position on their use, I draw from the empirical rather than the emancipatory variant of critical realism to elucidate CTO context-mechanism-outcome configurations (Pawson and Tilley, 1997, 2004). At the same time, such an approach by itself tends to ignore the ethical dimension to policy programmes, an understanding of which seems particularly important for a compulsory intervention such as the CTO. Governmentality allows for an ethical yet non-deterministic and descriptive analysis of different kinds of power as they operate through the ‘conduct of conduct’ (Foucault, 2007, Dean, 2010). Therefore, bringing critical realism and governmentality together provides a framework in which I can address both the reasons *why* CTOs may lead to a variety of outcomes - the effects of policy - and *how* CTOs work to regulate conduct and encourage self-conduct through coercive, disciplinary and reflexive means. To translate this framework to the empirical domain I

particularly draw on the work of Pawson and Tilley (1997, 2004) for critical realism and Dean for governmentality (2010), which together enable the CTO journey to be traced from policy theory through practice to its implications. In this way, I distil the complementary research and theoretical rationales explained thus far into the following set of research questions:

1. Why did CTO policy come to exist, and exist in the form that it does in England? How have problems been framed as problems for the CTO to solve?
2. In what ways are CTOs conceptualised by practitioners and service users? How do these conceptualisations align or not with policy-level reasoning? For practitioners in particular how do they formulate CTO practice based on these conceptualisations?
3. How do CTOs work, and what factors – inclusive of participant action - influence why they work in those particular ways?
4. What are the varying consequences of the CTO that result from these practices, how are these consequences thought about by practitioners and service users, and how do such consequences relate to policy and practice-level reasoning on their use? How do CTOs work to produce change in service user identities and conduct, and in what ways are the transformational potentials of CTOs realised or resisted?

For a rounded analysis of CTOs to be achieved which answers these questions, an ethnographic approach is necessary that gives a view of CTOs over time, within context and through a variety of methods utilised to capture both action and meaning in their everyday practice. I use such an approach to investigate CTOs as they are practiced within English mental health services. In addressing these questions in this particular way, I hope to generate and present findings which have significance for:

- Policy, by explaining how CTOs as an indicative case illuminate the potential gaps between policy and practice rationalities and the variability of outcomes that can arise from policy programmes.

- Practice, by showing the differing uses to which CTOs are put, how they are practiced and the implications of such practice.
- Research, by addressing facets of CTO use which have not been fully explored, through a research methodology which has not been employed in this field thus far.
- Theory, by bringing to the surface the governmental operation of different forms of power in CTO use, and how they are manifested through thought, practice and identity work.

Thesis outline

Chapters One, Two and Three respectively present the empirical, theoretical and methodological background to the thesis. In **Chapter One** I set out the research literature on CTOs and what it tells us about CTO effectiveness, stakeholder perspectives and CTO practice. The aim of this chapter is to demonstrate where the thesis is situated within the current body of research on CTOs, and what additional knowledge it could contribute to the research literature. In **Chapter Two** I develop the theoretical framework for the thesis, specifically explaining the rationale for employing a critical realist-governmental framework, and how the two are integrated in a way that is philosophically coherent. The chapter concludes with a mapping of this framework via realist policy evaluation (Pawson and Tilley, 2004) and an analytics of government (Dean, 2010) onto the research questions and ensuing ethnographic approach taken in the thesis. In **Chapter Three** I further detail the methodological framework for the thesis, substantiating the research design and methods used. I explain how I embedded an ethnographic approach within a case study design in two Mental Health Trusts to bring breadth and depth to the findings, and how combining interviews, observations and documentary analysis sheds light on different aspects of the research. The chapter also includes a description of how the fieldwork was undertaken, with particular reference to the recruitment, selection and characteristics of participants, and the ethical dilemmas faced during the fieldwork.

Chapters Four to Nine form the main body of the thesis, and elucidate the findings. These chapters are aligned with the four sets of research questions outlined earlier, and trace a route from CTO policy theory through ‘ground-level’ conceptualisation, practice and practice experiences, and reflections on CTO ‘endings’. In **Chapter Four** I undertake a CTO policy review, which aims to formulate why and how CTOs came to exist as they did in English mental health services. I draw out the ideational, historical and spatial elements which went into constituting CTOs in their current form, and end the chapter by conducting a comparative analysis which highlights the particular nature of CTOs as they manifest in England. **Chapters Five to Nine** move on to present the findings generated through the empirical fieldwork. **Chapters Five and Six** are ‘mirror’ chapters, in that they respectively deal with service user and practitioner conceptualisations of CTOs, each exploring the various beliefs that shape participant understanding of the CTOs and the associated purposes they see the CTO being put to. Specifically, **Chapter Five** explores service user identity formation in the face of severe mental difficulties, and how such self-perceptions influence their view of the CTO as either performing an important role in regards to provision, risk, recovery and maintenance, or blocking their ability to reach their goals. **Chapter Six** describes the disjuncture between policy and practitioner reasoning on CTOs, and in turn how practitioners’ reasoning is based on particular ethical foundations. Practitioners described the potential purposes of the CTOs in similar terms to service users and I separate these into short-term aims related to protection and risk and long-term aims related to stability and recovery. **Chapters Seven and Eight** are also ‘mirror’ chapters, this time exploring the everyday practice of CTOs from the position of the service user and then the practitioner, with attention paid to the personal, interpersonal and systemic factors that shape CTO practice. Both chapters are structured around the CTO process, starting with a discussion of discharge onto the CTO, before moving on to the role of conditions and finally the use of recall. **Chapter Seven** highlights the connections between service users’ beliefs regarding the CTO, their interpretation of how it works and their responses to it. I also foreground the significant mediating influence of the service user-practitioner relationship, and how this informed service user experiences of the CTO. **Chapter Eight** focuses on how practitioners made use of the CTO and the factors that shape that

use, referring to relational work with service users but also broader cultural and institutional dynamics. **Chapter Nine** is the final findings chapter, and is orientated around the decision-making process when discharge from the CTO is being considered. It covers relatively new ground in English mental health research through detailing the appeals process for CTOs, and particularly the main elements appeal panels consider when making their decision. It then moves onto the more contested decision-making arena of CTO reviews, and illuminates how practitioners deal with considerations of risk, evidence, causality and trust when deciding whether to end or continue a CTO. The chapter ends by highlighting the balancing acts practitioners perform when weighing up the benefits and costs of continuing the CTO, particularly in relation to change/stasis, dependency/responsibility and engagement/alienation. In this way the chapter also draws attention to the various intended and unintended consequences of using the CTO.

Chapter Ten draws together and analyses the findings in a discussion of CTO policy and practice. I align the findings to the research questions which were explained and outlined in Chapter Two. Accordingly I explore what the findings mean for an understanding of CTO policy development, ‘ground-level’ conceptualisations of CTOs, the operation of agency, interaction and context in CTO practice, and CTO ‘ends’ – their personal and social consequences. In doing so, I make explicit connections between the findings and the specific aspects of the critical realist-governmentality framework to which they are related. In the ensuing **Conclusion**, I elucidate what this discussion signifies for current CTO policy and practice, the CTO research agenda, and for the marrying of a critical realist and governmental approach.

Chapter One:
What do we know about CTOs?
Effectiveness, perspectives and practice

The research body on CTOs stretches back thirty years and across a range of countries, including Australia, New Zealand, Canada, the USA, Israel and the UK. The majority of research on CTOs can be described as attempting to measure their effectiveness across a range of outcome measures. A smaller group of studies, mostly qualitative in nature, have sought to ascertain how CTOs are viewed by stakeholders. Practice-focused studies which have explored the day to day use of CTOs are even fewer in number. In this research review I describe the kinds of research that have taken place, examining both findings and methodology in order to account, in part, for the substantive and methodological approach I have taken in this thesis.

Before doing so, a note on the search approach chosen for this review would be helpful. The search was deliberately narrative rather than systematic in scope, as my intention was to ascertain the extent of the total CTO research landscape, rather than focusing on inclusion or exclusion of studies based on quality criteria. The report prepared for the Department of Health by Churchill et al (2007) is still the most comprehensive account of CTO research literature to date, and I used that as a starting point to evaluate where the main foci had been in studies of CTOs. From their review I was able to get a sense of how to categorise the research literature, and more importantly to see what had been prioritised and in turn omitted from the knowledge base on CTOs. I structured my review – and this chapter – accordingly, starting with the main body of work on CTO effectiveness, before moving on to the smaller groupings of studies on stakeholder perspectives and on CTO practice itself. In order to bring the search up to date and to keep the review contemporary, I also searched the main health and social care research databases and Google Scholar at six monthly intervals during the course of the PhD. As the PhD progressed and I built up contacts with academics in the field, I also kept abreast of key research developments and publications in the field, particularly those that came from the Department of Health sponsored national OCTET study, and from other English studies such as

that undertaken by Stroud, Doughty and Banks (2013). In this way I developed an argument for what kind of methodological approach would be of use in extending the body of CTO research, which I present now.

Do CTOs work?

The effectiveness of CTOs has mainly been tested with regard to how they have affected admission rates to hospital, with lower rates being viewed as evidence of their effectiveness. Churchill et al (2007, 178), in their comprehensive review of CTO research also identified other reported indicators across 28 studies, including:

length of stay, remaining in contact with services, service intensity and compliance with treatment...social functioning, violence/threatening behaviour, arrest, employment, accommodation status, mental state and psychopathology, quality of life, criminal victimization, number of needs for care, carer satisfaction...and adverse events.

Most of this research consists of ‘before and after’ studies (for example Geller et al, 1997, Muirhead et al, 2006, O’Brien and Farrell, 2005), which in general show a clinical improvement in those made subject to a CTO, but have also been criticised for serious methodological deficiencies, particularly a lack of control for other factors (Kisely et al, 2005). More rigorous matched (Kisely et al, 2004, Preston et al, 2002) and randomised controlled trials (RCTs) (Steadman et al, 2001, Swartz et al, 1999) have been more equivocal in their findings, concluding that CTOs result in little or no difference, particularly in terms of the primary outcome of hospital admissions, but also in regards to contact with services, clinical functioning or quality of life measurements. A Cochrane review (Kisely et al, 2005, 2), of this experimental research accordingly concluded “it is...difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest”. At the same time however, there is some basis to suggest CTOs may work in reducing the length of admissions for particular client groups (Kisely et al, 2013, Segal, Silverman and Temkin, 2010). Secondary post hoc analyses of the Swartz et al (1999) and Steadman et al (2001) RCT data have also been more positive in their evaluations, with Swartz et al (2001) claiming that whilst short duration CTOs are not effective, CTOs of longer length led to

57% fewer hospital admissions than in the control group. Other secondary analyses of these two studies have shown a correlation between longer lasting CTOs and other more distal factors such as a positive impact on care-giver strain (Groff et al, 2004), reduction in risk of victimisation (Hiday et al, 2002), and reduction in violence towards others (Swanson et al, 2000). However there are two problems with the interpretation of such findings; firstly multiple post hoc analyses cannot be relied upon to demonstrate causality due to the increased risk of false positive results (Torgerson and Torgerson, 2008); secondly and relatedly, given that the two original studies reported no significant differences, these secondary analyses can only be seen as exploratory and hypothesis-generating.

The lack of statistically significant differences between control and experiment groups in those two RCTs is perhaps due to the inherent ethical and methodological difficulties in conducting controlled studies on ‘real-world’ policy initiatives such as CTOs (Gould, 2006). The complexity of CTOs means that problems arise in separating out the ‘active’ component under study from other localised factors, thus reducing replicability and generalisability. Indeed, it has been argued that a key issue with the findings of such studies is whether it is the care and treatment CTOs may engender or their compulsory nature which affects outcomes (Kisely, 2005). Furthermore, given that the two RCTs were carried out in the USA, it is difficult to see how they can be applied to the qualitatively different English CTO model. For this reason, the Department of Health commissioned the Oxford Community Treatment Evaluation Trial (OCTET) in 2008, a national RCT to investigate the effectiveness of CTOs. As with other experimental studies in this area, the main outcome measured by OCTET was the effect of CTOs on hospital admission rates, with secondary measurements of psycho-social outcomes also taking place. The study found no difference in numbers of readmissions to hospital, with the investigating team consequently proclaiming that the use of CTOs is no longer ethically justifiable (Burns et al, 2013, Burns and Molodynski, 2014). As with the previous RCTs, there have been criticisms of the fidelity of the research undertaken, particularly with regards to protocol violations (Curtis, 2014). Even so, the continuing rise in involuntary admissions in England - 10% over five years (Health and Social Care

Information Centre, 2012) - appears to be consistent with the more general claim that CTOs have not brought about a reduction in hospitalisation rates.

Despite the findings of OCTET however, there remains little consensus on CTO effectiveness, with proponents and opponents continuing to use effectiveness research in a rhetorical sense to support their stance (see Swanson and Swartz, 2014). As Kiseley et al (2007, 12) comment in a systematic review of CTOs, “it is striking how reviews of the same studies can come to markedly different conclusions”. Arguments on these grounds are often made with recourse to ethical reasoning, which in turn is limited to the question of whether CTOs ‘work’ or not. Such an approach may be problematic for three reasons. Firstly, even if the evidence for CTO effectiveness was unequivocal, it “may not provide sufficient justification for CTO use without the availability of additional information about potential negative consequences”, (Churchill et al, 2007, 19), some of which may not be obvious or easily discerned. Equally, equivocal or negative evidence does not necessarily negate the use of CTOs in particular circumstances, suggesting a weighing up of the implications is required. Secondly, the choice of what counts as an important measurable outcome is dependent on epistemic positioning, as demonstrated by the focus in much of the effectiveness research on rates of hospitalisation and length of inpatient stay. CTOs can incorporate a range of outcomes, which will be differentiated in importance both between and within stakeholder groups such as policy-makers, practitioners, service users and carers. Light (2014, 7) refers to this when posing the question “should CTOs be determined as lacking in efficacy based on a disputed primary research finding of no difference in readmission rate in a small number of randomised controlled trials and other studies?” In a related sense, experimental studies by their design prioritise outcome measures over process or output measures. For example, the OCTET study did not account for rates of recalls to hospital as they were counted as a process measure rather than an outcome measure. This raises questions around what counts as a meaningful consequence of an intervention. Keeping with the recall example, it can be posited that if an individual was recalled to hospital, that would likely feel a very real consequence of being on a CTO. Perhaps then, the implications or results of

being on a CTO can be seen in broader terms than that which is generally understood in experimental research.

Finally, whether outcomes are viewed as positive or negative depends on ethical stance, as is particularly evident in regards to hospital readmission rates for those on CTOs, where increasing rates of hospitalisation are consistently positioned as a negative outcome. It may be the case however that increased/static hospitalisation rates could be a positive sign that CTOs are working in identifying relapse early. As Kahan et al (2009) hypothesise, cultural cognition - the pre-existing cultural beliefs that people hold - may shape perceptions of the overall effectiveness of CTOs. This in turn suggests that in the study of CTOs, there is a requirement for “a more pluralistic approach to constructing the necessary knowledge of CTOs to enable communities to make sound decisions about their use” (Light, 2014, 8). The next section will develop further this argument in relation to the perspectives of service users and professionals regarding CTOs.

What do people think of CTOs?

Research approaches to ascertaining the views of stakeholders on CTOs can be categorised into; surveys of psychiatrists, qualitative studies involving practitioners, service users and carers as participants and experimental studies which contain outcome measures of service user perspectives. Research findings in this area have been dominated by the mixed-methods New Zealand Otago CTO study, which included a national survey of psychiatrists (Romans et al, 2004), and semi-structured interviews with 42 CTO service users, their psychiatrist and a family member. Various aspects of the qualitative section of the study have been reported on, including, the Maori experience of CTOs (Gibbs et al, 2004), perceived dilemmas for practitioners (Mullen, Dawson and Gibbs, 2006), family perspectives (Mullen, Gibbs and Dawson, 2006), women’s experiences of CTOs (Gibbs, 2010), as well as a general overview (Gibbs, Dawson and Mullen, 2006). A similar mixed methods study was carried out in Saskatchewan, Canada, involving a survey of psychiatrists (O’Reilly, Keegan and Elias, 2000) and semi-structured interviews with 14 CTO service users, their

family members and care coordinators (O'Reilly et al, 2006). Qualitative interview-based research has also taken place in Australia with smaller cohorts, (Brophy and Ring, 2004, Rolfe et al, 2008, Light et al, 2014). The American contribution to research on stakeholder views has conformed to an experimental research agenda, measuring subjective facets of CTO use such as service user attitudes to the fairness of CTOs (Swartz et al, 2004), and whether CTOs are rated as coercive by stakeholder groups as compared to alternative scenarios (Swartz et al, 2003). As with research on effectiveness, few opinion-focused studies have taken place in England post-CTO introduction, with the majority being on stakeholder views of its precursor, Supervised Discharge, and/or the proposed introduction of CTOs (Crawford et al, 2000, 2004, Franklin et al, 2000, Canvin, Bartlett and Pinfold, 2002, 2005, Gault, 2009). The exceptions are a recent survey of English psychiatrists' views on the CTO as it is currently being used (Manning et al, 2011) and a qualitative study on the perspectives of carers, service users and practitioners on CTOs within the context of personalisation (Stroud, Doughty and Banks, 2013).

Practitioner perspectives

Three of the four surveys that have been undertaken on CTOs (O'Reilly, Keegan and Elias, 2000, Romans et al, 2004, Manning et al, 2011) reported a positive attitude towards CTOs amongst psychiatrists, with the majority being in favour of a system that included their use. Interestingly, Manning et al (2011) reported a potentially positive shift in views over time amongst English psychiatrists. A previous survey of 1171 psychiatrists across England (Crawford et al, 2000) stated 46% supported the plans for CTOs and the authors concluded a "clear consensus on the need to extend compulsory powers into the community does not exist" (Crawford et al, 2000, 1). Out of the 566 useable responses Manning et al (2011) received, 60% were in favour of the CTO. A comparison of the two surveys needs to be treated with caution due to their different response rates and contexts, but it may be that the integration of CTOs into clinical practice resulted in them being deemed more acceptable than when they were only a theoretical possibility. Respondents to Manning et al's (2011) survey also generally agreed with statements that CTOs complemented pre-existing powers and that the

increase in powers CTOs represent would benefit service users. Combined with on average strong disagreement with the statement that ‘CTOs would not be necessary if community services were better resourced’, this suggests that psychiatrists believe that CTOs distinctively ‘fill a gap’ in provision and legislation. Despite the general acceptance of CTOs, a significant minority in both Romans et al (2004) (31%) and Manning et al (2011) (19%) held concerns that CTOs would hinder the therapeutic alliance between psychiatrist and service user. These surveys also highlight an important issue for the study of practitioner views on CTOs; the perspective of psychiatrists has been privileged over other professional groups, perhaps because they are the primary ‘formal’ decision-maker when applying CTOs. However, in England, it can be argued that the care-coordinator is likely to have a more in-depth understanding of the day to day use of CTOs than the psychiatrist. In addition, AMHPs also play an important secondary role in formal decision-making on CTOs and consequently their opinion on the merits or otherwise of CTOs should be considered.

The studies that have incorporated semi-structured interviews and focus groups have included a broader range of practitioners and have allowed for a thematic analysis of practitioner perspectives. In these findings it is evident that practitioner views on CTOs were largely context-dependent, and involved balancing potential benefits and harms. O’Reilly et al (2006) found that the majority of practitioners interviewed valued CTOs for the potential they brought for stability in the community, but some were concerned about the less easily quantifiable effects resulting from coercive experiences. Similarly Mullen, Dawson and Gibbs (2006) reported the uncertainty involved for practitioners in deciding whether CTOs would be helpful and the difficulty in considering the broad range of factors at play in individual cases. In this study, justification for the use of CTOs was linked by practitioners to the role they felt CTOs could play at the start of a long-term process of rehabilitation. By way of contrast, concerns were also reported that being placed on a CTO may remove an individual’s sense of autonomy and foster dependency on services and practitioners, as the CTO acts to ‘bind’ service users to services. From a legal perspective, AMHPs interviewed as part of the study by Stroud, Doughty and Banks (2013), although the most critical of all the practitioners interviewed, were of the view that CTOs

gave more legal protection and structure for service users than pre-existing legislative provision. What is also evident here is that practitioners' views on why they valued CTOs were variable, and did not always cohere with each other. For example, in contrast to the well-reported views referred to above that CTOs were seen as positive as they could allow for stability in the community, Stroud, Doughty and Banks (2013) report the key purpose given for CTOs by psychiatrists was to facilitate fast and preventative recall to hospital, as a risk management exercise.

Such findings reinforce the need for research to account for the plurality of CTOs. More specifically, the different purposes practitioners state CTOs can be put to suggests that there may be corresponding implications for how they are used, which could be explored further, taking a 'practice-focused' approach to research. In this regard, whilst these studies provide valuable evidence on the perceived advantages/disadvantages of CTOs and why practitioners think CTOs are necessary, they do not enable an analysis of how practitioners use elements of the CTO, what influences are instrumental in their perceptions and practice of CTOs, and what day-to-day ethical and practical challenges practitioners face in implementing CTOs.

Service user perspectives

An overarching theme in all the qualitative studies that include service user participants is considerable service user ambivalence towards the use of CTOs, with benefits like security being described alongside references to CTOs' stigmatising effects and the loss of freedom they entail. Themes that arose from studies were uncertainty about what service users felt they were allowed to do when under the CTO and strong views on the coercive element of CTOs, which were described as restrictive and carrying an underlying threat of sanctions (Brophy and Ring, 2004). Some service users were also concerned that being made subject to a CTO placed an additional label on them on top of their diagnosis, which might serve to differentiate them within services, and consequently negatively affect the way they are treated by practitioners (Brophy, 2009). The focus that CTOs placed on medication could be resented and seen to

displace other forms of support (Brophy and Ring, 2004, Gibbs, Dawson and Mullen, 2006).

However, at the same time, the studies highlight that service users could also appreciate the safety net CTOs provided, believing they allowed for quicker access to hospital if necessary and that they enabled the provision of higher quality, more attentive services (Gibbs, Dawson and Mullen, 2006). CTOs could also be viewed as helpful in providing structure and stability in the community through difficult periods in service users' lives (Gibbs, Dawson and Mullen, 2006). If the CTO had been experienced as helpful during difficult periods, then service users could become 'volunteers for compulsion' (Gibbs et al, 2005, 365). Similarly, Swartz et al (2004) found that if CTOs were believed to be effective by service users, they also tended to be perceived as fair. There was an associated theme that service users were likely to prefer CTOs in terms of freedom to hospitalisation (Stroud, Doughty and Banks, 2013, Gibbs, Dawson and Mullen, 2006). Swartz et al (2003) used vignettes to ascertain which outcomes would be least acceptable to different stakeholder groups and found the service user group had similar findings to the other groups in that being placed on a CTO was significantly more acceptable as an outcome than experiencing rehospitalisation, violence and poor interpersonal relationships. Service users interviewed in qualitative studies reported more ambivalent views on restrictions to their freedom through CTOs; Gibbs, Dawson and Mullen (2006) mention restrictions on medication choices, travel, residence, and more fundamentally a feeling of being prevented from making decisions, as being described by service users.

More broadly, comparing CTOs positively to hospitalisation does not necessarily tell us about the feelings of disenfranchisement that may result due to the CTO in itself or allow for a deeper understanding of service users' lives whilst on the CTO in the context of their experiences in hospital and the community. In this sense, Light et al (2014) make the point that the experience of CTOs is not as simple as a choice between freedom and control, and that ambivalence towards CTOs points towards deeper, more complex aspects of living under compulsion. Instead, being on a CTO can accentuate ontological questions of what it is to be

in the world as an individual within the mental health system. Indeed, an exploration of compulsion in the community in relation to coercion and its corresponding potential to affect sense of self, identity and belonging are aspects of the CTO experience that have been highlighted as requiring further attention (Churchill et al, 2007). Newton-Howes (2010, 218) in describing how compulsion should be dealt with ethically in practice, notes that:

When considering the ‘harms’ of coercion and compulsion it is the requirement to do ‘good’ that acts as a counterpoise....In other words the consideration of any ...coercive ‘loss’ is outweighed by the potential for ‘good’ to come...There is an increased burden on the professionals involved to be clear what that good is.

It is interesting that in the CTO research literature, much more attention has been paid to investigating the potential concrete benefits of compulsion, than the perhaps more nebulous and ambiguous effects it might have on an individual. If this argument is followed further, such an analysis would not only explore the effect CTOs may have on those who are placed on them, but would also take account of how individuals orientate themselves to the CTO and incorporate it (or not) into their lives over time. In other words, exploring how individuals see themselves in relation to the CTO would also shed light on how they perceive and respond to particular elements of the CTO, such as conditions and the recall process, and how those responses may influence the path the CTO takes.

How do CTOs work in practice?

The combined literature on practitioner and service user views on CTOs gives us an understanding of how CTOs are viewed. As I have highlighted however, how and why CTOs function in particular ways, inclusive of the positions practitioners and service users take towards CTOs, are aspects of CTO research that can be taken further. Whilst studies of stakeholder opinions on CTOs are fewer in number than experimental studies of CTO outcomes, research on how CTOs work in practice is even less common. Here, I will thematically describe the findings of that research which includes reference to CTO practice.

Challenges in using CTOs

In outlining how they felt about CTOs, practitioners also discussed the challenges that have manifested in their use. The additional burden of paperwork was highlighted in Manning et al (2011) as a factor that discouraged psychiatrists in England from using CTOs. Similarly, O'Reilly et al (2006) found that practitioners struggled with some of the procedures for CTOs, as not being 'fit for purpose' and overly bureaucratic. In more embedded systems however, such as New Zealand (Mullen, Dawson and Gibbs, 2006), such concerns had diminished over time. Both surveys in New Zealand (Romans et al, 2004) and England (Manning et al, 2011) stated a key concern for undermining the use of the CTO was lack of access to services and particularly supported accommodation for individuals returning to the community from hospital. Community service provision is less of a factor in the use of CTOs in England as it is in countries like the USA, where a fragmented health system means CTOs are viewed as important in holding services to account in provision, particular on discharge from hospital (Collins, 2005). Nevertheless, having the framework in place to support the CTO through a careful care-planning process was seen as necessary (Stroud, Doughty and Banks, 2013). In this sense, multi-agency/professional communication, and the local context of provision and 'politics', for example the state of relationships between inpatient and community staff, were mentioned as influencing the progression of CTOs (Stroud, Doughty and Banks, 2013, Manning et al, 2011).

Decision-making and reasoning

An important element of cooperative working is a shared understanding of what the CTO is for and how it works by professionals. Understanding of CTOs can be variable between different stakeholder groups (Stroud, Doughty and Banks, 2013), and there could be uncertainty for professionals in making decisions. What is missing from research into decision-making and reasoning on CTOs however is how they work 'downstream' (Dawson et al, 2003) particularly in relation to the central interlocking mechanisms of conditions and recall, and in regards to the legal oversight of CTOs, specifically the appeals process. The

research that has investigated decision-making practice has focused on the ‘beginning’ and ‘end’ of the CTO process. Mullen, Dawson and Gibbs (2006) highlight the dilemma practitioners faced in deciding whether to discharge a CTO or not. They report that this dilemma came down to the weighing up of probabilities and making a judgement on whether any positive progress made will continue following discharge. Deciding on discharge was dependent on the level of risk a practitioner was willing to accept, given their past experiences of CTOs and the profile of the individual they were making the decision about. It can be inferred from this that although CTOs may for some individuals prevent ‘short, sharp’ compulsion via involuntary hospitalisation, they may result instead in ‘defensive’ decision-making in the community, resulting in individuals being under compulsion for much lengthier periods of time. Nevertheless, risk management as it can be understood in terms of the protection of others is not necessarily viewed as being a significant element of practitioner reasoning in deciding on the use of CTOs. An interesting finding from the surveys (Romans et al 2004, Manning et al, 2011) is that CTOs were supported by psychiatrists on clinical grounds rather than in relation to risk management. Both surveys described how psychiatrists rated supporting treatment adherence, provision of authority to treat, contact with professionals, identification of relapse and protection of patients from consequences of relapse in their ‘top five’ decision-making factors for using CTOs, with reduction of risk of violence to others given lower importance. These findings also suggest that practitioner reasoning follows a particular chain of logic, with emphasis being placed on enabling mechanisms (for example authority to treat) and ‘foundational’ outcomes (such as treatment adherence) rather than what could be classed as secondary outcomes.

The role of insight in the justification and use of CTOs

Not adhering to treatment is commonly attributed by CTO advocates to a lack of insight by individuals into their disorder which makes them unable to make rational treatment decisions (Munetz and Freze, 2001, Swartz et al, 2004).

Research has suggested that people diagnosed with severe mental illness who

have poor levels of treatment compliance tend to display worse psychotic symptoms, relapse more quickly and are hospitalised more frequently (Valenstein et al, 2002, Eaddy, Grogg and Locklear, 2005). Accordingly, development of insight was ranked in the top two factors for psychiatrists in deciding whether to discharge a CTO (Romans et al, 2004, Manning et al, 2011). Insight in these terms is defined as an individual's ability to see themselves as mentally ill and to frame their experiences in pathological terms (David, 1990). Further, defining insight in such a way is associated with the view that a lack of insight is a 'neurological deficit' which manifests as a clinical symptom of mental disorder (Arango and Amador, 2011). Insight is therefore framed as a specific, measurable entity which is likely to be missing in individuals diagnosed with a severe mental disorder, especially schizophrenia. Through testing the hypothesis that a lack of insight leads to non-compliance, Swartz et al (2004) found that those individuals who did not adhere to treatment before being placed on a CTO tended to be less likely to perceive themselves as ill or to accept neurological explanations for their condition.

Focusing on a lack of insight as the cause of noncompliance, particularly as a neurological symptom of illness, provides greater justification for enforced treatment as it is based on the premise that the individual needs to be acted upon as opposed to the external factors that may contribute to their level of engagement. It also means that the individual's view of their own experiences may be underplayed in ascertaining the best way forward. Taking this stance towards cognition may limit the researcher or practitioner's ability to explore individual's explanations of their experiences, which could yield valuable knowledge and lead to different conclusions on treatment pathways or whether compulsion is necessary (Bracken and Thomas, 2005). Dawson and Mullen (2008), in a paper on the findings of their qualitative study relating to insight, suggest that if a service user does not hold the same view as their psychiatrist, capitulation may be required from the service user for discharge from the CTO to occur. More specifically, the use of insight as a concept in CTO research and practice can lead to tautological reasoning, where resistance to treatment is automatically equated to a lack of insight. A broader point can be made here about CTO research, in that it is largely descriptive in nature, and rarely seems to

theorise or critically analyse CTOs and the concepts CTO practice is based on. For example Swartz et al (2003, 90), in finding that the majority of their research participants did not endorse CTOs as personally beneficial, speculated that it was too much to expect a “recovery of insight manifested as an autonomous retrospective endorsement of...having been coerced into treatment”. Returning to the practice of CTOs, Dawson and Mullen (2008, 270) comment that insight can be used as a ‘covert standard’ in decision-making on CTOs, in which “treatment adherence is used both to measure insight, and attributed to degree of insight, at the same time”. In this regard, whilst attempts have been made to ‘objectify’ insight in CTO research, it is subjectively applied as a measure by both practitioners and researchers and as such it remains an “unhelpfully inexact” concept, particularly in the way it is used to underpin legal decision-making (Diesfeld, 2003, 371). Nevertheless, Dawson and Mullen (2008) report that insight in itself, whilst an important concept for practitioner understanding of service user situations and subsequently CTO progression, was not necessarily relied on inflexibly as an indicator for decision-making. The importance psychiatrists attached to insight did not always preclude the discharge of a CTO if insight was deemed not to be present but compliance with medication was still viewed as likely.

Treatment adherence and CTOs

The routine conflation of a lack of insight and noncompliance has been challenged. In particular Beck-Sander (1998) highlights studies where levels of insight have been defined separately from treatment compliance, which found a poor correlation between the two. Similarly, in comparing the attitudes of non-adherent and adherent patients to psychotropic medication, Scott and Pope (2002) did not find an association with measured levels of insight. More broadly, as Chakrabarti (2014) points out, the rate of compliance with medication tends to be similar across physical and mental illness, which challenges the theory that noncompliance is due to an inherent inability to value treatment in individuals diagnosed with psychotic disorders.

Noncompliance with medication can be seen instead as a complex process, dependent on social and service factors, life circumstances, resources, priorities and available information (Chakrabarti, 2014). Social factors that can contribute to noncompliance with medication include the stigma attached to being a mental health service user, the availability and closeness of a support network, housing instability, employment status and levels of substance misuse (Van Dorn et al, 2006). If a service user fears that compulsion may arise through maintaining contact with services, or feel that they are not included in treatment decisions, then levels of compliance can be affected (Oehl, Hummer and Fleischhacker, 2000).

The well-documented potential side effects of anti-psychotic medication (Calton and Spandler, 2009) and the possibility of treatment resistance (NICE, 2014) can also contribute to individuals deciding to reduce dosage or stop medication altogether. As Wales and Hiday (2006) point out, the arguments in favour of CTOs as a medication enabler are the consequence of assumptions that are rarely critically examined in the CTO research literature, about both the typical characteristics of individuals diagnosed with a severe mental illness and the usefulness of medication, specifically antipsychotics. NICE (2014) suggests that up to a third of people do not respond to antipsychotics, and if an individual displays treatment-resistance to one type, it is unlikely that they will respond to others. Some systematic reviews have provided evidence for antipsychotic effectiveness in helping reduce positive symptoms, improve functioning and lower the rate of relapse (David and Adams, 2001, Marder and Wirshing, 2003, Adams et al, 2013). Others have been more ambiguous in their findings when comparing individual antipsychotics to placebos, particularly taking account of the highly variable quality of research reviewed (Irving, Adams and Rice, 2006, Omori and Wang, 2009, Rattehalli et al, 2010, Matar and Almerie, 2013). As Fisher and Greenberg (1997, 362) conclude in an earlier review, “the potency of any [psychotropic medication] is typically inverse to the degree to which the drug trial in which it was tested was adequately controlled”. In a wider sense, it has also been suggested that the neo-Kraepelinian view of discrete diagnoses in mental health can lead to flawed prescription practice, where alternative drug

regimes may be more effective than those given simply because an individual has received a certain diagnosis (Bentall, 2004).

A common response to treatment resistance by psychiatrists is to combine different types of antipsychotic medication, or to increase the dosage beyond the standard dose recommended by the British National Formulary, which is set to maximise the balance between therapeutic gain and side-effects (NICE, 2014). However, neither of these strategies have been proven effective (Taylor, 2010), and in the case of 'over-dosing' can lead to worse outcomes due to the escalation of side-effects. Consequently, it could be concluded that if medication non-response is beyond the ability of psychiatrists to control, it could lead to relapse and hospitalisation for some proportion of service users, which partially challenges the claim that noncompliance is the primary cause of mental deterioration (Weiden and Glazer, 1997). Studies on service user opinions around medication management in mental health suggest that practitioners may not always listen sufficiently to concerns around treatment side-effects, or try and act to alleviate them, which may lead to medication self-management in the form of reduction or ceasing of medication (Gray, Wykes and Gournay, 2002).

Van Dorn et al (2006) examine the relationship between CTOs and perceived barriers to seeking support. They suggest that the complex interplay of personal and environmental factors that can lead to noncompliance means that those individuals who tend to be put under the greatest pressure to comply with medication via leverage such as being placed on a CTO, can also face the greatest barriers in being able to do so. In addition, they hypothesise that the CTO as a tool that should facilitate treatment and engagement may instead act to further estrange individuals, making it less likely that they will engage voluntarily. In finding a relationship between low level usage of services and CTOs, they considered that this may either be because practitioners were targeting those individuals who would not otherwise participate, or because CTOs have had the effect of "further alienating some individuals and strengthening the internal barriers that keep them from participating voluntarily in treatment" (Van Dorn et al, 2006, 504). Social support networks were a positive mediating factor in individuals' perceptions of barriers to support even if

they were on a CTO, and Van Dorn et al (2006) propose that practitioner support which focuses on quality of life may lessen the likelihood that individuals will avoid services and treatment. Given these findings and that CTOs “may constrain autonomy in multiple ways...[but] the heart of the matter, for proponents and critics alike, is the scope of the individual’s autonomy to make medication choices” (Wales and Hiday, 2006, 459) an argument can be made that research is required that explores how treatment is negotiated in the context of the CTO, and how the CTO may influence service user responses to medication, and support more broadly.

This is particularly the case considering the association of CTOs with the use of depot, which is an injectable form of anti-psychotic medication with long-acting effects, often used as a way of managing noncompliance (Brophy, 2009). Lambert, Singh and Patel (2009) in a demographic study of service users in Victoria, Australia, found that those on CTOs were more than twice as likely to be prescribed depot rather than oral antipsychotics. Whilst the use of depot is not as widespread in England as oral antipsychotics, Lambert, Singh and Patel (2009) go on to suggest that the introduction of CTOs may lead to a rise in their use, as the status of being on a CTO could lead to greater consideration of such methods to manage noncompliance. In their analysis of a sample of CTOs, the Care Quality Commission (2010) found that 65% of the cases were given a depot injection as part of their CTO treatment plan. Similarly, Patel et al (2011) found that the rate of depot use within their sample of 138 individuals on CTOs (63.8%) was double the rate reported in the mental health population. However, it is not clear whether this treatment pathway is chosen as part of the decision to use a CTO or is more a reflection of the type of cases where CTOs are being applied. Depot injections can be viewed by service users as more stigmatising than oral antipsychotics due to the method of administration and painful side effects (NICE, 2014). Just as importantly in terms of this discussion, the long-acting nature of depot, and the passive experience of receiving it are likely to result in increased feelings of coercion and a lack of control for service users. As Patel et al (2009, 1486) state in their study of the relationship between coercion and depot injections, “the power of others that is lack of true autonomy is more notable for those on depot than those on oral tablets...As depots are ‘given’

rather than ‘taken’ this sense of power may be seen as more potent”. Alongside an exploration of service user response to medication and the negotiation of medication within the context of community compulsion, it may be helpful to investigate practitioners’ perspectives and treatment decisions in light of such findings. Using CTOs and depots in conjunction raises questions for research around how conditions around medication are formulated by practitioners and how a dual-action approach of legal and ‘proximal’ compulsion (Watts and Priebe, 2002) is considered in relation to least restrictive principles.

Service user responses to the CTO process

As has been inferred throughout this chapter, the response of stakeholders to the CTO, inclusive of the specific elements through which it works, is an area of research that can be developed further. Central to potential responses to the CTO is how individuals relate to compulsory activities and events. Newton-Howes (2010) defines coercion as a potential, but not inevitable, product of compulsory intervention. In these terms compulsion is the objective ‘event’ that occurs, and coercion is the possible subjective reaction experienced in response. In support of this argument Newton-Howes (2010) highlights the complex range of informal and formal leverages that can be used on service users and provides an example from his research where a significant minority – a quarter - of voluntary inpatients he interviewed experienced feelings of coercion, to demonstrate that the relationship between compulsion and coercion is not entirely straightforward. What he and others (Olofssen and Jacobsson, 2001, Haglund, von Knorring and von Essen, 2003) suggest matters in mediating experiences of coercion are the ‘interactive processes’ that occur between service users and practitioners. The large-scale MacArthur coercion study (Monahan et al, 1999) used the concept of procedural justice to suggest that perceived fairness in the process of decision-making by practitioners can lead to lowered feelings of coercion. In particular, important factors for service users included feeling heard by practitioners, being respected and treated with dignity, getting clear and honest explanations for decisions in favour of compulsion, and of the future steps necessary for compulsion to be lifted.

A foundational element therefore for service users in formulating a response to the CTO is how they respond to practitioners' explanations of what the CTO is and what it entails. Research suggests that service users are not well-informed about the CTO, the CTO process, or about their rights in respect of the CTO. Rolfe, Sheehan and Davidson (2008) conducted a survey of service users in Western Australia, and found that a sizeable minority stated that the CTO and associated care plan had not been discussed with them, and that they were not made aware of the right to a tribunal and the process for reviewing the CTO. Evidently a survey cannot answer whether individuals received this information and did not remember it, but even if that were the case, it suggests there is a need for information-giving to be carried out in a more meaningful and enabling way. Stroud, Doughty and Banks (2013) found that even when practitioners stated written information had been given, service users did not remember receiving it. Assimilating and understanding information is the first step to being actively involved in the process and they also found that service users were not clear about discussions on the CTO, and reported not playing a part in them. Similarly, Brophy and Ring (2004) found that the majority of their participants did not know the legal criteria for applying a CTO, believing it was a straightforward clinical decision made by their psychiatrist, with no recourse to law and guidance. In England, the practitioner guide for CTOs (NIMHE, 2008) suggests service users should be as involved as much as possible in the CTO process. However the process of how a CTO is made and maintained, whereby CTOs can be drawn up by the inpatient team but implemented by the community team may militate against such involvement. Perhaps unsurprisingly then, service users in Stroud, Doughty and Banks (2013) described that they felt little sense of choice and control in the CTO process.

In regards to dealing with the everyday reality of the CTO, it seems likely that individuals who are placed on them may take different approaches, dependent on interpretation of the CTO and involvement in the CTO process, but also based on perception of self and others, and previous experiences. Canvin, Bartlett and Pinfold (2002) undertook a qualitative study of the predecessor to the CTO, Supervised Discharge (SD), and developed a model of 'compliant' service user responses to its imposition: fatalism and resignation, whereby compliance with

SD was seen as unavoidable and ‘the system’ was perceived to hold total power; dependency on SD as a perceived conduit of services and support, and consequent anxiety about it being discharged; a feeling of ‘ownership’ of SD, with service users using it to become actively involved in their care and take responsibility for their actions whilst on SD; and bargaining, where negotiation for reciprocal outcomes such as accommodation underpinned acceptance of SD. Resistance, as in pushing the boundaries of SD, for example missing appointments, was also present in service user accounts, and was seen by the authors as a way for service users to maintain a sense of self-efficacy. As the authors state, these responses demonstrate a diverse and dynamic range of self-determination within the parameters of compulsory community care. Therefore, although CTOs are qualitatively different from Supervised Discharge, the model presented by Canvin, Bartlett and Pinfold (2002) provides a potentially helpful theorisation of how service users may respond to CTOs.

The therapeutic relationship

Canvin, Bartlett and Pinfold (2002) conclude by suggesting responses to the CTO that are characterised by compliance are reliant in part on the nature of the therapeutic relationship service users have with practitioners. This coheres with the earlier discussion of Van Dorn et al’s (2006) findings, which considered that a central mediating factor for treatment adherence is the interaction between practitioners and service users. Practitioner concerns about the impact of CTOs on the therapeutic relationship are well documented (Manning et al, 2011, Romans et al, 2004). As Churchill et al (2007, 188) state, problems in the relationship between practitioner and service user may arise because:

The implementation of CTOs requires that mental health professionals fulfil potentially incompatible roles, becoming both “game-keeper” and “poacher”, providing treatment to unwilling patients, and monitoring and enforcing compliance with this treatment.

This may place practitioners in an uncomfortable position where the power disparity inherent within their relationship with service users is further emphasised by the legally mandated use of compulsion outside the prescribed boundaries of hospital and the extension of their role as supervisor.

Consequently, research on the practitioner-service user relationship within the context of the CTO has tended to focus on what effect practitioners and service users believe the CTO has had on the relationship, and as can be expected, findings are mixed.

The responses of service users in O'Reilly et al's (2006) study contained ambivalence towards their psychiatrist, resenting the perceived paternalism of coercive measures taken under the CTO, but at the same time understanding why such decisions were made. Psychiatrists in the study described having to accept that they were going to be viewed negatively because of the CTO, but also the importance of knowing an individual well before placing them on a CTO, in order to have a therapeutic foundation to work from. Likewise, Mullen, Dawson and Gibbs (2006) highlight the concern of practitioners that if the use of authority to mandate compulsion occurs at the beginning of the relationship between them and a service user, it may influence how the service user perceives future action by them. Indeed, they go on to state that the practitioners they interviewed held the paradoxical belief that a compulsory intervention such as the CTO can only be effective when the service user collaborates with the CTO within the context of an engaged relationship. However, the view of psychiatrists in the Romans et al (2004) survey was that a combative relationship at the beginning of the CTO was not necessarily insurmountable, because damage to the relationship can be ameliorated over time, as the service user may become accustomed to the CTO and change their attitude to its use. In this way, practitioners held the view that the CTO could act to improve the relationship through the framework it provided for consistent engagement. As a consequence, the general consensus was that the negative influence the CTO might have on the therapeutic relationship would be outweighed by the benefits it would bring (Romans et al, 2004).

These findings relate to the effect a sense of general coercion could have on interaction between practitioners and service users. Stroud, Doughty and Banks (2013) also reported on specific elements of the CTO that could cause particular tension. Although service users in their study generally reported good relationships with professionals, both service users and practitioners felt that the

requirement for regular appeals could bring to the surface disagreement and undermine the supportive relationship practitioners might have with individuals. Similarly, practitioners reported that the process of recalling an individual to hospital highlighted the importance of having the skills necessary to maintain a positive connection within the context of coercion. The challenges of sustaining a therapeutic alliance seemed to be of more significance for care coordinators, rather than for the psychiatrist who may not see an individual very often. More specifically, some care coordinators in the study reported feeling concerned that they now had to take on 'formal' legal aspects of work that they hadn't previously, which they felt affected both their sense of role and the nature of their practice with service users.

The research described here tells us much about how concerns regarding the practitioner-service user relationship have manifested. It seems that practitioners believe the state of the relationship can be important to the working of the CTO, in that positive interaction signifies collaboration with the CTO. The influence the CTO has on relationships is dependent on time, the nature of prior relationships, and changing responses to the CTO in itself. The structure the CTO may provide can also have a positive influence on the relationship between practitioners and service users. Particular tensions may surface through elements of the CTO process and this can mean skilled work has to be done by practitioners in order to maintain a good working relationship with service users. Different groups of practitioners have a range of perspectives on the relational effect of the CTO, dependent on their proximity to the service user and possibly, because of their role. These findings have implications for how future research into CTOs is carried out, particularly in highlighting the value a longitudinal approach might have, and reinforcing the point made earlier that more importance needs to be placed on the experiences and perspectives of those practitioners who carry out the everyday work of the CTO. The findings also raise a number of follow-on questions which could be addressed, such as: what changes do practitioners think CTOs bring for their practice; what actions practitioners may take to mitigate any damage; and in taking Canvin, Bartlett and Pinfold's (2002) work further, how such relationships might influence feelings

towards the CTO, and how such relationships might be acted upon by practitioners and service users to influence the progress of the CTO.

Ways forward in CTO research

In this chapter I have considered the substantive and methodological aspects of existing CTO research, and in doing so I have attempted to highlight four interconnected themes which form the basis for the approach taken in this thesis: firstly, in order to gain a fuller picture of the nature and significance of compulsory community care, an approach that takes into account the multifaceted ways CTOs are understood, used and with what implications is necessary. Secondly, such an approach would at least in part involve a deeper exploration than has occurred thus far of the everyday practice of CTOs and the mechanisms through which they work. Thirdly, central to the analysis of everyday CTO practice is a consideration of the diverse motivations and actions of practitioners and service users in the context of the CTO; in particular their responses to the CTO, the mediating influence of their interaction with each other and the way such responses affect how the CTO unfolds. Finally, in order to understand how practitioners and service users approach CTOs, it is also necessary to get a sense of where they are coming from, particularly in regards to the exercise of power the CTO represents. For practitioners this refers to the underlying beliefs that influence their stance to CTOs and underpin the various ways they balance the tensions that may arise in the use of CTOs. For service users, this would involve an exploration of how the CTO interacts with their identity and sense of self in the world within the context of consistent 'background' and sometimes foregrounded compulsion. A point that is worth reemphasising is that this last theme draws attention to the significance of such research not only for understanding the workings of the CTO, but also for understanding how the CTO may shape those individuals who experience it, both practitioners and service users alike. The CTO research landscape tends towards the descriptive and an analysis along the lines described here would go some way towards both generating theory and contributing to the application of certain pre-existing conceptual frameworks. In the next chapter I will explain and explore these frameworks further, with reference to the methodological implications they

incur, and with the aim of demonstrating how they may enhance an analysis of CTOs in practice.

Chapter Two

Making sense of CTOs:

Developing a theoretical guide

In the preceding chapter, I outlined how research has been conducted on CTOs thus far, with the aim of contextualising the development of this study. However, research aims are not solely dependent on the research landscape within which they reside. My interpretation of the current body of research on CTOs and the conclusions I have reached as to what research would be valuable, is dialogically related to the beliefs I hold on how to best make sense of the world. Whilst the relationship between philosophy and methodology is not straightforward, it is nevertheless important to draw out the connections between my ontological and epistemological inclinations, and the choices I have made in what aspects of CTOs to study and how to study them. As Greene states, “epistemological integrity does get meaningful research done right” (Greene, 1990 in Shaw, 1999, 22) and in these terms, I will explain how a critical realist philosophy has informed this study. The ontological concerns which lie at the heart of critical realism means it can be classed as a meta-theory, and as such it has underpinned the theoretical approach I have taken, namely governmentality. Critical realism and governmentality are not easily aligned, and I will explain how and why I have integrated them for this study, before describing how they have underpinned my methodological and analytical approach. This will then set the context for the next chapter, which will address the more practical ‘doing’ of the research.

Approaching the everyday practice of CTOs: path-finding in ontology, epistemology and theory

To recap on the previous chapter, whilst the majority of CTO studies have been experimental in design and aimed at measuring CTO outcomes, a small number of qualitative studies have been carried out which have sought the views of service users and practitioners on CTOs (Brophy and Ring, 2004, Gibbs et al, 2006, O’Reilly et al, 2006). However, given the potential variability in how CTOs can be used, there is considerable scope for enquiry in regards to finding out *how* and *why* they are being practiced in a ‘localised’ setting and with what

consequences for those affected by them. Such research would illuminate what CTOs look and feel like, thus joining the abstract political questions they engender with the concrete practical-moral concerns that surface in their use. The term practical-moral is used here as interpreted by Lishman (2000, 2) who characterises practice as a “complex, uncertain and ambiguous” activity, which involves the continuous evaluation of various responsibilities and standpoints. In this sense, although policies such as CTOs are based on certain ideas about human thought and behaviour, as service users and practitioners engage with each other and the broader system they also shape the playing out of policy in differentiated ways. Thus, gaining a sense of the operation of CTOs in practice should involve exploration of individual responses and micro-social interactions alongside the contextual factors (cultural, political and institutional) that mediate the CTO process as it unfolds over time. This, of course, needs to be considered as a mutually constitutive process, not only in terms of how the responses of practitioners and service users to the CTO influence the workings of the CTO, but also how the CTO shapes aspects of identity and choice for both groups. In this way, I want to formulate a dual analysis: both tracing the pathways that a CTO could take and what these pathways might lead to, as well coming to an understanding of the varying ways the CTO might shape the experiences and perspectives of practitioners and service users.

The tendency however in CTO research has been to take rather more linear approaches to investigating CTO outcomes. The trend in this body of research, although equivocal and contested, has been to suggest that CTOs do not deliver on key outcomes such as hospitalisation rates (Churchill et al, 2007). Most recently, as discussed in the last chapter, OCTET, a randomised controlled trial of CTOs in England, found they made no difference to numbers of readmissions to hospital, with the researchers then advocating that CTOs be abolished. As they conclude, “We believe that there should be a moratorium on the further imposition of CTOs (and consideration of those already in place) other than in research settings unless and until convincing evidence of their effectiveness is obtained” (Burns and Molodynski, 2014, 5). Yet, as also highlighted, research on practitioner opinions of CTOs has tended to find practitioners justifying CTOs on the basis they ‘work’ in a range of ways. Indeed, an interesting illustration of

these contrasting findings is provided by a psychiatrist (Mustafa, 2014, 1) in critical response to the Burns and Molodynski paper, where he relates the following rhetorical and hypothetical vignette:

Take the scenario of a...patient who is known to discontinue treatment immediately after discharge from hospital, invariably leading to rapid relapse and hospitalisation. Since discharge from hospital on CTO 3 months earlier, his mental stability has been maintained and he has been accepting his fortnightly antipsychotic depot injections. His positive psychotic symptoms are minimal. He has become more sociable and has applied for a part-time college course. A psychiatrist tells his patient and their carer that he is going to lift the CTO. To his dismay, the carer asks the psychiatrist 'have you not seen with your own eyes that the CTO works?' The psychiatrist replies, 'yes I have, but a RCT says this could not have been possible'.

Mustafa ends the vignette by asking, "would this be evidence based practice?" Mustafa is not claiming that such a conversation would take place, but instead is making the point that simply accepting that a RCT proves CTOs do not work is problematic. Knowledge generated from the examination of patterns of regularities between variables may not always translate into 'on the ground' experiences of outcomes based on particular pathways (Flyvbjerg, 2006). The prioritisation of certain forms of knowledge can lead to other forms of knowledge being discounted. Put simply, only asking 'what works' in the case of policy interventions does not always give a satisfactory answer for the world of practice. Incorporating complexity into the research process allows for a much wider range of questions to be addressed about the 'work' (in the broadest sense of the word) a particular policy programme does. Such an approach acknowledges that programmes can have multiple outcomes, in terms of both intended and unintended consequences. It also accounts for plurality in how these consequences are balanced, how they can be designated as 'good' or 'bad', and which consequences matter to whom. The moral and political dimensions of research are thus expanded by incorporating a broader and more complex theorisation of the consequences of CTOs, beyond only asking whether they are deemed effective by predetermined measures.

The potential of a critical realist approach

Acknowledgment of complexity has epistemological implications. Taking such a stance as a researcher can be aligned with a critical realist approach, where change is understood as explanatory and generative in nature. Put simply taking an explanatory approach means to draw conclusions on causality, or in other words, on why change comes about. Doing this in a critical realist way involves an attempt to turn the ‘black box’ of causal relations ‘white’ (Scriven, 1994). Clarifying what happens when change occurs relies on an analysis of generative mechanisms, which can be defined as the interactions between various properties which may produce change or maintain stasis. This analysis in turn depends on an investigation of contingency, which includes an exploration of context and interventions, the latter incorporating the thoughts, actions and interactions of those individuals with a stake in the substantive matter under review (Maxwell, 2012, Pawson and Tilley, 1997).

Critical realism has much to offer research in the field of social work, as it complements the contingent ‘open systems’ nature of practice, but does not accept a relativistic view of the reality inhabited by practitioners and the individuals they work with (Oliver, 2012). In this sense critical realist research offers potential to bridge competing ontological and epistemological positions, as it is founded on an ontological acceptance of reality and a ‘weak’ constructivist epistemology that premises our understanding of the world as imperfect and partial (Sayer, 2000). This is to say that critical realism assumes we construe, rather than construct the world. Construal can be described on the basis that the world (incorporating the social) can be to varying degrees³, ‘mind-independent’ (Sayer, 2000, 41), yet at the same time can only be known by us via interpretation. In making this distinction, critical realism avoids what Archer (1995) terms ‘downward conflation’, where agency is negated because the world exists for us only in discourse. At the same time however, emphasising the

³ It is worth saying here that although it is beyond the parameters of this thesis to go into in any depth, I am aware that the relationship between mind ‘dependence’ and ‘independence’ is complex (see Haslanger, 2012 and Hacking (1986) on ‘making up’ people and naming ‘kinds’). There is a constitutive interaction between what is in the world and what we make of it, the balance of which differs dependent on the object in question. Further, as I highlight in this discussion of the ‘real’, ‘mind-dependent’ objects may *become* independent, in that they can be causally implicated (see Hacking (1995a) and ‘the looping effect’).

construed nature of the world also allows for an acceptance of the fallible nature of knowledge. As Blom and Morén (2009, 117) highlight, there are degrees to which a ‘white box’ can be achieved, dependent on the degree of complexity under study; what the researcher may want to explain; and indeed what is explainable in the field. In other words, we cannot know *everything* about anything, but we can know *something* about some things.

Critical realism thus provides a framework to explore and distinguish between the map (the transitive) and the territory (the intransitive) (Bateson, 1972). Taking this further, the theory of causation which lies at the heart of critical realism relies on a stratified or ‘deep’ understanding of reality; what Bhaskar (1975) deems the empirical, the real and the actual. The empirical refers to what we can experience and/or know of the world; the real refers to structures and mechanisms that exist regardless of whether they are observable or not; and the actual to what happens (the events that occur) when the properties of such structures and mechanisms are activated (Hartwig, 2007). It is important to note here that experiences and conceptualisations can also belong to the domain of the ‘real’ in that they can function as properties in themselves with potential for activation as mechanisms. In this sense the cause of change can be ideational as well as material (Sayer, 2012, Hacking, 1995b, 1998). In turn, such a stratified view of reality means that causality can be understood as resulting from the confluence of various factors, or the “power of...particulars” as Sayer (2012, 181) describes. Emphasis is placed on the role of contingency in emergent states of change or stasis, whereby generative mechanisms occur when properties are activated and interact in particular ways to produce (or indeed block) change. We as conscious beings also bring contingency to the process, in that we can intervene and influence as well as be influenced by the process of change (Sayer, 2012).

It has been said that because critical realism places such a strong emphasis on ontological considerations, it can perform as a meta-theoretical “under-labourer” for the “reconstruction of particular theories” (Parr, 2009, 374). In this thesis, critical realism is used as a framework in which to embed and supplement Michel Foucault’s conception of governmentality, or an ‘analytics of

government' (Dean, 2010). The purpose of this particular combination is to theoretically ground an understanding of CTOs as an exemplar of compulsory community care, within an analysis of power. The theoretical and functional integrity of CTOs depends on their ability to ensure some form of conformity to particular goals. Consequently, developing an understanding of CTOs through the lens of power holds relevance in two ways: in a broad sense CTOs are an intervention intended to bring about change, which relates to power as a "summarising term for situations where some change is made to happen..." (Sayer, 2012, 181). More specifically, CTOs are about change through *compulsion* and thus foreground the role of different forms of power within social relations and institutional settings. A critical realist approach sheds explanatory light on the transformative potential of CTOs from macro to micro, whilst governmentality offers us one particular and helpful perspective on how CTOs might be thought and made into being for the 'conduct of conduct' via coercive, disciplinary and reflexive means (Foucault, 2007). Such an analysis does not orientate power necessarily as a hegemonic force, but rather as fluid and dispersed. Thus, through bringing together generative (why) and descriptive (how) analytical accounts, a view can be taken on CTOs which encompasses causality, but which avoids determinism by focusing on the decentralised relations and settings within which the CTO plays out.

Taking such an approach to the analysis of power as exemplified through CTOs both encompasses and enhances the dual analysis I am aiming for. Specifically, bringing governmentality and critical realism together allows me to address both the reasons why CTOs might lead to a variety of outcomes - the effects of policy - and how CTOs work (or indeed don't work) to regulate conduct and encourage self-conduct. The intention therefore is to allow for a flexible yet anchored analysis of power in action which accounts for, but is not bound by, theories of power as either inherently structural or devolved. It should be noted that whilst an argument can be made for the relevance and usefulness of embedding governmentality within critical realism, for it to be a coherent argument some philosophical problems need to be worked through, and these will be addressed shortly. Before doing so however, it would be helpful to expand on the foundations for governmentality that exist in Foucault's work.

Power, knowledge and ethics

Foucault critiqued the idea of sovereign power in which power is operationalised in a centralised, repressive and hierarchical way. Instead, Foucault contended that “power is everywhere” (Foucault, 1990, 93), being omnipresent and dispersed. As such, power is not ‘possessed’ by a few but is a force that is relational in nature and in constant flux within society; Foucault therefore “challenges the polarisation of such categories as ‘powerful’ and ‘powerless’” (Pease, 2002, 139). Consequently Foucault argued that power does not have to be thought of in coercive terms, but can also be productive and indeed necessary – an integral part of how societies work (Gaventa, 2003). Such a conceptualisation of power shifts the focus from an analysis of sovereign power to disciplinary power and how it manifests at a ‘micro-political’ level.

Foucault derived disciplinary power as a particularly modern invention, emanating and evolving from the Enlightenment period: “‘The Enlightenment’, which discovered the liberties, also invented the disciplines” (Foucault, 1977, 222). Disciplinary power is thus reliant on scientific discourses regarding the nature of human thought and behaviour, and associated techniques and strategies of objectification and subjectification, which are not premised on the use of force. In contrast to sovereign power then, disciplinary power is “a modest, suspicious power [which] regards individuals both as objects and as instruments of its exercise” (Foucault 1977, 170). The aforementioned techniques and strategies that underpin disciplinary power consist of various systems of surveillance and categorisation, made possible through the creation of the human sciences and associated expert-based disciplines such as social work, psychiatry, psychology and criminology. In this way a ‘disciplinary society’ is created, where individuals are measured against normalising judgements, and are disciplined, or discipline themselves accordingly.

As inferred here, Foucault’s conceptualisation of disciplinary power is entwined with another of his central ideas, that of ‘power/knowledge’. Whilst Foucault did not conflate knowledge and power, he was interested in the complex and inextricable relationship between them, arguing that “power produces

knowledge...power and knowledge directly imply each other” (Foucault 1977, 27). The formation of a ‘disciplinary society’ is reliant on particular ‘regimes of truth’ which as dominant discourses constitute normalising judgements and in turn the regulation of conduct, as Foucault (1977, 27) goes on to say:

Knowledge linked to power, not only assumes the authority of 'the truth' but has the power to make itself true. All knowledge, once applied in the real world, has effects, and in that sense at least, 'becomes true.' Knowledge, once used to regulate the conduct of others, entails constraint, regulation and the disciplining of practice.

The question that therefore arises is how discourse - via power/knowledge - constitutes the subject, in particular through the human sciences and the accompanying application of expertise. Accordingly, power is locally dispersed rather than centrally coordinated, using small-scale rather than hegemonic means.

Foucault also posits how subjects might interact with and work at their own constitution through ethical ‘practices of the self’. Foucault’s view of what ‘the self’ might mean is not easily categorised. He rejected humanism and the idea of an unchanging and universal human nature which allows each of us primacy over our selves and in a greater sense, our destinies and our world. However in his development of ‘practices of the self’, which is based on a ‘self-self’ reflexive relationship, Foucault does not take a nihilistic position. His focus is not on defining human nature, but as Hacking (2004, 288) posits, on how people become who they are; the “dynamics of human nature”. This presupposes that a flat, rather than vertical relationship exists between self-government, government by and of others, and government of the state (Dean, 1994, 196). If we accept that particular moral codes have held sway at particular junctures, and in turn interact with how we relate to ourselves and others via ethical practices, then the focus is on how we *choose* to form ourselves through a variety of means and in relation to a multiplicity of moral codes in the present. What this means is that: “Foucault – most assuredly, not a sociologist – offers us a thoroughly sociological sense of self that does not reduce the self to the social” (Dean, 1994, 216).

In this sense, Foucault is not quite as far removed from an existentialist perspective on the role of agency as has sometimes been supposed (Hacking, 2004). His ‘practices of the self’ refers to four dimensions necessary for ethical self-work: ‘ethical substance’ or the focus for moral conduct; the external stimulus that leads to recognition of moral obligation; ‘ethical work’ or the means by which we attempt change; and the *telos* of such work, the end person that is aspired to (Foucault, 1997a). As we shall see, these four dimensions map closely to those which make up an ‘analytics of government’ as developed from governmentality by Dean (2010). Governmentality thus brings together disciplinary and reflexive power, connecting the processes by which we work on ourselves to broader governance processes by which we might be worked on.

Governmentality

Governmentality can subsequently be constituted in two ways: firstly in the original sense it was defined by Foucault as an evolution in the ‘art of governing’ by and within the state at a particular historical juncture; secondly as it has been developed as an analytical framework to illuminate the ‘how’ of governing across a continuum that stretches beyond sovereign power, to a dispersed disciplinary ‘microphysics of power’, to reflexive power via reformation of identity and regulation of the self. Given that CTOs can be seen as a particular embodiment of power in action, the analytical framework offered by governmentality provides a helpful tool to make sense of their use. Specifically, an ‘analytics of government’ is focused on delineating various manifestations of the ‘conduct of conduct’ (Foucault, 2007, 192), which can be defined as “any attempt to shape with some degree of deliberation aspects of our behaviour according to particular sets of norms for a variety of ends” (Dean, 2010, 10). Mckee (2009, 466, emphasis in original) draws out the dual foci of thought and action that an analytics of government explores as:

Both the *discursive field* in which the exercise of power is rationalised – that is the space in which the problem of government is identified and solutions proposed; and the actual *interventionist practices* as manifest in specific programmes and techniques in which both individuals and groups are governed according to these aforementioned rationalities.

Governmentality then is concerned with both how conduct is problematised and how such rationalities are subsequently put to work through technologies which direct and reform conduct. However, the ‘conduct of conduct’ is not only in relation to how others are governed, but as highlighted in ‘practices of the self’, how we govern ourselves. In other words, how “individuals recognise themselves as particular kinds of persons and...work upon and transform themselves in certain ways and towards particular goals” (Hodges, 2002, 457). Individuals make choices in how they integrate influences; logically an individual who can respond positively to external mandates and techniques can also respond negatively. Foucault (2007, 75) terms such responses as ‘counter-conducts’, which he defines as ‘the will not to be governed thusly, like that, by these people, at that price’. ‘Counter-conducts’ therefore are not rejections of government in itself, but an expression of seeking different forms and means of government. Within governmentality, forms of conduct and counter-conduct reflect each other and are interdependent – they both rely on the same processes of rationalities, technologies and reformation. As such, counter-conduct does not translate to resistance in terms of a revolutionary and emancipatory ‘stepping outside’ of pre-existing power structures. Disciplinary power operates at the micro-level and Foucault posited that so did counter-conducts. “Thus there is no grand refusal, only dispersed and shifting points of resistance” (Death, 2010, 239) which draw on ‘subjugated knowledges’ to form alternative ways of thinking and going about governance.

Where governmentality has been empirically applied, such research has been criticised for being overly concerned with the ‘discursive’ aspect of governmentality and a corresponding neglect of the realisation of rationalities in practice (Clarke, 2004, Stenson, 2005, Marston and McDonald, 2006, Parr, 2009)⁴. This focus on discourse analysis emphasises a view of the “‘social as a machine’ reforming and constituting everything it comes into contact with” (Hunter, 2003, 331), which does not account for the techniques and technologies of government. I would take that argument further to suggest that the focal point

⁴ Nikolas Rose is perhaps the best known figure for analyses of governmentality as manifested in discourse and rationalities. I draw on his work as related to mental health and the ‘psy’ disciplines in Chapter Four when discussing the semantics of CTOs.

of governmentality - conduct itself - requires more detailed empirical exposition. The emphasis placed on discourse foregrounds power/knowledge whilst neglecting power/knowledge/ethics and the relationship between conduct, counter-conduct and 'practices of the self'. Specifically, this would involve study of the complex, unpredictable and contradictory nature of life as it is lived with agency and as embedded in varying and variable social relations and institutions.

Integrating governmentality and critical realism

As has been suggested, most notably by Stenson (2005, 2008) in his conceptualisation of 'realist governmentality', a full analytics of government cannot ignore questions of 'the real' which involves drawing together accounts and manifestations of power, 'from below' and 'from above' (Lippert and Stenson, 2010). Despite his acknowledgement of realism however, Stenson (see Lippert and Stenson, 2010) does not set his vision of governmentality within a critical realist framework. This is because he views critical realism as solely aligned with a Marxist materialist approach that emphasises structurally constituted power and a central aim of resistance and emancipatory change, as developed over recent years by Bhaskar as dialectical critical realism (Brown, Fleetwood and Roberts, 2002, Bhaskar, 1993, 2000, Bhaskar and Callinicos, 2003).

Indeed, Stenson is right that the focus on structural power and the ensuing privileging of the 'is-ought' relationship that is present in this version of critical realism, is not easily integrated with governmentality. The previous discussion on conduct and counter-conducts highlights Foucault's particular take on resistance as taking the mirror form to compliance. As Dean (2010, 40, 48) argues, through such prioritisation of process in power and of 'how' questions, governmentality rejects the theorisation of power as a "zero-sum game" and therefore does not "formulate a set of general principles by which various forms of the 'conduct of conduct' could be reformed". In other words, through focusing on the descriptive, governmentality avoids the monolithic ideation of power present in 'grand theories'. If power is seen as fluid and not engrained in

particular unchangeable patterns within society, then the focus of critique shifts from a dichotomous ‘either/or’ lens to one which accounts for a range of imagined possibilities.

Nevertheless, despite these cautionary provisions, two closely interlinked arguments can be made for why embedding governmentality within a critical realist framework is theoretically consistent and viable, one to do with how the operation of power can be conceptualised and the other to do with the value position of the researcher. Taking the conceptualisation of power first, a more nuanced perspective on how power can be thought about in both governmentality and critical realism allows some form of confluence between them to take place. Sayer (2012) suggests that Foucault’s avoidance of ‘the real’ was not reflected in his theorisations of how individual and population-wide change is produced. Consequently, Sayer (2012, 185) highlights that Foucault’s theorisation of power allows for “the interdependence of dispersed/capillary power and centralised/arterial power” to be acknowledged. In dismissing the ‘false choice’ that can be made between dispersed (disciplinary) and centralised (sovereign) power, Sayer (2012, 185) also suggests that the separation of ‘how’ (descriptive) and ‘why’ (explanatory) questions is fallacious:

Explaining how power works, that is how multiple causal powers are activated and interact to produce effects, and in virtue of what, tells us why those effects occur; and conversely to explain why they do, we have to explain how the mechanisms work, what the powers and susceptibilities of the relevant elements are and how they work when activated

Connections can be made between Sayer’s critical realist reading of Foucault and the work of Dean (2010, 8) who has argued that his interpretation of governmentality allows for the elucidation of “sovereign and coercive rationalities and techniques” alongside and in interaction with disciplinary and reflexive forms of power.

Dean (2010) explains how this can be understood, starting with Foucault’s (2000) contrasting notions of the ‘city-citizen’ and the ‘shepherd-flock’, derived from historical accounts of the Greco-Roman era and the early Christian church respectively. Both notions exemplify particular forms of ethical self-conduct

comprising of how one sees oneself, and how one sees oneself and acts in obligatory relations with others. The individual as *citizen* can be defined as operating within a juridico-political structure, on equal footing with other citizens in the exercise of freedom and rights. By its nature, this conception relies on there being a boundary between those who could be classed as citizens (due to their ability to exercise freedom and rights) and those who cannot. Within the ‘shepherd-flock’ concept, the individual can be understood in pastoral terms as “a *living being* who can be *known* in depth, whose *welfare* is to be cared for as an individual and as part of a population, as one *submits* to integration within complex forms of *social solidarity*” (Dean, 2010, 100, emphasis in original). Such an understanding is based on the belief that *all* individuals should be cared for. Whilst Foucault did not suggest that these concepts can be transferred unproblematically into modern times, he did argue that their enduring presence in some form holds implications for the administration of liberal government. Notions of pastoral care and citizenship bring between them inherent tensions because they depend on “human beings as both self-governing individuals within a self-governing political community and clients to be administered, governed and normalised with respect to governmental objectives” (Dean, 1994, 209).

This brings us to what Foucault deemed the potential ‘demonic’ possibilities inherent in liberal government, which can arise from the interaction between discourses of citizenship and welfare (Foucault, 1988). It is Dean’s (2010, 156) argument that such tensions, if sharp enough, can lead to the paradox of ‘liberal illiberality’, whereby the subject is managed via ‘dividing practices’ along the axes of autonomy and responsibility: “the subject is either divided inside himself or divided from others” (Foucault, 1983, 208). Such divisions often have a strong biopolitical element, which can be seen from extreme manifestations such as forced sterilisation of particular members of a society ‘for their own good’ and for the perceived good of everyone else, through to pervasive ‘whole-population’ messages on self-care and well-being. Certainly, CTOs can be seen as an example of a biopolitical intervention, as they are based on a particular understanding of embodied madness and their foundational function is to ensure the management of such madness via medical means.

Dean's development of governmentality thus chimes with arguments (Jessop, 2010, Olssen, 2010) that governmentality in its original incarnation does not disregard institutional and political power relations in the way some more recent approaches to governmentality suggest. At the same time, in his work on ethics Foucault also did not negate the role of individuals in changing themselves and their surroundings. Here we can see how the plotting of a path through the overlapping borders of each body of theory can occur,⁵ which is still defined enough to underpin a meaningful analysis of power in action. This 'middle' route is particularly salient for the purposes of my thesis, as CTOs can be theorised as containing both inclusionary and exclusionary elements which in turn are mediated by reflexive, disciplinary and overtly controlling processes.

In a broader sense, coming to an ontological reckoning on the nature of power also has epistemological implications for how power can be known about, and specifically what place the researcher has, if any, in making value judgements on the operation of rule in society. In a divergence from the variant of critical realism as proposed by Bhaskar and others (Bhaskar, 1989, Archer et al, 1998), there exists an alternative broadly defined 'school' of critical realism which has drawn out and developed the empirical implications of critical realism for questions of causation, and which does not insist on their inextricable relationship with political implications for emancipation⁶. Underlining the difference between these two strands of critical realism is the variable answers they give to the question of value-position in research. The strong position Bhaskarian critical realism takes on research as furthering the emancipatory project, places emphasis on the researcher as taking a particular normative stance that is orientated to this goal. By way of contrast, Hammersley (2009, 8, emphasis in original), critiques such a standpoint as privileging the understanding of the researcher:

⁵ I am thinking of the following quote from Stuart Hall: "I want to suggest a different metaphor for theoretical work, the metaphor of struggle, of wrestling with the angels. The only theory worth having is that which you have to fight off, not that which you speak with profound fluency" (as interviewed in Grossberg (1996))

⁶ See Maxwell (2012, 4) for a fairly exhaustive list of scholars who have taken an empirical approach to critical realism, perhaps most notably Donald Campbell, who Maxwell states had 'historical priority' in the use of the term critical realism. In this thesis, I have drawn particularly on the ideas of Pawson and Tilley (1997, 2004), Hammersley (1998, 2002), and Maxwell (2012). As is evident, I have also made much use of the work of Sayer (2000), who, as inferred here, has a rather distinctive take on critical realism.

My point is simply that social scientists...have no distinctive expertise to determine what is good or bad about the situations they seek to describe and explain; or what, if anything, should be done about them...even where value judgements rely on research evidence they also necessarily depend upon other factual assumptions *and upon value principles that are plural and often in conflict.*

Taking this point further, Pawson (2006) argues that the ‘critical’ part of critical realism should apply to the relationship researchers have to each other, rather than with the world at large. This is a perspective that broadly chimes with that which has been developed through governmentality, and is integral to its descriptive focus. Foucault (1997b, 131) takes an implicit stance against scientism when he states “The role of an intellectual is not to tell others what they have to do. By what right would he do so?” As alluded to earlier, an analytics of government “breaks the shackles of inevitability” through the avoidance of reductionist and totalising critiques of policy and practice (Marston and McDonald, 2006, 8). However, as Sayer (2009) suggests the position taken by Hammersley and others on the interaction between fact and value risks being as prescriptive as that which is being critiqued. Indeed, it is difficult to entirely escape the place of value within the field of social work research, with its applied nature and general orientation to individuals, groups and communities who can be described as marginalised. Thus, whilst I have largely drawn methodologically from what could be described as an empirical approach to critical realism, it has still been necessary to take a position on how to research the operation of power, with reference to questions of value and specifically to questions of “flourishing and suffering” (Sayer, 2012, 192).

Returning to the work of Sayer (2012) and Dean (2010), a more gradated approach can be taken to subjectivity and a consideration of value, which flows from the ‘middle-ground’ formulation of power developed earlier. Sayer (2012) argues that the ‘is-ought’ relationship has been overly simplified and neglects to consider that firstly, the process of ‘thick’ description of what is real necessitates some form of evaluation and secondly, that normativity does not have to consist of “that short but imperious word *ought*” (Darwin, 2004, 120). In other words, the researcher cannot escape their own moral perspective on what they see occurring in their field of study, but at the same time drawing critical attention to

what happens in society is not the same as ‘legislating’ on what change should occur. Such a way of thinking is compatible with a Foucauldian orientation of making the self-evident seem strange. Whilst Dean (2010) argues that an analytics of government should not invoke judgement, he also states governmentality is not ‘value-free’. Instead, its objective is to excavate the foundations of the ‘taken for granted’ so that space is opened up to consider “what is at stake when we try to govern in a particular way and... the consequences and effects of thinking and acting in these ways” (Dean, 2010, 48). This then implies that a critical approach involves the destabilisation of pre-existing and apparently well-embedded ways of thinking, doing and being. Coming back to the matter at hand, whilst much has been said about the *general* ‘rightness’ or ‘wrongness’ of CTOs, it is not my intention to make such a value judgement here. In taking the ‘middle ground’ through conceptualisations of power and questions of value, I hope to avoid the entrenched positions that have formed on CTO use. By exploring the plural ways that CTOs are understood, justified and exercised, their ‘greyness’ and specifically the various ethical compromises and balancing acts which make up their use, will be illuminated. In this way, mapping how and why CTOs *are* used and with what consequences, may help *others* consider how and why they *should* be used. The next section will describe at a methodological level how this mapping will take place.

Exploring the everyday practice of CTOs: developing a research focus

Before discussing methodology, it would be helpful at this stage to reiterate and state clearly the aim and associated research questions addressed in this thesis and what analytical frameworks have been called upon to develop them. To briefly recap the argument that has been made so far: the CTO framework leaves much room for practitioner discretion; there has been little research to date on CTO practice in itself; using a hybrid critical realist/governmentality approach allows for a rounded and theory-driven analysis of CTO practice as a particular manifestation of power in action; specifically, such an approach means both descriptive and causal questions can be addressed, including what is happening, how it is happening and why. Taking this into account, the overarching aim of the thesis is to establish how the implementation of CTOs has been realised and

with what effects on the practice and experiences of service users and practitioners.

Drawing up an analytical map

Two frameworks – derived from critical realism and governmentality - have been drawn upon and synthesised in order to shape the questions that ensue from this aim: respectively Pawson and Tilley's (1997, 2004) framework for realist policy research and Dean's (2010) analytics of government. Critical realism has sometimes been critiqued for not being easily applicable to the world of research, and so using Pawson and Tilley's (2004) framework provides a focus point for distilling critical realist sensibilities in a useable analytical form. Their work falls into the camp of critical realism which is generally empirical rather than emancipatory in nature, and which emphasises the generation of mid-level explanations for social phenomena. Therefore, they do not align themselves with 'traditional' critical realist philosophy, but the stance I have taken does not entirely conform with a Bhaskarian model either, as can be seen in my treatment of criticality and normativity. The important point to make here is that Pawson and Tilley's model includes the constituent elements necessary to make a critical realist analysis of causality, taking into account depth, contingency, emergence and consequently complexity. Specifically, Pawson and Tilley (2004, 6) take a 'configurational' approach to considering policy evaluation and as such, it is suited for an analysis of the policy and practice of CTOs. Prospective policies are "theories incarnate" (Pawson and Tilley, 2004, 4) but are also embodied within pre-existing and open systems which shape how policies come into play. In this thesis, such an analysis entails knowledge generation on the ways CTOs work (mechanisms), with whom and in what circumstances (context), and how the relationship between these two elements produces differentiated consequences, both intended and unintended (outcome patterns). By its nature then this analysis is suited to a broad analysis of power as can be understood in *generative* terms.

Dean's (2010) analytics of government takes a different yet parallel approach by elucidating the various dimensions in which 'regimes of practice' and their

associated programmes manifest. 'Regimes of practice' possess four distinct yet reciprocal dimensions: *visibility*, *thought*, *practice* and *identity*. An analysis of these dimensions allows for associations to be made between CTO discourse at national and local level, as well as how these discourses are played out in 'regimes of practice': "those...assemblages through which we...cure, care, relieve poverty, punish, educate, train and counsel" (Dean, 2010, 40) and at an individual level via 'practices of the self'. In this sense, an analytics of government adds an additional element to Pawson and Tilley's (2004) framework for realist policy evaluation. Realist policy evaluation as Pawson and Tilley define it is generally functionalist in nature, in that its aim is to help policy-makers 'do things better'. I am not criticising that aim or dismissing its role for this study; however in terms of what I want to achieve here, an analytics of government brings an additional explicit, critical and destabilising framework within which to understand how power operates. In doing so, it brings an additional and distinctive element to understanding power in *social* terms. I now explain how the two approaches can be brought together to form an analytical framework for the study of CTOs.

Pawson and Tilley (2004) assert that policy programmes begin as theories – what is the problem that requires change, and in what way can that change be brought about. In order to evaluate a programme, an important first step is to understand the theory behind the programme. In a governmental sense, analysing the field of visibility refers to examining how a problem to be governed is framed as a problem – how it is brought to light – and specifically pinpointing "who and what is to be governed, how relations of authority and obedience are constituted...what problems are to be solved and what objectives are to be sought" (Dean, 2010, 41). Dean (2010, 42) suggests that the evolution of policy goals is both a "rational and thoughtful" process and an "intensely moral activity" (2010, 19), in that it involves a clear and systematic explication of 'how things ought to be'. In this sense, the art of government necessitates the belief that the world can be made a better place, and therefore contains a Utopian element of continuous improvement. Undertaking an analytics of government should include working to "extract this Utopian aspect" (Dean, 2010, 44). In terms of CTOs then, the initial task is to trace how and why CTOs came to be

seen as necessary and why they came to exist in the form that they did, taking account of policy drivers and constraints; and to consider how particular ‘kinds’ of individuals became constituted as the focus for intervention through the CTO.

Moving from the macro of policy to the micro of practice, for a realist reading it is necessary to also understand what starting point those individuals at ‘ground level’ – practitioners and service users – are coming from in response to a policy programme. In order to fully make sense of the ways in which a programme functions, the translation of ideas from policy to practice level needs to be accounted for, both in terms of the connections and gaps between policy and practice rationales, and the reasons why individuals do or do not ‘buy into’ a programme. Alongside this, the second dimension of a governmental analysis – thought – requires that the forms of knowledge, expertise and know-how that are drawn upon to realise the conduct of conduct are excavated. To this end, the second task is to examine the motivations of practitioners and service users in relation to CTOs: what purposes they do or do not see CTOs meeting; how these purposes align or not with policy-level conceptualisations; and for practitioners in particular how they formulate CTO practice based on these purposes.

The third point of investigation shifts again, this time from thought to practice. Pawson and Tilley (2004) argue that the heart of a realist policy analysis is an understanding of programme mechanisms – what it is about a policy programme that brings about an effect. They explain programme mechanisms as the “process of how individuals *interpret* and act upon the intervention strategies” present in a programme (Pawson and Tilley, 2004, 6, emphasis in original). In this sense they suggest that programme mechanisms can be seen to work in negative as well as positive terms. Further, such action cannot be understood as ‘stand-alone’, but should be analysed in conjunction with context, which they define as encompassing participant characteristics and relationships as well as circumstances: “Context must not be confused with locality...what is contextually significant may not only relate to place but also to systems of interpersonal and social relationships...” (Pawson and Tilley, 2004, 8). As they go on to suggest, contextual factors influence the ways individuals respond to a programme and are therefore integral to understanding what it is that helps or

hinders a programme's success. Taken together, this means CTOs will be analysed in light of how they are "interpreted and acted upon in different ways by different participants in different positions" (Pawson and Manzano-Santaella, 2012, 180). The complementary dimension of a governmental approach is an analysis of the technical aspects of government - the 'means' by which governmental 'ends' are reached. As Dean (2010) states however, this practical element of regimes of practice is a condition of governing, 'a means to an end', but also can act to constrain what is possible to achieve. The third task therefore is to investigate the workings of the CTO, specifically: how the techniques incorporated within the CTO regulate behaviour; the ways programme participants act on the central components of the CTO; and the contextual factors which impinge on this process.

The final focus takes theory, thought and practice to their conclusion – the consequences of the CTO. Taking a realist approach through understanding the theory of a policy, and how it plays out in context-mechanism configurations allows us to form a broader view of what we mean by outcomes. Pawson and Tilley (2004) do not differentiate between outputs and outcomes, allowing for a fuller causative view of a programme. Furthermore, instead of being predetermined measures, we can see outcomes as intended and unintended consequences generated through the programme process; and instead of being discrete, we can see how these outcomes relate to each other. In this sense it is just as important to understand how the consequences of a programme are weighed up by those who have some stake in them. Here is where a governmental analysis supplements a realist approach through a consideration of reflexive and ethical 'self-work' in response to governmental practices. Potential outcomes are not necessarily limited to changes in behaviour and yet hoped for behaviour change is at the heart of policy programmes such as CTOs. Governmentality sees this in an internal as well as external sense – how individuals are encouraged to identify with new subjectivities that cohere with governmental rationalities. It is necessary then to reach an understanding of how individuals go about 'practices of the self' –the ways we think about and act on ourselves – and how these practices relate to the process of governance. Accordingly, the fourth and final task is to investigate the transformative powers

of the CTO; what their consequences are and how these consequences relate to policy theory and purpose; how and if they bring about individual change; and in what ways they might be implicated in forms of conduct via the development of various “capacities, qualities and statuses in particular agents” (Dean, 2010, 44) as well as forms of counter-conduct.

To sum up what this exposition means in the development of guiding questions for the thesis, I will be investigating the following:

1. Why did CTO policy come to exist, and exist in the form that it does in England? How have problems been framed as problems for the CTO to solve?
2. In what ways are CTOs conceptualised by practitioners and service users? How do these conceptualisations align or not with policy-level reasoning? For practitioners in particular how do they formulate CTO practice based on these conceptualisations?
3. How do CTOs work, and what factors – inclusive of participant action - influence why they work in those particular ways?
4. What are the varying consequences of the CTO that result from these practices, how are these consequences thought about by practitioners and service users, and how do they relate to policy and practice-level reasoning on their use? How do CTOs work to produce change in service user identities and conduct, and in what ways are the transformational potentials of CTOs realised or resisted?

In the ensuing final part of this chapter I will expand on the framework within which these questions will be addressed, translating the theoretical to the methodological.

Drawing up a methodological map

In order to explain phenomena, a realist methodology “endorse[s] much of hermeneutics [but also] insists a) on the material commitments and settings of communicative interaction, and b) on the presence of a non-discursive, material

dimension to social life” (Sayer, 2000, 17-18). It has been said however that critical realism is a “philosophy in search of a method” (Yeung, 1997, 51), and it has often been aligned with a pragmatic, mixed methods approach (Pawson and Tilley, 1997, Danermark et al, 2002). Nonetheless, because critical realism can be aligned with different methodological approaches, its implications can be developed regardless of the approach taken and consequently a convincing case can be made for marrying critical realism with qualitative methodologies (Maxwell, 2012). Byrne et al (2009, 3) for example suggest that qualitative research has been given a more prominent role in policy research in recent years because: “quantitative approaches have proven inadequate in addressing the issues of context and complex causation which underlie social interventions” Furthermore, Shaw (2003) makes the point that integrating qualitative and quantitative approaches in mixed methods research can bring challenges that test the way knowledge claims are made in both kinds of data. In this thesis then, some attention has been paid to how varying forms of data collection can be used in a complementary way, where differences that arise can be put to use in clarifying rather than confounding the questions at hand. In order to do this, I have adopted an ethnographically informed methodology; an approach which draws on diverse sources and methods in order to form a deeper understanding of the social world.

The potential of ethnography is well recognised in the critical realist and realist governmentality literature. Sayer (2000, 21) describes an ethnographically orientated approach to questions of depth in his explication of ‘intensive’ realist research designs, where questions might be asked such as ‘how does a process work?’, ‘what produces a certain change?’ and what did the agents actually do?’ The researcher thus seeks to go beyond the perspectives of participants; to find ways of examining the context they are acting within, the relationship between the two and what might arise out of this relationship over time. More specifically, Hammersley and Atkinson in their development of a ‘subtle realist’ approach to research suggest ethnography has much to recommend it in seeking to answer such questions, particularly because it focuses on the “meanings, functions and consequences of human actions and institutional practices, and how these are implicated in...wider contexts” (Hammersley and Atkinson, 2007,

3). Maxwell (2012) takes this further when he suggests intensive, long-term involvement in the field can help researchers to gain a clearer picture of causal process by allowing for the testing out of theories and interpretations. In sum, ethnography can be considered through a critical realist lens because it allows for experiences, actions and events to be considered together; it has an intrinsic focus on context; and it allows for social processes to be examined over time. More specifically, this particular argument has already been made in regards to CTOs. Swanson (2010, 185) notes that little research on CTO practice as it happens has been carried out, and thus argues:

To understand a topic as important and complex as...OCLs⁷, we need a variety of types of evidence, produced by a range of methodological approaches. We could...use an ethnographic accounting...to situate the story of OCLs in the particular context of social actors and groups and the social matrices of their thought and behaviour

There is a strong foundation therefore to suggest ethnography can give an insight into the workings of CTOs in a way more general qualitative research has not. In a broader sense, ethnographic studies of how policy is translated into practice are few and far between (Povall, 2006). ‘Policy ethnography’ as Povall calls it, “provides for lessons at the macro level, looking upwards to shed light on and deepen understanding of the processes there” (Povall, 2006, 1). This chimes with the move in governmentality studies away from pure discourse analysis and towards a more grounded approach. As Marston and McDonald (2006, 7) suggest, “an analytics of government is particularly relevant to the re-emerging genre of ‘street-level’ policy evaluation...because it focuses attention away from the institutions of government towards the actual practices of government”. As such, ethnography is suited to the premises of governmentality as it allows for attention to be paid:

...to the messy actualities of the empirical world; the multi-vocal nature of governing practices and their consequences; the experiences and perspectives of ‘targeted’ populations; and the tensions and conflict between shifting modes of power – all of which are in keeping with Foucault’s original analysis. (Mckee, 2009, 482)

⁷ As already mentioned, the terms used for CTOs vary from country to country. In the USA, where Swanson is writing from, one term used is Outpatient Commitment Laws (OCLs).

Ethnography thus forms the final ‘layer’ of the map, showing a route through the ontological and epistemological landscape formed by the melding of critical realism and governmentality. Specifically, ethnography allows for the distinct questions on CTOs generated by a critical realist/governmentality analytical framework that were highlighted earlier to be explored. The next chapter will focus on the particular methods through which these questions will be addressed, alongside the concrete concerns of the research process.

Summary

This has been a complex chapter to write, and I want to sum up here the process that I have worked through as the chapter has unfolded. The research literature as described in the previous chapter highlighted various areas for further development in the study of CTOs – notably the everyday practice of CTOs, how it is understood and acted on by practitioners and service users and with what implications. These conclusions on what is needed in CTO research are connected to a general orientation towards a critical realist approach, with its focus on explanations of generative change. Whilst I did not want to take a typical emancipatory approach to critical realism, nor did I want to ignore the ethical questions that the operation of power through the use of the CTO raises. Governmentality as a theory and tool for an analysis of the operation of power at the micro-level offers one particular and alternative way that such questions can be addressed. Specifically, it brings together Foucault’s central concerns with power/knowledge, disciplinary and reflexive power to delineate manifestations of the ‘conduct of conduct’. The incorporation of governmentality with a generic realist approach has been considered before – most notably by Stenson (2005) in his development of a realist governmentality. However, there are inconsistencies between critical realism and governmentality which needed to be considered in order to enable a coherent theoretical foundation for the study of CTOs. In this chapter, I spent some time developing a path between the two bodies of theory, which firstly relied on an understanding of the tensions Foucault understood to be intrinsic to the ‘art of governing’ and secondly on a particular reading of critical realism which questions the role of value judgements in research. Put briefly, coercive forms of power can be considered alongside more subtle forms

of governance and self-governance, and an analysis of such forms of power can be taken in an ethical but non-prescriptive way. In the penultimate section of this chapter I brought the focus back to the object of study – CTOs – by grounding these theoretical ‘workings out’ in an analytical framework which addresses questions of causality (‘why’) and description (‘how’). This framework – combining Pawson and Tilley’s approach to realist policy evaluation with Dean’s analytics of government – has, alongside the conclusions I reached in the previous chapter, informed the development of a set of research questions. In the final section of this chapter I argued that these research questions can be accounted for through a broadly ethnographic approach – a methodology which is advocated for in critical realist and governmentality literature, as well as the literature on CTOs. I move further towards a concrete consideration of research practices in the next chapter, where I consider the methods I will draw upon in conducting the research, alongside questions of study design, selection, recruitment, analysis and ethics.

Chapter Three
Examining CTOs:
How the study was conducted

The assumptions of both critical realism and governmentality can be well matched to the loosely ethnographic approach taken in this research (Hammersley and Atkinson, 2007, Sayer, 2000, Marston and McDonald, 2006, McKee, 2009). How this ethnographically influenced methodology has been embedded within a multiple case study design forms the first section of this chapter, in order to give an oversight of the study as a whole. Ethnography typically draws upon an eclectic mix of methods, “in fact gathering whatever data are available to throw light on the issues...that are the focus of inquiry” (Hammersley and Atkinson, 2007, 3). In the ensuing section I explore how the methods employed in this study illuminate varied aspects of CTO use, and specifically how they addressed the research questions. The use of multiple kinds of data, along with the inclusion of knowledge claims from practitioners and service users, means that the analysis process has been a complex task. With this in mind, in the next section I highlight the strategies used to help make sense of and manage the data. The practical ‘doing’ of research is then addressed, focusing on how decisions were made in regards to selection at the different levels of the case study, and the processes of gaining access and recruitment. A consideration of ethics played a large role in the research process, partly due to the NHS setting for the research which determined a rigorous scrutiny of the study’s ethical standards, and partly due to the nature of the study, in particular its inclusion of service users with complex histories, who are often deemed to be vulnerable. In recognition that managing ethics in social research is a reflexive undertaking, the various ethical issues that arose both during and after the study are expanded on in the final section.

Research design

Ethnography, “focuses on people’s ordinary activities in naturally occurring settings, uses...flexible methods of data collection, requires the researcher to be...involved in the field...and explores the meanings which...human activity has

for...people themselves and wider society” (Brewer, 2000, 20). Brewer goes on to state ethnography is not necessarily premised on particular methods. Instead, it is distinguishable by its aim to gain an “intimate familiarity” (Brewer, 2000, 11) with the participant experience. Hammersley and Atkinson (2007, 3) add that ethnography can be distinguished by the unstructured, naturalistic gathering of data, the use of a few small-scale cases and an analysis of data that focuses on the “meanings, functions and consequences of human actions and institutional practices, and how these are implicated in...wider contexts”. In other words, a naturalistic study becomes ethnographic when the data collected is connected to the broader milieu it is produced within. This study may not perhaps be entirely classifiable as ethnography according to these definitions, as the characteristics of the research setting means that the data collected could not be completely unstructured. Indeed, it should be recognised that ethnography as defined in traditional cultural anthropological terms differs significantly to how sociological ethnography can be understood (Barfield, 1997). However, in being guided by ethnographic principles, the study enables an insight into CTO practice from the ‘inside’.

Going further, a multiple case ethnography enables two types of analysis to be made, as Yanow (2000, 13) suggests, using the concept of a ‘frame’ for research:

“Frame” as a noun suggests a comparative analysis across communities of meaning...of the...ways in which a policy...has been “framed”...
“Frame” as a verb suggest a more dynamic analysis of change...“framing” over time...These two types of study suggest different constituencies: the duration and depth of the latter suggests an interest in understanding...processes; the former suggests more of an issue focus...

The objective of undertaking a multiple case ethnography is to combine the depth of ethnography with the comparative potential of a multiple case design, thus tracking CTOs over time and across settings. On this basis, the study is designed as an embedded multiple case study (Yin, 2003) on two different levels, the first being the inclusion of different CTO ‘constituents’, inclusive of the service user who is on the CTO, and the professionals involved in their CTO-related care⁸.

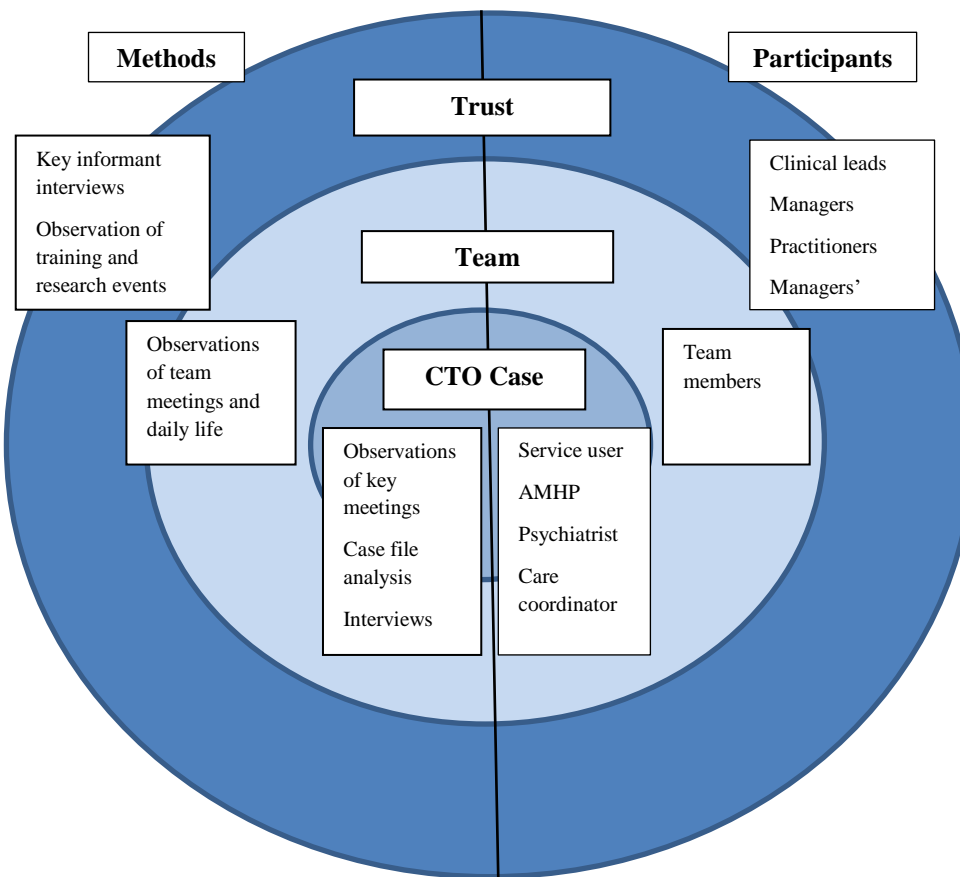
⁸ The original intention was to also include people who have caring responsibilities for individuals on CTOs but for various reasons that was not possible. 7 out of the 18 service user participants had individuals in their lives who could be described as having significant caring responsibilities for them. However, out of

To gain a holistic analysis, understanding multiple perspectives is necessary, as Naidai and Mader (2005, 7) argue, “...the findings from different fields should provide us with answers to different questions like elements of a puzzle that are put together to form a complete picture. Since the object of study spans more than one social world, it cannot be reconstructed by exploring only one field”. Following CTO cases as they unfolded allowed me to see the particular factors which came into play within and across each case over time. It also served a practical purpose in making it easier to gain consent from participants for all the methods used within the study. Furthermore, enabling service users to be heard develops a notion of democratic policy analysis, by including voices usually absent from the policy discourse (House and Howe, 1999).

The second level is premised on the inclusion of different field sites. Yin (2003) recommends multiple case studies of this kind, either through direct or theoretical replication. Direct replication is where cases are chosen so they produce similar findings, whereas theoretical replication is where cases are picked to produce different findings for predicted reasons (Yin, 2003, 47). A comparative analysis between cases can then be made. Not enough was known about CTOs in this country at the time of picking research sites to carry out theoretical replication, so cases were initially picked on the basis of direct replication. Both Mental Health Trusts (‘Trusts’) where the research was based had a relatively large number of CTOs. However, as the study progressed both similarities and contrasts between the sites emerged, which are noted later in the chapter. The study therefore builds on Yin’s (2003) approach, as it allows for concepts and contradictions to emerge that may not have been expected within a direct replication framework. *Figure Two* gives an overview of the research design as representative for both field sites.

this 7 I was only able to recruit 2 carers for interview, either because they or the service user did not wish for them to be involved. As the research focus is on CTO practice and the experiences of those individuals who are immediately affected by it, the carer experience was deemed to be ‘nice to have’ rather than essential to the study.

Figure 2: Overview of research design



Fieldwork took place within the two Trusts over a period of eight months, with time being split equally between each Trust. To maintain the familiarity necessary for ethnography, the majority of time was spent embedded within one Assertive Outreach Team (AOT) in each Trust. I was the sole researcher in the field, and each week was split between the two Teams to ensure consistent and longitudinal contact over the eight month period. Because the main purpose of AOTs is to work with ‘difficult to engage’ service users, they can attract a high volume of CTOs, and thus were selected on the basis that they would provide ample opportunity to observe CTO practice. At the time of fieldwork both teams carried on average a third of their caseload as CTOs. 18 CTO cases across the teams were tracked over the fieldwork period; this enabled CTO cases to be followed as they unfolded in different ways, thus forming the basis of an analysis of generative mechanisms. CTO cases were chosen to reflect a range of characteristics and perspectives of participants, and CTOs at different stages, although this was naturally constrained by concerns with risk and vulnerability.

The core of the study data derived from these cases and includes observations of key meetings, taking of notes from case files and semi-structured interviews with the service user, their care coordinator, the AMHP and the psychiatrist involved with their case. Throughout the fieldwork period, contextual information on the use of CTOs was also collected via key informant interviews with relevant stakeholders, field notes of daily team practice, observations of team meetings and attendance at Trust training and research events. The next section will explain in more detail how the three methods of interviews, observations and document analysis were put into practice.

Methods

McKeganey, Macpherson and Hunter (1988) write convincingly about the benefits of combining different kinds of data collection, especially interviews and observations, when exploring professional practice. As they say, interviews allow for individual cases to be explored in depth and to develop a sense of a timeline of events. Conversely, observations of meetings are not as helpful for this as they capture actors coming together at a particular time and place, and cannot account for 'back-stage' interactions. What observations do bring is a sense of how particular processes play out, and how different actors interact within that setting. Bringing the two together then allows a picture of a case to be built up from a number of different vantage points. The addition of document analysis to this equation means a source of data is included that is unmediated by the research process and helps give a sense of how actions and decisions are accounted for and justified in a professional context. As document analysis has been deployed for a review of CTO policy-making, it also sheds light on policy-making at a macro level. *Table One* maps how these three methods link to the guiding research questions for this study.

Table 1: Research questions and associated methods

Research question	Methods
Why did CTO policy come to exist, and exist in the form that it does in England? How have problems been framed as problems for the CTO to solve?	Document analysis (macro-level)
In what ways are CTOs conceptualised by practitioners and service users? How do these conceptualisations align or not with policy-level reasoning? For practitioners in particular how do they formulate CTO practice based on these conceptualisations?	Semi-structured interviews
How do CTOs work, and what factors – inclusive of participant action - influence why they work in those particular ways?	Observations; interviews; document analysis (micro-level)
What are the varying consequences of the CTO that result from these practices, how are these consequences thought about by practitioners and service users, and how do they relate to policy and practice-level reasoning on their use? How do CTOs work to produce change in service user identities and conduct, and in what ways are the transformational potentials of CTOs realised or resisted?	Observations; interviews; document analysis (micro-level)

Interviews

The interviews were semi-structured, using a topic guide⁹ to help explore participants' thoughts, feelings, perceptions and experiences of CTOs. In designing the topic guides, I drew from Patton's (2002, 359) suggestions on formulating questions that are open-ended, neutral, singular and clear. I also took advice from McCracken (1988) and 'set the scene' with informational questions about participant background before moving on to open, non-directive 'grand tour' (Spradley in McCracken, 1988, 35) questions underpinned by planned and

⁹ See appendices one, two and three for all supporting documents including topic guides, information sheets and consent forms.

floating prompts. I took particular account of McCracken's suggestions in 'manufacturing distance' (1988, 22) to bring to the surface taken-for-granted beliefs and experiences, for example questioning participants' key terms and significant words. Interviews with service user participants covered the significance of the CTO to them; the effect it may have had on relationships; their understanding of what the CTO meant; their involvement in the process and decision-making; compliance with the CTO; their understanding and experiences of the key mechanisms of the CTO; and their hopes for the future. Interviews with practitioner participants covered their experiences of using CTOs, drawing on the case in question as well as other cases; the effect practitioners believed CTOs had on their practice; decision-making processes and factors; and their views on the CTO more generally, including their purpose for using them and views on CTO policy. All interviews were recorded and fully transcribed.

The 18 service user interviews mostly took place in the participants' homes, with the exception of four, where the service user expressed a preference to be interviewed in an interview room at the respective team office. People with severe mental health problems can experience certain difficulties in the interview process that it was important for me to be aware of and manage. McCann and Clark (2005) note that the interviewer must take account of the cognitive effects of both the disorder and medication on the service user's ability to converse. Therefore careful thought was given to the method of questioning and types of questions asked to ensure they were concise and concrete. I also made it clear to the service user that they could participate at their own pace and ask for questions to be repeated or rephrased. Finally, the duration of interviews was altered to suit the participants' needs, and provision was made for shorter interviews and for breaks in the interview if participants required them. This resulted in interviews ranging from twenty minutes through to an hour in length, dependent on the participant. Out of the 18, only one interview was stopped prematurely, and this was due to my feeling that the person was not demonstrating the capacity to understand why they, or indeed I, were there. The care coordinator or another worker was present for three of the interviews, in two cases because it was not felt safe to leave me alone with the participant and in one case because the service user requested their presence for support. This

inevitably lent a different dynamic to those interviews, and it cannot be ascertained how much impact worker attendance had on what the service users told me.

It was always intended that a second wave of interviews with service user participants would take place near the end of the fieldwork period to explore any changes in their perceptions of CTOs. However due to time constraints I decided upon a more focused approach, whereby only those service users whose legal status had changed during the fieldwork period (meaning they had been discharged from their CTO, or had been admitted back into hospital at some point) would be interviewed. This amounted to five service users, four of whom were re-interviewed. One interview was not possible due to the service user still being in hospital and lacking capacity to participate at that stage. These second wave interviews were in general much shorter, lasting between ten and thirty minutes in length.

Altogether 36 practitioners participated in interviews, the majority being practitioners working 'on the ground' in services, and a smaller number being key informant interviews with clinical leads and managers. These interviews took place within the workplace and it was made clear that the interview would be adaptable to their needs, so for example a number of practitioners undertook the interview in two sessions due to work commitments. In general, interviews ranged from 45 minutes to an hour and a half, with the majority being over an hour in length. Although a semi-structured guide was used, many of the interviews had a narrative flavour, with practitioners telling in-depth stories of the CTO cases they had dealt with, particularly in response to the questions about cases when a CTO had or had not worked well.

As noted in the Introduction, the legal oversight of CTOs is maintained through an appeals process, where Tribunals or Managers' Hearings are convened to hear evidence on whether the CTO should be discharged or not, and to make a decision on that basis. The perspectives of these decision-makers have only rarely been explored in the literature (with the exception of Jaworowski and Guneva, 2002). To develop a more rounded picture of CTO decision-making, I

undertook two group interviews with Managers' Hearing Chairs (8 participants altogether) within the Mental Health Act offices of the respective Trusts. These interviews focused on the appeal process and their decision-making. The premise of conducting the interviews in groups rather than individually was so that the Chairs could draw on each other's experiences and compare and contrast to stimulate discussion.

Observations

Observation forms the foundation for much ethnographic research and is used to further understanding through watching and listening to what people say and do (Brewer, 2000). Observation gets the researcher closer to everyday practice than any other method and has been described as the "gold standard for the study of processes" in healthcare (Murphy and Dingwall, 2007). In the context of the study, observation generated data on decision-making in action, and particularly shed light on what discourses were prevalent in decision-making and how practitioners and service users engaged with each other in relation to the CTO. Advice was sought from practitioners in the field as to which meetings would be appropriate and feasible to observe, and on that basis consisted of a range of the following:

- Observation of a selection of team and handover meetings within each team
- Observation of CTO review meetings
- Observation of Managers' Hearing and Tribunal appeals
- Observation of informal meetings between service users and practitioners

In addition, I spent sustained periods of time in each team noting events that occurred naturally that were particularly relevant to CTOs. Field notes were taken of observations, using strategies described by Lofland et al (2006) as a framework. This involved making notes on significant elements of the observed situation; the concrete detail of what was said and done; and how the observed situation related to other events that had occurred. Care was taken when developing fieldnotes to distinguish as far as I was able between descriptions and

analytical/evaluatory considerations. Spradley's (1980) dimensions of social situations were also helpful for structuring fieldnotes when working them up, making reference to the space, the actors, the activity, actions, sequencing, goals and expressed feelings. Due to the ethical restrictions in place, these meetings were not recorded, but hand-written notes were taken both during and after the meetings.

I took different stances in relation to observation dependent on circumstance. Spending on average two days a week in each team over the fieldwork period meant I got to know the practitioners fairly well, and my role developed and shifted as the fieldwork progressed. However in formal meetings such as Tribunals, I was always in the role of a complete observer. Combining the widely used classification of participant observation (Gold, 1958), with Spradley's (1980) phases of observation, fieldwork progress can be summarised as follows:

First phase (two months): I was more observer than participant, spending time getting to know the fieldwork environment, the complex systems within community mental health services and building relationships with participants. Observation was therefore necessarily broad to ascertain what aspects of practice to focus on.

Second phase (five months): The research role moved more towards active participation as I made a place for myself within the teams. In this sense, it was particularly helpful to identify as a qualified practitioner situated within academia, as a number of the practitioners were engaged in post-qualifying training and requested advice and resources. I also tried to make myself helpful in other ways, for example passing on messages and information within teams. A two-way relationship was therefore developed with many of the practitioner participants which meant I began to be told more consistently about when CTO related events were occurring and observation therefore began to take on a more focused character. Getting to know practitioners also led to an increase in the undertaking of informal 'interviews' in the field, which meant I was able to develop an understanding of the detail of CTO practice as it happened.

Third phase (one month): This phase was largely taken up with managing endings and subsequently a conscious decision was made to shift position back to being more observer than participant, with less intensive time periods being spent in the teams. Various checks were carried out to ascertain I had the correct details of cases and selected observations of events which had not been able to take place earlier were completed.

The observations were separated between those that were ‘formal’ (appeals, reviews, training days) and ‘informal’ (within the office environment, team meetings, interactions between service users and practitioners). Formal observations were between half an hour and an hour in length, with the majority being nearer the hour mark. Informal observations varied widely, although most team meetings were around an hour in length. Where possible, verbatim notes were taken during or immediately after observations. After formal observations, contextual notes were also completed. Informal observations were incorporated into written up field notes, giving detail of what happened on a day to day basis within teams. Observations were also split between those that were case related and those that informed the more general workings of CTOs. *Table Two* shows the kinds and number of case-related observations taken.

Table 2: The number of each type of case-related observations

Reviews	Managers’ Hearings	Tribunals	Hospital discharge meetings	Miscellaneous*
12	8	2	3	7

* AMHP interviews with service users, AMHP interviews with family, and the general weekly visit between the care coordinator and the service user.

Altogether 32 case-related observations took place. On average 2.5 meetings were attended for 13 of the 18 CTO cases. It was not always possible to attend relevant meetings for each participant for a number of reasons. Particularly early on in the fieldwork, I would at times not be informed when reviews were happening, or as often happened, their date would be changed at short notice and

occur when I was not present. At times, practitioners did not feel it was appropriate for me to attend, especially if a lot of people were to be present, and on one occasion the service user told me they did not want me to attend a meeting. In regards to appeals, these did not always happen within the fieldwork period. Due to the legal framework regarding their use, Tribunals in particular were rare occurrences. In one Trust, the team was based in the hospital site and therefore it was possible to attend ward rounds and discharge meetings, but in the other the team was based in the community at quite a distance from the hospital and attendance at ward rounds and discharge meetings by practitioners was not as frequent. In four cases participants were discharged from their CTO before any meetings could be attended and in one case, the participant was recruited at a later stage in the fieldwork and no meetings occurred before it ended.

Document analysis

The final form of data that were included was documents, at micro level (case files, minutes) and macro level (practice guidance, legislation, policy frameworks, policy-making process). Using documents as data can “provide a new and unfiltered perspective on the field and its processes” (Flick, 2009, 261) as they have not been created specifically for the research. Their potential usefulness for analysis in the study was two-fold. Firstly, they provided information on the development and eventual form of CTO policy itself, thus enabling a review of the policy-making process to occur. Secondly, they also give an insight into how CTOs are written about by practitioner communities and more broadly, the decision-making process on CTOs.

For the policy review, searches of Hansard and associated parliamentary papers (such as Joint Committee reports, oral evidence to the Joint Committee, Commons research papers, policy documents and responses to lobbying) were conducted. Alongside this, policy analyses by bodies such as the Mental Health Alliance, and academic papers (some of which included ‘elite’ interviews with policy-makers) on the formation of the Mental Health Act and the history of mental health policy, provided valuable historical knowledge. Finally, the international context was accounted for, by drawing on academic, policy and

legislative sources to help construct a picture of how CTOs have developed globally over time. These two latter elements were essential to understand in a comparative sense how and why CTOs manifested in the English system as they did, and thus formed a large part of the analytical framework of the policy review, namely knowledge transmission over time and space.

For the case file review, the hard files and electronic records of 17 of the 18 service user participants were investigated over two months near the end of the fieldwork period. One participant did not give consent for their records to be accessed. Participants' paper files were held in the Trust Mental Health Act office¹⁰, and included details of formal decision-making on CTOs and copies of the reports made by practitioners for appeals. As much of the material was handwritten, a great deal of copying out of information was required, into separate anonymised¹¹ documents for each participant. Spending time within the Mental Health Act offices of both Trusts whilst completing this task provided a serendipitous alternative perspective on CTO use, as I was witness to the comings and goings of practitioners for legal advice and many frustrated phone calls when the administrators felt practitioners had not followed the legal framework. These paper files were complemented by the day to day recording of events by practitioners on the Trusts' database. For each participant, a search was made of the Trust database, starting from just before their earliest CTO had been applied. Each entry was read, and if it was relevant to the use of CTOs, it was copied and pasted into a document, which was then systematically anonymised.

The dual process of searching the database and the paper files led to two documents being made for each participant, one of 'official' decision-making contained in the paper files, and one of daily decision-making as demonstrated in the database entries. These two documents were then combined, in chronological order, forming one document, or 'time-line' of decision-making

¹⁰ Mental Health Act offices oversee any use of the Mental Health Act within the Trust. Their duties include: keeping a database of current active use of the Act in the Trust; maintaining and auditing case records; offering legal advice and managing any 'illegal' use of the Act in the Trust; and coordinating appeals.

¹¹ Anonymity does not only refer to the taking out of names and places, but also any detail I felt was so specific it was obvious who the participant was.

for each participant. As can be expected, these are fairly lengthy documents, with the longest being 22,000 words in length, and the shortest 2000, dependent on participant history. However, the majority of the documents are around 9000 words and give a good sense of the development of each case over time.

Analysis

The process of analysis in ethnography can “best be described...as a dialectic movement between data and theory, being shaped and reshaped as knowledge expands and deepens” (Sharkey and Larsen, 2005,179). To support this process, I built in time for reflection and interim analysis into the fieldwork, in order to create a foundation for the final analysis. Analysis was based on transcriptions from the interviews, document analysis and on detailed field notes and memos generated through observation.

A combination of thematic and narrative analysis were employed, in recognition of the need to create a network of cross-sectional themes but also to represent the ways that CTOs unfolded over time (Floersch et al, 2010). By using both thematic and narrative analytical approaches, CTO ‘story-lines’ became apparent, where the CTO was followed from participant conceptualisation of the CTO, through to active use of the CTO and finally decision-making on whether to discharge the CTO, taking into account contextual, interpersonal and personal factors at each stage. I managed this process by drawing on McCracken’s (1988) suggestions for analysis, which involves a close line by line reading of texts to understand first order concepts before moving on to develop second order concepts. These second order concepts were then developed into a thematic framework, made up of concept groups, for each of which I wrote a detailed account. As a practitioner I felt more ‘at home’ with professional perspectives and so began this process by analysing service user interviews so that I could explore the data from a less familiar starting point. Once I had developed a foundational framework from this data, I repeated the process firstly with practitioner interviews, then with the observations, and finally with the documents, thus moving from first person viewpoints through to enactments and

recording of the CTO process. I ended up with a framework of concepts for each kind of data (see appendix four for an example of a framework).

Given the volume of data that the research generated, data management was not an easy task. I decided however not to use a software package, as I felt that I would be closer to the data by taking an immersive approach. Once the analytical frameworks were developed, I used review functions in Microsoft Word, and a bespoke software programme to sort and separate out the respective data into discrete documents, each pertaining to a distinct concept contained within the framework for that data. I then went through these documents in turn to compare and contrast the data so that it could be separated into sub-categories. At the same time, I also continuously modified these sub-categories and corresponding memos in the analytical frameworks to ensure the ideas they contained matched the changes that were being made. In this way, I expanded and refined the frameworks. The penultimate stage involved bringing the conceptual frameworks from the different data sources together, to note connections and distinctions, both in terms of how concepts were approached, but also in how the different frameworks shed light on varied aspects of the field, and thus related back to the research questions.

In the final stage leading up the presentation of the data as findings, I created and built up configurational ‘maps’ of CTO stories (Sayer, 1992), incorporating the concepts emerging out of the practitioner and service user interviews, observations and documents. In this way, by moving through time and between first person, observational and documentary data, I was able to see how the factors that surfaced during the thematic analysis crystallised in the process of individuals interacting with CTO components, which helped lead to theory development on the different generative paths a CTO might take. In turn, following the narratives highlighted the kinds of outcomes that came of these interactions. Just as importantly, returning to the interview data shed light on how those outcomes were perceived in partial and differential ways by practitioners and service users. The next section will explore in more detail the research process itself, starting with the recruiting and selecting of participants.

Fieldwork considerations: participants

62 participants were involved in the study; 18 were service users, 20 were practitioners working with those service users, 16 were practitioners recruited as additional key informants, and 8 were Managers' Hearing Chairs.

Trusts and teams: recruitment, selection and characteristics

The initial approach to selection of Trusts was to write to the senior management (typically at Director or Chief Executive level) of ten Trusts geographically situated in the North of England (see appendix five). I was told early on in the research process by a researcher experienced in NHS-based mental health research that I would struggle to get access, particularly as I had no strong pre-existing practice links and it was at the beginning of a time of significant change and churn within services (mid-2011, following the Conservative and Liberal Democrat Coalition Government being elected the previous year and the start of their reform programme for the NHS). In this sense, selection was a pragmatic decision based on which Trusts would give me access. None of the ten Trusts I approached directly refused access, but given the timescales I was working to, I had to make a decision quickly when Trusts did show an active interest. Even so, the two Trusts who agreed for me to carry out the research held some interesting characteristics, which fitted into a theoretical model for selection where a comparison could be made between different local practice regimes and cultures. Both Trusts covered areas with a high level of poverty and deprivation. However, the contrast between their approaches to mental health service provision is marked. *Table Three* gives an overview of their key differentiating characteristics.

Table 3: Characteristics of the two Trusts

Characteristics	Trust one	Trust two
Geographical and socio-economic	Large urban area with high levels of unemployment, poverty and deprivation	A small urban centre and a large semi-rural hinterland. High levels of unemployment, poverty and deprivation
Mental health service provision	Strong community focus with a large number of ‘satellite’ team offices. Little inpatient provision. Outreach approach with few visits by service users to the office	Strong hospital site focus with most teams based within the hospital grounds. Relatively high number of inpatient beds Office-based approach with many appointments taking place on site
Structure	Large centralised Mental Health Act Office. ‘Traditional’ model of tiered services with Community Mental Health Teams, Assertive Outreach Teams, Crisis Teams, Early Intervention Teams	Dispersed administrative support through small localised Mental Health Act staff teams. ‘New’ model of services based on Care Clusters ¹² , including Recovery Team (psychosis, complex needs), Social Inclusion Team (psychosis and mood disorders, low-level needs) as well as Assertive Outreach.
CTO use	Larger numbers of CTOs. Average length of CTO > 1 year.	Fewer CTOs. Average length of CTO 8 months.

¹² Care Clustering was brought in by the Coalition government to support the ‘Payment by Results’ model in the NHS, and basically refers to clustering service user groups and linking them to specific tailored teams and services based on key characteristics.

Gaining agreement through various levels of gatekeepers within the context of NHS bureaucracy was a lengthy and complex task. The senior managers of the two Trusts who responded positively did so because they believed that the use of CTOs in their Trusts was an issue worth investigating. One of the Trusts had higher usage of CTOs than the national average and they were concerned about overuse; the other Trust had recently taken over services in an area where the use of CTOs was very different to the rest of the Trust and management wanted to find out how CTOs were being practiced in the Trust. The advocacy of these two managers was essential in filtering the research request down through the management structure to team-level. Throughout, negotiating access was an iterative process, moving between various levels of managers in the two Trusts, the Trusts' respective Research and Development Offices and the NHS Research Ethics Committee.

Within the two Trusts, I decided to focus on Assertive Outreach Teams (AOT) because they tend to have the highest number of CTOs and so would provide useful data on their use. Similarly, both of the AOTs which were selected were done so on the basis that they were the busiest and largest AOTs in the two Trusts. The two team managers were both receptive to my involvement, I think because they were both relatively new in post and were keen to gain an 'outside' perspective on team practice.

Practitioner participants: recruitment, selection and characteristics

Once an arrangement was made with the AOT Manager, I arranged to attend a team meeting in order to present the research and give practitioners information sheets. Following NHS Ethics and Trust-level approval being formalised, I then contacted practitioners individually to go through the information sheet/consent form, answer any questions and gain consent. Due to the case-led design of the study, practitioner consent forms were made specific to the level the practitioner was expected to participate; so if practitioners were working with service users on CTOs who were also recruited to the study, I asked the practitioner to agree to be interviewed and observed in meetings. All other practitioners in the team were asked to agree to my presence for general observations.

In addition to the ‘case-specific’ practitioners recruited from the two AOTs, 16 practitioners were included as key informant interviewees only, either because they were able to provide an overview on the use of CTOs (3 clinical leads/managers), or because I thought they would answer interesting questions that were raised during the fieldwork period. These interviews occurred more organically at a later stage in the study, when I was able to take advantage of recommendations and links built up within the two Trusts. For example, a number of AMHPs had mentioned in their interview that CTOs were used in a much more restrictive way within Learning Disability services, so a cross-section of practitioners (5) from Learning Disability services were included on this basis¹³. When examining the figures for CTO use within one of the Trusts, I noted that the other AOT in the Trust used CTOs a lot less than the AOT where the majority of fieldwork took place, and interviews were conducted with that team’s Manager and psychiatrist to investigate this difference. Thirdly, the AMHPs interviewed thus far had all been ‘in-house’, based within the two AOTs to deal with those teams’ cases and also taking on the dual role of care coordinating. I decided that it would be useful to also include duty AMHPs (2) who did not hold caseloads and who therefore dealt with CTOs as and when they arose across a Trust. Finally, some care coordinators (4) were interviewed from other types of teams, where CTO use was lower, including two ‘typical’ Community Mental Health Teams and an Early Intervention in Psychosis Team. This was to explore the differences in practice and perspectives that might occur in settings where CTOs were rarer.

Within one Trust 15 practitioners were recruited, with two not responding to my contact with them. 21 practitioners were recruited from the other Trust with four non-responses, so altogether 36 practitioners were recruited. *Table Four* shows practitioner participants by role and professional background.

¹³ The interviews with Learning Disability practitioners were eventually not included in the analysis and write-up for this thesis, as they were so different to the focus of the rest of the study. They provided interesting insights however into the use of CTOs within Learning Disability services and I intend to write them up in a standalone paper. It should also be noted that although the pool of participants was expanded to allow for contrasts, few marked differences came up in the analysis of data – for example between ‘team’ and ‘duty’ AMHPs’ accounts. The only notable difference is commented on in the findings – that between the AOT where few CTOs were used as compared to the AOT where CTOs were used in large numbers.

Table 4: Practitioner participants by role and profession

	Care Coordinator	Psychiatrist	AMHP	Manager	Total
Nurses	11			1	12
Social Workers	5		8	3	16
Occupational Therapists	1			1	2
Psychiatrists		6			6
Total	17	6	8	5	

Out of the 36 practitioners, 20 were female and 16 male, and gender was weighted towards women among all professional groupings, except for the psychiatrists. The majority (32) were White British with the remaining four participants being British Asian or Black African, again represented more in the psychiatrist grouping. A wide range of practice experience was demonstrated, with forty years being the longest time working in mental health services and one year the least. The participants' career length played quite an interesting part in interviews, with those who had worked longer being able to share their perceptions of changes in services over the years and those who had very short careers to date believing that they were less sure of how 'systems' worked, which in turn had an effect on the confidence they had in understanding CTOs.

The largest professional group represented was social work (16), with nurses making up the majority of the remainder of participants (12). In this sense, taking a case-led approach helped to rebalance previous research that has tended to focus more on the perspective of psychiatrists, and to understand CTOs as embedded in daily practice. It has been argued (Allen, 2014) that social work brings a distinctive set of values to multi-disciplinary mental health practice, but I found little evidence of that in the field sites in reference to CTOs. There was a similar and comparative range of value perspectives within all professions – social workers, occupational therapists and nurses – who took on the role of care

coordination. Differences in perspectives were generally premised on role rather than professional background. Hence although the AMHPs were all social workers, the distinctive perspective they took was related to their legal mandate rather than their profession. Similarly, psychiatrists as the primary decision-makers on CTOs tended to take a particular view which could be separate in some ways from their colleagues. Accordingly in the findings, I refer to practitioner contributions by role and not profession.

Service user participants: recruitment, selection and characteristics

Service users were initially approached via their care coordinator, who gave a brief explanation of the research to them, gave them an information sheet to read and asked their permission for me to contact them directly. Following a period of approximately two days, if they had agreed that I could, I contacted the service user and arranged to meet with them, in order to go through the information sheet/consent form, answer any questions and check their capacity to understand, retain and assimilate the information given, and communicate choice in regards to the research (Appelbaum, 1998). Service users were able to bring a ‘trusted supporter’ when negotiating informed consent and taking part in interviews (Ulivi, Reilly and Atkinson, 2009).

Within each team, all individuals on a CTO were considered; emphasis was placed on the characteristics of the CTO ‘case’ rather than the individual service user, specifically recruiting individuals who were at different stages of the CTO to ensure a range of CTO experiences were accounted for. With that in mind however, service users were not included if their care coordinator declined to take part in the study; if they were deemed to lack capacity to make an informed decision in regards to participation in the research; had a learning disability or a diagnosis of dementia; did not speak English; or were under 18. In one team, 22 participants were considered, and 10 eventually recruited. In the other, 8 participants were recruited out of a potential pool of 38. The reasons for not being able to recruit are outlined in *Table Five*.

Table 5: Service users who were not recruited

Declined	7
Risk	8
Capacity	10
Care coordinator not recruited	5
Gatekeeping*	9
Miscellaneous**	3

*This related to the Care Coordinator stating they did not feel the person would agree to take part as they were deemed too hostile to services in general.

** There were a small group who had agreed to meet, but for one reason or another, such as a change in circumstances or missed appointments, the initial contact didn't go ahead.

Two thirds (12) of the service users were male, as reflects the national and international trends on gender and CTOs (Care Quality Commission, 2011a, Churchill et al, 2007). Given that this is a qualitative study, the weighting of the selection to fit national trends was not intentional; however, an effort was made to ensure women were represented in the selection due to the known gender bias of CTO use. Almost all (16) identified as White British, which was indicative of the ethnic make-up of the field sites, but not of the higher than expected (as compared with the general population) national rates of CTOs for people particularly from Black ethnic groups (Care Quality Commission, 2011a).

As might be expected given the well-documented social exclusion and stigma experienced by individuals with severe mental health difficulties, the majority of the participants were socially isolated, with little in the way of support from family, friends or the wider community. All participants received Disability Living Allowance and most were on other benefits of some kind, with three working in a self-employed capacity. Five participants were also on appointeeships, which meant the local authority managed their money for them.

Most participants were single (14) and lived on their own in the community, either in supported accommodation or a local authority tenancy.

Most participants (14) were in their forties or fifties and had been involved with services for a number of years (range of 3 to 33 years); all had been diagnosed with some enduring form of psychosis. However this picture is complicated by the majority of participants also being given a number of different diagnoses over the years as well as half of the participants having secondary diagnoses of personality disorder and/or substance misuse. I found it problematic to approach participants from a diagnostic stance. Not all participants' saw their own experiences as fitting within such a conception and indeed were resentful of the labelling and subsequent stigma they felt diagnosis had brought with it. However, interesting themes particularly arose from practitioner interviews on the relationship between diagnosis (particularly personality disorders) and use of the CTO, and so such a framework was necessary to explore this data further.

During their time in services, all participants had had at least one involuntary admission to hospital, with the most experienced by a participant as over 30. In this sense, some but by no means all participants fitted the criteria for the 'revolving door' patient which CTOs were originally intended for. Another stated policy purpose for CTOs was to help practitioners' manage the risk of harm to others (Department of Health, 2012) and in the selected group of participants, risk was a documented issue in almost half of the cases (8).

Most participants had only been on one CTO, although a sizeable minority (7) had experienced two or more. These experiences meant those particular service users were able to describe their experiences of CTOs in some depth, both relating to the present and the past. The length of participant's current CTO ranged from three months to just over two years. Just over half of participants could be described as stable on their CTO, with only five having experienced one or more recalls to hospital, either on their current or on previous CTOs, and another three having been admitted voluntarily to hospital on their current CTO. Five of the eighteen participants were discharged from their CTO during the course of the fieldwork period and one was discharged shortly before it began,

but still included in the research due to the perspective they were able to give on their experience.

Fieldwork considerations: ethics

Given the study's focus on the ethical consequences and dilemmas of mental health policy and practice, it seemed particularly pertinent to pay close attention to ethics when making decisions on research design. It has been noted that research with mental health service users can be sensitive for a number of reasons, such as the potential to cause distress through talking about difficult experiences, the fear that involvement will impact negatively on services, and the complexities around informed consent (Keogh and Daly, 2009). The attainment of NHS ethics approval involves a rigorous and detailed ethical planning process¹⁴, which although at times convoluted and bureaucratic was ultimately helpful in making me carefully consider all ethical aspects of the study. In order to provide a framework for ethical research to take place, I implemented a number of procedures and safeguards, which are detailed in appendix six. As has been noted more generally in both health and social care settings (Murphy and Dingwall, 2007, Shaw, 2008), undertaking qualitative research also involves a continuous consideration of ethics throughout the research process, by consciously being a 'moral researcher' when making reflexive decisions in the field.

Ethical reflexivity in fieldwork

Being a social worker who nevertheless had little previous experience in mental health practice, I could be described as on the "inside 'out'" (White, 2001, 104), and it took a number of careful preparatory meetings with service users before I felt enough trust had been built to ask them to participate in the research. With practitioners I became aware that I would sometimes slip into 'coded language and communication' culturally common to myself and the participant (Kanuha, 2000, 443) and had to consciously remind myself to question what was held as self-evident. The keeping of a personal fieldwork diary and debriefing sessions

¹⁴ As my research was non-clinical, it was examined and approved by the national Social Care Research Ethics Committee

with supervisors helped me to work through these issues and my sometimes contradictory thoughts and feelings on how I could see CTOs being used. As the fieldwork progressed however, I did experience challenges in maintaining the balance between insider and outsider perspectives that ethnography demands (Hammersley and Atkinson, 2007). My identity as a practitioner who has worked in very similar teams in the past, meant it was easy to become engaged in familiar tropes of practice language and activity. This made it difficult to remain in the position of ‘acceptable incompetent’ (Lofland, 1971), and also to retain a marginal position where distance could be kept between myself and participants, particularly practitioners. Being in the teams over time meant sometimes being asked to contribute by the field members in unexpected ways which disrupted such a sense of distance and could create significant anxiety and discomfort. Quirk (2008, 134) in his ethnography of a mental health inpatient ward runs through a range of common anxieties for ethnographers including: being able to ‘pull the research off’, the problems of discreet note-taking, identity management and being an ‘unwanted guest’, the response of participants to his findings and threats to his well-being. All of these anxieties became familiar to me throughout the fieldwork, but as Quirk also notes, there is something about conducting ethnography within an institutional setting which can be distinctively destabilising. For me, his description of having an ambiguous institutional role rang particularly true; of being characterised by different actors as having particular sympathies, which in turn at times mediated what I was allowed to observe and know. Ethically this could be tricky to navigate. One service user participant following our interview asked me to write a letter for her upcoming Tribunal stating that she did not need to be on a CTO. I explained I could not intervene in cases, but could provide her with information about advocacy services if she wanted. At the next meeting I was expected to attend, she decided she no longer wanted me to be present; I had misjudged how she had understood the research process and she had misunderstood my role.

At the same time, being positioned by participants, whilst sometimes leading to ethically difficult places, could also generate potentially helpful insights. For example, I attended an appeal where the care coordinator was unable to be there and so the Team manager (who had never met the service user in question

before) reluctantly stepped in. As I had met the service user a few times by that point, prior to the appeal starting the panel members asked me some questions about the case, which in answering felt like I had overstepped a boundary which I had no control over; that lack of control emanating from being present in such a formal setting with individuals who held unambiguous authority. The service user came in, looking quite overwhelmed and commenting repeatedly about all the people present. I think probably because I was the only familiar face to him, the manager suggested he sit down next to me and he asked me nervously twice how I was doing. There is much that can be said in academic terms about the nature of meetings and how they may mediate service user (dis)enfranchisement. Being placed in a position where I felt I had no choice to answer questions I did not want to, coupled with feeling that I was the anchor for the service user in that setting, brought home in a fleeting but nonetheless immediate and intuitive way how difficult and disempowering such meetings can be. It also made me think carefully about how I could position myself in future meetings; for example, instead of already being in the meeting room, I began to experience the journey and preamble to the meeting alongside service users, thus acknowledging the importance of ‘mobility’ and ‘informal spaces’ for social research and practice (Ferguson, 2010, Ross et al, 2009). This served the dual purpose of both eliciting interesting data on how processes prior to such meetings worked/were experienced, and placing myself in a position that may have been more ethically sensitive to service user participants.

Ethical reflexivity does not end when exiting the field. Shaw (2008) highlights some of the ethical dilemmas social work researchers face in writing up and dissemination activities, including the risks inherent to the ‘taking and re-making’ of participant stories. Qualitative research involves the analysis of participant narratives beyond their initial descriptive meaning and so creates a tension between researcher and participant understanding and ownership. Furthermore, Finch (1986) argues that within qualitative research with its traditionally small sample sizes, it is important to not ‘betray’ individual participants by representing their group in ways which can reinforce public stereotypes. This point seems particularly pertinent for research with individuals who have diagnoses of severe and enduring mental illness, given the stigma they

already face in society. In presenting the research I tried to remain sensitive to original meanings and in how individuals may ‘look’ to various audiences. In this way, the thesis has been informed by a relational ‘ethics of care’ that attempts to “ground principles such as respect, integrity and justice in the concrete relationships of actual research” (Hugman, 2010, 162).

Connectedly, respecting practitioner perspectives whilst maintaining research integrity needed careful thought. It is important that the research experience is perceived as generally positive by participants and gatekeepers, both for intrinsic moral reasons, but also so that attitudes towards research and researchers in general are not adversely affected, thus affecting potential future access. To reassure team managers and practitioners, I emphasised from the beginning of the research process that my intention was not to do a ‘hatchet job’ of practice. By the point I started to share my research in various forums in the Trusts (including Trust Board meetings, Trust lecture series, AMHP and psychiatrists forums, service user and carer groups, and with the teams themselves) I had been embedded in the teams for some time. This familiarity sharpened the sense of responsibility I felt for how I presented findings, and what I did and did not include. With significant change afoot in both Trusts I was aware how sensitive the team managers were to how they were seen in the wider Trust context. In addition, there were dynamics in both teams that I became aware of over time, which whilst relevant to the research would need to be handled sensitively when reporting findings. Both teams had undergone recent changes in personnel which were still ‘bedding in’. There is no straightforward answer to these kinds of ethical dilemmas, but I have tried to strike a balance between such competing factors in an honest and open way that has maintained good relationships with research participants along with ensuring the findings are presented with integrity.

Summary

In this chapter I have outlined my methodological approach to the study, starting with research design before delineating methods, analysis, recruitment and selection criteria, and ethical considerations. In taking a case-based approach I

have been able to follow CTOs as they develop over time, gain access to a range of perspectives on their use, and utilise my chosen methods to their fullest extent. Through combining interviews with observations and document analysis I have orientated the study to the research questions I set out to explore. These methods have respectively allowed for an analysis of: participant reflection on CTOs, the everyday practice of CTOs, and an unmediated timeline of CTO decision-making, as well as a macro-perspective of CTO policy-making. My analysis of the data that has arisen from these methods has attempted to do justice to the complexity and range of material generated. I have amalgamated different participant perspectives and different data sources to allow for an analysis which accounts for cross-sectional themes and the development of CTO stories over time. In the latter half of this chapter I particularly focused on how the research was carried out, by giving a sense of the participants and their circumstances, as well as the ethical challenges I faced in carrying out the field-work. In this way, I hope I have given an account of the study which enables the reader to approach the findings presented in the next few chapters with a good understanding of where they have come from.

Chapter Four
CTO policy development:
The ‘how’ and ‘why’ of compulsory community care

This chapter represents the beginning of a narrative about CTOs which will follow their progress from a policy idea through practice to their various conclusions. Its primary aim is to ‘set the scene’ for the empirical findings which are to follow. The dual foci of the policy analysis that are presented here are *how* and *why* CTOs came to be present in the English mental health system in the form that they take. This is in keeping with the framework I highlighted in Chapter Two, of synthesising critical realism and governmentality. The former concept is addressed by theorising on *why* CTOs were introduced, in particular what the drivers were that led to their inception, and why CTOs were introduced in the configuration they were - that is, the enabling and constraining factors which mediated their final form in England. The latter concept is dealt with by illuminating *how* the problems CTOs were meant to solve were made visible and corporeal, and how certain kinds of knowledge and expertise informed the development of CTOs. In bringing the two together, an analysis which pinpoints the formation of a rationality of government in regards to CTOs, but also accounts for the complex nature of political processes and the diversity of influencing factors, is made possible. It should be noted that the incorporation of a realist approach (why) to this policy analysis alongside governmentality-informed questions (how) does not necessarily mean that all elements of why CTOs came to be in their present form in England have been accounted for. Indeed as stated in Chapter Two, realist accounts do not tend to claim to be a ‘complete’ picture of what they are studying. As representations of reality they are “fallible and theory-laden” (Sayer, 1992, 5) but nonetheless endeavour to illustrate and explain through a close analysis of materials what is happening in the field of study. This policy analysis of CTOs has drawn on a range of historical secondary sources to develop such an explanatory narrative.

It is necessary to trace the development of CTOs spatially as well as over time. Specifically, using a framework derived from the literature on policy transfer (Dolowitz and Marsh, 2000, Evans and Davies, 1999), the relationship between

domestic and international expertise and experiences is drawn out to illustrate how particular kinds and sources of knowledge were used to make the case for CTOs. Broadly summarised, policy transfer refers to the process “in which knowledge about policies, administrative arrangements, institutions etc in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place” (Dolowitz and Marsh, 1996, 344). As a form of knowledge transmission, “policy transfers and political rationalities are seamlessly intertwined: transfers make possible the existence of different political rationalities by quite literally putting political ideas and knowledge into action” (Moisio and Luukkonen, 2014, 12). In this regard, how CTOs came to be rationalised is ineluctably connected to the role of knowledge flow across jurisdictions. At the same time, it should be recognised that policy knowledge is not simply reproduced within a linear model, but instead is transformed through application in particular places and times (Wedel et al, 2005). Studying the interaction between local and global knowledge thus helps to shed light on why CTOs took the specific policy path they did, through an acknowledgement of the role of policy actors in shaping final outcomes within a hotly debated area of policy. Following on from this, a comparative analysis of CTO regimes helps to explain the nature of CTOs as they have been realised in England and some of the significant cultural and institutional factors which may have led to that particular realisation. Before doing so, a discussion of how and why CTOs became thought of as necessary both in England and elsewhere, will take place, beginning with some historical context.

The rise of compulsory community care: policy drivers and problem formation

CTOs internationally have taken a number of different forms over the last forty years. Ironically, given the human rights protestations they now engender, CTOs were initially developed as part of the patient rights movement in the USA during the 1960s and 70s, as a way of maximising individual liberty by minimising involuntary hospitalisation (Hiday, 2003). This ‘first wave’ of CTOs have been classified as ‘least restrictive’ (Churchill et al, 2007), as they effectively allowed for compulsory community care under the same legal criteria as compulsory inpatient care, thus creating an alternative to detention. However,

'least restrictive' CTOs were little used as it became evident that it was politically and practically unviable to treat people in the community who met the risk criterion for detention in hospital.

In response to these constraints on their use, a new kind of CTO, the 'preventative' CTO became prevalent from the 1980s (Churchill et al, 2007). Preventative CTOs have lower thresholds for use, and instead of being an alternative to inpatient detention, became a way of compulsorily treating individuals in the community either following their release from hospital, or before they reached the threshold for involuntary hospital treatment. Preventative CTOs thus have different legislative criteria from involuntary inpatient treatment and are often aimed at specifically targeted individuals, usually those defined as 'revolving door' patients who have a history of non-compliance and who go through rapid cycles of release from hospital, deterioration and re-detainment. In this sense, preventative CTOs are more explicitly concerned with risk management both for the individual and for society rather than the earlier aim of promoting civil liberty (Hiday, 2003). It is this type of CTO that has become most widespread and formed the foundation for the development of CTOs as they are used currently.

There is no definitive list of where preventative CTOs have been enacted, but a review of the literature suggests they are in place in around 70 jurisdictions, including in most US states by 1994 (Torrey and Kaplan, 1995), in all Australian states by 1999 (Power, 1999), Israel in 1991 (Bar et al, 1998), New Zealand in 1992, Canada in 1994, Scotland in 2005, almost all US states by 2006 (Churchill et al, 2007) and England and Wales in 2008. CTOs then seem predominantly to be enacted in countries with similar cultural backgrounds, and in the case of the Commonwealth countries, legal heritage. Less widely reported is their use in European countries; Norway has had preventative CTOs in place since the 1960s, but became a rare example of a state revising the law to enable least restrictive CTOs in 2001 and Sweden legislated for CTOs in 2008 (Sjostrom, Zetterberg and Markström, 2011). Switzerland and the Netherlands have also been reported to have CTOs (Dawson, 2005, Kortrijk et al, 2010).

Although the majority of countries where CTOs are present have aligned with the preventative model, within that broad category CTOs encompass a shifting range of legal and medical mechanisms dependent on the cultural and societal norms of the jurisdiction in which they are enacted. However, despite differences between countries, it is still possible to highlight broad trends that have instigated what Brophy and McDermott (2003, 86) term a “domino effect” in the global spread of compulsory community care. Delineating the possible policy ‘drivers’ for CTOs helps us to understand how different jurisdictions may develop similar rationales for their use. This is necessary to contextualise policy-making, because as Hall (1993) suggests, the role of ideas and ideology need to be accounted for in policy formation as the normative structure that is taken for granted by the general policy-making community, but which nevertheless shapes what are viewed as policy problems to be solved. The expansion of CTOs in developed countries has arisen from an array of interacting factors, beginning with the process of deinstitutionalisation, the ensuing increased focus on risk and community safety in mental health services, and what can be described as the associated dominance of a neurobiological approach, which emphasises the use of drug treatment as a ‘solution’ to mental disorder. CTOs can thus be described as a consequence of the burgeoning movement towards community care in the last fifty years, combined with the perceived need to maintain some form of control through treatment over individuals deemed as posing a risk to themselves or others (Brophy, 2009, Campbell, Healy and Brophy, 2006). All of these factors can be related to themes which have framed the growth of CTOs, and which reflect the concerns of mental health policy in general. As Moynihan (1996, 13) states:

The challenge for social policy in the mental health arena has been to find a way through four competing claims: the state’s interest in protecting the well-being of its citizens; the traditional value placed on medicine as a means of addressing issues of illness; the normative demands of citizens for the elimination of danger; and the recognition of rights of individuals.

It could also be added that although not a ‘claim’, certainly a constraint on mental health policy and services, as within any welfare domain, are questions of resources, such as to whom and in what ways they should be made available. In regards to CTOs this is particularly relevant in considering its broader implications for mental health services and service users more generally; CTOs

can be viewed in one respect as the latest means to managing areas of pressure in the system, such as bed shortages.

The devolution of care

To fully understand this coalescence of policy drivers for CTOs, we need to understand the foundational role deinstitutionalisation has played.

Deinstitutionalisation refers to the process in a number of Western societies from the 1960s onwards, whereby the focus of mental health care moved from the ‘total institution’ of the asylum (Goffman, 1961) to care in the community, driven by a combination of the growth of patient rights movements, the advent of anti-psychotic medication and the rising costs associated with inpatient care. Whilst community care has provided many people with a better quality of life (Leff, 1997), it has also been critiqued for letting down those service users who have characteristics that mean they struggle to survive in society and consequently have been left ‘rotting with their rights on’ (Appelbaum and Gutheil, 1979, Novella, 2010). Thus, particularly in countries such as the USA where healthcare is more fragmented, CTOs have been framed as a way of obligating services to provide quality care (Wagner et al, 2003). Whilst not articulated in the same way in England, changes in resources did play a part in policy reasoning. The number of beds in inpatient units in England fell from 154,000 in 1954 to 33,000 by 2005 (Joint Committee on the Draft Mental Health Bill, Session 2004-2005, HL 79-1/HC 95-1: Para 183) and continue to fall as recent concerns reported in news media about pressures on inpatient provision highlight. The Government explicitly linked CTOs with this phenomenon when drafting the legislation for it, with Lord Warner, a Minister of State in the Department of Health stating, “supervised community treatment is probably the key change in the Bill...It is important not just from a patient and public safety angle but because clinical practice itself has changed...” (HL Deb, 28th November 2006, Vol. 687, Col. 656). Indeed, the impact assessment carried out by the Department of Health (2007) predicted that CTOs would save the NHS approximately £34 million per year by 2014-15, due to a presumed 10% reduction in admittance to hospital under Section 3.

Troubled or troubling individuals?

As well as concerns about service users being abandoned to their fate, community care has become associated with public fears about insufficiently controlled individuals presenting a risk of harm to the community at large. Whilst the evidence of a link between violence and mental disorder is contested, it has become increasingly accepted that a co-occurrence of substance misuse and/or dependence with diagnoses of severe mental illness can lead to an elevated risk of violence (Monahan et al, 2001, Elbogen and Johnson, 2009, Fazel et al, 2009, 2010). However, it is also the case that substance misuse, and other environmental factors associated with mental illness and violence, such as socioeconomic status or experience of childhood abuse, are also correlated with general population levels of violence, regardless of the presence of mental illness (Stuart, 2003). Consequently:

it is simplistic as well as inaccurate to say the cause of violence among mentally ill individuals is the mental illness itself; instead...mental illness is clearly relevant to violence risk but...its causal roles are complex, indirect, and embedded in a web of other (and arguably more) important individual and situational cofactors. (Elbogen and Johnson, 2009, 159).

Furthermore, although the relative risk of violence may be slightly higher for those with diagnoses of severe and enduring mental illness, the absolute risk is still very low, which means that acts of homicide are unusual and isolated events (Taylor and Gunn, 1999). However, it could be argued that this ‘expert’ view is not deemed as important as the public, ‘lay’ view on mental disorder and violence by policy-makers. As Madden (2003) states, large-scale statistical studies do not address ‘catastrophic’ events when they do occur. It is clear that even though the majority of violence committed by individuals with a diagnosed severe mental illness is towards people they know, such as family members (Monahan et al, 2001), the public, “most fear violence that is random, senseless, and unpredictable and they associate this with mental illness” (Stuart, 2003, 121). Surveys of attitudes towards people with severe mental illness have shown that a large proportion of the public, whilst holding sympathetic attitudes, also experience feelings of uncertainty and fear, particularly towards individuals with a diagnosis of schizophrenia (Angermeyer and Dietrich, 2006).

Rose (2002a) describes how in this regard the focus of the debate has shifted over the years since the 1980s. Increasingly, instead of service failure being discussed in terms of the 'plight' of service users, it is now "posed in terms of the failure of assessment, prediction, and management of risky individuals and the minimisation of risk to the community" (Rose, 2002a, 216). CTOs as a tool for regular monitoring and medication compliance can therefore be posited as a political response to public concerns, most obviously in the North American practice of naming their introduction after the victim of homicide by a mentally disordered individual (for example, Brian's Law in Ontario, Kendra's Law in New York and Laura's Law in Florida). Sjostrom, Zetterberg and Markström (2011) describe how in Sweden, a number of high-profile incidents in 2003 (including the death of a government minister), although not acted on by government at the time in terms of introducing more compulsory measures, did resurface in parliamentary discussion five years later, when CTOs were debated with reference to dangerousness being the primary concern. A similar narrative was evident in England, beginning in 1998 when the then Secretary of State for Health, Frank Dobson proclaimed that 'community care has failed' (Dobson, 1998). As with Sweden, USA and Canada, a spate of much reported homicides committed by individuals¹⁵ in contact with mental health services provided impetus for policy reform, with the Home Office as well as the Department of Health shaping policy based on public safety. The public inquiries that arose from these killings attracted substantial media attention, particularly in relation to their key findings, which drew attention to common service failures and made a range of recommendations, including that legislation should be examined, particularly in regards to compulsory treatment and supervision in the community (Blom-Cooper, Hally and Murphy, 1995; Sheppard, 1997). Subsequently, the development of CTOs in England was part of a broader reform programme in which the Mental Health Act (1983) was to be replaced with a new legislative framework. The Government made it clear early on in the reform process that they believed the existing legislation for community supervision was

¹⁵ The most well-known and widely cited case was that of Jonathan Zito, a young man murdered in the London underground in 1992 by Christopher Clunis, who had a diagnosis of schizophrenia. The subsequent inquiry highlighted a number of cumulative systemic failures in Clunis' management and care in the months prior to the murder. Jonathan Zito's wife went on to set up the Zito Trust, which lobbied strongly for risk-related reforms in policy and practice, and specifically for the introduction of CTOs. The Zito Trust closed in 2009, stating that its objectives had been met with the introduction of the Mental Health Act (2007).

outdated, and had failed to either benefit service users or to protect the public (Department of Health and Home Office, 2000). As the then Minister for Health Services, Rosie Winterton made clear, the argument for CTOs was closely linked to risk:

There are 1,300 suicides every year and 50 homicides by people who have been in contact with mental health services. We believe that supervised community treatment is vital to helping patient continue to take treatment when they leave hospital and to enable clinicians to take rapid action if relapse is on the horizon (HC Deb, 18th June 2007, Vol. 461, Col. 1193).

As Pilgrim (2007) notes, the purpose of the reform and the contention it created were not unique to present times; an enduring feature of mental health law-making has been debate over balancing issues of rights and liberty with those of risk and constraint. Even so, commentators suggested that “an illiberal stance and an obsession with risk minimisation did dominate ministerial deliberations about legal reform” (Pilgrim and Ramon, 2009, 284). In this sense the reforms could be viewed as evidence of a general policy shift to the realm of the social under New Labour, which constituted an interventionist ‘culture of control’ (Lawton-Smith, 2005).

*The will to empower*¹⁶

However, it would be simplistic to suggest an overriding concern with risk was the sole driver behind policy-making on CTOs. CTOs have also been associated, albeit much less overtly, with a somewhat paternalistic version of the recovery approach in mental health, where it has been surmised they can act to provide a secure foundation for individuals to operate from and to encourage self-efficacy. The debate on whether CTOs will enable or constrict self-determination has been central to both CTO policy-making and resistance to CTOs. In turn, this has led to deeper questions on the concepts of choice and free will in mental health. A New York campaign group arguing against the introduction of CTOs in that state made the point that “people recover when they have a choice among alternative

¹⁶ Title in reference to Barbara Cruikshank’s 1994 book, *The will to empower: Democratic citizens and other subjects*, in which she undertakes a Foucauldian genealogical analysis of the concept of empowerment in liberal democracies.

treatments and services, when they are empowered to make their own decisions...and when they are offered hope. These conditions are impossible under outpatient commitment” (Swanson, 2009, 183). The centrality of medication within CTOs is an especially problematic issue in regards to choice, where it has been suggested by campaigning groups that the relatively cheap and quick nature of medical treatment combined with the compulsory power of CTOs will result in its inappropriate and unreflective use by clinicians, a further decrease in choice and involvement in treatment decisions by service users, and a lack of consideration of non-medical approaches.

Conversely, Dawson (2009, 29) argues that an understanding of CTOs as enabling self-direction and choice is philosophically grounded in the concept of positive liberty (Berlin, 1969) which he defines as “our capacity for self-governance...our ability to set goals and have some chance of meeting them, and to maintain important relationships, without being dominated by internal constraints that prevent this occurring”¹⁷. The framing of CTOs as a conduit for individual growth and empowerment is most evident in Munetz and Frese’s (2001) assertion that CTOs are reconcilable with the recovery model and indeed, can act as an opportunity for individuals to become ‘well enough’ through long term medication adherence to start the recovery process. In this way, they suggest longer-term outcomes of being on a CTO could include service users sustaining meaningful activity in the community, experiencing better quality of life and holding better relationships with significant others. The result of this thinking is that arguments for individual freedom are constructed as morally hazardous, as it is not enough to simply offer services and medical care which service users are free to reject (Kinderman and Tai, 2008). Munetz goes as far as to say that practitioners who do not accept the necessity for compulsory community treatment are negating their “obligation as helper and healer” (Munetz, Galon and Frese, 2003, 178). Sjostrom , Zetterberg and Markström

¹⁷ However, it is arguable that Berlin (2002) would reject this interpretation of his theory, where the case for paternalistic compulsion in the present is justified by the potential for self-determination in the future. In his essay (2002, 39) on types of liberty he states that it has become a “familiar and depressing phenomena” for positive liberty to be used “as a cloak for despotism in the name of...freedom”. In other words, the rhetorical use of positive liberty to justify restrictive interventions misconstrues its original conception, which is dependent on the ability of individuals to make choices, and for ensuing individual action only to be constrained if it contradicts such choices.

(2011, 425) comment that even though adverse incidents provided the ‘window’ for CTOs to be introduced in Sweden, “where the official rationale for the policy was eventually spelled out, it is striking to observe how reducing risk was pushed to the background by an agenda oriented towards treatment and rehabilitation”. Although less prominent as a rationale in England, CTOs were nevertheless defended with recourse to recovery in parliamentary debates:

Supervised community treatment...will allow patients, so far as possible, to live normal lives in the community. This will reduce the risk of social exclusion and stigma associated with detention in hospital for long periods of time or with repeated hospital admissions, (Roll and Whittaker, 2007, 21).

As discussed in Chapter One, the foundational argument for using CTOs for both risk management and recovery purposes has been the ability it would bring to ensure medication compliance. In this regard policy debates around the use of CTOs have mostly been based on a view of mental ‘illness’ as primarily a medically treatable concern, with the odd exception such as Kinderman and Tai (2008) who argue that CTOs should be implemented on the basis of behavioural and functional criteria, as opposed to the use of an illness approach which is reliant on symptomology. CTOs thus reflect the common culture of mental health policy and services, where biological explanations for mental illness are given causal precedence, and medication is consequently the dominant intervention with medication compliance the primary aim (NICE, 2014). Although it has been suggested that the biomedical model in the UK has been increasingly competing with other approaches in recent years (Pilgrim and Rodgers, 2009), research on the increasing rates of medication usage in mental health services and the shortage of alternative interventions indicate that it remains the prevailing policy and practice framework (Herrman and Harvey, 2005, Domino and Swartz, 2008).

In and out of the community: the language of CTOs

It seems then that the underpinning discourse for additional compulsory powers in the community can be understood in terms of biopolitics and biopower, offering a way of ensuring both ‘optimisation’ and control of ‘biological

citizenship' (Rose, 2007). Returning to Dean's (2010, 156) conception of 'illiberal liberality' introduced in Chapter Two, in relation to given attributes of responsibility and autonomy CTOs can thus be characterised as differentiating and categorising 'low-risk' individuals who are 'empowered' to become responsibilised, autonomous, and self-regulating members of society from 'high risk' individuals who require external regulation (Kemshall, 2002). In this sense, mental disorder is not only framed in biomedical terms, but as a problem situated outside of societal norms that requires management. Bentall (2004, 176) describes this latter perspective in the following terms:

The distinction between the pathological and the non-pathological inevitably involves some kind of implicit reference to human values...it is not enough that a...characteristic is shown to be statistically unusual in order for it to be regarded as pathological; it must also be perceived as undesirable, or at least to have consequences that are undesirable

As Rose (1996, 12) emphasises, "professionals...are not so much required to cure as to teach the skills of coping, to inculcate the responsibility to cope, to identify failures of coping, to restore to the individual the capacity to cope". If this is not possible, then the generation and sharing of risk knowledge through professional networks of communication and surveillance enact 'circuits of exclusion' in which the threat that 'high-risk' individuals pose within the "territory of the community" is managed (Rose, 1999, 262). Policies and practices that develop to meet this requirement are, by their nature, preventative in their aims and objectives.

Within this framework, CTOs can be viewed as a mechanism which contains both inclusionary and exclusionary facets so as to both manage risk and bring individuals into the fold of citizenship. CTOs enable the reformation of individuals and their conduct if possible, but also allow for control and separation of the individual from society and the application of sanctions, should this transformative optimism prove unwarranted. The terminology of CTOs reflects these dual objectives. They have a highly contractual flavour, most specifically in the use of the term 'conditions' which service users must 'agree' to. Behaviour control in this sense is concerned with a relatively abstract conceptualisation of risk, where prudent individuals are expected to make their

own way in society whilst complying with complex rules and requirements, or as Rose (2002b, 19) puts it in regards to mental health, “‘play the game’ of community care”. Citizenship is therefore defined conditionally, and ‘irregular citizens’ (Zedner, 2010) are expected to earn their way to full citizenship through conforming to prescribed expectations. As Zedner (2010, 397) describes, the use of ‘contractual devices’, specific to the individual, subvert “the universalism of the... law and [delegate] considerable quasilegislative powers to the public officials who determine their precise terms”. In this way, CTOs change the state of play in regards to the rights that those who are placed on them hold, as compared to ‘regular citizens’.

However, the inclusion of the word ‘order’ in their title suggests CTOs can also be viewed in a more concrete way as a preventative and potentially punitive ‘early detection’ system for events that have yet to, and may never, occur. Indeed, CTOs in England were acknowledged by Lord Hunt, the then Minister of State for Health for the Government, to be perceived by opponents as a ‘psychiatric ASBO’ (HL Deb, 2nd July 2007, Vol.693, Col. 842), thus situating them within the wider discourse of public order policy. Moreover, the defining characteristic of the CTO as a preventative community intervention, means that it can be used for a broad range of risk-related reasons, including early intervention and thus encompass a large number of service users. In England, the rationale for CTOs relied on a particular definition and categorisation of the ‘revolving door patient’; an individual who is repeatedly returned to hospital. This term has become a signifier for who has been made knowable for CTOs to work on, through the formation of such individuals via research expertise (see Churchill et al, 2007) into a homogenous group who share similar characteristics and patterns of behaviour. Within the legislative process, the Government overturned amendments attempted in the House of Lords which would have limited the use of CTOs to those individuals who fell within a ‘hard’ definition of revolving door such as having a certain number of previous compulsory hospitalisations, as happens in other countries (see later discussion on discretion). Instead they stated that clinical expertise on who does, or more importantly *may in the future*, belong to this particular group should take precedence. As Lord Hunt argued, to legislatively limit who was placed on a CTO would “immediately risk excluding

patients who might benefit...and would fetter clinical judgment” (HL Deb, 2nd July 2007, Vol. 693, Col. 843). Thus the accompanying Code of Practice for the Mental Health Act 2007 (Department of Health, 2008) advises that CTOs be aimed at the ‘revolving door scenario’ but does not state what this might mean.

Therefore, CTOs in England are not legislatively targeted and can be applied to any inpatient facing discharge, including those on their first admission and those who may agree to voluntary treatment. Indeed, the Care Quality Commission (2010) analysed 208 CTO cases and found 30% of them did not have a history of noncompliance or disengagement and therefore could be classed as having the potential to be treated voluntarily. Here then we can see how particular problems became identified as problems for CTOs to solve; more specifically tracing the way CTOs were explained at policy-level highlights who is being made ‘visible’ in order to be governed and how ideas on individual reformation via CTOs have developed.

The contestation and constitution of CTOs in England

Moving beyond the broad ideas that shaped CTOs to the ‘microphysics’ of their becoming, it is possible to identify the forms of knowledge and expertise that were drawn upon in constituting the ‘truths’ upon which CTOs were founded in England, as well as significant elements of the local causal narrative that determined their eventual form. Policy-makers drew on historical, practitioner and international knowledge in both rhetorical and substantive ways.

The evolution of a problem and a solution

Although CTOs have been constructed as the most recent manifestation of a preoccupation with risk in mental health (Kemshall, 2002, Campbell et al, 2006), it is interesting to note that they have been considered as a policy in England for over three decades. The evolution of CTOs in England can be traced back to the late 1980s, when the Royal College of Psychiatrists proposed their introduction in response to increasing legislative challenge of their use of existing community powers. The Conservative government instead legislated for supervised

discharge as part of the Mental Health (Patients in the Community) Act in 1995. Supervised discharge was similar to CTOs in that when released from hospital, individuals could be placed on it, with conditions, in order to protect themselves and others. However there was a higher risk threshold for their use, in that there had to be a 'substantial risk of serious harm' before it could be imposed. In addition, supervised discharge only allowed for individuals who were non-compliant to be conveyed to a hospital or clinic for treatment, but did not allow for treatment to be enforced once there. It was this latter proviso which meant supervised discharge was widely believed to lack the level of compulsion necessary to ensure adherence to treatment (Holloway, 1996, Pinfold et al, 1999) and consequently was not well used by practitioners. In this regard, Fennell (1996, 285) appears to predict CTOs when he stated at the time:

The introduction of supervised discharge may be merely the first stage of an inevitable extension of these powers, where...instead of defaulting patients being assessed for readmission, they would simply be taken to 'treatment centres' to be forcibly medicated and then returned home.

Although replacing supervised discharge, CTOs are perhaps most similar in practice to so called 'Section 17 leave', where detained patients are given leave from hospital as long as they comply with certain conditions. As with CTOs, patients on Section 17 leave remain 'liable to be detained', that is under Section, which means they can be forcibly recalled to hospital for compulsory treatment. Section 17 leave was supposed to be used for relatively short periods of time, in order to allow detained patients' access to the community or to prepare for their eventual discharge (Owino, 2007). However, during the 1980s when community care was escalating, Section 17 leave began to be used increasingly by practitioners as a 'long leash'¹⁸ mechanism, in order to resolve the tensions between deinstitutionalisation and the perceived need to maintain control over certain patients (Glover-Thomas, 2002). In this way Section 17 leave acted as a 'de facto' CTO, where patients were kept on extended periods of leave by briefly recalling them to hospital in order to renew their original detention Section before sending them back to the community. Some commentators (Bartlett and

¹⁸ However, it should be acknowledged that this type of leave was first introduced in the 1959 Mental Health Act and immediately began to be used as a 'long leash' by clinicians (although not to the extent that occurred by the 1980s). It was also questioned much earlier than the legal challenges to its use which began in the 1980s (see Fennell, 1996, 286) and was referred to as 'a misuse of powers' by the 1978 Interdepartmental Review of the Mental Health Act 1959.

Sandland, 2007, Woolley, 2010), have suggested that CTOs do not add anything new to the provision that already existed under Section 17 leave, and indeed could limit the flexibility and discretion that Section 17 provided. However, long term Section 17 leave has been subject to considerable human rights challenges through the Courts (Owino, 2007) and although more recent judgements have upheld the decisions of practitioners to use Section 17 leave in this way (Gledhill, 2007), it remains the case that a complex and undependable framework has evolved in regards to the basis on which Section 17 can be applied. Thomas-Glover (2002) argues that this legal process acted as a significant motivation for the development of CTOs, as the powers that extended Section 17 leave afforded to practitioners could no longer be relied on.

In this light, CTOs can be seen as a response to the concerns practitioners had about existing community provisions. CTOs in a sense formalised extended Section 17 leave, thus giving practitioners a consistent legislative structure in which to operate. Additionally, practitioner knowledge of the ‘failure’ of supervised discharge confirmed that the dual problems of risk and rehabilitation required a stronger version of existing community provisions. In this way, the ‘gaps’ that psychiatrists suggested existed in provision reinforced the idea of a ‘problematic’ in need of a solution (Rose and Miller 1992). The testimony of psychiatrists was regularly used in parliamentary debates to this effect, for example: “the existing powers do not enable us properly to do what we are doing through community treatment orders...Many psychiatrists know that they are not really intended for the purpose that they are using them for. CTOs will give them that tool and that power” (HC Deb, 18th June 2007, Vol. 461, Col. 1187).

In constituting CTOs, policy-makers also looked outwards to how CTO policy had been enacted elsewhere and with what effects. Policy transfer is not a straightforward concept to apply to the policy-making process however as it encompasses a wide range of activities, actors and ideas. As Evans (2009) describes, policy transfer can take many different theoretical forms, including ‘bandwaggoning’, social learning, convergence, diffusion, emulation, hybridisation and lesson-drawing. Evans (2009, 244) goes on to argue that to make the study of policy transfer meaningful, it should be limited to the analysis

of “action-oriented intentional learning: that which takes place consciously and results in policy action”, thus focusing on the actions of agents of transfer. In this regard, both Dolowitz and Marsh (2000) and Evans and Davies (1999)¹⁹ have outlined questions that are helpful to delineate the policy transfer process, and which will be used in a heuristic and amalgamated form to trace the policy transfer journey of CTOs to England.

Who are the agents of policy transfer?

Conceptions of agents of transfer emphasise pluralist governance, and the role of networks of policy-makers. Agents can therefore originate from a broad group of actors, from ‘state players’ such as politicians and bureaucrats, to policy entrepreneurs, academicians, pressure groups, national, trans and supra-international organisations (Stone, 1999). Cairney’s (2009, 681) research, which involved key informant interviews with those who played a part in the development of the Mental Health Act (2007) for England, concludes that there was “often low ministerial interest, but consistently high commitment”, to the core provisions, suggesting that elected officials were integral to keeping CTOs on the agenda. Here, CTO policy transfer relied heavily on expert knowledge transmitted through ‘epistemic communities’ (Haas, 1992), a term that denotes “communities...comprised of natural and social scientists or individuals from any discipline or profession with authoritative claims to policy relevant knowledge...” who share similar beliefs and values (Evans, 2009, 252). From the parliamentary debates and submissions to the Joint Committee on the Draft Mental Health Bill (Session 2004-2005, HL 79-2/HC 95-2), it is evident that international experts informed government thinking on CTOs. It is equally notable that the use of this expert knowledge was treated with scepticism in some quarters. In particular, reference was made by Tim Loughton, a then shadow Minister for Health, to the ‘predictable dozen’ experts who regularly briefed the government at the time in a positive manner on CTOs, including researchers

¹⁹ I want to note here that I am aware there are differences in perspectives between key authors in this field, but my intention is not to develop theory on policy transfer itself. Instead I use it as a helpful learning device about the policy-making process in the particular case of CTOs.

from the USA who had conducted favourable studies of CTOs (HC Deb, 18th June 2007, Vol. 461, Col. 1188).

Why do actors engage in policy transfer?

The lesson-drawing analogy used in policy transfer suggests a rational process of identifying policy problems, looking elsewhere to find solutions, before adapting said solutions to the local context (Dolowitz, 2009). Certainly, CTOs were introduced during a time when the discourse of evidence-based policy was at its height, with the Cabinet Office (1999) proclaiming government “must produce policies that really deal with problems; that are forward looking and shaped by evidence rather than a response to short-term pressures; that tackle causes not symptoms”. In this light, overseas experts and their research knowledge were presented as playing a key role in providing technical advice from arenas where CTOs had already become embedded. Such knowledge was combined with certain quantifiable kinds of ‘local’ expert knowledge in order for the government to construct a convincing narrative that the introduction of CTOs would be evidence-based. In particular attention was paid to the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (Appleby et al, 2006) which found that of the 249 homicides committed between 1999 and 2003, 40 (16%) were immediately preceded by noncompliance with medication and loss of contact with services. The authors go on to suggest that CTOs may have been effective in preventing this type of homicide, a claim that the Government subsequently used in support of CTOs.

Alongside the utilisation of international experts, two further themes are evident in the parliamentary debates; firstly, the use of other countries’ experiences to highlight the liberal nature of the proposed regime in England, as Rosie Winterton, then Minister of State for Health Services, stated (incorrectly), “It is only in Canada that it is necessary for a patient to be detained before going on to a CTO. Even in those circumstances, the detention need not take place immediately beforehand, as it must under our proposals” (HC Deb, 18th June 2007, Vol. 461, Col. 1190). Secondly, that if so many other jurisdictions are

using them, despite evidence to the contrary, they must be doing something right, as Lord Warner at the time argued:

Supervised community treatment is a new, modern and effective way to manage the treatment of patients with serious mental health problems. Whatever the detailed reservations about particular studies, they do not set aside...the clear positives I have mentioned. It is perhaps significant that other countries have not ceased using CTOs, and have continued to see benefits in using them (HL Deb, 17th January 2007, Vol. 688, Col. 703).

The use of an international context thus supported the positioning of CTOs as a modern, normative and reasonable response to problems in community care. In this regard, shared understandings of ‘how things are’ in the world helps not only in the importation of knowledge, but also in the formation and validation of political rationalities (Moisio and Luukkonen, 2014).

However, the necessity for rhetorical argument also demonstrates that it should not be assumed that a straightforward translation of knowledge into action took place. Conflicts and contestations which played out through the motivations, actions and interactions of particular actors also had effect on the path CTOs took through the policy process, which illuminates the ‘messiness’ that characterises the introduction and implementation of new policies and practices. England was distinctive as a jurisdiction that introduced CTOs in an especially oppositional and entrenched context, which undoubtedly affected how the policy process progressed. Institutional and external constraints including a sustained process of revision by the House of Lords and fierce opposition from pressure groups (most notably the campaigning group the Mental Health Alliance, formed expressly to challenge what was viewed as the new legislation’s unjustified focus on public safety) meant it took nine years for the Mental Health Act (2007) to be passed. Following a convoluted process of reviews, consultations and redrafts, the Government announced in 2006 that the then proposed Mental Health Bill was to be scrapped and replaced with a Bill that amended the Mental Health Act (1983) rather than fully supplanted it. Despite these pressures, the position of the government remained relatively consistent over time, with the key contentious areas of policy, including the use of CTOs, being retained in the amending Act. A Department Of Health official reported as saying, “it was trench warfare” but

“there was never any wavering...[against] the stakeholders’ position” (Cairney, 2009, 681). Indeed, certain forms of knowledge, in particular service user knowledge were relatively disregarded as part of this process. Cairney (2009, 676) reports a civil servant involved with the Mental Health Act (2007) as stating:

I was on the bill team for the 1983 Act. That was a piece of consensus legislation as was the 1959 Act. So the tradition is consensus. The new Act is the first departure from that. The UK has had a proud history and place in the world in mental health and is currently throwing that out. So this Act represents a blip in political history.

It is notable in the case of CTOs that the Department of Health commissioned a wide-ranging review of the international use of CTOs (Churchill et al, 2007), which concluded that there was little evidence to support either positive or negative outcomes for CTOs. That the government did not appear to incorporate any negative lesson-drawing from these findings suggests that their choice of expert advice was partly driven at least as much by political as evidential concerns. As Wolff (2002) argues in her analysis of the English mental health reform agenda, the policy problem - the purported failure of community care - was leading to policy solutions that were designed to mitigate political as well as actual risk. She goes on to suggest the government was managing the political risk of ‘error-in-judgement’ by deploying experts to support their view, and the political risks of ‘ineffectiveness’ and ‘inactivity’ by taking a ‘shotgun approach’ where in the absence of certainty about answers to the problem of ‘troublesome’ individuals in the community, a number of different initiatives, including CTOs, were going to be implemented at once in the hope that one of them would work. This can be characterised as defensive policy-making, where the government is seen to be trying all means possible to limit risk, even if certain strategies fail. This is hardly the idealised “rational and thoughtful activity” that Dean (2010, 42) refers to when describing ‘the art of government’²⁰. Instead, such a reading of policy-making indicates how selective interpretation of international research by key actors legitimises reform, by presenting “policy lessons from abroad...as

²⁰ This is not necessarily to say that the introduction of CTOs did not have a governmental Utopian element (Dean, 2010, 44) as implied earlier in the discussion of how the transformative potential of CTOs has been theorised in terms of recovery. The analysis of policy formation presented here does however partly delink the reflexive ‘rational and thoughtful activity’ present in the ‘art of government’ (Dean, 2010) from planned Utopian ends by highlighting the messy, ‘politic’ nature of political reasoning.

politically neutral truths” (Robertson, 1991, 55). Policy transfer therefore becomes more rhetorical than transformative (Dolowitz, 2009). Hence the reasons why policy transfer is called upon stem in the first instance from how policy problems are framed.

What conclusions can be drawn from the nature and extent of policy transfer?

Similarly, an analysis of the nature and extent of CTO policy transfer indicates the ways knowledge from elsewhere was put to use within the extant cultural and institutional context. Taking the question of the *nature* of policy transfer first, Evans and Davies (1999) distinguish between ‘soft’ transfers, such as ideas, ideologies and attitudes and ‘hard’ transfers, such as tangible programmes and instruments. Dolowitz (2009) takes a slightly different perspective, arguing that ‘hard’ policy transfers are associated with voluntaristic, rationalist approaches to learning, whereas ‘soft’ transfers are more common, because the policy-making process is likely to be conditional on factors such as cultural biases, institutional frameworks and ideological pre-dispositions that limit both what knowledge policy makers recognise and what they can implement in the prevailing system. From parliamentary speeches, we can see that proponents of CTOs used examples from a range of different policy regimes, and so perhaps the idea of what problems CTOs could solve mattered more than the mechanics of what they entailed. By taking this approach the link between policy form and outcome is downplayed, where “policy objectives may be borrowed but the form of implementation, the tools and procedures adopted in various locales may result in quite different outcomes” (Stone, 1999, 56). Indeed if we move on to the second question, the *extent* of policy transfer, CTOs can be seen as an example of transformative hybridisation of policy whereby elements of programmes from other regimes are combined to produce a culturally relevant policy, as opposed to direct copying or emulation (Evans, 2009, Peck and Theodore, 2010). Through conducting a comparative analysis of CTO regimes, the ‘character’ of English CTOs, as well as some of the cultural and institutional factors which contributed to it will be highlighted.

CTO policy regimes compared

In a helpful paper, Dawson (2006) used the metaphor of ‘fault-lines’ in order to contrast the divergent treatment of key concepts in CTO legislation across countries. He mentions among others, the principles of *capacity* and *reciprocity*, and the pre-requisites for use of a CTO. Additional differences that can be considered are how *risk* is dealt with and what *oversight* of the system exists. Taking forward the point that English policy-makers paid most attention to the experiences of Canada, the USA, Australia, New Zealand and Scotland²¹, this section will compare those countries in reference to the above concepts. *Table Six* provides an overview of the analysis.

Table 6: A framework for assessing the differences between CTO policy regimes

	Capacity clause?	Risk Level	Reciprocity clause?	Constraints on discretion	
				Conditions for use	Judicial approval
England	No	Low	No	Weak	No
Vic, Australia	No	Low	No	Weak	No
New Zealand	No	Medium	No	Weak	No
W Australia	No	Medium	No	Weak	No
NSW, Australia	No	Low	Yes	Medium	Yes
Scotland	Yes	Medium	Yes	Weak	Yes
Saskatchewan, Canada	Yes	Medium	Yes	Medium	No
Ontario, Canada	Yes	High	Yes	Medium	No
USA	Yes	High	Yes	Strong	Yes

²¹ CTO provisions are made at state level in Australia, Canada and the USA and so there are a number of distinct CTO regimes within each country. As within-country jurisdictions tend to be similar, for the purpose of this analysis, CTOs will be referred to at a country level, unless there are specific differences worth noting.

Capacity

Capacity refers to the ability of individuals to make informed decisions about their treatment (Appelbaum, 1998). The inclusion of capacity criterion in CTO legislation tends to reflect a general approach to capacity in mental health in that particular country. For instance, in the USA and Canada only those individuals deemed without capacity can be treated without their consent in hospital, and the same principle applies to whether CTOs can be imposed. This aligns mental health law with the ethical principles of autonomy and competence held in general healthcare, and consequently “removes the suggestion that the law discriminates against mentally disordered people when it applies less favourable rules to their psychiatric treatment” (Dawson, 2006, 486). However, including a strong capacity clause may preclude a preventative, longitudinal approach to treatment, which can take account of the fluctuating nature of mental health (Fistein et al, 2009). Hence the recently reformulated mental health legislation in Scotland (2003) has included a lower threshold for capacity, which goes some way to meeting both clinical ‘best interest’ principles and the principle of autonomy, as it requires that a patients’ decision-making ability must be ‘significantly impaired’ due to their mental disorder before any formal use of compulsion, including CTOs, takes place. In this sense, Scottish and English mental health law have diverged, with the English government explicitly stating it did not see the merit of including a capacity clause in the new Act on the basis that it may enable individuals who pose a risk but nonetheless maintain capacity, to refuse treatment (Department of Health, 2005). English law is most similar to Australasian statutes, where criteria for CTOs are based on the presence of mental disorder and an associated risk of harm, with no mention of capacity.

Risk

In North America the threshold is set high for risk, with probability of ‘dangerousness’ and risk of ‘serious harm’ featuring widely in criteria, and a number of states requiring evidence of previous violence to initiate a CTO. The criterion for what constitutes risk in English mental health law, including for CTOs, is broad and largely undefined, referring to whether an individual poses a

risk to the ‘health and safety’ of themselves or others. Fistein et al (2009, 152) argue that when no capacity test is adopted, a stringent risk test should be adopted to counterbalance its absence, and vice-versa. This would, “avoid overly paternalistic treatment of people who are able to make their own decisions” whilst protecting against potential serious harm. The flexible criterion for risk in the new Act, combined with the lack of a capacity test, sets a low threshold for compulsion. Indeed the new Act is placed near the bottom of Fistein et al’s (2009) table rating autonomy in mental health legislation in Commonwealth countries. As has been noted, (Campbell, Healy and Brophy, 2006, Lawton-Smith, 2005) in some jurisdictions such as in Australia, a ‘low-risk criteria/no-capacity test’ CTO regime may contribute to an increasing and defensive use of community compulsion.

Reciprocity

One way of justifying the use of compulsion in the community is to include a reciprocity clause in legislation, so the individual who is subject to a CTO would at least gain some benefit from their status (Wales and Hiday, 2006). Furthermore, it has been argued (Swartz et al, 2001, Wagner et al, 2003) that in order for CTOs to be effective, they must be combined with high quality care, which would make reciprocal arrangements a necessary part of the system. The principle of reciprocity can be incorporated into CTO criteria through the inclusion of arrangements for outpatient care and social support. CTOs therefore become contracts that work both ways, by binding services to provide quality care as well as compelling individuals to engage. The USA and Canada have the strongest duties imposed on services to provide care and support, whereas Australasian jurisdictions implement weaker criterion with no reciprocal arrangements specified, aside from New South Wales (Churchill et al, 2007). In Scotland, there is a duty placed upon clinicians to inform a Tribunal if services as per the care plan are not being delivered, and the Tribunal can revoke the CTO on this basis, although even with this procedure in place, it is questionable how much it is being implemented (Royal College of Psychiatrists, 2009).

When the legislation for the Mental Health Act (2007) was in process in England, the Joint Parliamentary Committee that oversaw the Bill argued that the Scottish model should be followed and services should be guaranteed to those on a CTO as an obligation, so that extended compulsion could not be imposed without an associated level of care (Department of Health, 2005). However, there is not a direct reference to provision of community services in the CTO criteria, and the government argued that it was not necessary in an Act for which the prime purpose is to enforce treatment without consent (Department of Health, 2005). In further support of their approach, the government stated that those on a CTO would in any case be entitled to Section 117 aftercare services, which place a duty on health and local authorities to provide an appropriate level of free support and accommodation to discharged patients. However, it has become clear over the years that the provision of Section 117 aftercare is not consistently applied and legal challenges have suggested that health and local authorities have a large amount of discretion in deciding what counts as appropriate, given resource limitations (Bartlett and Sandland, 2007). It is for precisely this reason that Dawson (2006) suggests jurisdictions such as New Zealand have weak and carefully drafted duties of care for service providers in CTO legislation, in order to avoid liability should they fail to provide services. By making changes to mental health law in terms of compulsion but not service obligations, it appears that England has followed suit.

Discretion

Discretion in the case of CTOs refers to the ability of a mental health practitioner to make judgements on when to use them and how to use them. The legislation on CTOs can constrain or enable this in two ways: firstly by the number and type of conditions that have to be met before a CTO can be used; and secondly through the level of oversight that CTOs are subject to. Pre-conditions include risk and capacity criteria as already described, but also whether an individual must have a history of hospitalisation and/or has been given the opportunity to engage voluntarily. In Canada and the USA, CTO legislation generally stipulates that a person has to have been detained for a certain period of time, or number of occasions in the past two years and in addition, most US states include a clause

that individuals must have been given the chance to participate of their own accord. Similar provision is made in New South Wales, but the rest of the Australasian jurisdictions and Scotland do not mention hospitalisation or prior engagement at all in their legislation. The criteria for English CTOs also leave considerable room for clinician discretion, particularly in the aforementioned refusal of the government to introduce criteria which would legislatively limit the application of CTOs to particular cases. In terms of oversight, only a few of the jurisdictions (New South Wales, Scotland and the USA) require that practitioners must apply to a Court with evidence in order to secure a CTO. Whilst England has a rather complex framework for legal oversight once the CTO is in place, initially an individual can be discharged onto a CTO entirely at the discretion of specified professionals. Following a judicial process can protect service user rights and ensures treatment is ‘proportionate’, but policy-makers may try to avoid it if it also places an extra administrative burden on the system (Dawson, 2006).

Through comparing the CTO as it has been defined in England with other countries, the nature of what has been implemented in England becomes clearer. It is evident that if CTOs were placed on a spectrum from those that contain a higher legislative threshold for use (USA, Canada, Scotland) to those where the threshold is low and practitioner discretion plays a large part (majority of Australasia), the English CTO would be included in the latter group. Mental health law in England operates via a system of *parens patriae* whereby it is “highly reliant on the judgement of the practitioners who are required to apply it” (Peay 2003, 118) and it appears that CTOs maintain this cultural tradition. This contrasts with the USA for instance, where the majority of states require a greater number of criteria to be met before CTOs can be applied, and where the process is controlled by Mental Health Courts from the outset. In this latter sense, the USA CTO is constrained by pre-existing parameters (the embedding of a judicial process into their mental health system) which do not apply in England, and helps us to account for similarities and differences in the actual form that CTOs take in practice. As has been noted (Dawson, 2006, Lawton-Smith, 2005), ‘looser’ CTO legislation is a key factor in enabling high levels of usage and

therefore it is not altogether unexpected that CTOs have been implemented in relatively large numbers in England (Care Quality Commission, 2012).

This is not to say however that the pre-existing cultural milieu in England only acted to encourage the broad applicability of CTOs. Returning to the historical narrative of law-making leading up to CTOs in England described earlier, and taking a ‘rights’ perspective, CTOs go further than supervised discharge in constraining rights in that they allow for compulsory treatment in hospital, but protect rights more than extended section 17 leave in that they contain a more robust system of oversight. Indeed, over the significant period of time when the Mental Health Act (2007) was being contested and revised, although the idea of CTOs were fiercely defended by policy-makers, they did become less restrictive in nature. When CTOs were originally proposed they allowed for the practitioner to choose whether to compulsorily treat an individual in the community or in hospital and were called ‘non-resident’ and ‘resident’ orders to reflect this. Sustained lobbying by the Mental Health Alliance in particular on the practical and more importantly, ethical consequences of forced community treatment led to the revised ‘compromise’ version eventually implemented, where an individual can only be placed on a CTO following hospitalisation for treatment under the Mental Health Act (1983) and can only be forcibly treated in a hospital setting. What this demonstrates is that the shape of CTOs in England has been partly determined by an overarching and consistent concern in domestic mental health policy-making with what balance needs to be struck between rights and risk. Over time, a slow progression towards and then away from the border of what is acceptable within this formulation has occurred. Where that balance lies has been influenced by external forces. The European Convention on Human Rights was cited by opponents to the original CTOs, and although this in itself might have been unlikely to have influenced policy-making beyond the minimum necessary to comply, the government would have been aware due to their review of legislation elsewhere that, “the line that emerges from the study of the statutes and from law reform debates, as the Rubicon that should not be crossed, is the authorisation of ‘forced medication’ in community settings” (Dawson, 2006, 489). It is evident that a widely held and normative concern with ‘first

generation' human rights in the field of mental health has played a role in ensuring the form CTOs may take can go so far but no further.

Tracing the policy journey of CTOs

As the analysis of the formation of CTOs presented here demonstrates, through giving due consideration to both 'how and 'why' questions, it is possible to track the 'twists and turns' of policy-making, taking account of constraints and contestations, whilst at the same time acknowledging the role of dominant discourses and how they translate into regimes of practice. In the case of CTOs, broad and commonly held cultural concerns around risk and recovery fuelled their creation, but were only triggered by specific historic processes and events in the countries where they have been introduced. Taking England as a specific case study, these dominant discourses made visible specific problems and 'problematic' individuals in need of reform, but were mediated by alternative discourses of liberty and human rights which limited what CTOs could become. Grounding an analysis of CTOs in the actuality of policy-making at the time further suggests that whilst particular forms of expertise were utilised to found CTOs on certain 'truths', this was not an entirely rational endeavour (Dean, 2010). The difficult environment CTOs were born into in England necessitated the rhetorical and strategic inclusion and exclusion of different kinds of knowledge by political actors. In turn, the final form that CTOs took as a disciplinary technology incorporated methods which arose from the logics of the 'conduct of conduct', but also emanated from particular combinations of cultural and institutional structures, mediated through a highly pragmatic political process. In the next five chapters, I will take this analysis further, into an exploration of 'on the ground' practice; as Dean (2010, 88) suggests studies of governmentality can gain critical traction from analysing the disjunctures and connections between policy rationalities and the internal and implicit logic of governmental practices. Moreover, I posited in Chapter Two that a neglected aspect of governmentality as empirically applied has been how conduct and counter-conduct are mediated through 'practices of the self'. Given that the use of CTOs in England depends so much on practitioner discretion, this further reinforces the argument made in the preceding chapters that this study provides

fertile ground for an analysis of ethical self-work by both practitioners and service users in relation to CTO use. In this way we should be able to formulate an understanding of how and in what ways CTOs are theorised and used by those constituents who are affected by them.

Chapter Five
Thinking CTOs through:
How service users conceptualised community compulsion

In this chapter I highlight the various ways CTOs are conceptualised by service users. As will be seen, this and the next chapter are connected, in that the following chapter takes the same approach to the perspectives of practitioners. Since the focus of both chapters is on participant perspectives, the data in each is drawn mainly from the interviews I conducted. In both chapters I firstly discuss the various *beliefs* that shaped participant ideation of the CTO and secondly the different *purposes* that service users and practitioners felt CTOs might have. The chapters are separate because a distinction needs to be made between how individual service users understood the purpose of CTOs as related to their specific treatment, and how practitioners thought about their purpose in a more abstract sense as related to the service user group they worked with. Nevertheless connections can be made between the two, which highlight how the guiding rationalities practitioners and service users employ for CTOs both coalesce and diverge. Hence these chapters need to be read as two parts of the same story, and I defer summing up to a combined conclusion at the end of the following chapter.

Returning specifically to this chapter, I begin with an overview of service users' experiences of mental distress and instability. How service users incorporated such experiences and more significantly how they negotiated a sense of self in the face of adverse circumstances is discussed next. Participant conceptualisations of CTOs did not arise from nowhere; the varying ways service users viewed themselves and their experiences had a strong influence on how they perceived the CTO, for good or ill. I describe how service users who felt positively about the CTO saw its purpose for them, which is separated into four categories: provision, risk, recovery and maintenance. I then explore the perspectives of those service user participants who could not see a straightforward purpose to the CTO; half of the participants expressed ambivalent or wholly negative thoughts and feelings about the CTO. These views are discussed in relation to how service users felt the CTO might act as a

kind of ‘anti-purpose’ by creating an additional barrier to the realisation of their goals and dreams, and also accentuate ‘cross-purposes’ between them and professionals.

Self and the CTO

As with any intervention, service users did not come to CTOs with a blank slate, and much of the participant interviews was taken up with talk of their experiences of mental distress, medication, services, and how their sense of self had developed in relation to all three. Whilst I cannot fully detail the service users’ hinterland of experiences here, it is important to sketch out such ‘self-work’ as it underpinned how service users then went on to form perceptions of the CTO.

On shifting ground: the consequences of mental distress

All of the participants had lengthy histories of mental distress, and associated periods of time where they had felt out of control of their lives, or had control taken from them. Behaviour associated with psychotic or manic states, and the subsequent response of services, had made it difficult for many of the participants to maintain stability. Patrick told me how the constant repeat hospitalisations he was subjected to meant that *everything stops* and this seemed to sum up the paradoxically dual sense of instability and being ‘stuck’ that participants described.

Being unable to maintain an uninterrupted life in the community could be described as an indirect consequence of severe mental distress, mediated by the institutional factors inherent in the process of hospitalisation. However, perhaps the most poignant accounts service users gave related to the direct impact of mental distress, especially the loneliness, isolation and associated fracturing of relationships that they had experienced because of their situation and the responses of others to it. Less than half of the participants’ had someone in their life who they described in terms of non-professional support, and in these cases, relationships were generally discussed as complex, precarious and difficult.

Exploring the various individual and social impacts of mental distress on participants highlighted the sense of flux a majority of them had experienced or continued to experience. Subsequently, the additional challenges living with mental distress brought to constructing a cohesive and settled identity and integrating dissonant aspects of self was present as a theme in most of the participants' narratives.

Identity formation in the face of adversity

One way in which participants tried to assert control over identity was how they explained their experiences of mental distress. Participants had a variety of causal explanations for their current circumstances, some more aligned with the language of diagnosis and biomedical models of illness than others. Often it would be the case that participants believed drugs (both illicit and legally prescribed) they had taken in the past were what had triggered their difficulties, as with Gwen²²: *I started on anti-depressant medication and it progressed from there you see. So I'm convinced it's the medication that's done it whereas everybody else believes it's psychosis.* Or they might offer alternative diagnoses to the one they had been given. Simon explained that he felt he had trapped himself into a diagnosis of schizophrenia by lying to professionals about what he was experiencing in order to get help. He described what he experienced in terms that were differentiated from diagnostic criteria: *it's more like I'm restless, I'm on the edge of life.* Similarly, Sarah took the diagnosis 'schizoaffective disorder' out of the medical domain by using the 'affective' part to explain her situation:

I think schizoaffective disorder sums it up, because one thing affects another thing affects another thing, affects your family, affects your relationships, the fact that your family and relationships are affected affects you again and there's...there's social consequences to having this illness, it's not just a medical thing.

In general then, many participants resisted or reshaped the meaning of their diagnosis to help them make sense of who they had become.

²² All service user participants have been given pseudonyms.

In a broader capacity, participant sense of self was often explained in terms of who they felt they 'should' be, particularly in terms of self-efficacy. Graham described the sense of institutionalisation that was present in some participants' stories when he said he: *Wanted to start taking my life into my own hands a bit. Start doing things for myself.* Here we can see a desire for independence which contrasted with the reliance Graham felt he had on professionals. Resentment about the involvement of services in certain aspects of life could follow, as Irene described when discussing her last experience of being hospitalised under the Mental Health Act: *I've shown self-reliance and so I haven't needed all that big type approach. And I've resented it, yes. That's all.* However, this self-conception sometimes contrasted with the described effects of participants' life experiences and associated stories of fragility, as Irene summed up: *I think there's a vulnerability about me.* Sarah, who had been in and out of hospital over a period of twenty years, felt that her age now meant that: *I'm more frightened now than I was about the possibility of being in hospital again. It's happened so many times it's knocked the stuffing out of me. As it happens more often, it's making me less and less confident, less and less able really.* This illustrates the ongoing struggle that many participants went through to retain self-belief despite challenging circumstances. At times, on-going and repeated experiences of compulsion led to a resigned acceptance of dependence in the face of authority

Alternatively, an acceptance of dependence could be caught up in an individual's view of him or herself as subsumed in a 'deficit' identity. Simon was the youngest of the participants, but had been in contact with mental health services and the criminal justice system since very early adolescence. He described himself in 'professionalised' terms: *because I am a poly drug user;* an identity which shaped his relationship with services: *And so for me it is like most people who have mental health problems and are on drugs, hospital is a safe environment, away from society, away from everything.* A similar process could be seen for those participants whose identity was shaped in response to others' beliefs about their abilities to cause harm. Michael drew a contrast to the gentle demeanour he presented when he responded to the question of who he thought CTOs were for: *I don't think it's something for everyone, it's something that is*

good for violent, psychotic people like me. In this sense, ‘dangerousness’ was a category that appeared to have been accepted by some participants as applicable to themselves, but which understandably could also be difficult to assimilate.

As can be seen here, participant narratives of identity segued between wellness/illness, independence/dependence and safeness/dangerousness. The overarching narrative however which incorporated all these facets of identity was that of being or becoming ‘normal’. The concept of ‘normality’ was one referred to across participant accounts, either directly or indirectly. In comparison to those participants who saw their identity at least in part through the lens of professional concerns, being ‘normal’ was used by others as a way of distancing themselves from, and questioning the attribution of mental illness to their experience. Although Brendon was accepting of the diagnosis he had been given, he still struggled to accept what this meant: *The doctor has suggested giving me some stronger medication. I was agreeable to it, although I was a bit...after he left I thought, ‘I’m a normal lad really’, I am a normal lad, and I don’t really need it.* In stronger terms, achieving what was deemed a normal life could be linked to rejection of professional involvement, as the emblem of difficult and ‘abnormal’ experiences. In this context, for some individuals a wholesale rejection of what the mental health system had to offer seemed necessary in order to preserve a certain sense of self. However, more typically a complex relationship existed between participant’s view of themselves and their stance towards services in general and CTOs in particular. Accordingly, the following sections explore the range of participants’ perspectives towards CTOs.

Service users’ perceptions of what the CTO could do for them

Such talk of struggles with security and identity resonated through service users’ descriptions of what the CTO meant for them. The relationship between compulsion as an objective event and coercion as a subjective experience is not straightforward; the former does not necessarily lead to the latter (Newton-Howes, 2010). For service users who saw the CTO as a positive development, it offered a range of purposes which connected to how they felt about their lives and themselves. Service user views on the aim of the CTO revolved around four

dimensions; provision, risk, recovery and maintenance. Provision, particularly access to support when needed through the CTO, could provide a much-needed sense of security and certainty about how difficulties would be dealt with. Risk, recovery and maintenance were more directly connected to identity. The CTO's role in managing risk to others as well as self was connected with participants' views of themselves as unable to manage such risk alone; recovery and maintenance were indicative of participants' hopes for both stability and positive change. All four dimensions of participants' aims for the CTO are now explored further.

Provision

'Provision based' accounts, similarly to service user accounts in previous research (Gibbs, Dawson and Mullen, 2006) included references to the higher quality of service provision some participants believed they received due to the CTO. As was noted in Chapter One, the function of CTOs in reciprocally 'binding' community services to service users who need intensive support is not as central in England as it is in countries like the USA. It could be argued however that the very legal framework of the CTO, particularly in terms of regular appeals, may prompt more scrutiny and regulation of CTO practice. In observations of appeals for example, the panel members habitually questioned the care plan as whole, rather than focusing solely on the legal status of the CTO.

Accordingly, participants referred to the CTO providing a clearer structure for what they should expect in terms of service response, and subsequently more leverage for them over services. This was particularly the case in regards to gaining admission to hospital. As has been noted, CTOs were in part introduced to alleviate the revolving door phenomenon, and the majority of participants could be described as 'revolving door' service users. This cycle is typically described as due to the actions of the individual and the CTO is aimed at ensuring compliance in such cases, thus stopping the revolving door. However, participant narratives of their movement between the community and hospital also highlighted the systemic forces that could influence this cycle (which were also highlighted by practitioners, as will be described in the next chapter).

Common experiences were related to professionals not having the time to try and avert involuntary admissions, as in Sarah's case: *They've wanted to keep me out of hospital but every time something happens they're either short of time, they can't really see me very long, they just do it [sectioning] for the sake of 'better be safe than sorry'*. A number of participants had previously had to wait until crisis point before being admitted, usually involuntarily by that stage. The CTO meant participants felt services would respond much faster when relapse was occurring. This was deemed particularly important in stopping the relapse spiralling out of control, as Glenn explained: *When it's mental health you need it sooner rather than later. The earlier you catch it the better, otherwise it just escalates. They don't have to mess about. It's not going to get any worse*. Difficulties with access to crisis care are a long standing and on-going problem within English mental health services, and it may be that participants viewed the obligations the CTO represents via recall as a means of ensuring they could get help when they needed it, rather than when best fits the system. For these participants, the idea of being recalled to hospital was not viewed in a punitive sense, but as a reassuring safety net should things go wrong.

The CTO also represented access to legal protection in other ways. James felt that the CTO framework limited practitioner discretion and therefore acted to protect his freedom:

It's there to protect you again. It protects you here and it protects you in hospital because under the rulings that are on it they've got to abide by that CTO. They can't just keep you in indefinitely for 3 or 4 months or 6 months again. It's there to say, 'look, he's back on his meds, he's listening to us okay, he's responding well, send him back out'. It's kind of two-fold.

More broadly, participants also expressed the view that the CTO could act as a 'passport' to ensuring their access to support was protected in other arenas. Specifically, participants referred to access to benefits, and being able to use the fact they were on a CTO in order to demonstrate that it was necessary for them to receive financial support. On-going changes to the social security system which make it harder for individuals to successfully claim support, meant those participants felt that the CTO helped their chances by signifying the level of their difficulties.

Risk

Risk was discussed by participants in terms of '*staying safe*' (Stuart), with the CTO offering a preventative framework to protect self and others. For Michael, the CTO was not linked to his level of engagement: *I accept visits from the nurses and the social worker*. Nor did he link the CTO in a direct sense to maintaining his mental stability: *I don't get the injections because of the psychosis*. Michael's view of himself as being dangerous when unwell meant that he saw the CTO as primarily being of benefit to others: *It's required by law that I take injections now because my mental health affects other people, not just myself. I think they did it for the benefit of the community. Well, the name says it all, community treatment order. Protect the community from me*.

As can be seen from Michael's perspective, the main aim of the CTO for him was to manage his behaviour when he felt he could not do so himself. In similar terms, Nick described how the CTO provided him with firm and clear boundaries which he had found reassuring both for himself and others:

It's given us a structure. I know what I've got to do. I've got to attend probation, I've got to get my injections, I can't refuse them. In the past I've had nothing like that, I've just refused and I've been taken in on Sections, but being on a CTO if the truth's known, I know deep down I'll never ever get to the point where I've totally lost control like I've done in the past.

The CTO performed an important psychological function for participants like Nick, through imposing control on them when they did not feel they were able to exercise self-control. They appreciated that the compulsory nature of the CTO brought boundaries which acted to keep them on what they perceived to be the right path. This was also the case for participants who talked about the CTO in terms of self-protection, as Christine describes: *You've got an order and if they want you back in you've got to go back in. And you've got no choice have you, really? But I think it's good, because you could harm yourself or....* The theme of delegating choice to an external force was significant for a number of the participants and in this regard, belief in the power of the CTO was as important as the actual power of the CTO.

The CTO could be seen by participants as leverage for positive risk-taking by professionals, as Patrick explains, *I can't see them not changing my medication, because if I am on a CTO it's much safer than not being on a CTO...If things go wrong, it's much easier for them to react.* In this sense, the CTO could be viewed as a safe space within which to try out different approaches. However, the CTO in itself could also present a personal risk. For those participants who believed the CTO had 'worked' for them, in that it had helped them achieve a level of stability they had not been able to have for some time, taking steps forward could be at times disconcerting. Attempting to live and address problems in a different way to usual presented a challenge, as Nick explains:

But all these feelings are coming back and I don't know how to cope. And it just builds up and builds up and I just lose it, I just lose my temper. And I find it really hard. Really hard. I need to sort my head out. I just want to carry on the way I'm going. Hopefully these feelings will go away, I don't know.

The fear of things going wrong could become more anxiety-inducing when things were going right, and yet at the same time established patterns of coping strategies (in Nick's case the triggering of admissions to hospital) were disrupted by the CTO. It is indicative of the symbolic power the CTO can hold that even though recall was not actively used in Nick's case he still saw the CTO as a significant mediator of his actions.

Recovery

Enabling recovery has not played as large a role in the empirical or discursive literature on CTOs as managing risk. Furthermore, whilst promoting stability in the community has been cited as a reason to use CTOs (O'Reilly et al, 2006), it is only one aspect of recovery, and recovery as a broader, future-orientated concept has not been fully addressed²³. However recovery as a purpose for the CTO was evident across participant accounts. The concept of recovery as it is applied here correlates with the broad definition of recovery as living a fulfilling and hopeful life alongside personal difficulties, with support from significant others through an on-going process (Anthony, 1993). Recovery was seen by participants as a

²³ Two notable exceptions are Munetz and Frese's 2001 paper on mandatory treatment and the recovery model, and Dawson's (2007) comments on the potential of CTOs to aid individuals in achieving positive liberty. For more detail, refer back to Chapter Four.

process of positive change, leading from the opportunity the CTO provided for stability. In this sense, stasis and change were entwined in participant narratives.

When participants talked about the CTO as promoting recovery, this tended to involve looking to the past and comparing where they were now favourably with where they had been, and then looking to where they wanted to be in the future. Connections could be made here with participants' shifting sense of self.

Changes in identity could be related to the movement between being ill and being in recovery. James felt that: *compared to when I first came on the CTO and now, it's like two different people...I mean from negative to positive. That's the difference...I mean my feelings towards people, my actions towards people.*

For James, the CTO had given him a sense of responsibility for safeguarding his future. James related this to the contractual nature of the CTO, with him upholding his side of the bargain: *You're responsible for yourself. That's what the CTO is about, isn't it? So the responsibility for taking your meds, for coming to your appointments, for seeing your doctor, I mean, yes, it's a huge responsibility.* Participants who spoke about recovery however tended to speak mostly in terms of sharing purpose and trust with the professionals working with them. Brendon expressed this most clearly when he said: *because I'd spent so long in hospital, the psychiatrist, and others, they wanted to safeguard a good, steady future, and a better quality of life. So that was their reasons for the CTO really.*

There was a sense of precarious hope about these narratives, as Brendon went on to illustrate: *I suppose being on a CTO and the right medication I'll conquer it, hopefully I'll get over things, but we'll see.* In this regard, participants viewed the CTO as helping them navigate through difficulties that might cause previous patterns of events to be repeated. The CTO then was *the next process in an ongoing process (Sarah)*, and participants talked in staged terms, with stability bringing change. Being able to stay well led to maintenance in the community, which could in turn lead to incremental differences in quality of life:

I never went to my church for quite a while and then with having the CTO in place it just-, it's a very slow-, I don't think it's instantaneous help. It's a long slow process and lately in the past few months I started going back to church

forming a relationship with-, making friends but forming a relationship...yes, it has helped. It has (James)

Given the entrenched nature of the majority of participants' difficulties, like James, they talked about change as a slow, gradual process, but nonetheless change which went beyond engagement with services and medication, and that affected various fundamental aspects of their life.

Maintenance

Furthermore, maintenance in the community in and of itself was viewed as a valuable aspect of being on the CTO. The CTO could be viewed as a favourable alternative to hospital, but also as a way of avoiding traumatic admissions in the first place. Participants thus did not only talk of being at home as compared to being in hospital, but also getting out of, and staying out of hospital. In this latter regard one of the participants, Sarah, suggested that the CTO should be weighted more towards keeping individuals in the community:

Well I think it would be better if the community health team had more powers to help keep us out of hospital because it would stop that high feeling, those high intense- you know when the adrenaline is pumping, because if you're brought into hospital against your will, there's a lot of panic there, there's a lot of feeling there...I don't know but from my point of view it's good for me to stay out of hospital

For four of the participants, the CTO had come at a time when they were at a crossroads, with the hospital treating team deciding what level of compulsion they should be made subject to. For example, Christine told the story of how when she was an inpatient, the decision for her future was between sending her to a secure unit or placing her on a CTO:

I saw the doctor without Sharon [her care coordinator and AMHP]. And I says, 'I'm looking forward to being discharged.' And he says, 'Well we'll see about that.' He says, 'I'll ask Sharon to come to the meeting next week.' And Sharon were reluctant to get me discharged you know, she kept saying, 'Oh no, I'm sending her to a secure unit' because she said that all time, 'I were going to a secure unit.' But the doctor piped up and he says, 'Christine's very well now on lithium, on this tablet and we don't see no reason why she should go to a secure unit.' Well I were smiling, you know (laughs), and then a couple of week after that I got discharged on the CTO.

Being discharged onto the CTO was therefore not always straightforward, and could involve negotiation between professionals, as well as with service users, across a surprisingly broad spectrum of options, from secure compulsion at one end, to community compulsion at the other. For Christine (and the three others), the possibility of the CTO gave them an opportunity to avoid being sent to more specialist ‘heavy-end’ services.

Similarly, for those participants who had had lengthy stays in hospital, getting out of hospital signified a return of hope, as Brendon, who had been in hospital for two years, describes: *When I was in hospital I felt ... I don't know, I felt condemned.* Being at home even if still feeling ‘fragile’, was widely perceived by participants to be an environment which was more conducive to recuperation than hospital, and the CTO was perceived by some to help with that immediate goal: *they said I can appeal against the CTO but I never bothered. I felt it was needed to help me to recover easier living at home (Graham).*

The CTO as a barrier: accounts of ambivalence and resentment

As noted earlier, the above views on the purpose of the CTO were expressed by participants who evidently saw some value in the CTO. Ambivalence could still feature in those accounts however; views on the CTO were not usually articulated in straightforwardly negative or positive terms. Indeed, it should be acknowledged that for a small number of service users, ambivalence meant having no strong feelings about the value of the CTO at all. Particularly for those individuals who expressed resigned attitudes towards authority, the CTO was seen as simply another unremarkable manifestation of their treatment. Gwen for example, said: *I've not got any feelings about it. It's there because it's there. I never looked into the ins and outs of it and delved into it. I've just accepted it.* For such participants, the CTO was of no particular consequence and they saw no reason to actively engage with it. In this section however, I look at how ambivalence in terms of mixed views was expressed, as well as participants who felt more undiluted resentment towards the CTO. Again, as with more positive conceptualisations of CTOs, strong connections can be made to participant self-

conception, particularly in relation to dreams of recovery and ‘normality’, and the framing of mental distress and how it is treated.

‘Anti-purposes’

For those who were ambivalent ranging to negative about the CTO, it could take the form of a coercive ‘anti-purpose’ for them, blocking or disrupting their attempts at accessing provision, at achieving recovery, at maintaining stability and at taking control of their lives. The Damoclean sense that the CTO was ‘hanging over’ them was raised by participants as being difficult to deal with, as Sheila describes: *life would be so much better [without the CTO]. So much more freedom and getting rid of this horrible heavy weight of waking up every morning and thinking ‘I’m on the CTO’. I’d rather I was in charge of my own affairs and in charge of my own life.* Sheila’s view of the CTO was strongly grounded in her experiences of services over the years and her rejection of a biomedical model of mental illness and associated treatment. Sheila had been on and off a CTO since they were first introduced five years earlier and over the fieldwork period I attended three (unsuccessful) appeals that Sheila brought, and witnessed the anger and distress the CTO caused her. In this regard, the CTO could be seen to be almost iatrogenic in its effects, as Sarah describes: *the decision [to be placed on a CTO] was made out of my hands and that’s something that’s upset me over the years, that lots of decisions get made out of my control and it causes other mental health problems, the fact that my life is out of my control.* Ambivalence about the CTO could therefore be complex; for example Christine appreciated the way the CTO would be activated to protect her if necessary, but at the same time expressed a consistent fear that the CTO would be used even if it wasn’t necessary, meaning she felt she was always: *looking over my shoulder seeing if they’re coming for me. I feel so well I don’t want to do it, you know, I don’t want to go back.*

Indeed, ambivalence was often in response to participants feeling that the purposes the CTO represented for them were in tension with other long-term aims they might have. Individuals could struggle to reconcile where they were with where they wanted to be. For instance, Michael stated:

I could relapse so I'm quite happy with the way it is, but I do find it a bit of a burden because I do want to go to university to study and they said under the CTO they'd still need to visit me and give me injections. I want to live a normal life and be able to work and study but the doctors said stress is a major issue.

At the heart of Michael's ambivalence about the CTO was a struggle with how he saw himself; on the one hand, he felt strongly the CTO in the immediate term provided him with the control over his actions that he had been lacking, on the other, he felt that it hampered his plans for the future. For many of the participants, being well over a sustained period of time could shift their view on what they felt was necessary to keep them well. Being told that they had a chronic and recurring condition did not always extinguish hope for participants that they would one day have a full clinical recovery and become medication-free. Michael encapsulated this when asked about his future: *I have to take medication for the rest of my life probably. I hope though that I'll make a recovery of some sort miraculously and then I wouldn't have to take medication anymore.* In recovery terms then, coming off the CTO could be seen as the point at which progress could be made, as Simon states when asked if it was significant to him when he came off the CTO: *it was actually, so I can move on and go in the army, it was the next step to doing that.* In both Michael's and Simon's accounts we can see that the CTO may be viewed as antithetical to dreams of 'normality'. Some practitioners struggled to understand how the CTO could be experienced as stigmatising given it is an 'invisible' intervention. These accounts suggest that the relationship between the CTO and stigma could be subtle, related to the CTO being viewed as a barrier to life lived without difference.

Perhaps unsurprisingly, such discussions on normality were often associated with participants' views on the stigma attached to their status in society. Craig framed his diagnosis in terms of punishment, stating: *I mean the stigma of being labelled mentally ill, once you're labelled nobody believes a word you say. Once they label you, that's it, you're mentally ill and you always will be.* This sense of having their personhood devalued and pathologised resonated in the majority of participants' experiences of discrimination and harassment due to their mental health status. Whilst participants who viewed the CTO in a more positive light

felt that it contained and over time diminished stigma by enabling them to live a life in conjunction with the majority of society, for others the CTO enhanced the 'outsider' status they already keenly felt. How participants constituted their pathway towards normality was therefore central to how they viewed the CTO.

Cross-purposes

Resentment about the CTO could also be related to feeling at cross-purposes with professionals as to the thinking behind the use of the CTO. Compliance with medication was viewed by all participants as the primary aim for practitioners when using the CTO and could be seen not only as a means to an end for practitioners, but as an end in itself. This is unsurprising, given that CTOs provide a framework for treatment in the community, and 'treatment' although defined legislatively very broadly, tends to be viewed in medical terms.

However, for service users it could be a cause of tension if firstly, they wanted the focus of the CTO to be on secondary goals, and secondly if they believed that practitioners disregarded ways to achieve those secondary goals that were not necessarily about medication, such as social and psychological support. A concern raised when CTOs were first introduced was that they may lead to further restriction of treatment options and certainly the views expressed here reflect previous research, where service users have expressed resentment at the focus within CTOs on medication (Brophy and Ring, 2004). This was a concern shared by some participants, as Sarah summed up when she stated, *if the purpose of the CTO is to keep you out of hospital then I'm all for it, but it does seem to come down to medication which over the years I've sort of gone against.* Indeed, medication compliance in and of itself did not strongly feature when service users talked about their own aims for the CTO.

Contrary to participants who saw practitioners as trusted allies in realising their purpose for the CTO, those who manifestly disagreed with the CTO viewed it solely as a mechanism for control. Patrick gave an account of when he was discharged from hospital onto the CTO and how agreeing to the CTO was an additional barrier to surmount before discharge from hospital could become possible: *They kind of forced me to do it. They said, 'look you're not getting*

discharged unless you get on the CTO'. So, I was between a rock and a hard place. Like Patrick, a number of the participants believed they would not have been discharged from hospital without 'agreeing' to the CTO and all that came with it. Such participants believed the CTO served professional interests, in that it allowed for defensive decision-making: *It's [the CTO] a way of controlling the situation or controlling someone's behaviour, which puts people's minds at ease and [sarcastically] I think everybody's minds have got to be at ease (Craig).* In this light, practitioners were viewed as using the CTO as a way of managing risk to their reputation. In turn, an associated, and underpinning perceived purpose of the CTO was to ensure monitoring and surveillance, or as Andrew noted, *just so they can keep an eye on me, so I can't operate.* Craig was perhaps the most vocal participant about having his rights denied through the CTO, as he says here:

Nobody has written that my life or anybody else's was in danger, you don't need more than that. I think it's highly unfair, there's no choice. You should have choice over your own health. If you've never hurt anybody else there's no justification for you to be medicated against your will.

Potential aims of the CTO were not only explored by participants as to do with the perceived motivations of practitioners, but also in more systemic, abstract ways. Irene believed that she was put on the CTO because: *they have a procedure which they go through with people and instead of me feeling that I'm taken as an individual I'm treated like the run of the mill.* The CTO was viewed by Irene as a deindividualised and routinised occurrence, with no specific purpose. Similarly, the role of resources was raised as a factor beyond the remit of individual practitioners, instead driven at a macro policy level. Patrick reflected on this based on his own experiences: *I think it's a much used thing now. Because I know quite a few people on them, they seem to brandish them about a lot. I suppose it costs a lot of money to keep a person in the hospital. I'm sure it's cost driven.* This was a view held by a number of practitioners too, and in this sense the CTO was seen by participants across both groups as being enmeshed in wider systemic patterns. On that note, I move on in the next chapter to practitioner views of CTOs.

Chapter Six
Thinking CTOs through:
How practitioners conceptualised community compulsion

This chapter is a ‘mirror’ of the previous one, in which I discussed the different ways that service users thought about the purpose of the CTO. In this chapter, I continue that theme from the practitioner perspective, examining how they thought about, justified and explained CTOs. To fully make sense of practitioner views of the CTO I firstly consider the ethical underpinnings for such views. I start by highlighting the gaps the practitioners felt existed between CTO policy and practice rationalities. This discussion of the disjuncture practitioners’ believed existed between CTO policy and practice in turn brought to the surface practitioner beliefs about how and why CTOs ‘should’ (or should not) be used. As with service users, practitioner perspectives on the value of CTOs were shaped by their contextual experiences and individual beliefs. Specifically, I relate this to practitioners’ understanding of what ‘good’ practice entailed, and how practitioners weighed up the potential consequences – both positive and negative – of CTOs for service users. Despite the ethical discomfort many practitioners felt about CTOs, they all saw some value in them, and in the second part of the chapter I delineate the various purposes practitioners felt were met by CTOs. These purposes are separated into immediate aims – protection and risk management - and longer-term goals related to stability and recovery.

Policy, practice and consequences: coming to a view on CTOs

Similarly to service users, practitioners expressed scepticism as to what they saw as the aims policy-makers had for CTOs, which they did not see as aligned necessarily with their perspectives. Accordingly, I start this section with practitioners’ views on the framing of CTO policy, before I move on to a discussion of practice beliefs and practitioners’ ethical ‘weighing up’ of CTOs.

Policy and practice

Although practitioners were generally sceptical about policy claims on CTOs, similarly to recent practitioner surveys on CTOs (Manning et al, 2011), they all felt that the CTO ‘filled a gap’ in policy and practice. As outlined in Chapter Four, CTOs effectively replaced two legal provisions: supervised discharge and Section 17 ‘long-leash’ leave. In relation to supervised discharge, practitioners believed that CTOs carried more power and therefore would be more effective in ensuring treatment adherence. Supervised discharge was widely believed not to have the ‘teeth’ of the CTO and consequently was viewed as more dependent on how service users responded to the idea of authority rather than having any intrinsic power to compel. As a psychiatrist noted: *We’re now getting the benefits of what supervised discharge should have given us but didn’t.*

In relation to Section 17 leave, commentators (Bartlett and Sandland, 2007, Woolley, 2010) have suggested that CTOs do not bring any additional benefits and indeed that long-term use of Section 17 would be preferable to psychiatrists, because it allows for more discretion and is easier to use. There were mixed views within the practitioner group about Section 17 leave as compared to CTOs. Whilst some did agree with this perspective, particularly psychiatrists who emphasised the bureaucracy of CTOs compared to Section 17, in an echo of previous research (Stroud, Doughty and Banks, 2013) other practitioners felt CTOs were more beneficial for service users in that they include stronger safeguards for rights. As an AMHP explains: *if someone’s on Section 17 leave, the psychiatrist they can just say, ‘right, we’re withdrawing your Section 17 leave, come in’, without having to justify it. And the person might not have any understanding of why that’s happened.* The greater capacity for discretion in Section 17 leave meant these practitioners believed it was more restrictive than the CTO, and would affect the daily life of service users in a concrete way that the CTO would not. CTOs were also contrasted favourably to Section 17 leave because Section 17 leave meant service users still had inpatient status, and consequently it was believed not to provide a ‘clean break’ from hospital. As long term Section 17 did not allow for a separation between hospital and the community, it was thought to hinder individuals moving on: *The Section 17 leave*

was a fudge wasn't it, because you stayed as an inpatient, and how does that help you psychologically to rebuild your life in the community if you're still on paper an inpatient. (Psychiatrist)

Although many of the practitioners thought that CTOs were an improvement on what had gone before, there was still a gap between how they thought about the purposes of the CTO, and why they thought CTOs had been introduced as a policy. Practitioners were particularly critical of how CTOs had been presented in regards to risk and public safety, whilst at the same time acknowledging their role in risk management, as discussed later in this chapter. Policy-makers emphasis on risk was believed by practitioners to be influenced by public opinion, as a psychiatrist put it:

I'd like to think that somebody thought that there was a group of patients who deserved a better deal, but I think I'm realistic and old enough to realise that actually one of the policy drivers behind that was this idea that there were homicidal maniacs who were being lost to services, and they needed a framework to contain them.

There was a widely held view by practitioners that policy-makers were doing both service users and practitioners a disservice in how they 'sold' CTOs. Furthermore, and similarly to other areas of policy and practice where risk is at the forefront (for example child protection), practitioners felt that policy-makers did not account for the realities and limitations of risk management in how they represented CTOs. Hence, practitioners generally saw at least some value in the CTO, but this did not necessarily align with its perceived presentation by policy-makers as a panacea to longstanding problems in community care: *the politicians or the policy-makers justified it like 'people are being managed in the community we've got a CTO, and it's all singing and all dancing' and it's not. (AMHP)*

In contrast to the broadly therapeutic reasoning practitioners expressed for CTOs, there was a widespread belief that the policy reasoning for them was also premised on reducing resources and saving money. Resource management was not only understood as keeping people in the community, but also using the CTO as a way of discharging them from hospital more quickly in the first place, as this care coordinator states: *But I just think it's almost like we'll do it on the cheap, we've got a piece of law that will compel people to come out [into the*

community]. Resource management was connected to ‘mechanistic’ practice, in that it was believed that community compulsion might lessen the need for ‘deep’, potentially more resource-intensive work with service users. As one AMHP commented in relation to ‘typical’ CTO cases:

You have psychosis, you're difficult to engage, you've had this number of admissions, therefore CTO for you, and actually all that involves is maybe that you get your depot every fortnight, it's going to keep you to a level of wellbeing where you're not putting yourself or others at risk, but maybe that's all people are going to get.

Practitioners understood CTOs in this sense within the wider context of service and policy shifts. Reference was made by a number of practitioners to the ‘Payment by Results’ model which has recently been introduced to mental health services²⁴ and how CTOs could be seen as part of a broader agenda of rationalising and rationing services: *With Payment by Results, people are clustered into a pigeon hole; this is your illness, this is your type, so therefore your care plan will be prescribed and it might be quite minimal and quite restrictive and actually the CTO will be part of that (AMHP).* Similarly, cuts to services figured in practitioner concerns about CTOs. In both Trusts day and respite services had recently been closed, the community resources that service user relied on were also diminishing and there were ongoing staffing constraints and restructuring in community teams. Whilst CTOs were viewed critically as part of this shift to residualised services, they were also seen as a pragmatic way of supporting service users in such a climate:

It would be fantastic if we had loads of resources to be able to manage people, because I think if it was an ideal world we would possibly be able to manage people in a different way. We haven't got those resources, and we have to think about the best ways of managing people without them. (Care coordinator)

In contrast to concerns that CTOs would lead to restricted care, this pragmatic view was premised on the basis that CTOs might channel resources to those who

²⁴ Payment by Results was implemented in its current form across many public services from 2011 onwards. Payment by Results (now called Mental Health Payment Systems) was introduced to mental health services in 2012. Essentially Payment by Results is a commissioning and service provision system where provider organisations are paid according to their ability to meet certain pre-determined outcomes. In mental health services, this entailed separating service users into one of 21 ‘care clusters’, differentiated by diagnosis and level of need, for example ‘ongoing psychosis with high disability’. Each cluster has an associated care package and tariff which is paid to the provider per service user. Although it cannot be addressed here, it is worth noting that Payment by Results has proved difficult to implement and has come under sustained criticism for a number of reasons relating to form, function and philosophy.

were deemed to need the most support, due to the obligations CTOs placed on services:

Patients can go to their appeal and say 'my care coordinator hasn't seen me once in three weeks and I'm quite happy to meet him but he hasn't come round'. The Tribunal will just say 'well the CTO's a nonsense, we can take them off it'. Because we're not doing our side of the bargain. (Care coordinator)

Practice beliefs and the CTO

As suggested here, practitioner views on the influence CTOs might have on their practice had an ethical dimension, related to what 'kind' of practice they valued. When practitioners talked about the ethics of the CTO, they broadly considered what constituted ethical practice, and also the ethical implications of CTOs for the individuals they worked with. Taking ethical practice first, practitioners discussed CTOs in relation to what they thought was 'good practice' within an AOT. Assertive Outreach is premised on working with individuals in their environment, meeting frequently over a sustained period of time, and using a needs-focused approach (Sainsbury Centre, 2001). Consequently Assertive Outreach work has a particular ethos and focus which practitioners drew upon, specifically in relation to: how they defined 'skilled' work; the difference between 'assertive' and 'coercive' engagement; and the difference between tailoring services to individuals rather than individuals to services. As a psychiatrist summed up:

We're a team that's expected to use assertive means to engage people, but without necessarily being coercive. Rather than blaming the individual, it's about what services can do to engage. So we're finding what we've got in common with patients, working with that, and finding what it is that they want, what's going to be the currency that engages them.

Within this approach, 'skilled' work was defined in relational terms:

We always try and use interpersonal skills, use therapeutic risk taking, be a good resource for them in the community. I think we have a way of being able to encourage people to do the right thing. Not always, but a lot of the time. I think it's because of that long relationship, it's not any special powers that we've got, it's just because we know people so well. (Care coordinator)

Alongside this, practitioners talked about being used to working with a high level of risk and 'crisis' in Assertive Outreach work, which meant they had become accustomed to working with incremental change, and handling uncertainty when

making decisions in complex situations. Such an approach was contrasted to how many practitioners saw CTO practice, which was broadly defined as ‘quick fix’ with little need for theorising, understanding or relating. Within this context, one psychiatrist who was very ‘pro-CTO’ still worried that CTOs: *can be deskilling for the team, because it can make us lazy, we don’t have to try and engage or we’re less creative about how we try. I think with the CTO some of the way we work can be lost.* In this sense, it may be that CTOs have the potential to change practice configurations as well as service user experience, with more of an emphasis on ‘surface’ practice (Howe, 1996) based on legal leverage. It is worth noting that practitioners viewed such practice changes via the CTO as potentially detrimental to them personally as well as service users, in that some felt their work would become less rich, complex and interesting as a result.

There are connections here with the concerns practitioners raised about broader policy shifts towards a rationalisation of services, as discussed earlier. At the same time however, links can also be made to the more pragmatic view that some practitioners took about managing cases in difficult circumstances. From this perspective, some practitioners saw Assertive Outreach as a ‘natural fit’ for CTOs:

Because Assertive Outreach works with people at this very narrow end of the spectrum, they don't want to see anybody, they don't want to take tablets, they don't want us to interfere, they want to be left alone to take their drugs, and be mentally ill on their own. So I think you have to have compulsion in that way. (Care coordinator)

CTOs could also be seen as positively affecting the workload of the team as a whole, meaning they allowed more time for ‘everyday’ work with service users. One care coordinator commented: *The resources of this team are not as stretched because CTOs are being used instead of referring people to us [Assertive Outreach]. I think as well for some people who are in a routine because of their CTO, they’re being chased a lot less, so we have more time.* Going beyond the pragmatic view expressed earlier that the ‘contractual’ nature of CTOs would oblige practitioners to provide a certain standard of care, from this perspective CTOs might even encourage better care. It can be surmised therefore that how CTOs played out in practice was not straightforward. As will be discussed in the next two chapters, whilst CTOs *could* encourage ‘routinised’

practice, they could also ‘kick-start’ relationships, and practitioners still demonstrated creative ways of working within compulsion. Indeed despite their concerns, the purposes practitioners felt CTOs could be put to suggests they tried to shape CTOs to their practice approach rather than the other way round. Before I turn to those purposes, I want to say something about the second ethical consideration practitioners discussed in regards to CTOs - that of their consequences for service users.

An ethical balancing act

Despite practitioners’ qualms about the possible effects of CTOs on practice, none of them expressed an outright negative attitude towards CTOs. As noted earlier, even when practitioners expressed considerable doubts about the policy framework, they still perceived some value in CTOs. Instead, practitioner perspectives on CTOs ranged across a spectrum of ambivalence, in that how they felt about CTOs was very much grounded in day to day practice and tailored to individual cases. Consequently, practitioners took a ‘balancing act’, weighing up the pros and cons of CTOs for service users in ethical terms and considering both sides of the argument. Sometimes, practitioners did not feel they had the ‘answer’ as to whether CTOs were harmful or helpful, as this care coordinator explained:

If we look at outcomes we may well say it's of benefit, but if we look at human rights you might say this person should have the same right as myself to choose not to accept services. Or does the CTO mean that people have more human rights because if they're unwell it means that we have more of a responsibility to them? But I'm still, a bit...the jury's out

Concerns about rights, unnecessary coercion and the reduction of choice and autonomy for service users were expressed by many of the practitioners, particularly in regards to medication, where it was felt CTOs could lead to side-effects being ignored and service users not being given the opportunity to try a different medication regime. On this basis, practitioners referred to the dual dominant discourses of recovery/choice and risk/control in mental health and the ‘mixed messages’ they could engender:

It's really difficult to do all that education with somebody and then say 'I want you to have control, I want you to recover at your pace, I want you to set your

goals...oh and by the way, if you don't stick to these conditions, we're going to whip you back into hospital, you're going to stay on this medication, you can't have a choice in what you take'. It just feels...sometimes it feels a bit odd. (Care coordinator)

Relatedly, it was felt that the short-term gains of the CTO in managing engagement could undermine the potential for longer-term and lasting change: *If you can work with somebody and help them to understand their needs and what they need to do to stay well, that becomes a much more powerful protector for the individual in the long term than the coercive, 'you have to take this because the law says you have to take it'. (Care coordinator)* In a similar sense, some practitioners talked in terms of using their knowledge of individual service users and how they responded to intervention in order to weigh up whether the potential damage to engagement and the therapeutic relationship the CTO could cause was worth it:

The dynamics of the CTO for some people where they're resisting against it and resent us, then it makes a lot more difficult because they don't see us as people who are working with them, often they see us as people who are working against them which makes a big difference. You end up in a stale mate. Because they're just angry we can't build on other areas of their life which would probably make a lot of difference as well, which would help to move on and hopefully relinquish the CTO (Care coordinator).

If practitioners felt that engagement could be managed without the CTO, they could also question its usefulness: *Sometimes I question the CTO because mine and Andrew's relationship is reasonably strong that I think that he would still engage with me, there would still be hiccups with appointments, you know but...sometimes you question whether or not it works or not. (Care coordinator)*

Deciding whether the benefits of CTOs outweighed such ethical difficulties was talked about by practitioners in terms of best interests and risk. In relation to best interests, and contrary to the above perspective, some practitioners took the view that CTOs meant 'short term pain for long term gain', in that they could help service users reach a point of stability:

We want to work with people rather than against them, but sometimes it feels that we have to act in the person's best interest. And you're almost saying 'okay well there are two opinions here, yours and mine but we'll go with mine'. But just keep in the back of your mind that this is for the greater good to help them in the long term. (Manager)

In regards to risk, the majority of practitioners felt that they could justify the CTO when more ‘gentle’ approaches would not be feasible, and also in utilitarian terms for the wider benefit of society: *As much as we are about helping vulnerable people and social justice and all that good stuff, we’re also about protecting the public from some people that are potentially quite dangerous, but that’s hidden away, isn’t it, in social work values. (Care coordinator)*

Where practitioners placed themselves ethically in relation to CTOs defined whether they felt the CTO should only be used when absolutely necessary for tightly defined reasons, or should be used for a wide range of circumstances and people²⁵. If practitioners were more of the view that CTOs had the potential to cause harm to the service user, and/or they thought in the majority of cases positive outcomes could be achieved by less coercive means, they tended to see it as a ‘last resort’. For these practitioners, CTOs were believed to hold a great deal of power and not to be used lightly:

We’re selective because we reserve it for when we think it’s really needed, rather than for when it might be helpful. As soon as we get somebody on a CTO, we’re always aiming to get them off it as quickly as possible. Because there’s a terrible danger of using it purely because you can and you’ve got that power and you can use that power then to affect somebody’s life. So we’re very careful about how we use them and only using them where the problems become intense, where either the risks to themselves or others increase and we don’t have a choice. Not because of social chaos, that’s totally different. (Psychiatrist at comparison AOT where CTOs were used less)

In contrast, for those practitioners who did not feel the CTO would have much of a negative effect on service users and/or that they could be an effective means by which positive outcomes could be achieved, CTOs were seen as a tool to be used proactively, preventatively and often:

At the time when they first started to be talked about, I think very quickly you were thinking ‘oh that would be great for Mr X or Mrs Z’. And the first lady I put on, they’d only be introduced a month or two beforehand when we went for it, and straightaway I thought that would be perfect for this lady for the sole reason of reducing the distress around admissions. (Care coordinator)

²⁵ I should note that ethical beliefs were not the only influence on how much practitioners felt CTOs should be used. The efficacy of local policy/practice systems was also influential - if the methods by which CTOs were supposed to work were not effective, then practitioners may lose faith in the process and did not see the point of using them. This is looked at further in Chapter Eight.

Such practitioners might be more likely to believe in CTO efficacy and to evaluate such efficacy broadly. In this sense, judging that CTOs are a success could have a low threshold; for this psychiatrist as long as medication adherence was being achieved then positive outcomes would automatically follow: *In my view each and every CTO has worked at least to some extent. I don't think there has been any kind of big failures with the CTOs, because under the CTO the authority is given to us, we are able to keep them in treatment and that cannot be a bad thing.* The purpose of the CTO – what outcomes it could achieve – is therefore interpreted positively for a range of individuals and situations. Indeed both the reasons why, and the ways how, practitioners thought CTOs should or should not be used played out in their talk on the purposes of the CTO. It is worth repeating that practitioners did not take a ‘black and white’ ethical view of CTOs and all saw some purpose to their use. These purposes are discussed next, and pick up many of the themes developed here around risk, best interests, autonomy, short-term and long-lasting effects, and prevention.

Short-term and long-term goals: practitioner perspectives on the purpose of the CTO

Practitioners viewed the CTO as meeting immediate goals, as well as longer-lasting purposes, dependent on whether they believed the CTO could stimulate positive change (personal and contextual) or not. Such purposes mapped significantly onto the service user perspectives discussed in the last chapter and I will highlight the connections here. The strongest theme in the immediate goals, and the one that is addressed first, is that of the CTO providing protection of various kinds to service users. This, somewhat surprisingly given the policy agenda behind CTOs (although maybe not if we take into account previous research which has reported similar attitudes (Manning et al, 2011)), held primacy over references to risk and risk management, which are addressed next. These two themes can be seen as relatively short-term aims of the CTO; purposes that can be met fairly quickly. Practitioners also talked of how they saw the purposes of the CTO over time. As with service user accounts on recovery, this talk was aligned with both maintenance and change, with the CTO being seen as a potential platform for meaningful transitions.

Protection

The use of the CTO as a form of protection for service users was conceptualised in a number of different ways by practitioners. In particular, a view that echoed service user thinking was that the CTO - via recall - worked to provide easier access to hospital, which in turn served three protective purposes. The recall function meant the CTO could be understood as: 'protecting' service users from difficult Mental Health Act (MHA) assessments; identifying and treating relapse early on; and providing a 'short-cut' in an overloaded mental health system. Taking the first purpose, practitioners talked about the CTO as being used in order to make compulsion 'kinder'. It has been suggested that the experience of being repeatedly sectioned may lead to severe anxiety and Post Traumatic Stress Disorder (Watts and Priebe, 2002). Certainly, the CTO could be viewed by practitioners as a way of using mediated coercion to mitigate the effects of more forcible and direct coercion. A care coordinator talked about the CTO being used for one of the women she worked with solely for this purpose:

The restrictions that were placed on her were about accepting her medication and accepting contact with the community mental health team, but those things she pretty much did anyway, it was more about this lady was going to relapse, she'd had lots of relapses even when she was medicatedthat was the nature of her illness, but we needed to be able to get her into hospital without the distress for everybody else including herself.

The interesting point to note here is that the CTO was not used in this case for medication adherence. As discussed in Chapter One, the fundamental premise of the CTO is that they are there to ensure medication is taken. This assumption can be problematic if we consider people for whom medication does not entirely work. The use of the CTO in this case only to protect against distressing admissions demonstrates the flexibility of the purposes to which they can be put. Other practitioners also talked about using the CTO for this reason, comparing the relatively low-key and planned nature of recall to the often reactive, potentially traumatic and stigmatising event of a full MHA assessment. Another care coordinator summed this up when discussing two individuals she was working with who were both placed on a CTO:

Both had fairly traumatic experiences I would say with the Mental Health Act assessment, at their homes you know, the Police being called, and all the drama around it and the others being there. And I think for me it was an opportunity to

look at a CTO to prevent that happening, or try to minimise the stigma that goes with it, and the whole street knowing that they've been admitted to hospital.

In a broader sense, practitioners talked about CTOs as being preventative in that they allowed for relapse to be dealt with proactively. Similarly to service users, practitioners talked about the difficulties of gaining an inpatient admission on a voluntary basis. They also talked about the problems that arose even when crisis point was reached, particularly the challenges in securing a Section when individuals might 'mask' symptoms during MHA assessments, meaning professional agreement could not be reached on whether compulsory admission was necessary. As recall has a lower threshold and only involves one formal decision-maker, it could allow for a 'short-cut' into hospital, thus bringing about faster treatment. In turn, dealing with relapse early was explained as being about the 'best interests' of service users as not only helping them through immediate distress but also protecting longer term well-being:

It's almost been this protective measure, that when people become unwell we've been able to react and catch clients before they deteriorate to such a level that they need lengthy admissions and perhaps increased medication because of that level of deterioration. We haven't had to wait until they've lost all their dignity, lost all their skills and gone into the state where they'll have to be in hospital for months or years. (Care coordinator)

In an echo of the ethical 'balancing acts' described earlier, it should be noted here that not all practitioners were comfortable with recall being used in this way. Recall may be felt to give 'protective' rights to access to hospital when needed, but a contrasting view was that the additional discretion it brings to compulsory hospital admissions could also erode service user rights to make fundamental life choices, as this Manager argues: *Nobody should ever be put on CTO just so they can be got back into hospital quickly. If I were a patient I think I would prefer to endure the odd Mental Health Act assessment rather than a recall on a CTO and having a CTO hanging over me all the time.* This point will be returned to when the use of recall is looked at in more detail in Chapters Seven and Eight.

Moving away from recall, other aspects of the CTO meant that practitioners believed they could be used to protect individuals who were deemed unable to

care for themselves sufficiently in the community. Practitioners felt that having a legal structure for access enabled them to support service users who may be vulnerable to exploitation by others, or have physical health needs that were not being met. A psychiatrist discussed a case where the individual was placed on the CTO to help control Diabetes, by making a condition that they had to allow access to the Diabetes nurse. As he said, if the individual had breached this condition it would not have been enforceable with recall, but: *if you know the person and you know they are going to comply with that, then I think it was a good condition in place, the patient managed his Diabetes after that so...*

An interesting question such thinking on the CTO raises is the broad sense in which 'health and safety' was constituted by practitioners. The CTO could be put into place to deal with not only proximal risk to self, but also as demonstrated here more nebulous risks to do with self-neglect and 'chaotic' living. Similarly, practitioners also discussed the CTO as being used to ensure socially acceptable behaviour and to protect individuals from 'shameful' experiences. One service user, Sheila, who was strongly opposed to the CTO had been on it for a considerable length of time because her care coordinator felt her actions when unwell caused significant difficulties for her in the community where she lived:

She's never been a risk to herself, or a direct risk to others, but her going out into the community and coming out with all these delusions, it's a small community that she lives in and then she has to return back there, so the risk of the community knowing all about her, all about her business, all about...you know it's not very nice for her. So to protect her in that way.

Risk

The use of CTOs to manage risk of harm to family members and to the wider community was talked about by practitioners as being very much framed by the kinds of individuals they worked with within Assertive Outreach. As one care coordinator who had recently transferred from a generic Community Mental Health Team said, he had felt it: *unfair to keep CMHT patients on the CTO, because they aren't heavy duty cases like here at Assertive Outreach.*

Practitioners certainly felt CTOs filled a particular gap in this regard, related to the presence of individuals who had come through forensic services to Assertive

Outreach. Individuals who are placed on a criminal treatment Section of the MHA (Section 37) can also be made subject to restrictions in the community under Section 41 once they leave hospital, referred to as a '37/41'. This may occur if the individual is deemed to be of particular risk to public safety due to the nature of their offence. The 37/41 effectively operates on similar terms to a CTO in that when they are in the community, individuals on a 37/41 have to abide by certain conditions. Individuals supported by the AOT could have a forensic history involving violence towards others and yet not be on a 37/41 for various reasons. Practitioners effectively saw the CTO as being the 'next best thing' for these particular individuals in managing risk. As an AMHP described about one of the individuals who participated in the study: *lots of people on CTOs now come from the criminal justice system, you know, and with the case of Glenn, his 37 expired and he got put on a 3. So-, yes, so as a result, he couldn't be a 37/41 so the CTO is the best thing that we've got.*

However, in reflection of their scepticism around the 'selling' of CTO policy in risk terms, practitioners were still ambivalent about the ability of CTOs to manage risk effectively. None of the practitioners felt the CTO made much difference to the ability to monitor risk:

Whether or not it reduces dangerousness is a debatable issue. People's risks will fluctuate daily whether they are on a CTO or not. They will fluctuate dependent on lifestyle choices, drugs and alcohol, stressors, relationships, all the things that we know that...deterioration of physical health, mental health, their psyche, their personality.

As this care coordinator went on to say, even seeing a service user twice a week cannot account for events that occur in the meantime. Where practitioners felt CTOs were able to respond to risk was in its ability to ensure medication compliance through the use of conditions and recall:

I think for the service users we have, you know with a high risk history, people are staying in treatment and if they slip out of treatment they are getting picked up and taken back and being given treatment a lot more quickly than previously, where you would have been waiting for things to deteriorate. (AMHP)

However, whilst medication compliance could help manage risk for many individuals, for others (for example those who did not respond to medication, or where their risk was associated with personality disorder or substance misuse

issues) their level of risk was not necessarily mediated by medication, and the CTO therefore could not serve that purpose as effectively. In this sense, practitioners understood the CTO to be as much about managing perceptions of risk rather than risk itself. The decision to place someone on a CTO could be weighted by defensive thinking, as this care coordinator explains: *I think we all worried that if something ended up in the coroner's court they would say 'why didn't you put that person on a CTO, these were the risks'*. However, it should be noted that the defensive use of CTOs was not only related to image management and 'back covering'. Some practitioners spoke in very personal terms about the reassurance the CTO gave them when working with people who were deemed 'high risk'. A care coordinator talked about a woman who she had recently started working with who had a significant history of violence and aggression:

So I'm really pleased it's there just in case, it gives me a bit of... because the care coordinator she had before me was literally living and breathing her name. She said 'there you are, she's all yours', and I thought 'oh, I'm never going to sleep again!' I was terrified and I mean terrified. But I told myself... 'I've ticked all the boxes and I've done everything and there's nothing else I can do, I can't be there for 24 hours a day and what she does, she does'. But it's not easy, so I'm glad she's on it.

Connections can be made here with the service user discussion of risk; not only did the CTO support a psychological purpose of feeling in control for service users, but for practitioners too.

Even so, a view held across the majority of practitioners (psychiatrists excepted) was that although they saw the value of CTOs in managing risk to others, the primary purpose of the CTO for them was not necessarily about risk management in itself. Indeed, practitioners spoke of the CTO being helpful in 'least restrictive' terms for example in that 'risky' individuals who had had long admissions or who may not have been discharged previously being given that opportunity because of the CTO. Furthermore, the management of risk was not necessarily what practitioners *hoped* to achieve through the CTO as summed up here by a manager: *It is in part a risk management tool, isn't it? That's an aspect of it. It would be hard to deny that, if we're being honest. But the bigger part for*

me is aiding the person on the recovery process. The next section will examine the more ‘Utopian’ longer-term goals practitioners felt CTOs could help towards.

Maintenance and recovery

In contrast to the immediate goals of protection and risk management, the future-orientated aims of maintenance and recovery did not rely explicitly on the functions of the CTO, particularly recall. Indeed, when talking about these latter aims, practitioners saw the active use of the CTO as signalling failure in reaching them, as this care coordinator notes in relation to one individual who posed particular risk issues: *there would be a good call for recall but we don't, because we're trying to allow people to change and have additional support and see what we can do.* It should be noted here that even individuals considered high-risk could be worked with in a way that was not solely risk-focused through the CTO. In this sense, there was not an automatic ‘match’ between what might be expected to be the purpose of the CTO and the actual purpose it was put to with service users.

Not all practitioners were entirely uncritical of a maintenance and recovery agenda for the CTO however. As noted earlier in the section on ethical balancing acts, if individuals responded in a strongly negative way to the CTO, it could be seen as blocking the possibility for work to be done in any area of their life, thus meaning they could become ‘stuck’ whilst on the CTO. More broadly, the use of CTOs as a pathway for recovery was seen as promoting an individualising approach to the problems service users face in the community, in that it placed the onus on the service user to maintain stability, despite adverse factors beyond the remit of the CTO or the control of service users. Furthermore, it was felt by some practitioners that this focus on a narrow, policy-directed view of recovery foregrounded independence and downplayed the roles of dependency, care and ‘asylum’:

There's nowhere for people to go to feel safe anymore. So I think because we've got CTOs there are more people thrown to the wolves than should be. But I think the whole thing about mental health is you've got to recover, it's all about recovery whatever recovery is. And for the vast majority that's absolutely fine

but for the people who it isn't fine for, it's really not fine. And I think it puts them at more risk, but (sarcastically) we've got a CTO so that's alright.

This AMHP was one of the practitioners who placed greater emphasis on proactive and protective use of the CTO in order to counteract such a narrative. The 'non-use' of the CTO to keep people out of hospital was therefore viewed as against the best interests of some of the individuals she worked with.

Even so, protection, maintenance and recovery come from a similar value position in that they are all rooted in different aspects of paternalistic care. As highlighted earlier, the use of recall was seen as protecting individuals' from themselves. The CTO as an 'invisible' yet controlling framework to maintain stability is based on the view that firm boundaries in the present will bring about positive change in the future. Reflecting the prior discussion of practitioners' concerns about service changes, it was also recognised that services had a reciprocal role to play in this process. Whilst reciprocity principles do not make a formal appearance in CTO criteria, there was understanding by most practitioners that the CTO needed to be planned and put into action carefully by services for stability to be safeguarded. Furthermore, although all practitioners felt they would provide the same level of treatment regardless of whether a CTO was in place or not, it was also acknowledged that the CTO could enhance obligations to service users. There was a strong moral component to reciprocity, as a psychiatrist explained:

There were people who were getting a raw deal. They weren't getting good community psychiatric care, and they weren't getting the stability that they needed to prevent the disability accruing. If you've got to take something away from somebody, you have to give them something back, so what do you give them back? If they contract to take the medication that you think is going to benefit from them, you don't leave it at that, you start to work in other ways.

Consequently, for practitioners maintenance was talked about in reference to stability in the community providing a foundation for service users to move forward and out of particular cycles. Stability in the community meant being able to stay well for sustained periods of time and subsequently being able to maintain housing, relationships and finances, and take part in fulfilling activities. A care coordinator discussed this in relation to a service user she was working with:

So she was your classic revolving door patient...when CTOs were being discussed, she was clearly identified as being somebody who would be a good potential candidate for a CTO. She's never been readmitted to hospital since she's been on a CTO, it's sort of kept her in treatment and family have reported recently that this is the longest stable period she's had, and they feel that she's generally much more settled, that was their word, since then.

It was generally hoped by practitioners that through achieving stability, service users' feelings of coercion related to the CTO would lessen. This was seen as a mutually constituted process, whereby longer periods of being settled would mean service user attitudes towards the CTO would soften and it would: *fade into the background*, ceasing to be of importance to them. In turn, a change in service user stance towards the CTO would be further reinforced not just by continuing stability, but also by the occurrence of positive changes due to such stability. Dawson (2007) has used Isaiah Berlin's (1969) theorisation of liberty, specifically positive liberty, to explain how the CTO can act as a framework for self-determination. As noted in Chapter Four, this reading of positive liberty is not without problems, but it certainly corresponds with many of the practitioners' understanding of the overarching purpose of the CTO. The purpose of the CTO here was seen to be acting on service users, in order to give them an opportunity to overcome internal constraints and to *get on with life*. This was seen as a process, starting with, but not limited to medication adherence:

Because the intention of it is you stabilise somebody, they keep them on medication long term and they engage in the other elements of therapeutic engagement. And then they build on that to improve to the point where they have an acceptance that the medication and the services are of value to them. And they negotiate ways to go forward with their life. That's the underpinning hope of it. (Manager)

As this quote suggests, compulsory medication was viewed as the platform on which psychosocial work could be done, with the eventual aim of increasing service user agency. Such thinking on the aim of the CTO was also associated with how practitioners viewed the duration of the CTO; achieving stability and change was recognised as a long process and consequently seen to require lengthier CTOs to ensure progress was secured.

This quote also makes reference to the connection practitioners made between changes in circumstances and individual change in beliefs and attitudes. Part of

the aim of recovery therefore was the development of reflexivity in service users; that they would not only accept the CTO, but that being placed on it would help them to 'realise' the 'right' way to think about their situation so that they could sustain recovery. In other words, the CTO becoming 'invisible' to service users by fading into the background would also signify the inculcation of its message. The CTO therefore was seen as a psychological catalyst to support the internalisation of particular norms.

Practitioners talked about this in terms of service users developing insight, which as in the research literature (Dawson and Mullen, 2008), was often conflated with treatment adherence. However, awareness that insight can be a problematic tautological concept was demonstrated by some of the practitioners.

Consequently a wide range of definitions of insight surfaced in the interviews, from the internalisation of dominant medical understandings of mental illness, through service users reaching an understanding of their condition and how to manage it, to a wider conception of accepting that 'life is better' when well and stable. The aim for practitioners was that service users 'reframed' their past experiences, which would help them to shift perspectives on their present and future. A signifier of this for practitioners was service users beginning to talk openly with them about such experiences and how to make sense of them:

He's engaging in treatment. And I don't just mean the medication, he's engaging in a way that he's never engaged before. This is the first that he's actively discussed his mental state and acknowledged that he was conscious of his actions before but felt a bit powerless to stop them really, because of the paranoia and confusion. (Care coordinator)

Practitioners made a further connection between the development of insight, and increasing responsibility and autonomy. Specifically, that the CTO gives the initial 'push' to service users to change their thinking, which in turn changes their behaviour. Such a view places emphasis on the individual as the driver for change and therefore that it becomes: *their responsibility to maintain their improvement, in a way (Psychiatrist)*. In this sense, there was a shift in emphasis from stability to recovery; stability was talked about as a mutual enterprise, whereas the 'next step' of recovery was framed as premised more on service user action. A more in-depth discussion of how practitioners interpreted insight, change and responsibility will be saved for Chapter Nine when discharge is

discussed. It is enough to say at this point that insight and personal change were key factors in discharge decisions, along with associated dilemmas about where practitioners thought responsibility *should* lie at different stages of the CTO, and how much potential the CTO had to shift the balance of state/individual responsibility. An interesting contrast can be made with the views of those service users who valued the CTO because of its potential to support their recovery. All but one of the service users who discussed recovery in relation to the CTO, saw recovery as being developed through interdependence rather than independence.

It should also be noted that not all practitioners made straightforward links between thought (insight) and behaviour change. The aim of the CTO in promoting recovery was not necessarily related to the development of 'responsibilised' thinking. This psychiatrist was quite sceptical of such a cognitive-behavioural approach: *It's quite a soft argument as well to say that if you put someone on a CTO, then you will demonstrate to them how seriously you're taking it and how important it is, and what the framework is, so you know, a switch will flick in their mind and they'll realise that they need to take it, and then they will.* Instead, some practitioners felt recovery was indeed possible through the CTO, but was more likely to occur through external compulsion rather than through a process of internalisation. The CTO would therefore be kept very much in the foreground as a framework to ensure progress despite the perspective of the service user in question:

There are other patients who are still struggling with their insight but otherwise have made such a phenomenal progress on the CTO and this lady I'm thinking about, she was having admissions twice a year before the CTO. In the four years since she's been out on the CTO, she's never had to be admitted to hospital. She's driving her car again, for the first time in her life she held a job, even though it was a voluntary job and she is able to care for her sick mother. (Psychiatrist)

In such cases, perpetuating change was seen as possible only through the maintenance of compulsion.

Concluding thoughts

In this chapter and the last I have drawn out the main themes that underpin practitioner and service user thinking on CTOs. In bringing to the surface how participants conceptualised CTOs, I have also touched upon some of the implications such thinking has for the use of CTOs. In this concluding section, I firstly reflect on the findings presented in these two chapters, before considering what they mean for the following two chapters on everyday CTO practice.

Neither service users nor practitioners approached CTOs as an abstract ‘problem’; their views of the CTO and why, how and when it should or should not be used, were very much related to their prior experiences, beliefs and values. For service users, questions of vulnerability and strength, dependence and independence, (self) control and riskiness, and above all difference and ‘normality’ were central to how they interpreted the CTO. Those individuals who came to the CTO as a positive development in their life, felt the CTO met some self-perceived need that had previously not been met, relating variously to security, self-management, stability and change. Conversely, ambivalence or more clear-cut resentment could ensue when service users felt the CTO enhanced the differences between them and professionals, deepened their sense of powerlessness and lack of control, and added to the barriers they had to surmount in reaching their goals.

For practitioners, their perception of the CTO and what it could offer was coloured by their beliefs on ‘good’ practice, particularly within the context of Assertive Outreach, which was aligned with skilled, complex, relational work. Relatedly, their concerns about the potential negative implications of CTOs for service users revolved around the effects of coercive ‘surface’ practice on choice, autonomy, recovery and relationships. Here we can see the tensions that some practitioners felt about working within the twin narratives of risk and recovery that exist in mental health. However, at the same time it needs to be acknowledged that practitioners did not take a binary approach to CTOs. They could see the potential gains CTOs could bring to practice, in particular that paradoxically the ‘surface’ nature of CTOs - based on rules and sanctions - might

in some cases encourage better relationships through providing space and clarity for engagement. They could also see the potential benefits to service users and to wider society of the stability and security CTOs might bring. Practitioners therefore engaged in a form of situated ethics, carefully weighing up benefits and harms when considering the consequences of CTOs for individual service users. For some practitioners this ethical balancing act was less problematic than for others, and it is here that we can see a difference in when and for whom practitioners felt CTOs should be used. How practitioners dealt with their varying levels of ethical discomfort is in turn connected to how they formulated the purposes of the CTO.

Through examining service user and practitioner perspectives on the purposes of the CTO together, we can see the ways that they mirror and diverge from each other. The accounts presented here and in the last chapter highlight how CTOs have been conceptualised in two relatively distinct ways by both groups. The first way relates to mutually aligned accounts of risk management and protection of various kinds. Putting CTOs to these kinds of purposes is characterised by: a consideration of the present, the CTO having immediate effects, active use of the functions of the CTO, and not requiring the exercising of self-control by service users. The second way refers to the use of CTOs as a vehicle for a staged process of maintenance, recovery and change. This can be characterised by: a consideration of the future; the CTO as enabling longer-term effects; the psychological use of the CTO to shape behaviour through boundaries; and requirement for service users to display self-control either through internalisation or through external leverage. Particularly within this latter way of thinking about CTOs there were some differences in emphases between service users and practitioners. Whilst service users considered maintenance in relation to staying out of hospital, practitioners focused on creating a foundation in the community. In turn, almost all of the service user accounts refer to recovery as a shared, interdependent endeavour between service users and services. Practitioners gave more weight to the CTO developing service users' autonomy and responsibility. It should be noted however that across both conceptualisations, the principle of reciprocity was referred to by practitioners as well as service users; there was a sense that the CTO should provide a *quid pro quo* of some kind. The practitioner

data therefore does not straightforwardly support the exclusionary/inclusionary, risk/responsibilisation policy narrative for CTOs described in Chapter Four. Whilst present in practitioner accounts, it was undercut by, or coexisted with a narrative of care and a sense of contractual obligations, which was set within the context of the current service landscape.

Practitioner views on the purpose of CTOs can therefore be differentiated from the dominant CTO policy narrative to some extent. Practitioners broadly felt that CTOs were better than what had gone before, being more effective and fairer to service users than previous legal provisions. However, there were concerns about the policy discourse and rhetoric on CTOs, with there being a disjuncture between what practitioners believed CTOs were capable of - particularly in relation to risk management - as compared to policy theorisation. Practitioners recognised the place of CTOs in risk management, but the purposes they saw as being most important were overwhelmingly weighted to the 'best interests' of service users. Whilst recovery is certainly present as a concept in CTO policy reasoning, risk has taken precedence and recovery is not as foregrounded as it was for practitioners. Moreover, practitioners rejected the idea of CTOs as a form of resource management and were largely critical of the part they saw CTOs playing in a broader agenda of service cuts. Indeed, at the same time it seems that there was a belief that CTOs could be used as a way of mitigating such short-falls in provision, particularly crisis support. Practitioners talking about the active use of the recall function for protective as well as risk-orientated purposes can therefore be seen in some ways as in opposition to policy thinking, where lowering rates of hospitalisation is the headline expected outcome for CTOs. There is a potential disconnect here between how CTOs have been thought about at policy level and the logic of how they might be thought of - and therefore why and how they are used - on the ground.

This brings us to the questions practitioner and service user conceptualisations of CTOs raise for their actual use, which is considered in the following chapters. The ethical debates practitioners engaged in about the CTO in conceptual terms also played out in CTO practice. The concerns that practitioners raised about 'deep' versus 'surface' practice, and the impact of coercive practices on service

users, manifested in how they thought and went about the everyday functions of the CTO, specifically the setting of conditions and the use of recall, as well as how they built relationships with service users within the framework of compulsion. Both the positive and negative attitudes service users held about the CTO strongly influenced how they understood what it meant for them in concrete terms. In turn, such attitudes and understandings shaped service users various responses to the CTO and consequently the different ways that CTOs unfolded in practice. As we will see however, the service user-practitioner relationship could be a significant mediating factor between service users' attitude/understanding and subsequent response, especially if practitioner interactions with service users keyed into beliefs service users held about themselves, their situation and their goals for the future. Policies such as CTOs that are based on control are often discussed in rather hegemonic terms, without taking into account the ways that individuals affected by them can respond to them or shape the path they take. However, the ways service users and practitioners act and interact through the course of the CTO are central to questions of CTO 'value', both in relation to ethics and effects. The following two chapters take forward these points, and develop them with reference to everyday CTO practice.

Chapter Seven
Putting CTOs into action:
Service users' experiences of their use

In the previous two chapters I drew attention to how CTOs were conceptualised by service users and practitioners. In this chapter and the next I focus on the everyday practice of the CTO, and draw out the personal, interpersonal and systemic factors that shape that practice. Again I have divided service user and practitioner stories into two complementary chapters in order to do justice to both perspectives. As with the preceding chapters, both groups have distinct yet at times interconnecting accounts, which need to be taken on their own merits as whole narratives and which lead to their own respective conclusions. Given the focus in these chapters primarily on the practice of CTOs, I interweave observational and documentary data with the interview data in order to give as rounded a representation as possible of the workings of the CTO.

In this chapter, I examine service user experiences of the CTO process and components²⁶, beginning with discharge onto the CTO, through navigation of CTO conditions, and finally the possibility of recall back into hospital. In all three sections, I highlight the reflexive connections between service users' overall beliefs about the CTO, their understanding of how the CTO works and their responses to it. In doing so, I particularly draw attention to the mutable mediating influence of practitioner intervention on these beliefs, understandings and responses throughout the different elements of the CTO process. Service user actions in response to the CTO were not straightforwardly or always channelled through the relationships they held with practitioners however, and I also explore the various ways service users demonstrate agency in relation to the CTO. In doing so, I highlight the effect the CTO can have on the individual, but also the effect the individual can have on the CTO and the path it takes. Before I begin this exploration of CTO practice, I give a contextual account of the service user-practitioner relationship, focusing on how service users constructed beliefs on professional expertise and motivation. Both elements together are key to

²⁶ The interview data included in this chapter therefore comes primarily from service user interviews. I have included supplementary practitioner quotes when I have felt it necessary to illuminate a point.

whether a trusting relationship is able to be formed, which in turn plays a constitutive role in how service users make sense of the CTO. At the same time, the advent of the CTO can affect this relationship, and I go on to explore what these effects might be.

The service user-practitioner relationship

In Chapter Five I drew attention to the strong relationship between service user beliefs around their identity and circumstances and their view on the purpose, or ‘anti-purpose’ of the CTO for them. I ended that chapter by talking about ‘cross-purposes’ and the sense that service users could feel they were thinking along entirely different lines to practitioners in regards to the CTO. In this section I carry on that discussion by examining how service users’ constructed professional knowledge and motivation coming into the CTO. Alongside service users’ prior experiences and beliefs about self, their beliefs around professional intervention were also significant in how they approached the CTO, and I explore the ways perceptions of expertise feed into the development of trust. Relationships are not static however, and in the second part of this section I turn more directly to the CTO and consider how it might affect the relationship between service users and practitioners.

What do they know? Professional expertise and the making of trust

Service users variably drew upon constructions of expertise and professional judgment when they considered the path their treatment had taken thus far. Much has been made of the breakdown of trust in authority in late modern society, where an important role has been played by profound changes to knowledge flow; information and associated beliefs can come from much more varied sources than previously possible. However, the majority of participants, and in particular those who were older, could be said to inhabit a world which did not reflect this societal change. Holding a belief in professional expertise could therefore involve taking a ‘leap of faith’ into the unknown, as with Irene whose understanding of her medication was filtered solely through professional explanation: *and I’m told, so I presume it’s true, that they help to stabilise your*

mood. Trust is in part about making a choice to be dependent on another (Brown and Calnan, 2012), and underpinning these views on expert knowledge was the sense of how individuals ‘should’ respond in the face of an authoritative action when they have delegated their understanding of their situation to a professional. James summed this up when explaining why he adhered to the CTO:

And the CTO, if you're not compliant to it, you're wasting people's time. You're abusing the system. They've got you well, you're on your meds, you're on a CTO, you know it works and then, if you don't do it, you end up back in hospital. It's like-, you're insulting their intelligence. They're saying, 'look, if you do this, we'll get you better', and if you don't do it, you're knocking yourself but you're knocking the system as well.

In this scenario, the individual is part of a larger system, in which they have to be responsive in the right way to guidance. The expertise of professionals as portrayed in these accounts is also related to beliefs about professional motivation. The thought that a professional must know what they are doing can be linked to the belief that they are acting benevolently. Glenn for example felt that the CTO was a positive development because: *the mental health are there to help. They're not there to ruin my life, they're just trying to make it better.* At the other end of the spectrum were participants like Craig, who had little belief in the knowledge or motives of professionals, as he says: *I don't know what qualifications these people get, because they don't have a clue what they're doing. I mean the brain is the most complicated thing on the planet which nobody has a clue how it works and they're just throwing drugs at you like they're Smarties.*

Participants combined their view of professionals’ general expertise, with their beliefs about how much knowledge practitioners had specifically about them as individuals, in order to judge the ability of practitioners to manage their situation. The extent to which participants felt practitioners knew them, helped them to weigh up how much they trusted practitioners to predict, and do something about, what was going to happen to them. James believed that when he relapsed, his care coordinator: *just saw it coming*, and that with the CTO it was a case of her and the psychiatrist thinking: *‘we’ve got James on a CTO; we know what we’ll do for James; we’ll get him well’ and that’s what it’s done.* In contrast, participants who believed that professionals had approached them in an

impersonal way had little faith in the power of professional prediction, as Sarah suggests when talking about her first experience of being placed on a CTO:
because something's happened in the past, they just assume something's going to happen in the future and you know there is prejudices, there is habits of behaviour among staff just as much as there is among patients.

When practitioners acted in ways that participants did not agree with, those participants who viewed professional knowledge and motivation favourably appeared to differentiate individual practitioners from the mental health system, or in other words, give practitioners the 'benefit of the doubt'. Nevertheless at times it could be difficult for participants to make sense of painful experiences whilst at the same time hold on to an underlying trust in professionals, resulting in a kind of dissonance which participants could struggle to integrate. James, who highly valued the input of professionals in his life and believed in their abilities and motivations, reflected back on when he was put on an injection for the first time following the CTO and how it initially affected his relationship with his care coordinator: *At the time, there was a bit of negativity towards my nurse. There wasn't a bond; there wasn't a friendship. It was like, 'no, you're the nurse and you're the injection and that hurts, I don't like it and I'm tired of it'.* It seems that the care coordinator's role in giving James the injection under the CTO created a professionalised distance and conflated her as an individual with the painful intervention she administered.

The nature of the service user-practitioner relationship and the CTO

From James' account, we can see that the CTO may have some mediating role to play in the relationship between practitioners and service users. Indeed, one of the questions that has most been asked about CTOs is in what ways, if any, they might affect the relationship between practitioners and service users. For some participants, the CTO did not particularly affect their pre-existing feelings - both positive and negative - towards practitioners. For others, as referred to in Chapter Five, the CTO appeared to erode the therapeutic compact they held with practitioners, by introducing a new focus for conflict and enhancing the differences in the views they held on treatment, support and future goals. As has

been suggested in previous research (Van Dorn et al, 2006) alienation and estrangement could follow. Statutory obligations under the CTO could encroach on the relationship and reinforce any distrust that already existed; for example Sheila felt strongly that the presence of the CTO meant her care coordinator was *not on my side* due to the role she took in supporting the continuation of the CTO. For Irene, the compulsory nature of the CTO acted as a barrier to her forming the collaborative relationship with professionals that she wished to have:

Psychologically, I like the feeling of working with a doctor more and agreeing with something, because that's what I've been used to with GPs in the past. So I didn't like the order where I was being made to have injections when I didn't want them so...you know I didn't like that feeling that I wasn't in agreement with the doctor.

Conversely, when service users generally accepted the CTO, it could signify a welcome shift in their relationship with practitioners. The potential for protection and provision was referred to in Chapter Five by some participants as important drivers behind their acceptance of the CTO. Taking this further, participants did not only view the CTO as a depersonalised safety net. It was also the relational aspects of the CTO that made participants feel secure and 'taken care of', as Glenn explains: *If I become unwell with my mental health I'll get looked after won't I. Everything will get sorted out. People will help me sort it out rather than me trying to do it myself and make a mess of it.* In addition, some participants felt the CTO could signal vulnerability and the need for attention:

But the reason why the CTO is good is because the nurses and the social workers come to my home and they give me medication, they ask me a lot of questions. People are more concerned about you because they find you very fragile so you should be looked after, and I'm very happy because of that that they take interest in me. (Michael)

Indeed, the relationship participants had with practitioners could be entirely conflated with the CTO, as Julie illustrates:

Interviewer: So if you weren't on a Community Treatment Order what you think would happen?

Julie: What would happen? I wouldn't be getting any help would I? I wouldn't be able talk to people.

What this seems to suggest is that reciprocity did not necessarily manifest in CTOs in the form of tangible improvements to care, but instead as a potent

psychological mechanism. As Michael goes on to state: *the CTO makes me feel stronger and more important in the eyes of the doctors.*

Although the CTO had placed some participants at odds with practitioners, for others even when they were not happy about the CTO or their medication, they might still welcome the broader support practitioners provided. It appeared that a significant element in keeping relationships and regular engagement working within the CTO framework was finding a point of agreement, however small. Practical help with day to day living could support participants to find a way through the CTO. Andrew refused to attend outpatient appointments with his psychiatrist, who he intensely disliked as a figure of authority, but would still regularly meet his care coordinator and receive his injection, despite not agreeing with it. As he says: *well my care coordinator, he has contact with us by mobile and he tells me when my money's due, when I'm going to get paid²⁷. He looks into things for us, he's trying to help.* For many of the participants, their care coordinator was valued as a person who they could talk to through difficult times, who was consistent and available, who would help them navigate various systems and who would advocate for them with other professionals. As Brendon stated when asked if he would stay engaged with services if his CTO was ended: *I think I would yes, because I feel like my care coordinator is a friend now, you know what I mean, whereas before I didn't.*

Many of the service users' accounts of interactions within the context of the CTO contained themes of professionals relating to them in 'depth' terms of relationship and personhood as well as 'surface' terms of compliance and risk. In this sense, whether practitioners were perceived as focusing on broader support (and ultimately shared goals) rather than solely on medication, and whether their mode of communication was seen as didactic or two-way, were the two central aspects which influenced service user's views of both practitioners and CTOs. Integrating surface and depth practice in regards to the CTO could be difficult for practitioners, as we will see in the next chapter. Part of that

²⁷ In Andrew's case a corporate appointeeship was in place, which the care coordinator helped manage. This is when the Local Authority has control over an individual's finances and budget, and is put in place when that individual is deemed not to have capacity to manage their money.

difficulty was in judging when and how to refer to CTOs in regular interaction with service users, and how to use the CTO as a tool in facilitating compliance through reminder and explanation. The following sections on discharge onto the CTO, and the use of conditions and recall, will therefore explore service user understanding of the CTO as a legal intervention, and particularly in terms of the explanations given by professionals.

Service users' experiences of discharge onto the CTO

This section highlights in particular how service users formed an initial understanding of the CTO and the legal framework within which it operates. Service users' understanding of the CTO in legal terms, more specifically what it allowed them to do or not to do, constituted the foundation for how they engaged with its boundaries. Understanding and involvement in decision-making go hand in hand; how much service users felt able to have a voice and be listened to in the early stages of the CTO also influenced their attitude towards, and subsequent engagement with the CTO. This early involvement will be considered first, before I explore in more depth how practitioners' could influence service users' initial impressions of and responses to the CTO.

Early understanding and involvement in the decision-making process

The initial explanation given by professionals was the starting point for most of the service users when beginning the process of understanding the CTO. Participants gave varied accounts of how they were told, and how much they were told about the CTO when being prepared for discharge from hospital. Observations of hospital discharge meetings certainly reflected this variability, with a wide range of practice being observed. For example, in Julie's discharge meeting, which I attended, the paperwork was completed very quickly and Julie and her partner were invited in once the decision to use a CTO had been made. The psychiatrist addressed Julie three times about her *conditions of discharge* but did not explain what this term meant or ask if she understood. The CTO was only directly mentioned at the end of the meeting and then only briefly, with: *when you get discharged we will put you on something called a community*

treatment order, being the sum of explanation given by the psychiatrist.

Professionals using jargon could make understanding difficult as Irene describes:

I would have liked it explained on a very ordinary level so that I could understand it. In addition to explanations being clear, having the time to think and digest the information, and being able to ask questions were viewed as important aspects of being discharged onto the CTO with a well-informed understanding of it.

Participant understanding in the early stages also affected how much they could take part in the initial decision-making, as Michael illustrates when asked how much involvement he had in the process of being placed on the CTO: *I couldn't say anything about it. I didn't know what it was initially, I didn't know what it meant.* Participants described whether during such decision-making they felt involved or marginalised, listened to or ignored, and talked to or with by professionals. Although practice guidance (Department of Health, 2015) on CTOs suggests service users should be collaborated with in making the initial decision even if they do not consent to the CTO, in reality it was more common for individuals to be informed but not involved. In addition, it should be noted that although all individuals on a CTO are entitled to support from an Independent Mental Health Advocate (IMHA) who can help them understand and navigate decision-making points on the CTO, none of the service users in the study had used them. Practitioners explained this in some cases as being down to inherent suspicion of any professional who was thought to be 'part of the system', or because the service user felt able to speak for themselves, but otherwise it appeared that service users were not always aware of this provision. Only one participant, Glenn, felt that he had played a relatively equal role along with professionals in the decision-making to use the CTO, as he states here when asked about the process of his discharge from hospital:

Interviewer: Do you know why they started talking about the CTO at that early stage?

Glenn: Because I wanted to...me and my solicitor and my funders wanted to know the full care package, and the pathway that we were going to be using, why it hadn't been set down clearly. If I was going to benefit from it, it had to be planned. It was my decision. It wasn't mine...obviously it can't be my decision but it was me that wanted to be on it

An important aspect of Glenn's ability to play an active role was that he was able to have early and on-going involvement in the process of being discharged into the CTO. However, and as has been reported in other research (Stroud, Doughty and Banks, 2013), case file analysis suggests the majority of participants were told very close to or at the point of discharge that they were going to be placed on a CTO, making it difficult for them to develop full understanding or be involved in decision-making.

Given that when being discharged from hospital, individuals tend to focus on going home, the initial explanation of the CTO by practitioners could lack meaning for participants²⁸. As one practitioner pointed out to me after a discharge meeting: *They're getting off the ward so you could say, 'you have to wear your underpants over you trousers' and they would agree to it.* All participants reported being given leaflets on the CTO but these did not appear to be a particularly effective way for them to gain understanding of the CTO, as the majority reported not reading them. Graham describes: *they gave me information but I just never read it. I just said, 'oh I'll just sign here' and take the CTO and do the CTO. I never questioned it or anything.* Like Graham, the experience of 'just signing' was common amongst participants, but this did not necessarily reflect a lack of interest in what the CTO would mean for them. Participant understanding of the explanations given tended to reflect their feelings more generally in regards to compulsion and relatedly, how coercive they found it to be. Michael's understanding of the CTO was refracted through the extreme powerlessness he felt at the time in the face of authority, and so he believed that the implementation of the CTO was a judicial rather than clinical decision: *It's a compulsory law order, its signed by the law courts of some sort and it's done by the law without my rights.*

Practitioners acknowledged that service users were not always as involved as they could or should be. As one Manager describes: *It's been put on them without their full knowledge and you know it's just kind of happened and now*

²⁸ This could create interesting situations in interviews, when participants would sometimes ask me about the detail of the CTO and be surprised at some aspects of my response, for example how long the CTO can last for.

they're stuck with it. People think it's been slapped on them and they don't know how or where and they weren't part of it and it's a bit of a concern to say the least. Along with the speed and timing of decision-making, the robust nature of Assertive Outreach work could also preclude active involvement:

They're implemented in a slightly touchy feely way in CMHTs, they're a bit more, 'would you agree to go on a CTO?' But I don't get that feeling here, it's like 'you are going on one because we can't get to see you when you go home, so you're on one'. We are more bullish about it. These are like rough and tough CTOs (laughs). (Care coordinator)

The perceived nature of Assertive Outreach service users meant practitioners often expected service users to be hostile to the CTO and not amenable to discussion: *it's a difficult conversation to have with somebody because it's not something that we expect people to be in agreement with really, so it's more of a 'this is what's going to happen' (Care coordinator)*

Changes in understanding and practitioner intervention

In this sense, a more in-depth discussion could be helpful both for the service user and for the progress of the CTO, particularly in mitigating coercion and encouraging acceptance (Canvin, Bartlett and Pinfold, 2002). I mentioned earlier in the chapter that a question often asked about CTOs is how they might affect the therapeutic relationship between practitioners and service users. A follow-on question is how the relationship service users have with practitioners affects their stance towards the CTO, and this is less straightforward to answer. Although I have talked thus far about service users in terms of positive or ambivalent/negative attitudes towards the CTO, in some ways the CTO is best seen as a process rather than an event, and it is not always helpful to constitute individuals' feelings about it in binary or 'fixed' form. Whilst some service users appeared to maintain a negative or positive stance towards the CTO throughout, others did not. Although those who were more positive about the CTO from the start tended to stay positive, some of the service users who had started from a negative viewpoint shifted over time to a positive perspective. As is discussed here this shift was often due to practitioner influence on service user understanding of the CTO, which in turn changed service user stance and their

subsequent ability to form purposive meaning for the CTO, as described in Chapter Five.

Those participants who started out feeling negative about the CTO before changing their view reported feeling initially quite anxious about how restrictive the CTO would be. For example, Patrick thought at first that *it was quite a drastic thing you know, like house arrest*. As an AMHP described, the semantics of the name ‘community treatment order’ did not help the formation of punitive impressions:

There is a problem with the naming of it for a kick-off, because a community treatment order actually sounds like it is a legal order, it's like a probation order you know? So I think there's an immediate assumption by the patient that this is something that they have to do or be punished for.

Turning points for participants whose view of the CTO had shifted from negative to positive, partly related to the CTO being ‘reframed’ in a more beneficial (and less restrictive) light, and in a way which chimed with their sense of self, identity and place in the world. Irene illustrated how explanation in this broader sense, which went beyond legalistic description of what the CTO meant, could help participants understand it more: *I think if I had had it explained to me more in detail what was it about my life which they felt needed this intervention I could've accepted it more*. Professionals not having a deeper discussion with Irene about the CTO meant she felt unable to make sense out of the role it played in her life.

In contrast to Irene’s experience, a significant event for Nick was a conversation with the community psychiatrist shortly following his discharge from hospital where it had been explained to him that the aim of the CTO was to keep him well, which was a different approach than the hospital psychiatrist had taken, which was to tell him the CTO was being used because he was considered, in Nick’s terms, *a danger*. This discussion appeared to help his change of view: *I thought well I might as well just go to jail. But then I had time to think about it and I thought, well, he's explained why I'm on it and then all ... everything just come to us, and you're not going to get as bad as what you were*. Even though Nick felt he had behaved unacceptably in the past, he still found it difficult to be

described in such a way, and having the CTO explained in 'softer' terms helped him to accept it.

The process of acceptance of the CTO was not only related to changes in understanding sparked through the terms professionals used when explaining the CTO. How service users felt they had been treated by professionals during the decision-making process was also important to attitude change. Sarah felt that she had been 'talked to' in a rather dictatorial, inflexible way by the hospital psychiatrist when placed on her first CTO: *The doctor who put me on the CTO, I'm very wary of him because he didn't seem to take into account anything I said. He seemed to sit there and already have an idea of what he was going to do and he was going to do it regardless.* This CTO had been an especially coercive experience for her, because it also resulted in her being put on medication she had a particularly adverse reaction to: *the first time they put me on an injection with the CTO I begged them not to, I didn't really want it at all, the side effects were really bad.* The way this initial decision was made - informing her after the fact, not allowing her to have any input, and keeping her on medication which she hated due to the side-effects - affected Sarah's ongoing view on the CTO.

In contrast, when Sarah was placed on a CTO a second time, the initial discussion had been more open and she had felt: *It was still out of my control but I was more agreeable to it.* A key difference had been not just discussion about the CTO but also about medication, where Sarah's concerns were listened to and she was given different options. As she said: *There's a very big difference between last time and this time. I didn't really want the injection that time but I found that this one doesn't seem to have the side effects that the last one had so I'm quite happy. It's something to keep me out of hospital, that's the main aim for the team and myself.* Through interviews with Sarah and her care coordinator, it was evident that the current CTO was based on a 'mutuality of accounts' (O'Neill, 1995) developed through ongoing explanation, discussion and reassurance about what the CTO would mean. This interplay between contextual experiences and the way in which the CTO was explained and negotiated by practitioners in the present was a significant aspect of the pathway

a CTO might take. Hence even though there were disagreements about diagnosis and treatment, a joint recovery-focused aim of creating stability for Sarah was emphasised, which made the CTO more acceptable to her. Sarah was an interesting case to follow in that she had experienced two CTOs one after the other and could compare the approaches taken by professionals. It is evident that an approach based on concordance, being informed and involved in decisions, in comparison to the earlier focus on compliance, made a difference to her stance.

However, it should also be noted that for some service users, coming to an acceptance of CTOs was more driven by their own actions, and could be despite practitioners not because of them. In this sense, becoming accepting of the CTO generally involved some movement to shape the CTO in a way which was coherent with participants understanding of it. If we refer back to how participants made sense of the CTO in terms of its purpose in their life, their active engagement with the CTO could shape this meaning-making. James illustrated this iterative process when explaining how he had come to accept the CTO:

Interviewer: And that's how the CTO was explained to you at the time?

James: Well, not-, that's how I explain it; that's how I took it on; that's how I understood it. I started formulating my own ideas about what a CTO meant and what it would do for you.

Interviewer: Right. Okay. So to make it make sense to you.

James: Yes. That's how I got round it.

The telling phrase there of 'getting round' the CTO denotes some activity on James' part. James had shaped the CTO by placing himself at the centre and taking 'ownership'. One particular observation of this was at James' care review where the psychiatrist wondered whether the CTO was a *security blanket* for James, and James after a long pause, carefully responded: *it's like a ring (pointing to his finger). I've made a promise and it was a choice for me to do that.* James did not see the CTO as being 'done' to him, and he demonstrated considerable agency in making the reality of the CTO fit with his conception of it, which revolved around him taking responsibility for his recovery as part of a trusting partnership with professionals.

The key issue for James had been feeling that he lacked control over his medication under the CTO. As mentioned earlier in the chapter he particularly disliked it being administered by his care coordinator, which caused considerable feelings of dissonance for him. In response to this he made a unilateral decision to have his medication given by his GP instead. Here we can see that an element of the CTO which would be ‘taken for granted’ by practitioners as being inherent to how the CTO worked, was viewed very differently by James as being in opposition to how he saw the purpose of the CTO. He explained:

I felt that part of my Community Treatment Order and part of my injections were in conflict because I didn't feel in control of my injections. I was being told you've got to have them. It felt like the responsibility had been taken out of my hands. It was in the hands of the nurses here and the doctors here and I thought, well, that's not fair because my CTO says I've got to be responsible; I've got to be in charge and then, when I went up to the medical centre and they started doing it, I settled down a bit better.

James' creative resolution of the tension between his perception of the CTO and how it was practiced also highlights, as with Sarah, the importance of meaningful medication choice within the CTO framework to support positive outcomes. For James, making this choice was a recovery-orientated step which supported him ‘settling down’ and achieving stability. In this sense, acceptance of the CTO entailed taking some control over the process.

Understanding the CTO process: conditions

The prior section explored service users' initial understanding of the CTO, and how participation, practitioner intercession and service user action could influence such understanding, thus shifting some service users' early negative views on the CTO. This section moves on to consider service users' understanding of the day to day mechanics of the CTO, specifically in relation to their understanding of CTO conditions. I start with an overview of how service users understood (or misunderstood) their conditions with (or without) the help of practitioners. I then explore how service users negotiated the most significant condition for many of them - the requirement to take medication.

Beliefs about conditions

Some participants expressed significant ambiguity about what was expected of them under the CTO and either could not say what their conditions were, or held beliefs about their conditions which were not the case. A broad view of what conditions entailed - particularly around drug and alcohol use - was relatively common among participants and seemed to reflect a belief that the CTO was not just focused on their engagement with services and medication but on other aspects of their life and behaviour as well. Despite these beliefs, case file analysis demonstrated that although conditions might include that individuals see a dual diagnosis worker, none of the participants had specific conditions on abstinence or reduction in substance use as part of their current CTO. Such ambiguity about expectations of behaviour under the CTO meant that service users could feel that they had to watch everything they did, giving the CTO a sense of pervasiveness, as with Ian who admitted: *actually I don't even have a clue what I've got to do but I do everything right in here, go for my medication, don't sleep out, don't take drugs, keep away from women (laughs).*

The perceived encroachment of the CTO into areas beyond its actual legal remit was not only illustrated by participants' views about 'lifestyle' conditions. When participants found the CTO coercive, it tended to manifest in a physical and literal sense for them in the belief that the CTO constrained their movements. Sheila for example held the belief that she would not be allowed to go on holiday, despite her care coordinator explaining this was not the case: *They just said it would mean it was a community order programme and I would be able to do such and such and I wouldn't be able to go away, I wouldn't be able to leave the area.* As a logical follow-on, 'escaping' from the CTO could be viewed as quite a radical step, which Craig described here when asked what he understood by travel restrictions: *Because you're breaking the CTO [by moving], and you're not technically allowed to break it doing anything. But no one can stop you going to Scotland, but if you wanted to emigrate for real you break everything don't you.*

It could be surmised from these accounts that coercive feelings towards the CTO might result in overly restrictive perceptions of how the CTO works. However, it should be noted that the influence of attitude on understanding of how the CTO works was also applicable to service users with more positive attitudes towards the CTO. I mentioned earlier that for some service users, the CTO had become closely correlated with care to the extent that they believed they would no longer receive such care if the CTO was ended, despite reassurance from their care coordinator that this was not the case. All CTOs contain a condition that service users have regular contact with practitioners, and for these service users, the ending of the CTO would also mean the demise of the obligations practitioners held under the CTO. It appears then that regardless of whether the CTO was perceived positively or negatively, its power could lie as equally with the psychological impact it had on service users as much as how it affected their lives in actuality.

As with the CTO as a whole, practitioners could at times reshape service users' interpretation of the 'workings' of the CTO. Revisiting the CTO at different points with service users could help develop shared viewpoints, particularly once service users were more stable. Discussion of concrete aspects of the CTO, such as conditions, could provide practitioners with an 'anchor' around which to base explanation. For some service users, practitioners were able to work with them to clarify CTO conditions. Glenn for example, had been actively involved in working out what he would and would not have to do on the CTO:

We sat down and did a lot of talking about it. Because you want this person to comply you see, so there could then be a split second where I disappear and I'm not taking my meds and I'll go stop in somebody's house say in London or something. I'll go live there. You've got to sit down with them and make sure it's a mutual understanding and agreement.

For others, such as Shelia mentioned above in relation to travel restrictions or those service users who thought their care package would stop if the CTO ended, reassurance by practitioners about the actual nature of their conditions did not change their beliefs. It may be that for those service users, their *general* beliefs about the role of the CTO in their life were so engrained that practitioner intervention could not make any difference to their *specific* beliefs about how the CTO worked.

Getting support from practitioners in order to clearly understand how the CTO worked was not always what participants experienced however. This was particularly the case with conditions around drug and alcohol use, where service user ambiguity around such conditions could be reinforced by practitioners. On the one hand, practitioners expressed the view that the conditions of the CTO had to be clearly understood, because it was unethical to expect an individual to adhere to boundaries otherwise. Having the capacity to understand what the CTO means is not part of the criteria for its use in England. Nevertheless if service users demonstrated little or no ability to understand conditions, the CTO was generally seen as not viable by practitioners. On the other hand not being entirely clear about conditions could be seen as part of making the CTO work for some practitioners, in terms of reinforcing the power of the CTO and mediating certain kinds of behaviour, as this AMHP describes:

I suspect patients are not being told in very clear straightforward terms that while these are conditions, if you breach these conditions, it will actually have no effect in terms of you being recalled back into hospital. If you explain that, then it weakens the order and it weakens the boundaries.

Certainly, observation of interactions between practitioners and service users turned up examples of obfuscation by omission, as shown here in a home visit following the renewal of a CTO:

*Care coordinator: So this is about why you're on a CTO, what happens when you're on a CTO, what happens if you don't keep to the conditions. Though I have to say you don't have many conditions. So can you tell me what they are?
Stuart: Keep taking medication, not smoking cannabis, not drinking heavily and seeing you.*

Care coordinator: And do you know what happens when you don't keep to them?

The practitioner did not go on to explain to Stuart that his conditions did not make any reference to drug or alcohol use. When I asked Stuart later in interview what his conditions were, he replied: *no overly excessive alcohol drinking, no weed and that's about it.* In this sense, service user understanding and subsequent level of certainty about conditions and what would happen if they were broken, was dependent to a certain extent on how definite, clear and honest practitioners were about the process.

Medication and consent

One condition that all participants were clear about was compliance with medication. As inferred in Chapter Five, there could be many complex and interlinking reasons why individuals did or did not adhere to medication, relating to both internal and external drivers. For some participants however, internal drivers to take medication were not as important as the external factors which compelled them to adhere to medication regimes, regardless of how they felt about it. External factors were not limited to ‘straightforward’ compulsion. As has been suggested elsewhere (Monahan et al, 2001), compulsion under legislation is at one end of a spectrum of compliance from persuasion upwards, and communication of various kinds between practitioners and service users was influential in medication adherence.

Nevertheless, participants’ held the view that: *the very strict rule of being on a Section and a CTO is that you conform and comply with medication (Brendan)*. For all but one of the participants this meant medication being administered with a depot injection rather than taking oral medication of their own accord. For a very few participants, such an imposition of control by professionals over medication administration was accepted, as they did not feel able to maintain medication adherence by themselves. For example, Michael explained that when he was floridly psychotic, his mental state meant he had no choice over whether to take medication or not: *when I came out of hospital the doctor confirmed I would be put on a CTO so I could take medication regularly, because I wasn’t able to take oral medication regularly, sometimes the voices wouldn’t give me a chance to take my medication*. However, oral medication was the preferable choice for most participants; being on the depot injection could bring up issues for many participants around privacy, dignity and a lack of control when medication is “‘given’ rather than ‘taken’” (Patel et al, 2011, 1486). In this regard, having medication via injection was the condition that most encapsulated the loss of control the CTO can mean for individuals, as Sarah makes clear:

I think it’s only the injections that make it more control, the fact that you’re given an injection and the patient can’t...because there’s times in the past when I’ve hid the tablet under my tongue and spit it out afterwards, there’s loads of times when I haven’t taken medication. It’s you know, it’s a fact that if someone doesn’t want

to do something they'll try their damndest not to do it. So the injection is the only way that the staff know that the patients get the medication.

This raises a broader point about the nature of consent in the use of CTO conditions. Whilst in legal terms, individuals on a CTO can only be given treatment in the community if they consent to that treatment²⁹, in practice this was much less clear-cut and could highlight the ambiguous nature of the term 'consent'. Irene's understanding of the medication condition for her CTO was expressed in highly coercive terms:

I just realised I was being forced to take medication. I understood that part of it and they were going to come out and see me, and that I had no say in it. So I thought that wherever I was on injections I would be on a community treatment order, whereas if we mutually agreed on a different strategy that would mean I would be off the community treatment order.

Irene did not appear to be aware of her rights under the CTO, specifically that medication could not be 'forced' on her in the community. However, as will be discussed in more depth later, even when recall was not used, the threat of recall meant that such rights could mean little. Subsequently, service users might feel they had very little choice over how they managed medication and that their preferred strategies for coping were removed from them. Sarah had a very ambivalent attitude to medication and in the past had preferred not to be on it, accepting her on average yearly hospitalisations as the price to pay for being able to live medication free *and lose weight and feel healthier*. She did not necessarily see medication as central to her remaining well, as she said: *I think my distorted thinking turns itself round anyway*. Sarah did feel though that the CTO, and the threat of recall, meant she could no longer make choices about whether to accept her medication or not. Being on a CTO might be preferable to a long admission in hospital, but one of the potential consequences of long-term compulsion in the community for individuals like Sarah was the continuing loss of self-efficacy over the path their treatment might take.

Even so, although the psychiatrists observed in discussion with service users at reviews tended to be resistant to requests for changes to oral medication, they

²⁹ The exception being that treatment in the community can occur without consent if the individual is deemed not to have capacity to make treatment decisions.

were more open to trialling reductions in medication, or trying different kinds of medication. Christine was given the choice to try Lithium for the first time by the hospital psychiatrist, and as it worked for her it was written into her conditions with her agreement. This supported her belief that ongoing decisions about her medication were a joint endeavour: *If it needs changing, we'll cross that bridge when we come to it.* It appeared then to make a difference to the service user experience if practitioners elicited service users' views on medication and make clear that some negotiation on medication conditions could be possible from the outset. Moreover, as will be discussed in relation to recall, those participants who said they took medication only because they felt compelled to, also gave accounts of the greyness of compulsion in practice and the ways they acted at times against compulsion.

Understanding the CTO process: recall

Medication was the most tangible manifestation of coercion under the CTO. However, as has been referred to earlier, when participants talked about the CTO as a coercive force in their lives, it was in psychological as well as experiential terms. Participants who were ambivalent or negative about the CTO were especially fearful of 'quick and easy' recalls to hospital even if they had not experienced recall whilst on the CTO³⁰. Holding a firm belief that they could be recalled at any time, but at the same time not knowing what would cause them to be recalled, caused participants considerable anxiety. Hence, the coercive impact of the CTO was not necessarily related to the active use of compulsion, but about more incorporeal effects, specifically in relation to feelings of powerlessness and loss of control over what *might* occur. In this section I thus explore service user beliefs about recall, and the emotions such beliefs could cause. As I have suggested throughout this chapter, practitioners could play a part in mediating service user understanding, and so I then move onto a discussion of interaction in relation to recall. As I have also inferred throughout, many service users did not passively allow practitioners to act upon them; they could be an active partner in coming to terms with the CTO, and at times took the lead in shaping the path the

³⁰ Five of the eighteen service users in the study had experienced recall either during this or previous CTOs.

CTO would take. Service users' beliefs about the boundaries of the CTO and their responses to practitioner mediation of the CTO did not necessarily limit their attempts to negotiate the CTO on their own terms. Returning full circle to the beginning of this chapter, whether service users pushed the boundaries of the CTO or not was related to their understanding of and trust in authority, and an associated sense of agency. Accordingly, in the final part of this section (and this chapter) I outline how such actions materialised.

Beliefs about recall

If participants believed that they could be recalled at any time regardless of their mental state, then this would mean they also believed it could happen for no discernible reason. Patrick's belief that the recall process could be evoked at the whim of practitioners was grounded in his understanding that he could be taken back to hospital on ill-defined grounds: *I don't really understand the CTO ... I know if I do anything they think is wrong I'm straight back in there. I can't afford to take chances like that.* Such fear could also be dependent on previous experiences of hospitalisation, as illustrated by a conversation I had with a care coordinator about a recall he had just instigated:

Care Coordinator: Well Bob has been picked up by the police

Me: Was he at home?

Care Coordinator: He must have just got the recall letter because he rang up sounding absolutely terrified saying he'd be in until 1pm, but no one was here to take his phone call

Me: Why do you think he was so frightened?

Care Coordinator: He's been in hospital five or six years, he doesn't want to go back in. I don't think he understands that it's only recall for treatment. I think he thinks he'll be taken in for another five or six years.

Extreme anxiety could lead to avoidance tactics; when recall did occur, service users who were particularly anxious sometimes absconded. Craig disappeared for a number of days when he was issued with a recall and told practitioners he would: *rather commit suicide than go back to hospital (case note).*

Conversely, participants who were more positive about the CTO expressed an optimistic view of the recall process, which related back to their underlying sense of trust in practitioners. Gwen, who perhaps had the most 'passive' stance

towards the CTO out of all the participants, felt that with recall: *You'd have to listen to them because they're professionals. So, I would be quite happy to go back again.* Similarly, Brendon held the belief that he would not be recalled unless it was deemed absolutely necessary: *But I don't really see any reasons why I would get recalled back to hospital so it's hard to really tell you how I would feel...But if I was, there would have to be a good, solid, strong reason behind it.* For Brendon, the aim of the CTO was to keep him out of hospital and he trusted practitioners to keep to that aim, so the recall part of the CTO held the least personal relevance for him. Brendon's account highlights that the key mechanism of the CTO – recall - which gives the CTO its structure and which is aimed at ensuring behavioural compliance, may not be of particular importance to individuals who accept the CTO, and in their view, may not be the element that makes the CTO 'work' for them, dependent on what purpose they see the CTO holding. As concluded in the previous two chapters, the very value of the CTO for practitioners and service users alike could lie in not putting it to use.

However, as also discussed there, recall could also be seen by service users as one of the main benefits of the CTO in ensuring quick treatment. Such participants tended to express the view that recall had a particular remit. Recall is limited to a 72 hour period, and a common response in interviews with those participants was that they believed recall was intended to stabilise the situation before a quick discharge back into the community. None of the participants who expressed this view considered that recall might lead to a longer stay in hospital through the CTO being revoked, as Glenn explains: *it's not going to be forever is it. It's not as though I'm going to spend another three and a half years in hospital, it just remind you a bit...It's just to get everything sorted out and get back out again.* Consequently, participants generally varied between those who thought they would only be recalled only if they started to become very psychotic, as with Stuart who said to be recalled he would have to: *think the TV were watching me again or something, or saying something to the staff, like if I started talking psychobabbly bullshit,* and those who believed that they would be recalled at any time if they did not 'stick to the rules'.

Interaction and action in the recall process

Similarly to conditions, such beliefs were mediated to a certain extent by practitioner description of when recall would happen, which could range from dichotomous to more nuanced explanations. Observations of explanations of recall suggest that practitioners tended to try and manage service user anxiety with a mixture of levity and reassurance, as seen at Christine's review:

AMHP: So does the CTO make any difference to you?

Christine: Oh yeah, I'd be much freer without it. I wouldn't be looking over my shoulder all the time.

AMHP: Do you understand the CTO doesn't make any difference to if you come back into hospital? It's only if your mental health deteriorates that you will have to come back in. We can't just come and go [clicks fingers], you're in.

Christine: Yeah, yeah...I'd just feel better if it was lifted

Psychiatrist: Why is that Christine?

Christine: Because I've always got that fear about someone banging on the door.

This exchange was typical of other interactions I observed, where practitioners would reassure service users that the CTO should act like an *insurance policy*, in that recall would not be used unless needed. It should be noted however that as will be discussed in the next chapter, practitioners themselves did not always have a clear handle on when to use recall or not. Indeed the actual use of recall did not always match such explanations. It can be imagined that incongruence between explanation and action is likely to fuel uncertainty and anxiety rather than assuage them. Hence, service users' responses to practitioner reassurance were variable, and as pointed out in the section above, pre-existing trust in practitioners and the system played a large part in how they approached recall. In Christine's case, she had experienced recall before and so such reassurance did not change her fear of the possibility of recall. At the other end of the spectrum from reassurance, in order to try and instigate compliance practitioners could use the threat of recall even if it were not likely to occur. For example, Andrew rarely came to reviews with his psychiatrist but would meet with his care coordinator and take his medication. At the review I observed, the psychiatrist pointed out: *The other thing about your order is that you need to see a psychiatrist, and you haven't seen me have you? You've seen me once since you left hospital. Now if you're not keeping to your conditions, that means I would have to see if you have to be back in hospital.*

Even though the belief that recall would happen if conditions were broken was common, the level of latitude participants displayed within that remit demonstrated subtle yet significant differences in the amount of power they felt they had in the process. Service users could know which boundaries they might and might not push; in relation to drug/alcohol use, even when individuals erroneously thought that abstinence was a condition of the CTO, it seemed unlikely to stop or limit their substance use. But finding ways around the CTO could also occur in relation to medication. As stated earlier participants understood medication conditions to be absolute, but they could also demonstrate some control over their medication intake. In this sense, a tension between choice and control underpinned participant narratives on medication. Simon described how even on the CTO he sometimes missed his appointments for medication, so that, *the CTO doesn't affect when I get my depot. It just means that if I turn around and say 'No I am not going to take it full stop', then they can section us and give us it.* Conversely, the only way other participants felt they could take some control over medication was to force the hand of professionals, as in Graham's account when he described how his medication regime was changed:

Interviewer: So you got your medication changed recently?

Graham: Yeah, I took myself off Risperidone and got recalled.

Interviewer: Oh is that how it happened?

Graham: Yes, I wanted a different tablet, different dose of medicine.

In situations where medication was not being negotiated, acts like Graham's where recall was manipulated to meet his medication needs can be seen as a way of regaining some proximal integrity.

Moreover, service users at times 'played the CTO game' in order to meet other goals, with varying success. This involved triggering recalls through non-compliance as a way of getting access to hospital for respite in the absence of other alternatives, or as an escape from social pressures. Whilst practitioners did not always respond as service users hoped to these actions, attempts to subvert the recall process could still undermine the efficacy of the CTO by creating uncertainty for practitioners about when recall was 'truly' needed. It should be noted however that service users' demonstrating agency was not necessarily

about taking action, but could also be about *not* taking action in order to regain some sense of control over their lives. For some service users, protesting against the CTO was seen as hopeless, and passivity resulted from resignation. For others, a passive response was a way of subverting practitioners' expectations for the CTO. A few participants described how they did everything they needed to for the CTO without complaint so as to not trigger use of recall, but without opening up to practitioners or engaging in any deep sense with what practitioners wanted regards internal change and motivation. Surface compliance and 'doing the right things' whilst at the same time not losing sight of their own goal (discharge) was seen as a way of gaining control without losing integrity. Sarah described this in relation to the first CTO she was placed on:

No I was complying, although I really didn't want to. I was very unhappy about that decision but I wasn't fighting it. I know some people try to avoid the person coming to give them the medication and all sorts of things but I wasn't doing anything to avoid it. So...because I was complying they saw no need to have the CTO, you know compulsory, so in the end they decided to take me off it.

Finally, it should be noted that outright resistance in the face of recall was also the route taken by some service users. As discussed earlier, negative attitudes towards the CTO could exacerbate poor relationships and distrust between service users and services/practitioners. This was certainly the case for Craig, where the CTO prompted a breakdown in engagement with services. As his care coordinator told me:

It completely wrecked any trust he had in mental health services and his whole focus and his whole interaction with mental health services became about the CTO rather than him recovering, rather than him getting well and getting on with his life. It just became a personal crusade and a battle and I think that's the same with a lot of clients really.

Craig would avoid appointments and medication which in turn triggered recall, from which Craig would run away, thus causing a drawn-out process involving his family, mental health services and the police. In Craig's view, this was the only option he had in terms of engaging with the CTO. Although Craig's motivation in such actions was to manage his anxiety about hospital admission, a side-effect was that continued recalls followed by lengthy searches for him when he went missing could cause significant strain on services.

Dawson et al (2003, 253) suggest that the CTO has the capacity to “both advance and limit [an individual’s] freedom, in different respects and at different times in their lives”. This complex and fluctuating interaction between compulsion - as characterised by the CTO - and freedom was certainly reflected in participant accounts. The CTO is a compulsory measure, but how much room for manoeuvre participants believed they had within the CTO varied, both individually and in relation to different aspects of the CTO.

Concluding thoughts

In this chapter, I have discussed how CTOs are experienced and negotiated by service users. Three main conclusions can be drawn from these findings. The *first* conclusion relates to the nature of service users’ understanding of the CTO. Service users’ feelings and beliefs about the CTO in general filtered down to how they understood and experienced it in their daily lives. Particularly if the view is taken that CTOs act as an ‘insurance policy’ - being present in the background but not used unless necessary - it can be argued, and indeed was by some practitioners, that CTOs have very little concrete effect on individuals. However, this disregards the central place of medication in service users lives. Furthermore, what these findings suggest is that coercion is not necessarily linked to the ‘concrete’ manifestations of compulsion. As demonstrated by some service users’ understanding of what their conditions entailed, and when and why recall would happen, the CTO has the potential for potent psychological effects, causing feelings of restriction, insecurity and anxiety. At the same time, it would be wrong to say that the psychological implications of CTOs were necessarily correlated with negative beliefs about the CTO. Attitude and understanding were interlinked and mutually reinforcing, and this was also true for those service users who had accepted the CTO as a signifier of care.

The *second* conclusion relates to the practitioner-service user relationship as a mediating factor in the CTO. Service users were not as involved as they could be with the initial stages of the CTO and this lack of involvement can influence their on-going attitude to the CTO. For those service users who were actively involved in decision-making and where time was spent explaining the CTO in

terms that chimed with their sense of self, feelings of coercion could be mitigated. Furthermore, it seems that when practitioners were willing to negotiate on aspects of the CTO, particularly regards medication, and work with service users to create a sense of mutual enterprise, the CTO could be ‘reframed’ in positive terms. It seems that the earlier this relational work took place, the more likely it was to have an effect. Earlier intervention about the CTO as a whole could help reshape its meaning, but reassurance further down the line about specific aspects such as conditions and recall could be more variable in its effects, particularly with service users who had engrained beliefs about the CTO as a whole. It should also be acknowledged however that practitioners’ could reinforce coercion during the course of the CTO through what they did or did not tell service users about how conditions and recall worked, and how clear and honest they were. It appeared then that what supports more positive CTO experiences is not necessarily direct mitigation of the CTO itself, but the relational context it resides within. The practitioner-service user relationship did not only influence the CTO; there was a simultaneous process whereby the CTO could influence pre-existing dynamics between practitioners and service users. As noted particularly in relation to recall, beliefs on practitioner expertise, motivation and the consequent level of trust service users felt towards practitioners, could trickle down into how they understood the CTO. Conversely, the presence of the CTO could magnify such beliefs about practitioners, thus engraining relationships of trust or distrust.

This leads us on to the final and *third* conclusion – the varying ways that service users displayed agency towards the CTO. As referred to throughout this chapter, despite the powerlessness expressed by some service users, they could act on the CTO in a variety of ways in order to gain a sense of control, relating to either acceptance, rejection or subversion of the CTO and its ends and means. As noted above, acceptance of the CTO involved mutual work on the part of service users and practitioners – a co-construction of a good relationship within compulsion and a shared narrative of the aims for the CTO. However, active acceptance was not only about acting in response to practitioner instigation. As described, it could also be a process very much led by the service user, as a way of making the practice of the CTO conform to what they saw as its purpose. Alternatively, for

service users who actively resisted both any purpose for the CTO and how it was operationalised, it became a point of conflict characterised by cyclical power struggles, particularly regards adherence to CTO conditions and the use of recall. Subversion of the CTO can be seen as somewhere in between rejection and acceptance, in that it involved service users turning the CTO against itself in order to reach their own ends, which did not correlate with practitioner aims. All three of these approaches have been described thus far in terms of action, but as stated in the chapter, service users also used more passive tactics relating to avoidance of deeper engagement in order to negotiate the CTO on their own terms as much as they felt they could. This in itself could be seen as a form of subversion. All three stances - acceptance, rejection and subversion - have implications for CTO practice and caused dilemmas for practitioners, both in terms of everyday CTO use and the shaping of discharge outcomes. It is the practitioner perspective on the day to day use of CTOs I turn to now, where amongst other things these dilemmas will be discussed in more detail.

Chapter Eight

Putting CTOs into action: Practitioners' experiences of their use

In drawing out service users' experiences of the CTO in practice, the focus was very much on their individual journey through the CTO process, where I explored their responses, actions and interactions within each of its stages, and how these personal and relational elements might shape the path the CTO takes. This chapter turns to practitioners' experiences of CTO practice, and although I use the same structure – moving through discharge to the use of conditions and recall – the ground I cover is more varied. The focus here is on how practitioners make use of the CTO, and the various factors that impinge on that use through the different phases of the CTO. Hence, whilst I provide the 'other side' of the story to the last chapter by detailing how practitioners dealt with the ethical challenges of the CTO, and went about relational work within its bounds, I also weave in the influence of other contextual and systemic factors. These include the effects on CTO practice of: team dynamics, the relationship between inpatient and community services, the role of other agencies in the CTO process, and resource issues. I also draw attention at various points to the roles different practitioners take in implementing the CTO, and how this affected the way they approached the CTO, specifically in relation to AMHP work and the differentiation between psychiatrists and other members of the team.

In the first section I cover the discharge process and how decisions to impose a CTO are made. There are various formal and informal actors involved in this decision-making and I elucidate how these actors engage with each other to come to the CTO. In doing so, I also refer to the constraints and institutional framework practitioners operate within, and the potential implications of these for how the CTO is embarked upon and subsequently unfolds. In the latter two sections of the chapter I explore how practitioners' both interpret and use conditions and recall, with emphasis placed on how practitioners variably negotiate practical-ethical challenges and dilemmas throughout the CTO process. Although emphasis is again placed on practitioner action and interaction with other actors in context, I also highlight how the internal logic of the CTO may

encourage particular defensive patterns of practice which could be at odds with practitioners views on how it ‘should’ be used. I end the chapter with a consideration of cases where the activation of the CTO might not be possible, which raises questions about its potential limitations.

The practitioner perspective on discharge from hospital onto the CTO

As highlighted in the last chapter, discharge onto the CTO could sometimes be experienced as a rushed and unplanned event by service users. In an echo of practitioner concerns around CTOs being introduced as a form of resource management, practitioners expressed similar discomfort about how discharges were handled. In one of the Trusts there were frequent disagreements about discharge decisions, with the community team often believing individuals needed more time in hospital whilst the inpatient team were keen to discharge. This tension is not uncommon in mental health services when it comes to discharge more generally, especially with current pressures on beds, but similar to previous research (Stroud, Doughty and Banks, 2013) the addition of the CTO sharpened the view that better planning was needed. This section explores the process of discharge onto the CTO with these issues in mind. Specifically I examine how decision-making on CTO discharge took place, and the interpersonal and systemic factors which influenced that decision-making.

Discharge decisions onto the CTO are relatively complex, involving a number of actors, both formal and informal. The formal decision-makers – the ones who sign off the CTO and decide its details – are the inpatient psychiatrist and the AMHP. Therefore, I firstly give an account of AMHPs experiences of CTO discharge, focusing on the difficulties unplanned CTOs could engender for them. Whilst the inpatient psychiatrist and an AMHP formally decide on the CTO, the community team who oversee the everyday care of service users have an important informal role in directing decision-making. Consequently, I follow on by exploring the role of team dynamics in shaping whether CTOs were advocated for or not by the community team. In the final part of this section, I give an account of the interaction between community and inpatient services in shared decision-making on the CTO, the systemic factors that could cause

communication breakdowns and the potential outcomes when shared decision-making did not occur. I particularly pick up here a major theme developed in the last chapter on the implications of the CTO for practitioner-service user relationships.

The role of AMHPs in discharge onto the CTO

Rushed discharges often meant last minute CTOs, with little time given for planning. As second decision-makers who have to agree the CTO with the inpatient psychiatrist, AMHPs could find last minute CTOs particularly difficult to manage. The AMHPs spoken to felt there could often be an expectation that they ‘rubber-stamped’ CTOs as a matter of routine, particularly if they were called in to sign a CTO off on the day of discharge, as described here:

Generally, things have got better but I still think the involvement of the AMHP is quite tokenistic. And I still think a lot of consultants have seen the involvement of the AMHP as just sort of a paper exercise, something to jump through. I've heard lots of AMHPs complain about that as an issue, where they've been asked to attend on the day and the CTO is pretty much signed, sealed and delivered, bar their signature.

In both Trusts, AMHPs had ‘pushed back’ against this practice, asking for time to hold a planning meeting and to speak to the individual, their family and the professionals involved in their care. Generally it was recognised, as discussed in the last chapter, that starting service users out on a well-informed footing would help the progress of the CTO in the longer-term. For AMHPs, refusing to attend last minute and ‘holding things up’ could be an uncomfortable position to be in however, especially if the service user was pushing for discharge as well. More generally, whilst all the AMHPs emphasised their independence and the responsibility they had to consider the CTO ‘in the round’, none of them recalled ever disagreeing to a CTO. The momentum of discharge was part of the reason why CTOs had a certain inevitability, but the broad legal criteria for CTOs also made them difficult to oppose:

An AMHP goes in independently to look at a CTO, but often the criteria really to fit them, it can be applied to pretty much anyone and it's difficult because if you've got a weight of evidence from a number of people it's quite hard to be a lone professional and say, ‘well let's take that risk’. (AMHP Lead)

This is a particularly important point to consider given that it has been suggested that social workers (as most AMHPs are) can act as a counter to the over-use of CTOs (George, 2011). Where AMHPs saw their role as having importance was more in deciding the detail of the CTO, particularly the conditions that were placed on a CTO, which will be returned to later.

The influence of team culture on discharge

Whilst the AMHP and the inpatient psychiatrist were the formal decision-makers on the CTO, the community team played a key informal role, as they would be the ones making a CTO work once in place. Team dynamics within community teams were thus an important factor in the decision on whether to put in place a CTO. This was particularly in regards to the relationship between the community team psychiatrist and care coordinators. In one of the Trusts, I conducted comparative interviews within an AOT in a different area of the Trust where the numbers of CTOs in operation were much lower, to see what had made the difference. One clear factor was that the whole team, including the Manager and the psychiatrist, agreed that CTOs should only be used in very limited circumstances, which meant that they did not tend to advocate for CTOs and indeed would decline them, as the Manager explains here: *almost any time any of our people are admitted on a section, the inpatient consultants are suggesting discharging them on a CTO. But 9 times out of 10 we're saying no.* This contrasted with the AOT where I was mostly based in that Trust, which had a large number of CTOs; the psychiatrist there was very keen on CTOs and would take the lead in arguing for them, which some of the care coordinators could at times find problematic, as this one told me: *He loves them, he loves them. It's quite easy to recall. Plus it's protecting him just in case something goes wrong. Do you know what I mean? He's using it for protecting the public, protecting him and his professional practice.*

Conversely, in the other Trust where field work was carried out, the psychiatrist in that team was much less active in pursuing CTOs, which could also cause frustration for care coordinators who saw the need for them. Consequently, those

care coordinators were more instrumental in asking for and securing CTOs, as the psychiatrist explained:

My personal feeling is that some care coordinators are usually too risk averse in my view really about the CTO. I must say very clearly I'm not a huge fan of CTOs anyway, I think they're too bureaucratic. So I see care coordinators to be usually more cautious in pushing for CTOs, possibly for good reason, they know the patients more than I do.

In this case, the care coordinators were more likely to take the view 'better be safe than sorry' than the psychiatrist. Thus the decision to advocate for a CTO relied to a great extent on the dispositions, influence and interactions of the different actors involved. As this latter case in particular demonstrates, the psychiatrist was not always at the forefront or the driver of such decision-making. Further, these team dynamics continued into how CTOs were used once they were in place, a point that will be picked up in the discussion of recall.

Shared decision-making

Shared decisions across inpatient and community services tended to be the norm, whereby the community team would lead in advocating for the CTO and the inpatient psychiatrist and AMHP would agree to it on that basis. As noted above it was often the care coordinator – as the person who knew the service user the best in the community - who would make the initial suggestion for the CTO (or indeed argued against the CTO) and who carried the decision through different forums. One care coordinator explained their role as being at the crux of decisions: *So, if the AMHP asks us, 'no I don't think they should be on a CTO', if the psychiatrist asks us, 'I don't think they should be on a CTO'. And the likelihood is by me saying that they probably wouldn't.*

The involvement of the community team was not always clear-cut however. In both Trusts where the field work took place, a functional split between inpatient and community psychiatrists had been introduced recently following policy reform. Consequently, instead of having a 'patch' psychiatrist who would oversee the care of individuals within a geographical area both in and out of hospital, responsibility was transferred from an inpatient psychiatrist to a community psychiatrist on discharge. This could sometimes lead to breakdowns

in communication between inpatient and community teams and tensions in responsibility, with a lack of joint planning in discharge/CTO decisions. As mentioned earlier, practitioners could feel that inpatient teams discharged service users onto CTOs without enough time to plan. A widely held concern was that the outcome of such fast discharges on CTOs would be exacerbated revolving door scenarios, whereby the service user would quickly return to hospital on recall because they were not ready to be in the community.

The two other main outcomes of fragmented decision-making observed in the field sites were: inpatient teams overseeing discharges without the community teams knowledge and without authorising a CTO when the community team had been advocating for a CTO; or the reverse situation where the inpatient psychiatrist made the CTO against the opinion of the community team. In the latter case, one psychiatrist told me that he had refused to have a CTO transferred to him because he felt that it was unnecessary:

We had one person, who was being discharged and inpatients wanted to put on a CTO. I just didn't see the need for it, the team didn't think it necessary and we fed that back, but they still went ahead with the CTO. There was no risk, no risk at all. The CTO is to manage risk. In the end I refused to take him on under a CTO and the inpatient consultant had to keep him on in the community for 6 months. As soon as he was handed over to me I discharged the CTO. It's funny because usually I'm all for CTOs, but this time I was really strongly against it.

Discharge onto the CTO against the advice of the community team was not only disapproved of because it was seen as unnecessary; it was also challenging for practitioners because it could make post-discharge care difficult. In the last chapter I discussed how the CTO could cause or exacerbate relationship breakdowns; not involving community practitioners who knew the service user well in the discharge decision could make such an outcome more likely. This was because - as was mentioned in Chapter Six - one of the ethical 'balancing acts' practitioners carried out was whether the benefit of the CTO would outweigh damage to their relationship with individual service users, based on what they knew about how different service users responded to compulsion. Here it seems that process – whereby practitioners might recommend a CTO not be used – could be bypassed. Indeed, one care coordinator talked to me about a

woman with whom she had worked for years, who had been placed on a CTO against the care coordinators advice, and the damage she felt it had caused:

The recommendation from the consultant was she would go home on the CTO, and I said to them 'I don't think she needs the CTO, I'm sure I'd be able to deal with it' but I think because she was still very poorly... Well I knew she would accept medication off me, I knew she would. I thought 'oh god she's going to hate this, this is just going to throw such a spanner in the works'. And it was horrendous - 'I don't want you in my house' - you know this was such a long relationship that had completely broken down. The relationship just went completely and utterly downhill, and it was really difficult. It was quite traumatic for me as well because it really did upset me. It took every skill I had to get her to come round really, and she's only just warming and it's been over a year. I don't feel that we've got the same rapport at all, I think it's completely broken, we're just playing at being nice to each other, that's how it feels to me.

It is worth noting here the emotional investment practitioners sometimes made in their work with service users, which meant relationship breakdowns such as this could be experienced as extremely difficult. In a sense collaborative work on the CTO, with mutual goals agreed to, could therefore be for the benefit of practitioners as well as service users. In the last chapter, I observed that service user accounts of interactions with practitioners demonstrated that practitioners often attempted to build a therapeutic relationship with them within (and sometimes despite) compulsion. I expand on how practitioners went about this in the next section on the use of CTO conditions.

Practitioners' use of conditions

As with the initial decision to use the CTO, the legal criteria for imposing CTO conditions are broad, which means professionals have a great deal of latitude in deciding what conditions to include. Despite this, it became evident during the field work that practitioners were typically careful about what conditions they included, and used their discretion within particular boundaries. Similarly to findings elsewhere (Lepping and Malik, 2013, Smith, Branton and Cardno, 2014), the three main conditions placed on service users in this study were variations on: adherence to medication, attendance at care reviews and consultant appointments, and allowing access to members of the care team. Four out of the eighteen service users also had attendance at appointments with substance misuse/dual diagnosis workers included in their conditions, although as already

stated in the previous chapter none had abstinence from drug/alcohol use as a condition. The other condition that has been reported as sometimes used is to reside at a particular address, but this was also not present for any of the service users here. There were three aspects to practitioners' boundary-setting when they considered conditions: lawfulness, feasibility and ethicality, and these are discussed first. As I note, formulating 'ethical' conditions also involves considerable work with service users in order to make the conditions acceptable, and I next consider the relational work practitioners do with service users within the remit of the CTO. Such relational work has limits however, and I conclude this section by describing how practitioners handled medication compliance as part of the CTO.

Lawfulness, feasibility and ethicality

In regards to lawfulness, the AMHPs in particular had a view on human rights and possible challenges that could be made to conditions. This caused some uncertainty about what conditions could and could not be included. For example, even though residency can be and is used as a CTO condition, there was some debate and uncertainty about it in the field sites, even among AMHPs: *I'm not sure how lawful they would be if you put that as a condition that you would reside at a particular residential home or...so I don't actually see how they could do that. I'm not sure if the CQC would be keen on that.* Through talking to AMHPs and the AMHP Leads in the two Trusts, it seems that there had been a 'bedding in' period where a greater range of conditions had been attached to CTOs, but this had changed over time:

I think initially there was quite a lot of anxiety with it being a new piece of legislation. There were teething problems with certainly a lot of inappropriate conditions that AMHPs were being asked to look at. Which were almost if you had signed up to those you'd be looking at a breach of article 8 rights to be honest, a lot of them were really highly intrusive (AMHP Lead).

Subsequently, as second decision-makers, whilst they rarely disagreed with the imposition of a CTO in itself, the majority of the AMHPs talked about sometimes having to play a mitigating role in countering the more 'extreme' conditions that might be suggested by inpatient psychiatrists.

In making those arguments, AMHPs relied more on questions of feasibility rather than legality however. In Julie's hospital discharge meeting, the psychiatrist was planning on including drug/alcohol abstinence as a condition, at which point the AMHP intervened: *there's no point putting anything about drugs or alcohol, we're just setting her up to fail and she'll never get out of here otherwise.* This point about 'setting individuals up to fail' was a broadly held one; conditions which service users could not be expected to keep to might result in continuous breach of the CTO and subsequently risked repeated hospital admissions. At the same time, including 'unworkable' conditions which admission to hospital would do little to rectify also risked rendering the CTO meaningless and 'toothless', as highlighted in Nick's case notes:

Nick is subject to a CTO which originally included a condition on abstinence from illicit drug use, but this was removed by his psychiatrist due to the difficulties in enforcement and that recall to hospital could not occur as treatment for his illicit use cannot be provided on an acute inpatient bed.

As seen here, the community psychiatrist could act in a similar mitigating way as AMHPs sometimes did, by modifying the conditions that the inpatient psychiatrist had initially put in place. For two of the service users involved in this study, Nick and Simon, this had resulted in the community psychiatrist altering the conditions 'after the fact', thus tailoring the CTO as it progressed.

Making CTOs feasible was closely connected to making them ethical – a kind of 'practical ethics'. Conditions were separated into 'hard' conditions which are easily monitored and enforceable (such as seeing professionals and medication) and 'soft' conditions which are not (such as abstinence from drug/alcohol use and attendance at talking therapy). 'Soft' conditions were viewed as unusable not just because they were unenforceable, but also because of practitioners' expressed beliefs about when and where individuals should be 'allowed' choices in how they lived their lives. Such beliefs could be related to perceptions of social norms, in particular regard to personal autonomy³¹:

I know that using cannabis is illegal but lots of people do it you know, and would the police be allowed to use the same power if you didn't have a mental illness,

³¹ It is interesting however that there exists a contradiction between this ethical stance on 'soft' conditions and how, as discussed in the previous chapter, practitioners did not always correct service users' beliefs about the existence of such conditions in order to try and manage what was perceived as errant behaviour.

say 'right that's it now, we're sick of arresting you for smoking cannabis and we're going to lock you away'? They're not allowed to do it, so why because you've got a mental illness? (Care coordinator)

Similarly, practitioners broadly held the view that service users had a 'right' not to take part in talking therapies and forms of social rehabilitation in a way that did not hold true for medication. Therapeutic and social activities consequently did not feature in CTO conditions in the field sites, as if the service user was amenable to such interventions then it was viewed outside the compulsory remit of the CTO, and if service users did not want to take part, practitioners did not feel comfortable or able to 'make' them. Service user groups have raised concerns that CTOs could limit professional involvement with service users to medication and negate other forms of treatment. It was certainly the case in the field sites that talking therapies for example could be hard to access; in four of the appeals I observed, practitioners were asked by panel members why talking therapy was not included in the broader care plan and were told that suitable therapy was not available for those service users. However, it was also the case that practitioners responded to service user concerns around intervention, by limiting conditions to the 'bare minimum' of medication and access, as this care coordinator explains: *it almost feels like maybe you're giving people all these conditions to live, it just doesn't feel very human.*

Even in relation to the 'hard' condition of allowing access to practitioners, there were a number of occasions where practitioners described negotiating how such access would be enacted, to allow for ethical acceptability for the practitioner and to try and respect service user preferences within the boundaries of compulsion. A quote that sums this up is taken from a care coordinator discussing a particularly difficult case where she had struggled to form a good working relationship with the service user:

There's a requirement that we see him weekly but it's not specific that he engages. We've agreed in the care plan that if he doesn't turn up every second appointment, we can more assertively chase him. He doesn't like to see professionals at his home so we agreed to meet him in a city centre cafe which was more agreeable to him, because we didn't think it would be ethical or a good way to engage him, to insist to use the CTO to see him in his own home.

The conditions of CTOs tend to be set out very definitively and briefly; what this example suggests is that there is a lot of ‘behind the scenes’ work in both making conditions feasible, and in making them acceptable, particularly in ensuring the care plan provides contextual guidance for the CTO. As a psychiatrist noted, such an approach was not only about ethical practice, but also about making the whole CTO viable: *that's the sort of things that need to be done to make the CTO work, redesign the conditions to fit that patient better somehow.*

Relational work within CTO conditions

Reaching a point of ethical equilibrium on the CTO was therefore often correlated with being able to maintain some kind of working relationship with the service users who were on them. As noted above, this might be achieved through flexibility and compromise on the specifics of access via the CTO. Practitioners also talked about a number of other ways they mitigated the potentially coercive effects of visits under the CTO conditions, which could be resented as intrusive by service users. Practitioners described in a general sense how they drew on their personal attributes in order to make these visits a more affirmative experience. A care coordinator explained how she had done this with Irene:

Irene did allow me to visit, but it had to be very tentative. She didn't want me mentioning medication, she didn't want me mentioning illness and it was more about building relationships so...I gradually built up a relationship with her over maybe 6 months or so and it started to get easier. It becomes more of an interpersonal thing rather than ‘I must comply, I must attend the reviews, I must do this’. Maybe when it becomes seeing me as a person it's more, ‘Rebecca is coming, that's okay because I know her’, rather than an agent of the hospital is coming to check up on me and get me if I don't comply.

The care coordinator’s focus on her relationship with Irene, rather than the expectations present in the CTO, and the taking of a slow, consistent approach, seemed to have enabled Irene to separate out the care coordinator from the compulsory framework the visits were occurring within.

Alongside this general relationship-building, practitioners talked about trying to keep the CTO positive, by providing hope and being optimistic about change. Such an approach chimed with what service users reported in the last chapter on

how practitioners could ‘reframe’ the CTO. This could take the form of therapeutic work, looking backwards and forwards to review where the individual had been and wanted to be, as this practitioner described:

You can't change the CTO but you can work through it. You can reflect back with them and get them to understand the reasons you've had to do that. It's about how you use the CTO in a bigger sense, it's not how you use it at a time of crisis. When they're well you can start to introduce things like 'what do you think happened there?', 'how could we change that in the future?', so that there's a longer-term process to becoming well. It's about putting things in place so it's not a forever sanction. (Care coordinator)

As demonstrated here, the CTO could be used as a starting point for this kind of conversation. In this sense, and as noted in Chapter Six, it was not simply or only the case that practitioners used relational means to ‘work around’ the CTO. As reported elsewhere (Romans et al, 2004), the strictures of the CTO could also encourage constructive engagement. The necessity of regular visits as set out in CTO conditions had the potential to ‘kick-start’ relationships by providing a structure and boundaries to work within. Michael’s care coordinator commented on how this had worked for him, who prior to the CTO had avoided contact with services:

I think it's given us the space to work with him, to see if we can overcome his resistance. It's about building that relationship up where you can actually challenge in a gentle way, it doesn't have to be confrontational. The CTO can be a good starting point because the clarity and the consistency are there.

More specifically, the conditions – and explaining why service users had to adhere to them - could give practitioners a ‘way in’ to conversations about risk, which they might otherwise struggle to have, thus supporting collaborative working on risk management:

Stuart understands that the reason he's on the CTO is because he's considered to be a higher risk...with lots of our clients, obviously we talk about recovery and we talk about meeting their needs and maintaining their independence and that's what you'd rather be talking to people about. But the CTO it allows you to have more conversations about risk as well, about people's offence, about their risk triggers. (Care coordinator)

‘Routinised’ practice via the CTO in the form of conditions, could therefore encourage as well as discourage engagement with service users. In this case, relational and risk focused work reinforced each other, rather than being in

opposition. Whilst practitioners were sceptical about the CTO enabling effective monitoring of risk, it was still felt that using the CTO as a tool to get service users to talk more openly about the struggles they were having would help signal if difficulties were ahead.

It was also the case that – as discussed in the previous chapter – some service users tried to maintain control over the CTO and their lives more broadly by choosing to restrict their relationship with practitioners as much as they were able, thus meaning that practitioners could not get beyond a superficial connection. Ian’s care coordinator explained how this limited what meaningful contact he could have with Ian:

Because he doesn't want to engage, he's concordant in the very narrowest sense of the word. He knows that he's adhering to the conditions of the CTO by having his depot and engaging, it's seen as though he is engaging with the staff, because he's seen them. I don't think we do much more than monitor him and make sure he takes medication, but I think that's what he wants.

A focus on monitoring and risk management in practitioner visits could therefore be shaped by the service user as well as by the CTO regime, and suggests that risk-focused practice is not always shaped from ‘above’ and in this sense is not clear-cut. In contrast to the example of collaborative risk management given earlier, only being able to act in a monitoring and compliance role meant practitioners sometimes struggled to ‘read’ service users and find out what was really going on with them, ironically making effective risk management more difficult.

Medication, compliance and risk management

Medication compliance was more complex for practitioners to negotiate with service users than access and visits. In the last chapter I described how medication could be the most significant ‘concrete’ coercive aspect of the CTO, and as such it could act as a stumbling block to service users engaging with practitioners but also alternatively as a ‘way in’ for practitioners if meaningful choices on medication were encouraged. Care coordinators described how they sometimes used their role (specifically not being a psychiatrist) to distance

themselves from medication conditions in order to try to maintain progress with service users who were resentful at being compelled to take medication:

I tried to step back away from the medical side of things so I could get in to see him and work with him around other areas. When he raised issues with his medication I would be quite empathetic towards him and try and bridge some gaps that way. But ultimately putting out that 'the doctor chooses what medication you're on, I can speak up for you but I can't change his mind per se'.

In doing this, care coordinators seemed to be attempting to protect their engagement with service users by ensuring medication was not the focal point of their work, but also at times by positioning themselves as advocate and the psychiatrist as the 'enforcer':

My personal feeling is that sometimes the doctors haven't got as much to lose with regards to engagement so they can be a little bit more outspoken, and I kind of...I suppose I don't hide behind that because I support the doctor, but I feel as if I can let them take a bit of a lead and say 'OK you can debate this with your doctor'.

When care coordinators were successful in advocating for medication changes, it could signal to service users that they had been listened to and supported, thus bolstering the relationship, as this care coordinator explained in relation to a service user who had been angry with her about the imposition of the CTO:

Recently she wanted a reduction of her depot. In the past I've always agreed with her because it makes her feel tired so she hasn't got a lot of quality of life and I do understand that. I've always advocated for her, so I thought, this will either go one way or the other. If she does get a reduction and it doesn't go right we're going to be back where we started but I'm going to have to show her that I trust her, how she feels and what she's saying to me. So I did, managed to talk the doctor into reducing it and she was quite grateful and so after that she's been alright.

However, even if practitioners understood service users' feelings about medication, worked with service users to find a dosage that was therapeutically viable, and distanced themselves from the medical aspect of care, as noted in the last chapter very few of them would consider what the majority of service users wanted, which was a move from injections to oral medication. There have been a small number of studies (Lambert, Singh and Patel, 2009, Patel et al, 2011) carried out which suggest a strong correlation between CTOs and the use of injections for medication. This seemed to be the case in the field sites; an experienced Managers' Hearing Chair told me he had not seen any CTOs where

oral medication was stipulated, and as described in the last chapter all but one of the service users in the study were on depot injections whilst on the CTO, despite the majority stating a preference for oral medication. Practitioners' described a symbiotic relationship between the two; the CTO was viewed as difficult to implement in terms of monitoring of treatment adherence if an individual was on oral medication, therefore where possible the use of injections was written into the conditions. If the use of injections was not possible the CTO as a whole might be questioned, as summed up by one care coordinator talking about a case where she advocated for the CTO not to be used, *the only medication that works for him is in oral form, and they were talking about putting him onto a CTO this last time but I disagreed with that...we need to monitor their medication, how can we possibly do that?*

The pairing up of CTOs with depot injections can be seen as a 'belt and braces' approach to risk management. If an individual is on oral medication, is being seen once weekly as part of their CTO, and deterioration is noted, then recall can be used. However, because that individual is on oral medication, the issue seemed to be that the practitioner would not know if lack of compliance had led to the deterioration:

Time tells if they've been compliant, because you might see a more rapid deterioration in their mental state if they're not taking them. There's still grounds to recall because you've seen the deterioration but it's not a definite given that it's because they're not being compliant, they might still be taking it. (Manager).

On the other hand practitioners also talked about cases where they eventually found out that a service user had not been taking medication but had remained well for some time: *Well he was stable though, he was fine. I mean he was taking them but when he felt like it. Not concordantly like every day as he should have done. He had clearly broken his CTO though and I think they put him on a depot after recall.* It appeared then that the real concern was being able to use medication conditions to have certainty over medication compliance, rather than taking a 'wait and see' approach to mental state. More generally, this relates to a difference between practitioners who were able to live with greyness compared to those who preferred clear rules of engagement. In Chapter Six I explored practitioners' general ethical stance towards the CTO as connected to how they

saw its purpose. This can be summed up here as either a leaning towards it being ethical to ensure treatment by constraining choice or towards it being more correct to allow for some autonomy and wait for if/when adverse effects could be observed. The next section will carry forward such ethical debates in discussion of the use of recall.

Practitioners' use of recall

Recall is a process which whilst acknowledged by practitioners to appear as simple and clear in the guidance (NIMHE, 2008), could be confusing, time-consuming, bureaucratic and unpredictable in practice, often involving skilled coordination and persistence. In one of the teams under study, one care coordinator had six CTOs on his caseload and because those service users regularly refused their treatment, he often spent two days a week coordinating recalls back to hospital. In this sense, care coordinators often undertook work which would usually be carried out by AMHPs when managing a MHA assessment, such as coordinating the Police and the ambulance when necessary, finding and booking a bed, delivering the recall notice and carrying out the recall itself.

In the first part of this section I examine such practical challenges in more depth. As I have inferred throughout this chapter, practical and ethical difficulties in the use of CTOs were often entwined, and in the following part I discuss the ethical challenges recall could cause, specifically in relation to its variable value in making a positive difference for service users. The value of the CTO was particularly questioned when service users got into 'recall cycles', whereby they were regularly brought back into hospital for treatment, and I discuss this next. As with conditions however, practitioners demonstrated a range of approaches to negotiating and allaying recall where possible. These approaches are accounted for before I move onto the final part of this section - those cases where recall was seen as ineffective and/or damaging, and which highlight the potential boundaries of the CTO.

Practical challenges in recall – disjointed services

Observations in both teams suggests that bed shortages could cause considerable difficulties in executing timely recalls; often recalls were issued but then not put into action until the following week when a bed became available. More fundamentally, differences in the perceptions of the purpose of inpatient care could hinder the recall process. Inpatient teams saw admissions as being for the provision of acute care rather than for preventative work, the latter being what recall is often aimed at. In the absence of respite or ‘halfway’ services, this could cause problems, as this care coordinator explained: *they don't want people on the ward if they're not acutely unwell because there's pressure on the ward, whereas with CTOs we're getting them in to get them back on track, I think that you have to do a bit of pushing for it to happen.* Slow or ‘blocked’ recalls, and fast recall turnarounds could negate the protective purposes of the CTO in relation to dealing proactively with relapse and providing a ‘short-cut’ to inpatient care.

The circumstances of the recall could also vary; the service user should be encouraged to make their own way to hospital as the ‘least restrictive’ option, but practitioners reported it was often necessary to involve the emergency services due to the potential for resistance and absconding. A regular problem that arose in these circumstances was communicating with the police what their responsibilities were in picking people up and conveying them to hospital. The police tend to deal with individuals with mental health difficulties in emergency situations, and there appeared to be a sense of bemusement as to why they would be compelling someone to go to hospital when their mental health might seem stable. This could cause care coordinators a great deal of frustration, as these case notes for Sheila infer:

Sheila stopped by police at 3am this morning driving. It is reported by the officers that they did not have any concerns regarding her mental health or presentation and accepted her explanation of visiting a friend close by. I discussed with the operator that given the fact that the Police have been notified to bring her to hospital under recall on CTO it was a missed opportunity to pick her up.

As the CTO did not yet seem to be 'bedded in' in terms of all agencies understanding what it meant, practitioners could bend the truth; one practitioner described to me shortly after a recall that she had to be *a bit funny* with the police, telling them that the person was AWOL from a section 3, because it was easier for them to understand than explaining what the CTO entailed.

Ethical challenges in recall – disjointed care

As with practitioner talk on conditions, when practitioners discussed the difficulties they had had with recall, it became clear that the separation of practical and ethical difficulties could at times be a false divide. A particular issue that was talked about where practical problems compounded ethical discomfort was the dislocation that could occur for service users when recalled, particularly with frequent recalls. Lack of bed space meant that when service users were recalled, this could be to anywhere within the Trust, which created difficulties on discharge for service users in that they could be left far from home with little money and for practitioners who had to subsequently facilitate transport. This points to a process which is system rather than person focused, and indeed, could be seen as rather unfair if the service user was discharged from recall within a few hours, or did not want - or as could be found out on assessment - need to be recalled in the first place. More fundamentally, incongruence existed between what practitioners viewed as the theory of recall and its practice, and secondarily to that, the discontinuity of care and knowledge in the recall process. In theory, recall was seen as an opportunity to find out what needed to happen to support that service user in the community, as this care coordinator describes:

The theory, I think, was very much around your discharge from your local hospital bed into the community. If things go wrong and you're recalled, you'll be recalled to the hospital bed where you know the doctors, the nurses, people know you well and there's that assessment from those clinicians about how things are and also that helps with collaboration. The reality is because you're not guaranteed to get a bed in the last ward you were in, and the reality is more, service users who have had frequent recalls, have been in pretty much every bed around the Trust.

It was deemed important by practitioners for inpatient staff to know the individual beyond their case file, in order to be able to conduct a well-founded assessment at recall and for the service user in return to feel able to discuss their circumstances more openly, as this AMHP states: *It would be a safeguard almost, for them to comfortably explore some of the problems with the care plan, but they go to a different doctor on a ward they don't know and sometimes the recall is just give them the depot and send them back out, so I think it's more superficial.* As stated here, superficiality was not only related to the lack of pre-existing relationships and knowledge in the recall process, but also with pressures inherent to inpatient services which meant they might discharge individuals prematurely from recall who may have benefited from a longer stay in hospital.

Blurring boundaries through recall

Such practice keyed into the unease practitioners expressed in Chapter Six about the CTO as a whole encouraging mechanistic and reductive practice. Recall was really at the heart of these concerns, particularly in cases where individuals had got into 'recall cycles', similar to the 'revolving door' problem which CTOs were at least in part meant to alleviate. In one of the field sites there were a small number of service users who were recalled to hospital on a monthly basis, as they always refused or avoided visits and their injection. As noted in Chapter Four, one of the characteristics of CTOs across all countries where they are enacted is that none of them 'cross the Rubicon' (Dawson, 2005) of enforced treatment in a community setting – people are always brought back into hospital for enforced medication. The cycling of a small group of individuals in and out of hospital on a monthly basis to receive their depot meant that the concept of 'crossing the Rubicon' loses its potency, as the boundary between community and hospital became porous and enforced treatment in the community happened by proxy, as commented on by one AMHP:

Obviously you can't make somebody have the treatment if they don't want it in the community but then the alternative is in reality that they end up getting recalled and they are made to have it when they get recalled to hospital. You've created a new version of revolving door, instead of them coming into hospital for

a couple of months and then going out for a year, it's come in for a couple of hours or a couple of days and then out for a month.

As mentioned in the previous chapter, service users' rights to consent to treatment could become meaningless in such circumstances. None of the practitioners interviewed felt comfortable with CTOs being used in this way; guidance states that recall is "not expected to be used regularly" (NIMHE, 2008, 34) and repeat recalls particularly raised concern regards what the CTO was supposed to be used for. The consequence of using recall in this way was not only related to ethical difficulties around enforced treatment, but also (and in an echo of the service user concerns described in the last chapter) that it may remove the ability of service users to self-manage and use their own strategies to cope:

I think often people aren't given very much leeway, and people don't have the choice like they may be used to have to actually say, 'yes well I know actually in 6 months after not taking my depot I'll become really unwell, but actually I feel so rubbish when I'm on that depot that I'd rather have 6 months where I'm enjoying my life and choose to take that risk' (AMHP)

Furthermore, as noted in the last chapter, regular recalls could signify the breakdown of relationships with service users, where active resistance could mean community care becomes an on-going conflict with recall the 'battle ground'. This care coordinator distinguished between service users thusly:

It works very well with those people who have traditional respect for the law and authority and they've learnt they don't take their medication, they get recalled, they think, 'oh, I can't be bothered with this hassle, I'll just have it'. However, there are others where it doesn't work so well because they've got no respect for it. They don't believe it has any validity in their life.

Some service users would resist the involvement of services whether a CTO was in place or not, but for others the CTO had become a point of contention and meant engagement became increasingly difficult. As with Craig's case described at the end of the previous chapter, not only relationship breakdowns, but also the significant strain on resources of such complex and constant recalls could cause significant difficulties for practitioners.

Even so, recall could be seen as the 'lesser of the two evils' in other cases, particularly those where recall although consistent was straightforward and

where those service users would not have agreed to treatment in any circumstances. Although being caught in a recall cycle was still recognised as disruptive to these service users, it was deemed better that it be used in this way especially if risk was a key concern. One care coordinator talked to me about how he and the psychiatrist had managed what he called their *shared moral ambiguity* about such cases by testing it out at appeal:

We were asking, 'are we doing this the right way, is this the right thing to do?' If the Tribunal said discharge them we would've had no problem because we're becoming that cleft stick, you know, we're morally muddled up and legally...But then the court said that you're doing the right thing by keeping the CTO running, that's fine.

Gaining legal approval gave repeat recalls legitimacy, particularly in terms of proactively dealing with risk for service users who were deemed as being difficult to manage in the community. Although most practitioners accepted this argument, at the same time some did not only feel service users' right to choose was limited by the use of recall, but that their own discretion could also be restricted by it. As discussed earlier, the imposition of a CTO could be seen as a defensive decision, and so could the active use of recall, as this care coordinator states: *The CTO defines the actions that we will have to take. There's always emergencies come up. But recall creates the emergency.* The very presence of recall as an option could make it difficult not to use.

Similarly to the almost blanket use of injections in CTO conditions, the use of recall can thus be a way of managing uncertainty, as this care coordinator sums up: *it's just a kind of, very quick, immediate response and a sort of definite response and this is just what we're doing.* Where practitioners were unsure about the nature of the situation and what they could do, recall provided a way to act. One way this manifested was in the 'Catch-22' embedded in the recall process where individuals can be recalled without prior assessment. This meant that if an individual cannot be seen, and the practitioner does not know their status, the response can be to recall them 'just in case', which could result in 'false positives' and unnecessary admissions. In one case, a woman had not been seen for some time as her care coordinator had left the team and there had been little follow-up with her since. I noticed on the team board that she had been

recalled and one of the practitioners related to me what happened: they had started to try and contact her but *she just doesn't want anything to do with services*. So they had sent recall papers *and all of a sudden we get a phone call, 'what does this letter mean?'* The practitioner went on to tell me the woman *sounded fine so she'll just be in and out*. The inpatient case notes stated that she had *apparently not been compliant with her medication resulting in disengagement from the team*. However, given that the team had only contacted the woman twice in the preceding two months it seems that recall was more of a way of getting her back in the system rather than being due to non-compliance or her mental state.

Negotiation and mitigation in the recall process

Despite the potential for defensive practice, the use of recall was not always clear-cut. I described at the beginning of the thesis the guidance on when recall should be used, but as demonstrated by the use of repeat recalls for breach of medication conditions, how such guidance is put into practice is highly variable. In Chapter Six, we saw that recall was central to many of the purposes practitioners saw the CTO fulfilling. Regardless of the practical and ethical difficulties that recall could raise, it was a broadly held view that recall could be a beneficial preventative intervention for a number of reasons related to protection, provision and risk management. At the same time, some practitioners preferred to use the CTO in a more non-intrusive way, keeping recall to a minimum. In this sense, as with the CTO as a whole, practitioners could broadly be separated into those who saw recall as only to be used when necessary, and those who felt it was a helpful tool which could be used more freely. Within these categories practitioners displayed varying levels of flexibility about when and how recall was implemented.

The majority of the psychiatrists interviewed had what can be described as a 'black and white' view of recall, where early recall was seen as the best approach: *Recall is something that you use when the adherence contract is broken. And I think you do that within a week. I think the point is actually to do it early, otherwise what's the point in the CTO?* There was a dual argument

here that firstly, for the CTO to have authority it had to be treated like an enforceable contract and secondly, that recall could be justified on the assumption that non-adherence to medication would always bring risk. Other practitioners could be less sure, treating recall as a ‘grey area’. A care coordinator who worked across Assertive Outreach and Forensic services actually thought his exposure to individuals classed as high risk meant he had a more relaxed approach to recall: *it is about knowing individuals, knowing what the trigger factors are, knowing the risks that they pose, and looking at them realistically and saying ‘what’s the point in recalling someone?’*

Such practitioners could express discomfort about the ‘contractual’ focus on compliance to conditions and whether injections had been missed, rather than individual circumstances, as this AMHP explains: *Decisions to recall are made much more around ensuring ongoing medical treatment than ‘what is the current risk at this time?’* Moreover, some practitioners expressed the concern that using recall in this way could undermine the work they had done to maintain a relationship with service users within the CTO. It was felt that a reactive approach to recall could further embed the superficial compliance that some service users demonstrated as described earlier, because it could lead service users to not be honest and open about what they were experiencing, particularly if they were anxious about the idea of recall. Stuart’s care coordinator described such difficulties in relation to their relationship:

I try to say to Stuart, the more open and honest he can be about what he’s experiencing, the less chance there is of him ending up back in hospital. There’s no reason no matter what he experiences we can’t manage it, because he’ll never be in a more supported environment than where he is now. But, at the same time, I think he’s scared that, if he says ‘the TV started talking to me again’ or ‘I’ve started to see the dark shadows’ or, you know, ‘when I look back at the time when I was the Son of God, actually, I think I might be the Son of God again’, but he’s never going to say that to me because I think he’s terrified that the CTO allows us just to whip him straight back into hospital and he hated it on the ward.

Consequently, and as with the decision to make the CTO in the first place, care coordinators, could play a significant mediating role in recall decisions.

Psychiatrists filled in and signed off recall papers, but care coordinators were the ones who initially drew attention to whether a recall was needed. Negotiation

and ‘steps to compulsion’ were used as a way of averting recall where possible. Such negotiation was not always feasible, in particular with those cases as described earlier where recall was a point of resistance for service users, as this care coordinator explained: *there are some service users who may not want to have that conversation, it may just be about them saying, ‘I’m only going to have my treatment if you recall me to do it’.*

For those service users where it was felt there *was* a chance recall could be avoided, practitioners talked for example about giving service users a set number of chances to meet with them before recall was triggered. They also described ‘reminding’ service users of the CTO in order to achieve compliance: *Kid, cajole, jest, bad jokes, whatever. You never argue with anybody anyhow, that’s pointless. With other people it might just be literally a blunt statement because you know that’s how they respond best (Care coordinator).* A Managers’ Hearing Chair explained the various ways he saw recall being dealt with:

What happens is they get extra support going in there to maintain or get them back on their medication or change their medication rather than the power of recall and it seems to be the threat of the power of recall, rather than the actual usage. I mean over the past months I’ve chaired quite a lot and I can remember one actually being recalled although several have not complied with medication, but other methods have been tried rather than the power of recall actually being invoked.

Even once the recall papers had been issued, hospitalisation was not necessarily the result. A Mental Health Act Officer in one of the field sites told me they regularly saw paperwork for recalls which did not eventuate, where the recall notice was being used by practitioners only for leverage even though they are legally binding documents. Such actions by practitioners could be seen as a way of maintaining good relationships and attempting to alleviate the anxiety of service users by being ‘true to their word’ regards their explanations of when recall would happen. It should be noted however that averting a recall did not necessarily result in lowered feelings of coercion. The leverage sometimes used could reinforce feelings of powerlessness, as seen here in an excerpt from Patrick’s case notes written by his care coordinator:

Patrick was angry that the dose had been increased and refused to take the depot. I reminded him that he is under the Community Treatment Order and he will have to accept the increased dose. I told him that he is free to accept this

depot at home and if he doesn't do that then he will be recalled to hospital and given this injection. Patrick was very angry with that and said 'just give me the injection' and didn't want to have any further discussions. I tried to reinforce that, even though my reaction might look punitive I am trying to act on his best interests and don't want him to end up in hospital again.

It may be that using the threat of recall to avoid recall could sharpen service users' sense of being in a 'no win' situation, despite practitioners best intentions. As will be picked up in the next chapter, the potential for safeguards and 'protection' from the CTO to deepen service users' sense of disenfranchisement is a recurring theme.

It should also be noted that the narrative of psychiatrists being quick to use recall, and care coordinators ethical discomfort with this meaning they try to avert recall, was not always the case. As discussed earlier, team dynamics played a role in the initial decision to make the CTO and continued to play a role in how CTOs unfolded. In the team where the psychiatrist was very keen on CTOs, recall was used actively, including repeat recalls. In the team where the psychiatrist expressed reluctance about CTOs he was also cautious about using recall, which could cause frustration for many of the care coordinators. The psychiatrist told me that:

I would not be shaking the remit of the CTO over the patients head, 'you have to obey me otherwise I will recall you', that's not the way I see it at all. CTO or no CTO I think the care of the patient has to be provided in a respectful way. We need to show some flexibility, we can't follow this rigidly – 'once you breach conditions then that's it, you come to hospital immediately'. We have to remind the patient that 'this is what you agreed on', they might cooperate, or they might have a good reason for not doing it.

His view was that the service user needed to be listened to, and an attempt made at a mutually agreeable solution before recall was triggered. However the view in the rest of the team was that their professional judgement was being ignored, as this care coordinator explained: *We say, 'we really need to get them in, let's recall', and then you're met with a brick wall sometimes, and that's frustrating. Because when we say they need to be in, that means they really, really do need to be in. Not yesterday, not tomorrow or next week, now.* Not being able to use recall proactively for protective and risk-related purposes could undercut the value of the CTO for practitioners. However there were two particular kinds of

cases across the field sites where recall was unlikely to be considered by all practitioners.

Distinguishing between 'recallable' and 'non-recallable' cases

The first kind was those that can be described as 'complex cases', where the individual did not only have a primary diagnosis of psychosis but also of substance misuse and/or personality disorder. In these particular cases the individual's circumstances would often not 'fit' the CTO, making it difficult to actively use. For example, it was seen by practitioners as pointless to recall someone with a diagnosis of personality disorder because:

Our inpatient consultants don't believe in personality disorders as such or, if they do believe in them, they don't believe that an inpatient acute unit is the right place to treat someone with a personality disorder. Because you can't give someone a tablet and settle them down and send them back out again, it's more long-term work. (Manager)

Psychosis by itself can be monitored to a certain extent, whereas deciding whether an individual's behaviour is caused by their psychosis or by substance misuse/personality disorder is a more difficult task. Often practitioners would have to try and differentiate between the two when deciding on recall. As the following Manager's account of an appeal discussion suggests, recall was therefore not always used when significant risk was present; for recall to occur the risk also had to be related to a mental state that could be treated immediately with medication in hospital:

The panel were concerned about the potential risk that client posed and whether management in the community with a CTO was the appropriate way or whether he should be actually back in hospital as an inpatient. And the client, he's quite a complex client because he's got the paranoid personality behaviours as well. I was trying to explain to them that the CTO is in place for the voices he hears in terms of compliance with medication. But he's making threats against people and it's not linked to his voices, it's his personality and we can't recall him because of that really. The panel really struggled to get to grips with that.

As seen here, the purpose of the CTO could be questioned if risk was not being seen as dealt with. This questioning also arose in multi-agency working, with other agencies struggling to understand why an individual was not being recalled when behaving riskily and the team making the argument that risky behaviour

not caused by deterioration in mental health was outside the remit of the recall function. In this sense, practitioners were making a similar argument to the one they made against the use of ‘soft’ conditions such as drug/alcohol abstinence; that it was not the role of mental health services to ‘police’ behaviour that fell more into the social rather than the medical realm. A care coordinator recounted to me a meeting about Nick, where probation were pushing for recall due to a spike in Nick’s amphetamine use which caused aggressive behaviour, but the team had assessed his mental health as stable and so the psychiatrist had refused. Therefore, whilst risk was one strong criterion for recall, it was still carefully delineated as being in or outside the boundaries of the CTO.

Practitioners also felt that for some individuals with a diagnosis of personality disorder, the CTO, and specifically the recall function, reinforced negative interactions with the team. In one professionals meeting about a service user who had made threats against members of staff it was noted that the CTO had resulted in: *an escalation in his behaviour towards our team. The threatening behaviour is increasing, the threats to staff are becoming more significant. He’s doing everything that he possibly can to sabotage the treatment that we’ve given him.* Although the individual was breaching his conditions, recall was viewed as unfeasible because bringing him to the hospital site would increase the risk for staff. Furthermore with the CTO in place law enforcement agencies were less likely to deal with such behaviour. Not only did the CTO mean other agencies placed pressure on mental health services to act in regards to risk, it could also mean they did not act themselves. One practitioner said the CTO meant agencies such as the police felt they could *wash their hands* of difficult ‘borderline’ cases. In this case the care coordinator commented: *Because of the CTO, the CPS didn’t charge him when he breached his harassment order against us. Apparently I should understand as a healthcare professional that I’m fair game.* CTOs could thus shift the burden of responsibility for ‘risky’ individuals onto mental health teams and individual practitioners, rather than maintaining a shared responsibility across agencies; instead of managing risk the CTO could therefore exacerbate it. Such individuals could be seen as ‘impossible’ cases, with no resolution in sight, and with the CTO muddying what was already a complex and challenging

situation. As this service user's care coordinator said to me after the meeting: *As a case study, he's really fascinating, because he's got us beaten so far.*

The second kind of case where recall would not usually be considered was where the service user was deemed to be attempting to use the recall function for their own purposes, which did not chime with the purposes of the team. As noted in the last chapter, individuals who used hospital admission as a coping strategy for various reasons would try and trigger recalls when they felt it necessary, for example by refusing their medication. Simon was a good example of someone who had done this with varying success whilst on the CTO in order to escape social pressures such as difficulties with housing. As Simon's CTO went on, it became increasingly difficult for him to be recalled; in his case notes it was requested that practitioners no longer initiated recall unless absolutely necessary, and in an appeal report it was noted: *His social worker felt that the CTO was not necessary since if anything Simon was too demanding of support.* There was a potential dichotomy at work here; practitioners talked about recall in protective terms, and indeed as discussed in Chapter Six understood why service users might act in this way, as a natural response to the changes and subsequent limitations of services:

I think he doesn't like the CTO and he would like to be in control of it himself. He'd like to be able to say, 'I need a break now', when he's slightly unwell and had enough of dealing with living alone, and that's how he was managed previously. But unfortunately we don't have respite care anymore... so the only way he can get respite is by becoming non-compliant, deteriorating and getting into hospital that way, where he feels safe. (Care coordinator)

However that sense of protection and reciprocity could be limited when it came to service users' self-perceived welfare needs, partly because it was felt that inpatient services were likely to immediately discharge a service user who was recalled for these reasons. In such cases differentiating between when recall should or should not be used was also framed in terms of 'breaking the cycle' of dependence. As was observed at Simon's appeal, the care coordinator explained how they weighed up such decisions:

I think if it was psychosis we'd be looking at recall, not voluntary admission, that's what the CTO is for. So you have to separate out the two things, his psychosis and his risks with that and his ability to cope and live independently.

We've been trying to treat him at home when he's feeling like this, trying to break the cycle of him coming in when he feels that he can't cope.

As with personality disorder and substance misuse, recall in these cases was seen as only feasible for psychosis related behaviour. Service user actions that reflected problems with well-being or emotional distress were not deemed as being liable for recall. Again, this raises broader questions about what the limits of CTO usage might be, a point that will be returned to in the next chapter in relation to discharge decisions.

Concluding thoughts

For practitioners, these findings highlight how decisions are made, the factors that impinge on such decisions, and the ethical tensions inherent in the practice of CTOs. As described at the discharge stage, the broad criteria for CTOs could make them difficult to challenge. Similarly, once CTOs are in place they could hold a logic of their own, whereby the easily applicable nature of recall and the pressure to avoid costly mistakes could make it difficult not to use.

Paradoxically, having room for discretion could narrow the choices practitioners might make, thus encouraging defensive practice. Such practice did not automatically occur however - contextual factors played a significant mediating role. Team dynamics did not always play out as would be expected; it could be assumed that the team psychiatrist would be an advocate for the CTO, driving its imposition and active use. Whilst this was often the case, the psychiatrist could also hamper the CTO, thus leading care coordinators to question its purpose if they were not able to put it into action. Similarly, the broader institutional relationships the CTO operated within – between inpatient and community services and between community services and other agencies – were influential on when and how the CTO was used. In turn such institutional relationships were shaped by structural forces which have gradually shifted the focus and remit of services in general. Hence, although in Chapter Six I noted that practitioners could see the CTO as a way of challenging these structural forces through providing access to services, in effect this was not always possible.

The potential for defensive practice was also mediated by how much practitioners were willing to live with uncertainty, which influenced both the approach to medication practitioners' were willing to take under the CTO, and their use of recall. This variation was connected to the ethical stance practitioners took towards the CTO, which can be categorised as either taking a 'hard and fast' approach to activating the CTO to ensure treatment, or a more flexible approach to allow for some autonomy. Practical-ethical beliefs on feasibility and autonomy meant that many practitioners engaged in sustained work to try and maintain a space where flexible and negotiated engagement could take place within the framework of compulsion. Furthermore, practitioners held in tension views on how they believed CTOs 'should' work with how they do work, as can be seen particularly with concerns about the lack of care and continuity in the recall process, the use of repeat recalls and the blurring of boundaries on consent and compelled medication in the community, and more broadly the focus in recall on compliance rather than mental state. Altogether, this points to an underpinning tension between what can be described as 'surface' practice where the CTO can be used routinely and superficially to maintain compliance and in turn manage a very particular kind of risk, or 'depth' practice where the use of the CTO is tailored to individual circumstance and to encourage meaningful interaction.

I should note here that although it may seem the case, I am not trying to entirely argue that one kind of practice is more valid than the other. How engagement plays out within the CTO is a mutual undertaking between practitioners and service users. It therefore needs to be acknowledged that with some individuals 'surface' practice was seen as all that could be managed, and indeed could be seen as an attempt to limit coercion, firstly by making it possible for such individuals to be in the community in the first place and secondly, by respecting their wishes for minimal involvement. Equally, attempts to avert unnecessary compulsion such as using the threat of recall as leverage could lead to increased feelings of coercion. Furthermore, routinised practice under the CTO framework should not automatically be seen as encouraging reductive and 'surface' interaction. The structure of the CTO could also stimulate relationship-building through continuous contact and act as a jumping off point for in-depth

discussion. Indeed, given that risk-oriented work is often critically aligned with proceduralised approaches (Webb, 2006), it is interesting to note here that risk management could be enhanced within a relational context. Conversely a more stereotypical approach to risk in terms of monitoring and surveillance could be seen as hampering effective risk management.

Indeed, it should be recognised that the CTO could exacerbate risk rather than control it, by aggravating service user behaviour, and by signalling to other agencies that they could take a step back in active risk management. In this sense, there were particular individuals and circumstances where the CTO was deemed not 'workable'. For service users who were particularly resistant to the CTO, it could become an emotionally draining experience for practitioners, and could render the recall mechanism difficult to operate. In a more fundamental sense, for particularly 'complex cases' the limitations of what practitioners felt was the responsibility of mental health services and the unintended consequences of activating recall, effectively nullified the CTO. This chapter ended with a consideration of such cases, and I use this as a bridge to the next chapter where discharge dilemmas will be discussed.

Chapter Nine

Discharge dilemmas:

Deciding whether to continue or end a CTO

The previous five chapters have traced the ‘story’ of CTOs from policy-level formation, through service user and practitioner conceptualisations and experiences of CTOs, the means by which CTOs are put into practice, and the factors that influence that process. In this chapter, I focus on the potential ‘end’ of the CTO, specifically the dilemmas that arise in CTO discharge decisions. A focus on the final stage of the CTO also acts as an end point to the previous chapters, following the suppositions I reached in those chapters to their conclusion. As such, this chapter departs from the format I have taken so far of mirrored service user and practitioner chapters, in that I present both perspectives together. Through data taken from observations and interviews, I draw out the power dynamics present in discharge decision-making forums, and the varying ways both practitioners and service users use accounts of change, stasis, risk, responsibility and relational knowledge to support their arguments for and against discharge. These arguments bring to the surface deeper concerns regarding how change can be known and interpreted, in relation to proof, causality and judging the effectiveness of CTOs.

In the initial two sections of this chapter I explore decision-making on CTO discharge as it happens at appeals. I firstly provide some context on the appeals process and how it is experienced by service users, as an under-researched area of mental health practice in England. The main finding here is the gap between the proclaimed aim of the appeal system to protect rights, and the experiences of service users. I then move on to delineate the different factors that appeal panels consider and progress through when making their decision, starting with insight, then risk, contextual factors and timing. Through this analysis I demonstrate that the decision-making pathway is heavily weighted towards upholding the CTO, due to the broad criteria for CTOs, the way arguments are framed by practitioners and the cumulative and interrelated consideration of such factors.

The following section considers decision-making at CTO reviews, where there is more room for debate, contestation and negotiation in discharge decisions. I start this section with a discussion of the differing stances practitioners may take to uncertainty and risk in decision-making, before considering the role of the service user in discharge decisions and the forms of persuasion they may use to encourage discharge. This leads on to a broader analysis of the dual roles of trust and evidence-gathering in ‘proving’ whether the CTO is ready to be lifted. As I note at the end of this section, if service users ‘step outside’ this assigned role of responsibility post-discharge, then the result may be the formation of a ‘CTO cycle’; discharge from the CTO can be difficult to achieve, but taking that further, once having been on a CTO escaping entirely from legal forms of compulsion can be just as challenging.

In the final section of this chapter, I argue that discharge decisions are not only influenced by judgements of risk based on proof. Practitioners also balanced the potential positive and negative effects of the CTO for individual service users when considering discharge. These were not ‘hard’ effects such as hospitalisation rates, but ‘soft’ effects related to the tipping points between dependency and responsibility, and therapeutic engagement and alienation as they play out in individual service users’ responses to the CTO. Such responses also highlight the potential perverse consequences of CTOs, whereby discharge from the CTO can encourage the very attitudes and responses the CTO is supposed to stimulate. Furthermore, not all service users wish to be removed from the CTO, and I end this chapter by noting the counter-intuitive responses compulsion can produce. Compulsion and coercion are often closely linked; what I suggest is that coercive experiences can also be related to the removal of compulsion through proposed discharge of the CTO.

CTO appeals

In this section and the next, I explore the role of Tribunals and Managers’ Hearings in discharge decisions, as they essentially form the framework of legal oversight that the CTO operates within. I start with an overview of service user

experiences of the appeal process, before considering how discharge decisions are made in appeals, and the factors that influence such decisions.

Managers' Hearings are the responsibility of the local Trust, and the three panel members that make up a Hearing panel are usually drawn from volunteers in the community. Mental Health Tribunals are run as part of a national Tribunals service and the panel must include a medical and a legal member, as well as a lay representative. Tribunals are more formal than Managers' Hearings, in that they are classed as legal 'courts', hold greater powers and can lead to the formation of mental health case law. However, in practice the role of Tribunals and Managers' Hearings in relation to CTOs are very similar, in that both must decide whether the legal grounds for the CTO are applicable at that point in time³². Individuals who are on CTOs can choose to appeal to both bodies. An appeal can be made to a Managers' Hearing at any time during the CTO, and an appeal to the Tribunal can be made once in each CTO time period. There are also regular mandatory appeals. A Managers' Hearing has to be held each time a CTO is renewed. A Tribunal has to be held within six months of the initial detention in hospital which led to the CTO, and then three years later, if the CTO is still in use. This 'two-track' appeals system of mandatory and voluntary appeals means that Managers' Hearings in particular are regular CTO events³³, often not at the behest of the service user who is on the CTO. This in turn means that attendance by service users at mandatory appeals is variable.

³² The process of both is very similar too; the panel members receive reports from the psychiatrist and care coordinator beforehand. If it is a Tribunal, the medical member meets the service user prior to the appeal to gain their views as well. During the appeal, the psychiatrist and care coordinator are questioned by the panel, and then the service user and their carer (if either is present) are asked their perspective. If the service user has a solicitor present, the solicitor can then question the professionals and make representations to the panel on the service user's behalf. Attendees are asked to leave the room whilst the panel makes its decision, at which point they are called back in to hear the verdict. At Managers' Hearings I asked beforehand if I could stay in the room whilst the panel deliberated, and was allowed in all cases. I did not do this at Tribunals, as they were much more formal events and my presence had already been carefully negotiated – I did not want to 'push my luck'.

³³ Although it should be noted that in 2012 a practice direction was issued which stated that the mandatory CTO Tribunals could be 'paper-only' exercises (so attendance by involved parties is not necessary). These 'paper' appeals can be held if the service user is deemed by the psychiatrist to be consenting to the CTO, and is also deemed to have capacity to consent.

Experiences of appeals

Little has been written about service users' experiences of Managers' Hearings and Tribunals in England, but the findings here reflect a report from the Care Quality Commission (2011b) on Tribunals which states that the process of attending them can be difficult for service users for a number of reasons. The oversight of CTOs was generally felt by both practitioners and service users to be geared more to the needs of the system rather than the individual. The formal, sometimes adversarial nature of appeals where the service user might feel 'outnumbered'; the difficulties the venue can bring, such as being hard to get to and often in the hospital where the service user would previously have been detained; and the timing of the meeting to suit the appeal schedule, can result in a process that may be insensitive to the individual who is at the centre of discussion. The Chairs³⁴ of Managers' Hearings I interviewed described how they made every effort to make the appeal as comfortable and welcoming an environment as possible; for example not sitting behind a table, openly acknowledging how difficult the experience might be, encouraging the service user to take part, and ensuring the service user had representation. Even so, despite these efforts such forums could be highly intimidating, as Brendon explains:

When he [care coordinator] asked me to have a Tribunal I thought that they were all going to try and trick me and I thought that they were all going to try and make me look very little, all these men in suits, all these important men, and all these psychiatrists, so I agreed to have a Tribunal twice, but I never went to them. And he says, 'why aren't you going to them?' I said, 'I'm not going to them because you're going to try and make me look that big'. I said, 'so you can all have a little discussion amongst yourselves', I said, and ... and that was it, you know what I mean.

The content as well as the nature of the appeal could be off-putting for service users. As discussed in the previous chapter, practitioners were keenly aware of the adverse effects CTOs could have on the practitioner-service user relationship. Similarly to findings reported elsewhere (Stroud, Doughty and Banks, 2013), practitioners described how such relationship difficulties could be intensified by

³⁴ I only interviewed the Chairs of Managers' Hearing panels, not the other panel members. By virtue of being appointed Chairs, they were the most experienced panel members and could talk in depth about CTO decision-making. I did not interview Tribunal members as this was not feasible within the remit of the fieldwork.

the regular appeals that occurred under the CTO, where they had to present what was often ‘deficit’ based information, which could differ significantly to the more positive day to day communication they had with service users. Whilst both panel members and practitioners took opportunities to encourage service users on progress made, the justification for maintaining the CTO relies on a narration of difficulties. As a care coordinator explained:

You’re writing a report pointing out why you feel they should be on it, which is often negative, so you can get [from the service user] ‘why are you writing that, that’s historical, does that need to go in, why are you saying that’? Having to go through that process does damage the relationship with your client. In my experience, I often find that you spend a long time building up the relationship with the client, which could be just shattered by your report. You go in this board room, very formal and you think ‘oh all that work I’ve done to engage’.

For many of the service users interviewed, reading the reports written by professionals on their progress prior to the appeal, and listening to their lives being discussed with in detail with the focus on what has ‘gone wrong’ was understandably difficult. This became particularly evident to me through the observation of appeals. Although service users have to be given the professional reports to read before the appeal, when they are given the reports can vary, especially as practitioners are often working to tight deadlines. At Michael’s first (mandatory) appeal, he was given the reports to read just before the appeal happened. I sat with him and the care coordinator whilst he read through them. When he read the psychiatrist’s report, he got visibly upset and said to his care coordinator: *is that really what I’m like when I’m ill?* Later on he said: *it just makes me want to cry.* He was evidently shaken by what he had read and told me it had made him feel more nervous about the appeal hearing.

Abstract vs. concrete rights

Accordingly, both Trusts reported low levels of participation at CTO Managers’ Hearings and Tribunals. Nevertheless, service users explained that ‘opting out’ of CTO appeals was not only because they could be demanding and intrusive experiences. Very few of the participants stated that they attended mandatory appeals or actively pursued appeals, and their reasons for this demonstrated the gap between the intention of the appeals system as protecting the rights of those

who are on CTOs and how it was viewed by participants. Similarly to how service users might respond to practitioners' attempts to alleviate coercion during the course of the CTO – for example by avoiding recall – appeals whilst supposed to be a safeguard, could heighten feelings of coercion. For those participants who were unhappy to be on the CTO, they saw little point in appealing because they did not feel their view would be listened to and the only view that would be considered would be that of the psychiatrist. As Patrick commented: *When they renewed it I could've got a solicitor to fight against it but I didn't. I just left it because I thought, well, I'm fighting against higher powers here.* When participants did attend appeals, this could reinforce their feeling that they were not heard and had no rights in the process. Sarah summed up this view when she said:

You know the purpose of the judicial system is that one person can stand up against the many and have their voice heard and they could come out to be the one that's, not necessarily telling the truth, but the one where their situation is, they're right and the others are wrong. It's so everybody has rights but that isn't the way the system...it doesn't give the feeling that you've got any rights, the process. It makes you feel quite useless, like they're having a joke with you or something, like it's a laugh, you know, the law's for one person and not the other.

Through the interviews and observations it became evident that the Chairs tried to take a 'procedural justice' approach, where the appeal process was presented as fair, transparent, impartial and respectful of the service user and their voice. As noted in Chapter One (Monahan et al, 1999) such an approach can mitigate disappointing outcomes for service users. Indeed, one Chair told me how: *On occasions when we've had a contested hearing, patients have shook hands with me at the end of it and said 'thank you very much', even though it was not the result that they wanted. I think the very fact that they've gone through this process and had the opportunity to express an opinion, was valued.*

However, attempts to ameliorate feelings of injustice could also go awry. When the panel reached their decision at Ian's Managers' Hearing and called him back into the room the following exchange occurred, which illustrates both Ian's feelings about the appeal, and how explanation by the panel can backfire:

Ian: Come on then, shock us [said sarcastically]

Chair: Ian, we do think the CTO is essential for the time being, it's obviously benefitting you. It's pretty early days. It does seem to be putting the structure in place that you need.

Ian: You just haven't understood a word I said. What benefit is it to us? I mean it would have been easier...I didn't want to come here this morning. It's cheap talk again, it's been a waste of time.

Chair: Well you've stayed off drugs...

Ian: I'm a 44 year old man, you don't need to tell me what to do. If I want to take drugs, I'll take drugs.

There was a paradox at play here in that service users did not always see the point of exercising their rights, but because of the automated nature of the appeals process they could feel compelled into doing so. The *safeguard* thus becomes another *requirement*, which in turn could reinforce feelings of powerlessness and resentment of the CTO 'adding insult to injury'.

Participants who were happy to remain on the CTO also did not view appeals hearings as having a place in protecting their rights. By nature of being content to remain on the CTO, these participants did not attempt to lodge an appeal against the CTO anyway. However, they were still subject to the mandatory appeals, which they saw no reason to attend, as James explained: *I'm entitled to one but I don't want to go. I've actually turned down a lawyer. I looked to my care coordinator being there and the psychiatrist and thought that's enough. They know me well enough. They're there to make me better, make me well. That's why I did that.* These findings suggest that Tribunals and Managers' Hearings are not viewed as particularly valuable by participants. Consequently, practitioners described feeling a tension between encouraging service users to exercise their right to appeal which was seen as good practice, whilst at the same time being aware that service users either saw appeal hearings as simply another *cog in the mental health system (AMHP)* or as inimical to their best interests. Of course, the purpose of the appeals process is to provide a safeguard and uphold rights; to maintain that purpose does not necessarily mean it has to be viewed that way by those made subject to it. Indeed and as can be expected, Chairs of Managers' Hearings believed their role was of importance in ensuring that professionals did not overreach in the use of their statutory powers.

Nevertheless, the Care Quality Commission's (2013) latest findings suggest the numbers of successful appeals on CTOs are low, with 84% of Tribunals in 2010-2012 upholding the CTO, compared to 65% of inpatient detentions being upheld over the same period. There are significant dilemmas in the decision to

discharge from a CTO which may be implicated in the low rate of successful appeals, and which will be explored in this chapter. At this point it is enough to say that perhaps a clearer argument can be made for discharge from detention in hospital, as it may be seen more obviously as a restriction of liberty. When service users are in the community on CTOs, the potential restrictions it brings can seem less evident and subsequently the implications of upholding the CTO less serious.

Influences on appeal discharge decisions

It is unsurprising that individuals who want to come off the CTO and do not win their appeal are going to be disappointed with the outcome. However, when individuals choose not to attend appeals because they believe that the CTO will always be upheld, it could become a self-fulfilling prophecy, as Chairs reported that service user attendance at appeals made a difference to their ability to make a well-informed decision. Being able to see *the whites of their eyes* as a couple of Chairs stated, was deemed important to finding out what was really going on in a service user's life. One Chair described a decision they had made recently to uphold a CTO thusly:

We had a case this week, where we had a split decision, I mean we were on the cusp of discharging the patient and the only reason we didn't discharge was because the patient wasn't there. As it happened he was represented but just having to rely on the solicitor wasn't sufficiently strong. Perhaps you would ask more searching questions if they were present about whether the duty of recall, which is the key one, is really necessary in their situation. We would have been able to probe a little bit deeper...I mean we'd get a feel of his body language and all those sort of issues

Although panels were heavily inclined towards professional (and particularly psychiatrists') reports, sharp incongruences between professional accounts of a service user's state and the presentation of the service user could at times tip the balance to a discharge decision. Moreover, whilst service users might not win an appeal, if present they could use the process to leverage changes to their care and medication, or ensure their care plan was being met. Panels could act as influential arbiters through the making of recommendations, as happened with

Irene's case where the written decision by the panel including the following, which was subsequently acted upon by her care team:

Irene did express the view that she does not like depot injections due to the indignity of these and the discomfort they cause her, she would much rather be on oral medication. The psychiatrist and care coordinator both said that they were worried that currently Irene has insufficient insight into her condition for this to happen but Irene was very anxious about this matter and we would therefore encourage insofar as we can that the possibility of moving onto oral medication is considered as soon as possible.

Of course, being present did not always work in the service user's favour. For example, at Sheila's appeal, the Chair asked if she had anything she wanted to add near the end of the Tribunal, and she replied: *Yes, I was born telepathic*, a disclosure which certainly did not help her case for discharge.

Seeing the interaction between professionals and service users could also help the panel in clarifying how 'meaningful' the CTO was. It seemed that panel members particularly valued CTOs that they saw as making a difference to a service user's life beyond risk management, as this Chair makes clear:

My first question always is, to both the consultant and the care coordinator, 'how well do you know this patient, how often do you see them?' And you can actually watch body language and see the empathy between parties. I think that's important particularly when you've got a care coordinator who's going out and visiting patients, that they're giving them support to stick to their conditions and to be leading the best life that they can. You know, when people are getting support as well as monitoring.

Indeed, when practitioners did not appear to know service users well, it could influence panel members' views on the validity of their evidence. For instance in Michael's Managers' Hearing (observed), the Chair expressed dismay that the psychiatrist had only met Michael once, despite the psychiatrist explaining the report was based on discussions with the care coordinator, case notes and records. In their ensuing decision-making, the panel had a lengthy discussion about whether to discharge or not, with the Chair saying: *I was a bit shocked at how long he'd been in the community and not having a review for almost four months. And this doctor has only seen him the once. It's not clear from this report at all that there'd only been one meeting.*

How panels accounted for professional expertise and ‘expert truths’ and how much they felt able and willing to question these truths was central to decision-making. The ways professionals displayed knowledge of the service user was one important factor in such decision-making; the following will describe the factors that appeared to influence the views of panel members, and how professionals presented such factors.

Insight

The main question that Managers’ Hearings and Tribunals considered when deciding to discharge a CTO was whether the power of recall was still believed to be necessary. This in turn was based on probabilistic beliefs around whether the individual being considered would maintain contact with services and take medication if the CTO was not in place. In other words, the possibility of being discharged from the CTO was increased if the panel was convinced the service user would keep to their treatment plan – a kind of ‘future contract’³⁵.

Accordingly, and in line with the practitioner decision-making described here and in previous research (Dawson and Mullen, 2008), a key factor that panels appeared to base their decision on was the perceived presence or not of insight in the service user. As this Chair points out: *Insight is the biggest thing. If you feel the patient has insight into their condition, then they are more likely to continue the medication and obviously the power of recall is tied to the insight into the condition.* Chairs ranged in their perspectives on insight, with some being more critical of the concept than others:

The concept of insight is something that we're been taught well. I've been advised to challenge, in other words, insight means agreeing with your doctor [laughs] therefore if you disagree with your doctor clearly you lack insight and if you lack insight you clearly need to be medicated. So I think it's something that I haven't thought about before I was advised in this respect but I do think one needs to bear that in mind.

However in practice, the task of challenging and analysing what practitioners meant by insight could be difficult for panels to do, especially with limited information. For example, in Graham’s case notes there appeared a pattern of

³⁵ As will be discussed later, this meant that even if a CTO was discharged, its influence over both future treatment and behaviour was likely to continue

him not wanting social support, and repeated failed requests for medication change. He had also undergone a recent change of team which he had found stressful. However, these factors contributing to why he might not want to engage with services were not dealt with at appeal, with the decision being based on his non-compliance with medication and associated lack of insight after being discharged from a previous CTO, when in fact there was no record of him being on a CTO previously.

As touched upon in Chapter Six, the gaining or recovery of insight through the CTO acts as shorthand for a process of internal change, but this could be difficult to qualify. Practitioners sometimes talked in appeals about service users *paying lip service* to the CTO, or *saying the right things*, hence differentiating between surface and ‘true’ change. One signifier of insight that panels relied on was if and how much the service user had actively sought help when necessary, for example requesting voluntary admissions. In these cases, service users were seen to be taking responsibility for their treatment and acknowledging that they required support, hence the need for the psychiatrist to retain power of recall could be questioned. Indeed, as with practitioner accounts in Chapter Six, panel conceptions of insight were closely aligned with ideas of responsibility. At a previous Managers’ Hearing where Sheila had been discharged, the reason the panel gave was:

The panel were impressed with the patient’s insightful presentation. The key element in reaching the decision to discharge is that her freedom is limited by the MHA. She is keen to take personal responsibility and there seems to be an acceptance by the team that she needs to be given an opportunity for self-reliance.

Conversely, when a service user was deemed unable to gain insight, the CTO could be seen as supporting them to maintain a semblance of ‘normality’ and responsibility regardless, as this Chair explains:

There is a lady I saw who came with her husband and the comment in the psychiatrist’s report was that this was one of the most insightful patients he’d ever met and to me that speaks volumes. The CTO was continuing to be extended and I think she was in her second year. And it does seem an awful long time but then you think well she could live a reasonably productive life, she had a small part-time job, her kids had a good relationship with her, she’s got a husband and you think, wow, if the CTO can facilitate that, she was contributing economically to the household and to the workforce, you think what a success story that is.

Risk

In this sense, even if a service user was believed to be ‘low risk’ they would still be unlikely to win an appeal if they demonstrated little insight. At Craig’s Tribunal, the judgement in favour of the CTO noted that there was a lack of evidence regards threats to his safety or others, but because Craig lacked insight, there did remain a risk to his mental health deteriorating if the CTO was lifted. This suggests that panels accepted practitioners’ broad interpretations of ‘health and safety’ as a basis for their decisions. There were individuals who clearly presented a serious risk of harm to self and/or others, and where the renewal of the CTO was a relatively straightforward decision on that basis. On the whole however, whilst concerns about the seriousness of the implications if a service user did not maintain engagement were certainly present, they appeared to be secondary concerns. Nevertheless, risk figured as a constant factor in practitioner testimony, even if it was not entirely applicable to the case in question.

Indeed, in many cases there appeared to be a risk ‘shorthand’ whereby risk was talked about in a vague sense without delineating what it actually meant for that individual. As noted in Chapter Six, risk was conceptualised by practitioners in a number of ways, including ‘nuisance’ or socially problematic behaviour. Alongside broad discussion of the nature of risk, the history of risk was also accounted for by practitioners in various ways. There could be a lack of differentiation between predictive risk based on probability and ‘proven’ hazards, including events that had already occurred, as shown in the following exchange about Sheila:

Chair: Would there be a risk to her safety?

Psychiatrist: Yes because when she is a psychotic state she is more vulnerable and at risk of being harmed by others.

Chair: Do you consider this a potential risk?

Psychiatrist: Yes

Second panel member: But there’s no history of her being harmed in this way?

Psychiatrist: No, but she’s put herself in danger.

Second panel member: So it’s not an actual risk as there’s no evidence of this happening in the past.

Furthermore, there was at times a ‘stickiness’ to risk narratives, whereby ‘one-off’ or long-ago incidents would still be referenced by practitioners in their arguments for the CTO. With Gwen, the psychiatrist put the following in his appeal report: *As she has a history of lacking insight when becoming unwell with associated risks of the illness which include taking overdoses and aggression towards her mother, it is necessary that I should be able to exercise the power of recall.* In the appeal it became evident that Gwen, now a woman in her forties, had taken an overdose in her late teens, and had pushed her mother once during an argument some five years earlier. There is a marked disparity between the psychiatrist’s written presentation of these events in order to justify renewal of the CTO based on risk, and the reality of what and when had actually occurred.

Contextual factors

Out of all the cases I observed at appeals, Gwen’s appeared to be the strongest for discharge from the CTO, in that she had been stable for three years with no recalls or admissions, had no issue with her medication or the team, and there appeared to be little evidence of risk to her or others. However, her case highlighted how important contextual factors could be in decision-making, specifically here the influence of family. Gwen’s parents attended the appeal and argued strongly for the CTO to continue, as her mother said in the appeal: *It took us three years to get help for Gwen and we feel the CTO is there to help provide a safety net for her. The CTO is a comfort factor, it reassures us.* Whilst Gwen’s parents were vocal during the meeting, Gwen said little and displayed a ‘passive’ attitude to the CTO. In the panel discussion, the panel decided to extend the CTO for a further year, and it was evident the views of the parents were integral to that decision:

Second panel member: If she has sufficient insight you could argue she doesn’t need the power of recall in order to take medication.

Third panel member: I think she’s functioning fairly well but it would appear that she’s getting an awful lot of support from family and from services to a lesser extent actually. But we need to renew to keep that all in place.

Chair: But it would be in place anyway.

Third panel member: Yes but the parents would see it as a disaster. At the moment they desperately need the term ‘CTO’ to feel supported.

It appears that although it was doubtful that Gwen met the legal criteria for the CTO, even being as broad as they are, the symbolic value the CTO held for her parents was influential in the panel's final decision to uphold the CTO.

The CTO in this case also represented stability, in that the panel recognised the need for Gwen's support system to be maintained. In a wider sense, the stability or not of the service user's life circumstances was significant in appeal discussions. It appears that it was not only service user's 'internal' stability (via insight) that was deemed important, but also 'external' stability in terms of their housing, occupations and relationships. Many of the service users lived precarious lives, where constant change was a given, and consequently practitioners often justified continuation of the CTO on the basis of 'life stressors'. As this Chair answered in response to a question about the kinds of arguments that practitioners made for CTOs:

Well, a likely change in the person's placement, moving from a hostel to independent living...Some sort of change in their circumstances that would cause them stress. Because I think the psychiatrists are very aware of stress factors that could cause a relapse, so it could be any sort of stress, a death or...you know anything in their personal circumstances that has changed, and you know that can cause a quick dip in their mental health and that's really what the psychiatrists are looking at.

Timing

On this logic, if a service user was deemed to have insight and be low risk, but was going through a period of change such as a housing move, then the CTO could be successfully justified as an anchor during that process. Further, if such instability in circumstances was relatively continuous, then an argument could be made for on-going CTOs. This brings us to the final factor that influenced decision-making, that of timing. As noted at the beginning of the chapter, CTOs are open-ended in that they can be renewed without limit and some Chairs reported that they were more cautious about renewal the longer the CTO:

It gets more difficult because obviously they are on the mend in terms of progress they are making. So I think funnily enough it brings a bigger challenge to the hospital managers to decide at what point they will not support the renewal. I've certainly had instances where I feel the clinician is being too risk averse and we have to really intervene to stop that, because otherwise it can go on forever.

But there could be a tension between this stance and practitioner views on making the CTO work. As discussed in Chapter Six, many practitioners took the view that for the CTO to be effective, it had to be in place for a significant amount of time. Hence even in cases where the CTO had been in place for some time, with adherence and stability achieved say for a year or more, and no recent ‘risk events’, practitioners would argue that the CTO should be retained in order to maintain progress:

And I've said in CTO tribunals, 'if it ain't broke, don't fix it'. The patient has to be on the CTO for a while before the full benefit can be achieved, so lots of times even though the patient is engaging very well, they are saying all the right things, they are happy to take the treatment, they are happy to see us, we are still going for a renewal. Because it has only been a year and it is too short a period for us to say whether they will be able to stick to that.

Panels often seemed to accept this argument, with the following comment in a panel discussion being typical: *I think it's quite a difficult one. If there had been two or three months more of progress then I'd think more about whether to renew or not. But it's just a bit early now.* Whilst in theory panels needed to consider whether the legal criteria for the CTO were still valid at that particular point in time, in practice it seemed that they often agreed with maintaining the status quo for the foreseeable future if it was seen to be ‘working’. Conversely, as highlighted throughout this section, if there was evidence of any (broadly interpreted) difficulties in relation to insight, risk or contextual factors despite the presence of the CTO, this too could justify continuation, as practitioners argued that the CTO provided a framework to manage such issues over time. For example as discussed in the last chapter, in cases where there might be repeat recalls and where practitioners were unsure about the CTO because it was not working in the way they would like, appeal panels were sympathetic to extending the CTO as a form of case management. Similarly to AMHPs when making the decision to impose the CTO, the decision by appeal panels to maintain the CTO could thus have a certain inevitability.

To summarise, what we can see is that the CTO may become a ‘lobster pot’ - easy to get into but difficult to get out of - because convincing arguments can be made for its continuation both when it is deemed to be a success or a failure.

Table Seven below, which compares practitioner perspectives on when to extend

the CTO, illustrates this point. However, the table also shows that practitioners could hold similar views when it came to the appropriateness of discharge, thus demonstrating the difficulties in reaching clarity on discharge decisions. This section has described appeal decision-making, where due to the function of appeals, practitioners are almost always making a strong argument for the CTO to continue. The following two sections will examine the variety of participant perspectives on discharge and how they play out in the CTO review process.

Table 7: Practitioner perspectives on when to discharge or extend the CTO

	‘Success’	‘Failure’
Argument for extending the CTO	<i>If we think that patient has clearly achieved that level of being well and complying then we'll just go for renewal of the CTO, because from my point of view it is better to have them on the CTO for another period of 6 months or a year rather than putting all that kind of improvement down the drain and start the process from scratch all over again. So I will take a cautious view of discharging someone from a CTO.</i>	<i>With some of them it hasn't worked in that sense, if they're not making any progress. All it's done is enabled us to get them back into hospital quicker when there's any sign of relapse or the risks are increased due to non-compliance. So, it's reduced the risks and it's probably reduced the length they stay in hospital. They haven't engaged with us any better but it's still worth keeping the CTO on rather than the alternative of having to section them every few months.</i>
Argument for discharging the CTO	<i>Where we have taken them off the CTO, it's because all the evidence is that they're complying, they're moving forward. I hate the word insight, I don't actually think there's such a thing, but they're displaying something that people would call insight. So, therefore the moral, legal and ethical realities are that that person shouldn't be on a CTO.</i>	<i>It wouldn't work if a patient breaks their agreement from day one. I can think of one patient who has no insight and he has no regard for the conditions of the CTO. So that puts a person in a dilemma somehow because we kept bringing him here, recalling him every time he needed to have his injection. And again it becomes time consuming and you have to ask whether it's the best way to manage him or we can manage him in a different way, whether he needs to be on it if he's at that level of uncooperation and lack of insight that it's not worth it.</i>

Negotiating discharge

On the basis of the above table, we can see that there are two kinds of CTO discharge scenarios that practitioners have to deal with:

- Those individuals who were resistant to the CTO and whether to maintain the CTO as the framework being necessary to contain such difficulties, or to take a risk and discharge on the basis that support and treatment could be provided more effectively in a different way;
- Those individuals who were adhering to the CTO and whether to maintain the CTO because it was believed that the individual would not maintain progress without it; or to take a risk and discharge on the basis that the individual has a moral right to that opportunity.

CTO reviews, where the decision to extend or discharge was made, brought to the surface such dilemmas through debates between different practitioners, and practitioners and service users. In this section I explore how such dilemmas manifested in reviews, beginning with a description of practitioners differing attitudes to risk, and the effect on service users of these attitudes. I then look at how practitioners worked out whether discharge from the CTO should happen or not in reviews, specifically in relation to the influence of service user testimony. I end the section with a discussion of the difficulties of escaping the CTO for service users, even post-discharge.

Reviews typically occurred in the weeks before the CTO was up for renewal. They were more informal arenas than appeals, and usually included the care coordinator, the psychiatrist, the AMHP who had seconded the initial CTO decision, and the service user. Family members could also attend, although this did not happen for any of the reviews that I observed. Reviews tended to be more discursive environments than appeals. At appeals, the main participants aside from the panel have already ‘made up their minds’ so to speak. In reviews, there was more room for persuasion and negotiation. Whilst none of the service user participants was discharged at appeal, 6 out of 18 were discharged at the review stage during the fieldwork period. It should be noted that the pattern of discharge followed the team dynamics presented in the last chapter. For example

in the team where the psychiatrist was not a proponent of CTOs, 5 out of 10 of the service users included in the study were discharged. He always used current engagement as a basis for his decision, that is if the service user was engaging in the here and now. In the team where the psychiatrist was an advocate for CTOs, 1 out of 8 of the service users included in the study was discharged (and only after much persuasion from the care coordinator). He always used potential future engagement as a basis for his decision, that is forecasting what the service user would do post-discharge, hence making the possibility of discharge much more difficult.

Risk-taking or risk-making

Where practitioners differed in their views then, in an echo of previous research (Mullen, Dawson and Gibbs, 2006), it was around how best to manage the uncertainty and risk inherent in the discharge decision. In Christine's case, the psychiatrist felt it was time for the CTO to be discharged whereas the AMHP felt strongly that it should be maintained due to her knowledge of Christine's history. The care coordinator (who remained neutral during the review) commented afterwards:

Thing is, I know Jenny [the AMHP] has known Christine for a long time, but you can get things wrong sometimes. And with Christine, she has to have a chance. We can always bring her in under the Mental Health Act if needs be. Is it really worth it in the balance if she feels unhappy about it? I mean who is it for, her or us? At the end of the day, it's Dr Stokes' decision. Though Jenny probably won't like it.

The care coordinator illustrates the role of positive risk taking in CTO decisions, whereby defensive decision-making can be challenged and where the potential for individual change would be respected. Practitioners talked about the need for hope and proving their trustworthiness to service users by not 'shifting the goalposts' on when discharge would happen. This psychiatrist explained that preparation for discharge should start from the beginning of the CTO: *So being clear from the start about what would constitute success of the CTO, and for how long that CTO would have to be successful, or what other conditions would have to be met for you to consider removing it. They need a little bit of hope, if they're not happy about it.*

This was not the case for all service users however. For service user participants where professionals had not got to the stage of discussing discharge as a possibility with them, it could seem like a far-off prospect. This meant some participants described holding a rather fatalistic attitude to discharge from the CTO, with for example Andrew stating: *It's just down to time to elapse, time to run its course, that's what I have to do with the CTO, keep out of trouble and all that.* This in turn could engender a sense that the CTO was 'never-ending', as illustrated by Michael, who expressed uncertainty about when the CTO could end: *I'm not sure how long a CTO can last for, if it's a lifetime event for instance or if the CTO is just like a six month investigation into a person who is not well.* Trying to 'read' professional intentions could be difficult, particularly when professionals were uncertain themselves, or differed in their views. Sheila described in a frustrated tone how she had tried and failed to get a clear answer from her psychiatrist: *I did ask him point blank, I said 'how many more years do you think I will have to be under the Mental Health Act?' and he said 'about another two years'. Well two years is nearly up with but I bet if I asked him he'd say something different. You never know where you are with them you see.* As can be imagined, holding any hope or optimism about coming off the CTO could be difficult in such circumstances, as Patrick illustrated when asked what would have to happen for him to be discharged, and he answered: *I don't know, a miracle.*

Evidence and Trust

Despite this, it was interesting to observe the differences between how service users were positioned (and positioned themselves) in discharge discussions, as compared to when they were first placed on the CTO. As described in Chapter Seven, very few participants reported being meaningfully involved in discussions when they were placed on the CTO. However, being discharged from the CTO was a different matter, with service users taking centre stage in discussions about whether to continue the CTO or not. Because discharging an individual from a CTO was seen as taking a risk, the ability of participants to persuade professionals of their intentions was an important factor in the process, as Graham illustrates when asked how he had been discharged:

He [the psychiatrist] just says 'I don't know whether to take you off it', but I just said 'I'm ready to volunteer now. I've been on medication a long time, different ones, and this one works, so it's medication I need. They'll [his family] make sure I take it anyway'. So he said 'I'm not going to extend the Order'. For him to do that, he would have kept me on it if I'd said no to medication.

Invoking the dual elements of evidence and trust were necessary for service users to secure discharge. Trust has been referred to previously in these findings in relation to service user trust in services and practitioners, yet trust in service users also figured in practitioner decision-making, particularly on discharge. The presence of the CTO may make it difficult for practitioners to judge whether an individual's actions are representative of internal or external drivers and therefore likely to be consistent over time, or only responsive to compulsion. For the majority of participants therefore, they had to persuade the psychiatrist of their intentions to work collaboratively and honestly with the team, as Irene describes: *if there were any changes in the way I was feeling, I would definitely tell him, and as long as he was happy about that he was happy to take me off the treatment order.*

Observation of CTO reviews illustrated the different ways service users went about this persuasion, including: contrasting the past and present, appeals to the strength of relationships with practitioners, presentation of coping strategies, and dealing with practitioner doubt. The following exchange in Christine's review illustrates all of these elements of persuasion:

Psychiatrist: Have you had any issues with taking your meds?

Christine: No, I know they keep me well

Psychiatrist: So do you think the CTO...without it you'd take your meds?

Christine: Yeah...

Psychiatrist: That wasn't a strong yes [smiling]

Christine: It is a strong yes [emphatically]. This is the welllest I've been in the last 5, 6, 7 years.

Psychiatrist: And contact with the team, is it because of the CTO you do it?

Christine: No, it's helpful. I get on with Naomi [care coordinator] and if she's not there I can always ring Martha [the team secretary].

Psychiatrist: If we took you off the CTO would you still ask for help if you needed it?

Christine: Yes, because I'd phone the ward if I was feeling unwell

AMHP: But you haven't done that in the past have you Christine?

Christine: Yes, but I'm weller now

In Christine's case, even though the AMHP was strongly against discharging her from the CTO, the psychiatrist was sufficiently satisfied with Christine's responses to discharge her, as he concludes in the review:

I think if being freer would be helpful for you, and you could feel more in control of your treatment, I would support the move to remove the section. But if I think the CTO was making you have contact and take medication then it would be different. But you've said it's your wish to take medication so I'm quite happy to take you off the section.

The development of a reciprocal relationship seemed particularly important to practitioners in deciding to discharge, where care coordinators in particular 'knew' the service user would accept their involvement, as happened in Irene's case: *She didn't want to take medication, but she knew I thought she needed it, and she was probably likely to take it because at that point she had built up enough trust with me, trust in my judgement.* Sometimes, as described in the last chapter, practitioners did not feel they could get a sense of what was going on 'under the surface' with a service user, either because of a lack of relationship or because the service user was not 'enacting' enthusiastic compliance and instead doing the 'bare minimum'. As also noted in Chapter Seven, such behaviour from service users could be deliberate as a way of retaining some control whilst simultaneously doing what they needed to do in order to secure discharge. However acting in this way could also make discharge decisions less certain, as the following example demonstrates:

I had one case, where I didn't know him that well, he was on a CTO and I did think 'now then, I'm not sure if he's going to comply or not'. And he really was a man of very few words so I wasn't sure what was happening. You wouldn't get anything from him. and you could never get underneath to see, well is he masking stuff or is he just very blunted, or is he getting on fine and he just doesn't want us knocking on his door every fortnight? And I thought 'I think we'll get this renewed' and we did renew it and I thought 'do you know what, I think there really wasn't a need for that but it's done now'. And then it was coming up to lapse, we let it, and it was fine in the end, but it was because I didn't have a feeling either way of what would happen. (Care coordinator)

Practitioners also talked about 'testing out' service users' trustworthiness by progressively lessening the level of intervention whilst still on the CTO and gauging the service user response to increased freedom before deciding on discharge. This could take the form of 'bargaining' with service users about expectations. For example in an observation of a home visit, a care coordinator

told the service user: *make the right changes in your life then when the next review comes up we'll look at it seriously about whether we need this CTO or not.* More often, the 'testing out' was in relation to moving from injections to oral medication³⁶. The CTO in such cases could be seen as a way of meeting service user goals within a controlled environment, as this care coordinator commented in relation to an upcoming Tribunal:

I'm thinking of changing my view to the tribunal to say we could try a phased self-medication with his current medication, to show we're using the CTO in a positive way, to try and reach his goals. We might not have shared goals about what's wrong with him, but we can have shared goals for plans for the future

Certainly, some participants described meeting their own desired outcomes through the CTO as well as those of professionals. Referring back to Chapter Five, service users could see discharge as a step towards recovery and 'normality'. In particular James was very clear about when he would feel ready for discharge: *So I'd want a stable relationship, financially better off which would be a job or just, well, money, and then still be compliant and then I could say to them, 'look, I've got this, this, this, can I come off it?' I'd hope they could respect that.* From James' perspective, making such progress should signal to the professionals who worked with him that he was prepared for discharge. In this sense, service users had to do more than 'talk the talk' in terms of persuading practitioners of their readiness for discharge.

CTO cycles

Such enactments of responsibility did not necessarily end when the CTO ended. As noted earlier, the 'threat' of future compulsion could act as a way of binding service users to standards of behaviour in the future, even when they were no longer on the CTO. Although Irene believed her relationship with the team and in particular her care coordinator was much improved due to the lifting of the CTO, she also described taking her medication under some pressure: *They said if I get unwell, I'd end up put back on the Community Treatment Order, so I decided to take it.* Irene's care coordinator explained to me that she had tried to

³⁶ Although it was more likely that service users would be moved onto oral medication at the same time or shortly after discharge from the CTO.

talk about the CTO discharge in positive terms with Irene, as a chance for them to work together, but that the psychiatrist had taken the opposite tack at the discharge meeting: *he said to her 'this doesn't change anything, you need to keep taking your meds, because I hate to say it but if you don't the whole thing will start again and you'll be on the CTO for a very, very long time'.*

This meant that when service users did relapse they could become caught in CTO cycles, whereby relapse once the CTO ended was seen by practitioners as a result of coming off the CTO and 'proof' that it worked. An AMHP remarked that:

Very often it is that, 'well I told you so', and that fits in with the risk-averse culture and way of working, because it might have had bugger all to do with the CTO the fact they've relapsed and they've come back in, but then that massive unscientific link is made, 'it's because we've taken them off the CTO that this has happened'. It's quite a useful leap of faith for a consultant to make if he wants to put them back on the CTO without any questions for a long time again.

Consequently, once an individual had been placed on a CTO it could colour any further treatment and intervention; if an individual was placed on a CTO more than once, it could become increasingly difficult to be discharged from it.

Patrick had been on the CTO for over two years without a relapse by that point, the longest time he had been well for a number of years, and felt he had done everything that could be asked of him: *I don't know what they want. I don't know what they expect. Two years. I would've thought that after two years they would've discharged me.* Ironically Patrick did experience a serious and lengthy relapse shortly after this interview whilst still on the CTO, and was re-hospitalised and eventually released back onto a CTO which his care coordinator stated would be for the foreseeable future. The CTO therefore could act as an encompassing form of compulsion, facilitating movement between levels of compulsion, but making it difficult for individuals to be entirely free of it. In this regard being taken off the CTO could also be seen in resigned terms, as Patrick stated: *it's just swings and roundabouts.*

Discharge dilemmas and balancing acts

For practitioners, discharge dilemmas were not only related to making judgements based on service user presentation and their trust in the service user.

They also talked in a more direct sense about balancing the potential positive and negative consequences of maintaining or discharging the CTO dependent on the individual in question. In this sense, the ethical balancing acts that practitioners maintained, as highlighted particularly in the last chapter, carried on into decisions to discharge. The two balancing acts that practitioners considered at this point can be related to firstly weighing up dependency and responsibility, and secondly weighing up engagement and alienation.

Dependency vs. responsibility

As has been discussed in this and previous chapters, the rationale that CTOs could foster a sense of responsibility was widely held by practitioners. The provision of boundaries and ‘contractual’ obligations via the CTO could be seen as a way of generating behaviour change through sanctions (recall) and incentives (staying out of hospital) over time. An ideal scenario was if such behaviour change led to stability, recovery and eventual attitude change, with the service user not only adhering to desired ways of interacting and being, but actively pursuing self-care and adherence. Nevertheless, practitioners generally held the view that some individuals would never reach this final stage. For service users who had been in the system for a long time and who were deemed institutionalised, the very reason the CTO was perceived to be effective was because of their conditioned attitude to authority, and it was difficult to see how the CTO would be removed in such cases:

The moment we take them off the CTO, they've stopped being compliant again. I suppose that's just about boundaries and the way people respond to them isn't it? Some people just do really well with boundaries in place, and the moment they don't have them anymore they just don't know how to function ultimately. And that's probably true of a few clients within Assertive Outreach, who have spent long periods of time in either secure environments, prison environments, they just become accustomed to having those boundaries in place and having to deal with them. (Care coordinator)

There was an acceptance here of the need for dependency in some cases. At the same time however, some practitioners had concerns that a ‘tipping point’ might be reached on lengthy CTOs, whereby they would foster a sense of dependency and undermine self-efficacy. In this way, the CTO could be framed as a

continuation of institutionalisation - what one practitioner called *a virtual asylum*. Practitioners wondered about the fairness of on-going community compulsion simply because it was less restrictive than detainment in hospital, as this AMHP points out:

The temptation would be just to keep something that's keeping the person stable in place ad infinitum and gloss over the fact that it is actually still a section of the Mental Health Act and having some impact on their liberty. There's not that many people who would have been on section three for the same length of time.

Such potential 'soft' negative outcomes of CTOs have typically been neglected in research and policy discussions (O'Reilly et al, 2006), but a number of practitioners expressed the view that: *There is a big risk in taking away somebody's autonomy and how that makes you feel as a person and how that affects your long term development.* The decision to remove a CTO is usually seen as taking a risk, whereas in this light, keeping the CTO on is viewed as the potentially harmful option, albeit in a more nebulous way.

Furthermore, it was felt by some practitioners that the CTO could discourage accountability and unfairly shift responsibility onto practitioners, as one care coordinator talked about in reference to a service user where criminal charges of assault had been dropped because he was on a CTO³⁷:

So now he takes no personal responsibility for his actions because he knows that we'll monitor him, we'll make decisions for him and if anything goes wrong again, it's not his fault. So, for me, him not being on a CTO and having some responsibility might be better, a CTO makes it my responsibility.

Indeed, removing the CTO could encourage the 'responsibilised' response it was hoped that the CTO would elicit, as this psychiatrist explains:

There have been times where the patient was under the CTO and engagement had been a problem. With one we decided to give him a try to see how he'd cope without the CTO because he'd been on it for three years, and actually engagement has improved, the patient is taking more responsibility for his problems. We must have done at least ten recalls for him in those three years for his depot, but now he's off the CTO for a few months, and he's been happy to have his depot without any problems. He knows he's not obliged to engage with

³⁷ This connects to a point made in the previous chapter about the CTO shifting responsibility from a range of agencies onto mental health services. In this particular case: *This decision [not to prosecute] was based mainly on the fact that Stuart is at present being adequately supervised/monitored on his CTO and CPS felt that if the matter went before court that the court was not likely to impose anything more effective.* (email from police in case notes)

the team so he's happy to see us, and he's more involved in his own care.

This was particularly the desired outcome of removing the CTO when service users were believed to be subverting the CTO for their own purposes. In the last chapter I noted that where service users had absorbed the CTO into their coping strategies, the CTO could be deemed firstly as meaningless as the recall function became undermined, and secondly as reinforcing dependency through the engraining of patterns of behaviour. Other service user responses to the CTO could also influence discharge decisions, as described next.

Engagement vs. alienation

Some practitioners held the view that in cases where individuals on CTOs were resentful of them, continuous CTOs would negate any therapeutic work that could be done: *I always try and get them off the CTO within 12 months. As a therapy move, because you can only work against somebody's liberties so long before you alienate yourself from them because you keep on renewing it.* As with the effect of the CTO on service user autonomy, a 'tipping point' could be reached. In the last chapter I discussed how the contact the CTO ensured could support the building of an initial relationship with service users, but in the longer-term the CTO could get in the way of sustaining such relationships. Alternatively where service users resented the CTO from the beginning, it could damage any pre-existing positive relationships between practitioners and service users, or worsen an already difficult relationship. For those service users, there was little overlapping of their position with that of professionals, as they rejected any purposive meaning for the use of CTOs and consequently the institutional means it entailed.

As noted in the last two chapters, the challenges caused by this kind of response were not only limited to damage to the therapeutic relationship. In particularly complex cases where personality disorder and/or substance misuse were present alongside psychosis, the CTO could not only be ineffectual in managing the variable risks that arose, but could also exacerbate conflict and consequently risk. The CTO might be kept on in such cases as an overt practice of defensive decision-making, as a care coordinator commented in a CTO review on such a

case: *I'm just thinking about the unknown. To take it off now with the increased risks, we'll be hung out to dry.* In this sense it is ironic that whilst it might heighten risky behaviour, the CTO could be kept on solely in order to give the impression risk was being managed.

More broadly, individuals who were actively resistant to the CTO could undergo significant 'battles' with practitioners to regain a sense of control, either through working within the system, by using every appeal possibility to challenge the CTO, or working outside the system, by acting like the CTO did not exist (avoiding appointments and disregarding notices of recall to hospital). In Craig's case, he used both routes in acting against the CTO, and the problems the CTO caused between him and his care coordinator led to the decision to remove it:

I'd say the biggest factor to take Craig off the CTO...when I visited him, he sat with a notebook and a pen while we were having a conversation and I thought I can't-, how on earth do you work with someone when they're sat with a notebook and a pen recording every element of your conversation ready for the next tribunal...you can't work with someone like that, can you? It's impossible...so that for me was the-, this is nuts...he's got to come off it.

During follow-up interviews with service users post-discharge it became clear that despite the continuing presence of leverage and the potential 'threat' of a further CTO, removing the CTO could be a step towards repairing the service user-practitioner relationship and enabling more effective support. Rebuilding a mutual sense of trust and moving the relationship away from a 'surface' focus on monitoring and compliance, necessitated practitioners disassociating themselves from the CTO. For Craig having a 'fresh start' without the CTO meant for him that: *we've turned it around pointing in the right direction for once*, towards a place where he felt he could work together with his care coordinator. Irene, when talking about the post-CTO changes to her relationship with her care coordinator said: *We've got a lot closer now. I'm more free, I've got more choice now. I feel she helps me more now. Because they know I want help now.* The CTO is designed to encourage individuals into engaging with practitioners, but what these participants' experiences suggest is that feeling compelled into accepting help can sometimes undermine more meaningful engagement. Moreover, in Irene's view, having to accept support meant that practitioners

'had' to provide it; being taken off the CTO for Irene represented more freedom on both sides of the relationship, and in turn she felt more valued by her care coordinator. In a mirror image to how practitioners worked with service users to create shared meanings for the CTO, discharging the CTO could act as a way for practitioners and resistant service users to find a 'mutual account' within which they could work together.

Similarly, and as noted earlier, the majority of participants who were accepting of the CTO still looked forward to a future without it, as having the CTO removed signified they were able to thrive without the legal structure the CTO provided. Whilst practitioners may see maintaining the CTO as supporting individual stability and (potentially) change, being 'stuck' on the CTO could negate a sense of any forward momentum for service users in the longer term. However a significant minority of service users who were happy to be on the CTO wanted it to be a long-term presence in their lives, which could bring its own set of challenges for practitioners. As discussed in previous chapters, service users could closely align their sense of self and what they subsequently felt they needed in terms of support and external authority with the CTO. For these service users who appreciated the boundaries the CTO provided, the idea of the CTO being removed could generate similar feelings associated with coercion that the participants who were resentful of the CTO described, such as not having their view respected, anxiety and a lack of control. Nick expressed considerable anxiety about the thought of being discharged: *I'd like to stay on it for the rest of my life, if I could. I wish they'd done this years ago to us. Maybe things wouldn't have turned out the way they have turned out.* In such cases, a pattern of uncertainty surfaced in practitioner discussion of individuals, in terms of how and if to bring about CTO discharge. On one hand, practitioners often thought the service user was more than ready to be taken off the CTO, on the other they were aware of the distress such a decision would cause and recognised that the CTO offered meaningful security to the service user. This psychiatrist talked about the difficulties these situations could bring:

There are cases where the CTO has to be continued at the insistence of the patients themselves. Very surprising. There is one particular patient, she is so adamant to remain on the CTO, so that makes the decision-making very difficult. Myself and the other people involved really strongly feel the CTO has run its

course and she could function extremely well and engagement is not an issue. But I think it would be unwise to go against the express wishes of the patient. It would definitely affect the therapeutic relationship, we'd definitely be blamed if it goes wrong. It's going to be quite a battle to convince her really.

As one AMHP commented, if it were an inpatient section, there could be gradual discharge from hospital to acclimatise the individual, but *you can't do a gradual discharge for a CTO*. The service user in this kind of situation thus has a substantial amount of control over discharge decision-making. 'Never-ending' CTOs are usually presented (and indeed have been in this chapter) as generated by the nature of the CTO framework and by practitioners, but in these cases it is the service user who drives sustained compulsion. This highlights both the variety of responses the CTO can provoke, and the complexity of discharge decision-making in relation to such responses.

Concluding thoughts

In this the final findings chapter, I have examined the two main routes to discharge from the CTO – appeals and reviews, interpreting how and why decisions to uphold or end the CTO are made. This chapter has carried on a number of the themes developed in the previous chapters to their conclusion and I summarise these themes here.

As with the decision to apply the CTO in the first place, and to use the CTO once in place, the decision by appeal panels to uphold the CTO could follow a compelling logic. As noted near the beginning of the chapter, the rate of successful discharges at appeal from the CTO is low – 16 % compared to 35% for discharge from inpatient detentions. Through examining the factors that shaped panel decision-making we can potentially see why this might be the case. The legal criteria for CTOs are broad, and as shown here also broadly interpreted. In deciding whether the power of recall is still necessary – the key question for CTO continuation or discharge – panels drew on extra-legal and underpinning concepts. Indeed, panels rarely considered whether recall *is* necessary in the present, instead taking a future oriented view on whether recall *will be* necessary for the foreseeable future. In doing so, they made similar

connections to practitioners between the development of insight, internal change, treatment adherence and service users taking responsibility for their lives and their actions. Whilst panel members might have a critical awareness of concepts such as insight, it was also difficult for them to ‘step outside’ the prevailing discourses in mental health as filtered through professional explanations and consider alternative ways of thinking about the paths service users had taken to that point.

Risk – as defined in terms of the health and safety of others – was generally a secondary concern for panels, but was also presented in a way that made it difficult for panels to critically engage with. Practitioners took their wide-ranging conceptions of risk into the appeal, both in terms of the presumed nature and history of the risk in question, meaning it became rather a mutable concept to pin down. Insight and risk were not the only factors panels took into account however. In this sense they went beyond the legal criteria in making their decision through a consideration of context, specifically the views of family, the presence or not of life stressors and the timing of discharge. In order for panels to weigh up legal criteria they can be expected to a certain extent to draw on context to reach a full understanding of an individual’s situation. Nevertheless, an evaluation of such factors alongside the already broad approach taken to the legal criteria could significantly weight the decision against discharge of the CTO. It seemed that it could be successfully argued that it was never the right time for the CTO to end, regardless of whether service users were deemed to have made a ‘success’ of the CTO or not – discharging the CTO is always framed as taking a risk. CTOs have sometimes been compared metaphorically to a ‘lobster pot’ in that they are easy to get into, but difficult to get out of, and these findings provide some insight as to why that might be.

Given the difficulties in being discharged from a CTO, the appeals process was viewed with some scepticism and indeed anger by those service users who wished to be discharged. This highlights a further ongoing theme – that the strategies used in order to mitigate the coercive effects of the CTO may instead make both feelings of coercion worse and further undermine relationships with service providers. In the previous chapter, we saw how this could happen in

relation to practitioners' attempts to avoid recall. Here, the oversight system that is intended to ensure service user rights are safeguarded could have the unintended consequence – often despite the use of a procedural justice approach - of reinforcing to service users that their rights are not considered important. Such feelings could lead to service users' not attending appeals, which ironically could at times be the factor that would lead panels to uphold the CTO. The relational aspect of CTO practice came to the fore here, with panel Chairs stressing the importance of seeing service users and assessing their interaction with practitioners for themselves.

The responses of service users were also of importance in the review process. Given that CTO reviews allow for contestation and shifts in decision-making, how service users presented their progress took a more significant role than it had at other decision-making points in the CTO process. In order to overcome practitioner qualms about risk-taking and alleviate their sense of uncertainty, service users who had managed the CTO well then had to persuade practitioners that they would continue to engage with services and to make progress in their lives. To do this, service users called on evidence of their progress and the trust that they had built up with practitioners. Where practitioners believed they really knew and trusted the individual in question and witnessed adherence through different phases of the CTO, a decision to discharge was more likely. In turn, practitioners were more likely to elicit such a response from service users if they were clear and honest about when and why the CTO would end. Hence the agency service users displayed in acting on CTOs, together with the mediating influence of the service user-practitioner relationship on the CTO, continued to be present in its final stage as they had throughout. At the same time it needs to be recognised that a reliance by practitioners on particular kinds of proof and conceptualisations of causality could make it difficult for service users to entirely escape the CTO. Whilst individuals who have been within the mental health system for a long time tend to be consistently subjected to various kinds of formal and informal leverage, the very fact that a CTO had been in place could frame future service user actions and service responses in a way which meant the CTO could not entirely be escaped.

For service users who had not adhered to the CTO, practitioners also had to decide whether to take a risk in discharging. Such dilemmas were framed in ethical terms, and continued the balancing acts practitioners had taken during the course of the CTO about whether the CTO could be deemed morally right and relatedly the effect it had both on individual service users and their actions towards the CTO. In this sense the practical and the ethical remained entwined; practitioners expressed qualms about the impact on service users of reaching a ‘tipping point’ in dependency and engagement, but also about the responses such effects could engender and the difficulties they might bring for service provision and practice. Given the nature of such cases, deciding to take this risk was not based on active persuasion on the part of service users, but instead whether maintaining the CTO was worth the ethical discomfort and associated difficulties it had brought or exacerbated. I mentioned earlier the unintended consequences of attempts to mitigate coercion within the CTO. Here we can see the unintended consequences of the CTO as a whole in terms of the outcomes it might produce, and indeed how removing the CTO could elicit the outcomes it was hoped that the CTO would bring in relation to relationship-building and inculcating responsibility. Conversely, I hope I have made clear throughout these findings that not all service users struggled against the CTO, and that a range of responses were presented by service users, from passive resentment and active resistance, through subversion to passive acceptance and active engagement. Indeed, passivity and activity do not necessarily correlate with a sense of agency, and different responses might surface at different stages of the CTO, dependent on the individual’s frame of mind and circumstances at that point in time. Service users who had valued the CTO for various reasons and worked within it in various ways could also push for discharge as a way of moving forward. Alternatively, those service users who felt strongly that the CTO met a need for them that could not be met in other ways might experience anxiety and disenfranchisement about the idea of being ‘forced off’ the CTO. In sum, the CTO may be least effective for those for whom it is supposed to work - those who resist compulsion - and in a sense too effective for those where it is not deemed necessary - those who are willing to engage.

Chapter Ten
The ties that bind?
An analysis of compulsion in the community

In this thesis I have endeavoured to get underneath the surface of CTO *practice* – how and why it manifests itself in particular ways, what drives these manifestations, and the implications for service users and practitioners who are invested in them. In doing so, I hope to have made a distinctive contribution by building on the existing body of CTO research and more fundamentally by theorising CTOs in relation to particular accounts of power and change: by exposing the ‘ins and outs’ of CTO practice; how it keys into both service users’ and practitioners’ ethical beliefs and sense of self; how it influences and is influenced by the therapeutic relationship; and how it may result in mixed and unexpected responses and consequences. Accordingly, in this discussion chapter I draw together the findings I have developed in reference to the four sets of research questions outlined in Chapter Two, which are premised on a combined critical realist-governmentality framework. To recap, those questions respectively relate to:

- How and why CTOs came to be seen as necessary and why they came to exist in the form that they did.
- The motivations of practitioners and service users in relation to CTOs: what purposes they do or do not see CTOs meeting; how these purposes align or not with policy-level conceptualisations; and for practitioners in particular how they formulate CTO practice based on these purposes.
- The workings of the CTO: how the techniques incorporated within the CTO regulate behaviour; the ways programme participants act on the central components of the CTO; and the contextual factors which impinge on this process.
- The transformative powers of the CTO; what their consequences are and how these consequences relate to policy/practice theory and purpose; if and how they bring about individual change; and in what ways they might be implicated in forms of conduct and counter-conduct.

On a final note before moving on to the discussion of the findings, I have not included a summarising section in this chapter. Instead, the next and final chapter draws together the different aspects of what I say here and assesses its implications for policy, practice, research and theory.

CTO policy: theory and development

In Chapter Four I presented the findings of a policy review of CTOs, which set out to answer how and why CTOs came to exist as they did in the English mental health system. I placed CTOs within the context of broad international trends and policy drivers, in particular describing how deinstitutionalisation and the associated rise of community care created new political problems to be solved. The creation of a ‘residuum’ of individuals with severe mental health difficulties in public spaces led to widespread concerns in regards to public safety and a related emphasis on risk management. In this sense, CTOs were presented as a solution by way of strengthening the surveillance and (primarily medical) control of risky individuals in the community. I argued that risk management was not the only policy driver however; a concern with risk can be seen as the mirror to an agenda which encourages the individual to be prudential in managing their own lives. The recovery agenda as it has played out in mental health policy has been largely defined in ways which individualise social problems. Bringing ‘irregular citizens’ (Zedner, 2010) through recovery and back into the fold thus requires that strong boundaries are put in place in order to overcome internal constraints, so that individuals are able to develop the discipline to comply, maintain stability and eventually operate in the community with a sense of self-efficacy. From this perspective, CTOs can be seen as a typical governmental practice which is aimed at influencing what individuals may become; the limitation of freedom through control in the short term encourages individuals’ capacity for freedom in the longer term.

The underpinning premise for both the risk and recovery drivers for CTOs therefore is that the problem and the solution are located within the individual. There are connections here with a broader narrative which describes an intensification in recent decades of a behaviourist trend in social policy and an

associated turn to 'coercive support' across a range of welfare domains, which is aimed at ensuring individual responsibility (Rodger, 2008, Flint, 2009). In these terms, it is the individual's refusal to comply with medication and services which leads to their riskiness and/or lack of recovery. There is little acknowledgement in this explanatory framework of the complex reasons why individuals might be non-compliant, or the societal and institutional factors which mediate risk and pathways to recovery. Indeed in a very corporeal sense, it was a 'thin' biomedical model which was called upon in the policy development of CTOs; non-compliance is due to a lack of insight framed as a neurological deficit, and subsequently the prevalent mediating factor for risk and recovery is medication adherence, which will enable self-regulation. The CTO is supposed to act as a contractual device between the individual and services, to enforce treatment and engagement in the face of non-compliance, thus triggering this transformative process. Here I linked the intended 'work' of CTOs back to the 'dividing practices' which are present in governmentality. To recap, individuals are either divided in themselves by being encouraged to cut off aspects of the self which do not contribute to autonomy and responsibility, or divided from others if they are unable to do so. In this way, CTOs contain both inclusionary and exclusionary facets as exemplified through conditions and recall, which provide both an incentive to comply and a sanction if compliance is not met, allowing for reformation but also control.

An important dimension of a governmental analysis is linking the rationalities behind governmental practices to who is made visible to be governed. In other words: who are these 'irregular citizens' that require reformation or control through the CTO? I posited that the 'revolving door patient' - someone who cycles rapidly and repeatedly between hospital and the community - categorised who would be made subject to CTOs. Although CTOs were to be aimed at a group of 'revolving door patients', the Government would not define in legislation or guidance how this category was to be categorised for the purpose of the CTO. Instead, psychiatric expertise was to be relied upon through the operation of professional discretion to decide who would belong to this group and therefore be made subject to the CTO. CTOs could then be applied to a

broad range of individuals in a preventative as well as a reactive way, based on prediction of aberrant behaviour patterns before they have occurred. In addition, aiming CTOs at ‘revolving door patients’ coheres with some policy drivers more than others. Keeping individuals out of hospital fits well with the particular vision of recovery through CTOs I have described here, whereby individuals are shifted out of the ‘revolving door’ pattern and take on responsibility for maintaining progress in the community. Further, if recovery through the CTO is posited as encouraging the autonomy of individuals in the community then it can also be understood to lower dependence on services. This suggests that the development of CTOs for ‘revolving door patients’ was also partly resource-driven, particularly within the context of the continuing roll-back of inpatient services. However, if we also consider risk as a key policy driver, aiming CTOs at ‘revolving door patients’ does not necessarily correlate. As I mentioned earlier there is a necessity for an exclusionary component to CTOs, for when control of an individual in the community is not possible. For CTOs that ‘safety valve’ is recall to hospital, which does not straightforwardly fit with the aim of lowering hospitalisation rates through stopping the ‘revolving door’³⁸. In this way, we can see potential breaks and tensions between policy rationalities and CTO practices in terms of who CTOs are aimed at and how they are intended to work.

Of course, the various competing claims on policy development make it unlikely that programme rationalities follow a straightforward path. In the latter half of this chapter I moved from a governmental consideration of how CTOs were thought into being and who was to be made subject to them, to a consideration of the pragmatic and ‘messy’ process that generated their eventual form in England. Although I have talked thus far broadly in terms of international trends, policy drivers for CTOs still differed in emphasis from country to country. The reciprocity principle - whereby CTOs were seen in some countries as a way of ensuring good quality care, thus in a sense balancing out the focus on the individual - was deliberately not part of the policy reasoning or criteria for CTOs in England. The Government reinforced the individualised focus of the CTO by

³⁸ Indeed these tensions in policy drivers may help to explain at least in part why the OCTET study found no evidence of a reduction in hospitalisation rates for those individuals on CTOs.

asserting that it was intended to be a one-sided contract, there to ensure treatment compliance but not to ‘bind’ services to a level of care. Furthermore, risk and recovery, although described here as dual policy drivers for the CTO were not ‘sold’ as such in England. Risk had a far higher profile than recovery in the national policy debate for CTOs, reflecting the audience – the public – who policy-makers were largely addressing in an attempt to allay political as well as actual risks.

CTOs in England thus have a particular ‘flavour’ and I explained the generative processes which formed a distinctive CTO regime in England with reference to historical precedents and knowledge flow from other CTO regimes via policy transfer. Regarding the history behind CTOs in England, I described how they did not suddenly appear as a policy prescription, but could be seen as a gradual evolution of national policy, particularly from the late 1980s onwards. This history was integral to the development of the more defined, dependable and ‘tougher’ provision of the CTO, which coincided with an authoritarian shift in policy-making more generally. In conjunction, policy-makers learnt from other countries how CTOs were practiced elsewhere and how they could be adapted to fit the English system. I explained how particular kinds of international and ‘local’ research expertise were combined and drawn upon at the expense of others to justify CTOs, under the guise of the then recent enthusiasm for evidence-based policy. Further, I noted how CTOs were framed in policy debates against the backdrop of their use elsewhere, thus positioning the English version as timely and reasonable but also carefully circumscribed.

The rhetorical and ‘political’ case made for CTOs was necessary because of the mobilisation in England of a significant opposition to CTOs in particular and the 2007 Mental Health Act in general. Indeed, whilst I noted that the English CTO regime was in line with extant cultural and institutional traditions in national mental health policy - in that it was much broader in application than in many other countries - its final form in England reflected to a certain extent concerns about the rights of service users. Specifically I mentioned that an earlier version would have included enforced treatment in the community which in light of protests, and being a line which had not been crossed in other CTO regimes, was

eventually discarded from policy deliberations. It is noteworthy that this earlier version seems to be more in keeping with aiming CTOs at ‘revolving door’ service users for both risk-oriented and recovery purposes, thus suggesting that the programmatic ‘logic’ of CTOs was shaped to a certain extent by the political struggles that took place over their introduction. However, despite the compromises made in the final form CTOs took, the threshold for their use in England is still low. If we combine the loose definition of the target ‘revolving door’ group for CTOs with the broad criteria for their imposition and more importantly activation once in place, there are implications for ‘net-widening’ in terms of numbers placed on CTOs but also effects once on a CTO. Making CTOs easy to activate means risk management potentially continuing to take precedence over recovery in CTO practice as well as policy theory. At the same time, the amount of discretion afforded practitioners via this framework means there is significant room for the evolution of CTOs in practice, which may not be solely ‘defensive’ in nature.

There are particular threads of argument I have begun to pick out in this section which I will develop for the ensuing discussion on the empirical findings. To begin with however, if we take Chapter Four as discrete from the later empirical chapters, it provides a good standalone example of the bringing together of governmental and causal analyses in relation to the first set of research questions I set out to answer on CTO policy development. From a governmental perspective, the formation of policy problems and solutions can be seen in an inevitable way. Foucault argued that programmes of government include the seeds of their failure, which inevitably leads to on-going strategies and mutations in forms of government (Lemke, 2000), and we can see how that plays out with the evolution of CTOs. The unintended effects of deinstitutionalisation can be seen as a starting point for programmes such as CTOs, which in turn are based on specific ways of thinking about the ensuing problems to be solved. A particular assemblage of behavioural and biomedical rationalities was thus called upon in the creation of CTOs. Equally, pinpointing *how* those problems were to be thought about does not mean that they only exist in the realm of discourse; the management of individuals with severe mental difficulties in the community raised long-standing issues that needed to be dealt with, and from a political

perspective seen to be dealt with, hence *why* CTOs came to be embedded in policy regimes. In turn, moving from broad rationalities and rationales to the level of policy detail, again we can see *how* CTOs were constituted through the illumination of a particular group to be targeted – those classed as ‘revolving door’ - and through drawing down on particular forms of knowledge. However, an analysis of the CTO policy journey must also take account of the ‘push’ and ‘pull’ factors which brought about their eventual ‘local’ formation; in other words *why* they came to be as they are in one particular place. Dean (2010, 251) argues that a governmental analysis does not and indeed should not “amount to a study of politics or power relations in general”. It is my view however that taking account of institutional and cultural legacies, the role of political ideas, actors and agendas, and the pragmatism and rhetoric inherent to political reasoning, is required to fully understand the conception of policy programmes such as CTOs, and how they go on to play out in practice. Indeed, it can be argued that for a governmental analysis, such work is necessary if we wish to present the ‘inconvenient facts’ about discontinuities between explicit governmental rationalities and their strategic effects (Dean, 2010). In this way governmental and causal analyses are interwoven and mutually dependent. As Lemke (2000, 9) suggests, struggles and compromise are integral to governmental programmes, “actively contributing to...‘fissures’ and ‘incoherencies’ inside them”.

This brings us to what this section offers for the following discussion of the latter three sets of research questions, as addressed through the empirical findings. Here, I have suggested that the risk management and responsabilised version of recovery for which CTOs are intended to work, carries tensions which are not easily reconciled and which can be seen to shape the framework for CTO practice. Through examining ‘ground-level’ rationalities and ensuing practices we can see how these tensions are realised. Connectedly and as I noted earlier, because programmes like CTOs are based on ‘thin’ assumptions about drivers for behaviours, they can also contain simplistic expectations about the responses of the ‘target’ group and subsequently what the programme outcomes will be. Looking ahead to the empirical findings, it seems that both the multifaceted motivations and challenges service users bring to CTOs, coupled with the

complex ways they interact with CTOs, mean such expectations are not always fulfilled. Policy interventions framed as ‘carrots, sticks and sermons’ (Bemelmans-Videc, Rist and Vedung, 1998) do not account for such context or the reflexive work it instigates. Together, these conclusions provide the starting point for an analysis of how and why CTOs are practiced and with what consequences, which I turn to now.

Ground-level conceptualisations of CTOs

In order to make sense of CTO practice, the theories of those directly affected by the CTO should be accounted for, as these conceptualisations act as a ‘bridge’ between policy-level thinking and practice. This section therefore primarily draws on findings from Chapters Five and Six, but also makes reference to the other findings chapters. I revisit the gaps and continuities that exist between participants’ thinking on CTOs and policy, and what that might mean for CTO practice. In conjunction I explore what forms of thought are drawn upon in the formulation of CTOs, particularly with reference to practitioner explanations for how CTOs might work.

I noted in Chapter Six that practitioners saw a need for CTOs, and that they felt the CTO filled a gap in mental health practice. In this sense, practitioners were aligned both with the policy narrative on CTOs and prior research on practitioner attitudes towards the CTO (Manning et al, 2011). Specifically, CTOs were viewed as giving practitioners more control and certainty regards the oversight of particular individuals in the community. It is noteworthy that practitioners did not only welcome CTOs for practice-oriented reasons, but also thought that CTOs represented a ‘better deal’ for service users too, in that CTOs were more transparent and structured than previous legislative provision, particularly Section 17 leave. Indeed, this latter belief points to one particular difference between policy and practice-level theory on CTOs. As I discussed earlier, a consequence of aiming CTOs at a distinctive policy derived version of recovery might be lowered dependence on services and therefore a reduced requirement for resources, particularly inpatient services. Although such a justification of resource management through CTOs did not play a prominent part in policy

debates, it was clear that practitioners felt that it was an underlying driver for CTOs, particularly in the context of on-going service change and rationalisation. CTOs were therefore understood by many practitioners as an economically driven programme, aimed at maintenance through the enforced provision of medically-focused ‘bare minimum’ support. What is interesting is that despite this, in a paradoxical sense practitioners felt that CTOs could be turned to service users’ advantage through giving them access to resources via the obligations they held under the CTO. It seems therefore that an element of practitioner reasoning for the CTO was that they framed it in a reciprocal way as a ‘true³⁹’ contract, rather than the relatively one-sided version that had been argued for in policy formulations.

In broader terms, this points to a practice-level purpose for CTOs that was entirely missing from the policy agenda - that of giving service users’ protection of various kinds. Protection was a strong motivator for some practitioners, either through seeing the CTO as an intervention which would mean more coercive methods could be avoided, or through ensuring relapse was dealt with through access to inpatient services in a timely and preventative manner. This way of thinking brings back in a category which is missing from the dual risk/responsibility narrative for CTOs - that of dependency - which does not align easily with “contemporary practices of government...which have come to rely on the agency of the governed themselves” (Dean, 2010, 82). It is worth quoting here from a practitioner, who commented in a team meeting: *What’s wrong with just caring for people when they’re unwell? Everyone seems obsessed with moving people on, why can’t we just accept that some people aren’t going to move on, and need our support?* Some service users also valued the CTO in similar terms, as a signifier of care. Indeed, as I pointed out in Chapter Nine, it could be that the CTO had become such an emblem of enduring and reliable support that service users might feel they are being coerced into having it removed. For those individuals, compulsion did not equate to coercion; instead the opposite – potential freedom from the CTO - was experienced as coercive. It has been argued that that the use of control mechanisms to direct behaviour

³⁹ Here I am referring to the principles of contract law, whereby the terms of a contract should be fair to all parties in order to be acceptable and implementable.

undermines a sense of care (Brown and Calnan, 2012, Pilgrim, 2007). In a perhaps counter-intuitive way, it seems that with CTOs perceptions of care and control can at times reinforce each other. As Flint (2009) suggests, the public positioning of policy programmes aimed at behavioural change as premised on coercion can hide the provision of enhanced support such programmes may provide to the individuals made subject to them, particularly when more universal provision is becoming increasingly restricted.

Furthermore, given the long-standing arguments that mental health services are focused on an instrumentalist process of risk minimisation (Vassilev and Pilgrim, 2007, Szmuckler and Rose, 2013), it is worth pointing out that protection was as important, if not more so, for many practitioners than risk management. Of course, as I described in Chapter Five not all service users saw CTOs in a straightforwardly positive way, and for some, the CTO magnified their sense of lacking control over their lives and the treatment they received. As I will come to in the next section, practitioner assumptions about allaying coercive components of the CTO with 'kinder' coercion could sometimes have the opposite to intended effect, and the same could be said for the CTO as a whole, with some service users preferring the 'short, sharp shock' of intermittent compulsion rather than the sense of 'never-ending' compulsion of the CTO. In this light, using the CTO for protective purposes is aligned with paternalistic rather than autonomy premised best interests (Peay, 2005). Accordingly, protection - ostensibly more 'needs-focused' and typified by practitioners believing they are acting in the best interests of service users even if against their wishes - can be as central to the defence of restricting autonomy as risk management, yet a preoccupation with risk in mental health discourse means that this aspect of control can arguably be overlooked. Taking this perspective calls into question the ways that risk can be presented as the dominant framework in mental health, moving beyond what Rose (2000, 333) describes in discursive terms as "community protection through the identification of riskiness of individuals, actions, forms of life and territories".

This is not to say that risk did not figure in practitioner views on the purpose of the CTO. There was ambivalence towards the risk management orientation of

CTOs in policy-making, with acceptance by most practitioners of the broad premise if not the spirit of such reasoning. Given practitioners' close involvement with the everyday reality of service users' lives, there was little support for the idea that risk 'events' could be understood or managed in the simplistic way presented in CTO policy debates, with emphasis rather placed on the compound elements which made such events unpredictable. Nevertheless, by ensuring medication compliance, practitioners felt that CTOs helped to manage *certain* kinds of risk for *certain* kinds of individuals, and therefore were better present in such cases than not. Campbell and Davidson (2009) note the deep-seated personal and emotional responses practitioners might have to service users, including fear, which can influence the use of compulsory intervention. The emotional toll of working with individuals in the community deemed as high risk due to a history of violence cannot be underestimated, and defensive practice was not simply about 'back-covering' – CTOs could give practitioners psychological ballast in feeling they were controlling what risks they could. At the same time, and akin with protection, it should be acknowledged that some service users also saw themselves in terms of risk. 'Taking on' a risk identity has particular implications for governmental self-work, which I turn to later. For now it is enough to note that coming to a mutually aligned understanding of risk meant risk management played out through CTO practice in perhaps unexpected ways, a point I return to in the next section.

Before doing so, it is worth highlighting that the tensions in CTO policy formulations between risk and recovery were also present in practitioner conceptualisations of CTOs. Whilst practitioners did not take a straightforward view of CTOs or their purposes, more often than not referring to more than one, a general difference could still be drawn between those who referred to CTOs meeting risk and protective purposes, and those who saw them more as a vehicle for recovery. Accordingly, recovery could not only be in tension with risk management, but also with the protective notions of care and dependence discussed earlier. It could be difficult for practitioners to reconcile these different theorisations for CTOs, and how they went about this appeared to be premised on the 'web of beliefs' (Bevir, 2010) they held about practice and what it is to be a 'good' practitioner (Evans, 2012). Such difficulties were at the heart

of the ethical dilemmas and balancing acts many of them experienced in CTO practice. For those practitioners who saw their work as based more on a recovery model, the CTO should be used only when necessary and then only in a ‘light-touch’ way in order to both counter potential coercion and to discourage dependency. In recovery terms then, the imposition of the CTO would be seen ironically as only worthwhile if it was not activated once in place, providing an ‘invisible’ guide for service users. It is with recovery that we can see practitioners perhaps most aligned with policy-level drivers for CTOs, theorising CTOs as providing a foundation for maintenance, subsequent behavioural change and even service user ‘enlightenment’ on the best way forward, leading to autonomy and responsibility in the community.

In this sense, and similar to what has been reported elsewhere (O’Hare et al, 2013) the notion of recovery was viewed by practitioners as being most relevant when service users were deemed ‘ready’ to recover. The concept of insight can be seen therefore as one particularly significant manifestation of expert knowledge that practitioners - and as seen in CTO appeals, decision-makers more broadly - drew upon in formulating CTO practice. As I discussed in Chapter One, insight is a difficult concept to pin down, containing “a multiplicity of meanings within, and across, discourses” (Diesfeld and Sjostrom, 2006, 90). Nevertheless, presented as a scientifically derived, ‘objective’ state, insight is a central facet of how CTOs are theorised as a way of inculcating particular norms and ways of being. Used clinically to direct when CTOs are needed, and to decide if they are ‘working’ in recovery-oriented terms, insight thus provides a significant foundation for the ‘conduct of conduct’ through the CTO. In contrast, service user understanding of responsibility through the CTO was integrated with their description of recovery as a precarious journey, reliant on the care and aid of others. Such a view suggests a broader conception of recovery, more aligned with its original user-led formulation than the individualised form discussed thus far, which also accounts for shared and cross-cutting responsibilities. As Trnka and Trundle (2014, 139) point out the notion of responsabilisation does not account for the fact that “descriptions of the self-managing individual frequently reveal a subject entangled within widespread ties...and duties to others”. This latter approach provides something of a

counterpoint to the idea that CTOs must stimulate autonomous action. Indeed, whilst practitioners used insight as a core concept for CTO decision-making, this was not necessarily reflected in their day to day practice with service users. The invocation of insight could act to distance practitioners from service users and hamper the development of such mutual goal-setting. What we have here then is a rather complex interplay between the strong influence of insight on CTO formulations and ensuing decisions, and the everyday reality of CTO practice where obligations were negotiated when possible and practitioners often attempted to shape CTOs to ‘fit’ service user beliefs and goals. In this way, CTOs are a good example of a “responsibilisation program that...devolves some forms of decision-making onto patients and yet also encounters significant counter-pressures through the persistence of pre-existing networks of responsibility and care” (Trnka and Trundle, 2014, 148).

In excavating the conceptualisations of CTOs present in the field, we can see that, as with the discussion on policy development, governmental and realist analyses are closely connected to each other. From a realist perspective the conceptualisations of CTOs outlined here hold both similarities and important differences to the policy agenda for CTOs, which as will be shown influence the ways that CTOs work. Most significantly, I have drawn attention to the abiding tensions between risk and recovery which are translated from CTO policy to practice, and filtered through practitioners’ ethical standpoints. At the same time, a third driver – that of protection and care – surfaced in practitioner and service user accounts, which had not been accounted for, and indeed can be seen in opposition to policy-level reasoning on CTOs. Delineating these over-lapping or contradictory practice-level drivers tell us both what is hoped and/or planned for in the use of CTOs and points to the problems that might arise in meeting such goals, thus giving a foundation for CTO outcomes to be interpreted further down the line both in relation to policy and ground-level expectations. Additionally, finding out where practitioners and service users stand in relation to CTOs is a necessary starting point from which to understand why it is CTOs might unfold in particular ways. As Pawson and Manzano-Santaella (2012, 180) comment, “outcome patterns come to be as they are because of the collective, constrained choices of all stakeholders”.

From a governmental perspective, the discussion undertaken here has also highlighted the various forms of thought that underpin the intended purposes of the CTO. It seems that practitioners formulated various theories on how CTOs might work dependent on the ‘ends’ they were aiming towards. The most explicit formulation I have presented is the consideration given to insight as a foundation for maintenance and recovery, which by its nature predicates recovery as an individualised process. At the same time, presenting government as a rational and thoughtful activity (Dean, 2010) is not entirely straightforward. Practitioner theories on how CTOs might work are ‘muddled’ to a certain extent by what they know about the circumstances of individual service users – for example in the emphasis on dependence and protection which does not align with typical governmental logic, or the ambivalent way practitioners considered risk. As Broadhurst et al (2010, 1059, emphasis in original) posit in a discussion of the informal logics of risk, “Risk management is embedded in *social relations* and the worker’s strategies are *contingent* or case-specific...Here, we see a *multiplicity of rationalities* operating, to do with not just instrumental, but also moral concerns”. I would add that for practitioners in relation to CTOs this meant moral concerns relating not just to the individual in question, but to the community that individual is embedded within. Relatedly, the interaction undertaken in the operation of CTOs further cross-cuts and sometimes under-cuts “the more or less explicit, purposive attempts to organise and reorganise institutional spaces, their routines, rituals and procedures, and the conduct of actors in specific ways” (Dean, 2010, 43). Through elucidating both practitioner and service user purposes (or in the case of the latter sometimes anti-purposes) it is possible to see the ways that mutual work on the CTO can be undertaken, and indeed when it is difficult to do so. Here is where there is space for situated ethics and associated ‘balancing acts’ to be considered, which align somewhat with Barnett et al’s (2008, 632) argument that “rationalities which govern strategic interactions are not [solely] the pre-existing properties of the different actors involved, but are an emergent dimension of ongoing interaction itself”. In this way the process of subjectification via governmental means is complicated by how people are ‘made up’ from below via communicative action and the application of lay normativity as well as from above via discourse (Hacking,

2004, Sayer, 2005). On that note, I move onto the central aspect of the empirical work – the ways that CTOs work in practice.

CTO practice: agency, interaction and context

The heart of my analysis derives from understanding CTO practice and I relate here how my findings illuminate the workings of the CTO. As with the prior section, much of what I draw on is loosely aligned with particular chapters – Seven and Eight – but I also refer to other parts of the findings. Pawson and Tilley (2004, 8) warn that “context should not be confused with locality. Depending on the nature of the intervention, what is ...significant may not only relate to place but also to systems of interpersonal and social relationships”. Therefore, what is deemed contextually salient refers both to the personal and micro-social experiences of those individuals made subject to a policy programme as well as the systemic factors that mediate their experiences. As I have explored at various points in this thesis, individual responses to the CTO are influenced by complex interactions between beliefs about self and identity, and past and present experiences of services, medication, and relationships with professionals. To add an additional layer of complexity, such an analysis should not only be limited to those on the receiving end of CTOs, but also the practitioners who implement them, taking into account practice beliefs and ethical standpoints. I therefore examine the roles of agency and interaction in generating CTO mechanisms alongside the broader institutional, cultural and systemic factors that impinge on the use of CTOs. I also consider how the work carried out through the CTO does or does not regulate behaviour in particular ways, drawing attention to service user responses to those techniques.

An obvious incongruity of policy programmes such as CTOs is that even though they are based on compulsion, for certain purposes to be met (particularly related to maintenance and recovery) they depend at least partly on the self-directed choices and actions of the subjects of intervention (Dean, 2010). Consequently, an important facet of understanding the ways that the CTO might or might not work is to explore how individuals become ‘invested’ in the CTO. As I described in Chapter Seven, a catalyst for this investment is the way that CTOs

are talked about with service users by practitioners, and how much involvement service users feel they have in directing the CTO process. It seems from the findings that there were two related aspects to this interactional activity. Firstly, when and how service users are informed about the CTO and involved in its implementation, and secondly how the CTO is framed in various ways which might fit with the underlying beliefs service users hold about their lives in the past, present and future. It appears that where early ‘groundwork’ was undertaken with service users, and careful negotiation took place - particularly on medication under the CTO – coercion was more likely to be alleviated. In addition, if sensitive explanation of the CTO was given by practitioners based on prior knowledge of the service user and their self-beliefs, then service users were more able to accept its imposition and operate within its bounds. Such findings reflect the body of research (see Newton-Howes, 2010) on how the experience of coercion can be alleviated by positive interactive processes, although as I note later in relation to the active use of CTOs, this was not always the case and indeed could result in the opposite outcome. Practitioners broadly held the view that with a small group of service users, their beliefs on mental health and how best to manage it would always place them at odds with mental health services, regardless of such relational effort. Even so, it did seem that with skilled work, practitioners and service users could construct a mutually conducive narrative of how the CTO might meet shared goals. In this sense, the connection practitioners and service users did or did not make with each other within the context of the CTO was a central generative driver of why the CTO manifested in the way that it did.

At the same time, as was outlined in Chapter Eight, this important early work could be constrained by institutional and cultural factors. Specifically, the tensions that exist between inpatient and community services due to resource constraints, fragmented communication and differing beliefs on the role of inpatient care, made it difficult at times for CTOs to be planned and carried out in a way that was conducive to mitigation of coercion. It seems that individuals could be discharged onto CTOs before they were deemed to be ready, raising concerns about how they would manage in the community and making it more likely that they would be recalled back to hospital quickly. As I also noted, in

cases where the CTO was deemed inappropriate by community practitioners and yet was still imposed, it could have a damaging knock-on effect on the ongoing relationship they held with service users and consequently on the provision of services to those individuals. AMHPs acted as gatekeepers to a certain extent, by ensuring that the initial process was carried out thoroughly and that the CTO was reasonable and ethical in its scope. However, I pointed out that none of the AMHPs recollected ever disagreeing to a CTO, and indeed suggested they would find it hard to do so given the wide remit of the legal criteria and the pressures inherent to group decision-making. This illustrates a broader theme regarding the implicit logic of the CTO and the difficulties practitioners sometimes faced in contesting such logic, even when they felt the CTO should not be imposed in a particular case, or should be used differently than it was being used once in place, for example in the activation of recall. Evans and Harris (2004) make the point that an increase in rules and bureaucracy can ironically lead to more space becoming available for practitioners to operate with discretion. My findings demonstrate that in a mirror of this, the breadth of latitude present in CTO criteria and operation meant practitioners could feel their range of choices became restricted and consequently their ability to act with discretion limited, especially in the face of external pressures for defensive decision-making. Dean (2010) suggests that the technical means by which governmental rationalities are put into action can limit the ends that can be achieved, and with CTOs it seems they could take on a momentum of their own which was in some ways distinct to the motivations and ethical beliefs of the actors involved in their use.

The evolution of CTO practice in particular directions – the most obvious example being the creation of recall ‘cycles’ – also highlights the relationship that runs throughout the findings between what can be constituted as ‘surface’ and ‘depth’ practice⁴⁰. These two concepts emerged from the findings and seemed to cohere with practitioners’ concerns around what practice ‘should’ be like, and what was possible under the CTO in relation to risk, recovery or protection. Surface practice related to the potential deskilling influence

⁴⁰ I became aware *after* deploying these two concepts in my analysis that David Howe (1992, 1996) had coined and used them in a similar way, which illustrates that such tensions are a relatively longstanding concern in social work.

practitioners felt CTOs could have for the relational work they believed was central to Assertive Outreach, where particular skills and approaches had been developed to engage with individuals. CTO practice in this light is arguably mechanistic, reductive, and control-oriented, involving fast and definite responses to infractions of the CTO ‘contract’. As with when the CTO was first imposed, institutional factors could undermine the intended purposes of CTOs for practitioners and act to further alienate service users. This could particularly be seen in the way recalls were sometimes handled as quick ‘turnarounds’ with little time given for exploration of the issues at hand, thus not offering much in the way of protection, or thinking ahead to how the CTO might work better to achieve maintenance and recovery. Cultural practices within teams, for example the differing stances practitioners might take to the CTO could also act to shape CTO practice. This could be seen in the way that some decision-makers maintained focus on adherence to medication when considering recall rather than keeping an uncertain watch on the secondary outcomes that might or might not arise from breach of the CTO. Conversely, as explored in some depth in Chapter Eight, many practitioners tried to alleviate the effects of the CTO and encourage a recovery-oriented approach via negotiation on treatment ‘sticking points’ and using ‘steps to compulsion’ instead of acting immediately when conditions were not adhered to.

Even so, and in some ways I think more interestingly, the kinds of CTO practice I witnessed were not always straightforwardly ‘superficial’ or ‘deep’ in application or effect. Surface and depth practice cannot only be characterised by a tension between external mandates on practice and practitioners’ preferred ways of working. Instead, the way it manifested here was in a less hierarchical and more interactional way. Surface and depth practice was influenced by surface and depth responses, and it was the case that superficial engagement via the CTO could be a way for both service users to maintain some sense of control, and practitioners to lessen coercion by maintaining a minimal presence. Alternatively, attempts to mitigate the CTO framework by demonstrating flexibility and working with service users could exacerbate coercive experiences by sharpening service users’ sense of the compulsion they were under, as illustrated in Chapter Eight with the circumvention of recall by practitioners and

in Chapter Nine with the operation of procedural justice in the appeal process. Furthermore, the structure and routine the CTO framework offers can enable as well as constrain deeper levels of engagement. The use of conditions, particularly in ensuring regular contact, could help to build trust and acceptance of support where previously it had not been possible. Having a contract to work to could also clarify the boundaries of intervention for service users and give practitioners a starting point for ‘difficult’ and reflective conversations, for example on risk. Boardman and Roberts (2014) note that there has been little attention paid in mental health research or practice to service users’ views on risk and risk management, and they comment that risk planning and assessment is often carried out without the service user’s knowledge or involvement. They conclude that there is a need for joint safety planning between practitioners and service users. Whilst CTOs have been criticised for being ostensibly another ‘top-down’ tool for risk management (Lawton-Smith, Dawson and Burns, 2008) it appears that they can act to make concerns around risk explicit and become a cooperative and co-constructed risk management endeavour, embedded within relational work.

Indeed, it seems that this relational work was important for effective risk management within the CTO. Building trust can help mitigate risk concerns by curtailing hazardous events through increased access, disclosure and cooperation by service users. The interplay between a lack of trust in practitioners and the fear that the CTO brought for those service users who viewed it coercively could result in an unwillingness to disclose sensitive information, thus making it more challenging for practitioners to pre-empt difficulties. In more complex cases, particularly where signifiers of risk such as a forensic history, substance misuse and a diagnosis of personality disorder were present, it seems that the CTO had the potential to stimulate risk. A complex combination of the negative response of the service user to additional control, a lack of ability to use recall as a safeguard in such cases, a reluctance on the part of practitioners to manage ‘social’ causes of risky behaviour, and the CTO giving other agencies the opportunity to divest their responsibilities, meant that contrary to policy formulations, a possible perverse consequence of the CTO was further entrenchment of what might be deemed the ‘riskiest’ of cases. It seems therefore

that considering the CTO as a standalone risk management tool is not enough. Szmukler and Rose (2013) argue that risk management is used as an all-encompassing approach in mental health services. I am arguing that the limits the CTO can be put to and the delineation of different kinds of risks by practitioners suggests that this might not always be the case.

Whilst I have talked thus far primarily in terms of the role of interactional, institutional and cultural factors in the constitution of various CTO mechanisms, I have also made inferences to the agency of service users in why CTOs play out as they do. A key factor that influences individual response to the CTO is how medication is managed and negotiated. Through observing decision-making on how CTOs were enacted, it appeared that practitioners believed that putting service users on an injection as part of their conditions was central to making the CTO 'work'. However as the findings suggest, for service users, actively accepting the CTO and making it 'work' in their terms could depend on medication choices remaining broad and practitioners acting in concordance with them in working toward wider goals, instead of expecting compliance. Hence, service users did not only act in response to practitioner mediation, but also on their own terms within the constraints placed upon them. Similarly to Canvin, Bartlett and Pinfold (2002) in their analysis of supervised discharge, I noted a range of responses to CTOs, including various forms of acceptance, resistance and subversion, both passive and active. I will talk further about service user responses to CTO 'ends' and 'means' in the next section, as the potential 'soft' outcomes of a programme aimed at attitudinal and behavioural change and also as forms of conduct and counter-conduct. An interesting point I want to focus on here is that particularly 'down-stream' of the initial decision, service user responses to the CTO were less easily amenable to practitioner intercession. In this way, we can see not only the effect the individual can have on the path the CTO might take, but also the effect the CTO has on the individual as a governmental programme acting to regulate conduct. Accordingly, this is where an ethical consideration of power through the CTO is brought back into the discussion, which moves beyond understanding what it takes to get service users 'on side' in order to achieve the various purposes of the CTO and instead considers how they are worked upon through the CTO.

More specifically, I highlighted in Chapters Five and Seven the various connections that can be made between service users' conceptions of self coming into the CTO and how they responded to it as an intervention in their life. As I noted, the view of those practitioners who saw the CTO as a helpful tool for a broad range of individuals tended to be that the CTO did not hold much in the way of concrete implications and therefore as an 'insurance policy' should not affect service users adversely. However, this does not account for the potent psychological responses service users could have to the CTO as premised on the way it keyed into their sense of identity. In this sense, feelings of stigma were not related to the CTO being a visible 'badge' of difference, but instead to how it was perceived to limit what was possible and hoped for in life. Zedner (2010) talks about the way that 'irregular citizens' – those who are deemed outsiders because they do not fit with societal expectations – can be placed under conditional citizenship which requires them to adhere to contractual requirements in order to become included in society on equal terms. It seems that much of the resentment some service users felt towards CTOs related to feeling that it magnified their pre-existing sense of being 'outsiders', and acted to further exclude them in some way. Here we can see a reflection on self and self in relation to others as an articulation of belonging. Such feelings translated into how the CTO framework was interpreted, and the most obvious indicator of this was the way that the CTO was perceived to pervade various aspects of life even if it was not the case. CTOs then can be experienced in ways that overstep the boundary of a discrete intervention, which in turn reinforced distrust in mental health services in general, and the actions and motivations of practitioners in particular. As I noted in Chapter Seven, this process of internalisation of CTO 'messages' and binding them to pre-existing notions of self did not only apply to those service users who saw the CTO in a negative light. Returning to a point made earlier in this chapter on how it is that policy is thought to shape thought and behaviour, 'thin' theorisations of change through policy programmes do not account for the individual – their history, hopes and self-conceptions. Thus, the CTO cannot be understood as transformative in and of itself, but instead as in conjunction with ethical 'self-work'. The CTO could play into beliefs on vulnerability and fragility, but also could trigger ambivalence through underscoring tensions between where individuals saw themselves in the present

versus where they wanted to be in the future, and accordingly between what they might need but also want in terms of service involvement. What I have discussed here is the various thoughts individuals had in relation to CTOs, but part of exploring how conduct is managed or not is the ways these thoughts are translated into action, and this is where service users beliefs about the CTO in relation to self coincided with responses to the authority held over them. Various forms of conduct and counter-conduct can be seen through the CTO, and I describe them in the next section which explores the final and fourth set of research questions I posed.

CTO 'ends': consequences, change and identity work

In this final section, I attempt to pull together the arguments I have made thus far and apply them to the 'ends' of CTOs. I hope I have managed to demonstrate the many and complex ways CTOs can play out dependent on different contextual factors. Accordingly, there is no straightforward account I can give about what the implications of CTOs might be. Instead, what I discuss here is the *range* of consequences we can garner from CTO use and how they might unfold in unexpected and sometimes unintended ways. In order to develop a pluralistic understanding of CTO practice, I also draw attention to the ways these consequences are thought about by practitioners, and put to use in discharge decisions. I begin this section in a continuation of the previous one, by reflecting on the change-oriented nature of CTOs and how service users responded to this mandate with forms of conduct and counter-conduct.

I argue that the findings demonstrate diverse connections between 'practices of the self', conduct and counter-conduct in the face of compulsion. I take a different approach to that taken thus far in this chapter by grounding my argument in a reflection on six specific cases. Service users' conception of identity, sense of self and self in ethical relation to others led to complex, ambiguous and perhaps unexpected responses to compulsion which are not always easily categorised into binary forms of compliance and resistance to the CTO. If we revisit Foucault's (1997) dimensions of ethical self-work, we can see that they relate to: external impetus for change, the means by which we act

upon ourselves to bring about such change, and the end person we seek to become through these means. In formulating forms of conduct and counter-conduct, the CTO acts as the external stimulus, and the task here is to delineate how the means and ends service users have conceived for themselves relate to the means and ends of the CTO. I have discussed throughout the thesis how service users can be placed along a spectrum from acceptance to resistance, and the cases I refer to take different points on this spectrum.

Acceptance of CTO means and ends: the contrasting cases of Nick and James

Nick and James can be described as the two service users who whole-heartedly accepted the CTO the most out of all the individuals followed and both expressed strong respect for the authority of the professionals who worked with them. Neither of them had experienced recall, as they had adhered to the CTO and practitioners saw the role of the CTO in their cases being for boundary-setting rather than active intervention. In a superficial sense, they both can be seen as CTO ‘success’ stories, particularly regarding behaviour change. However, there are interesting contrasts that can be drawn between them which are not quite as clear-cut, beginning with how the CTO related to the changes they wanted to see in themselves. Nick and James aligned themselves with different aspects of the CTO agenda, each corresponding to how they saw themselves and their relationships to others. I mentioned earlier about how some service users self-conception was refracted through a ‘risk’ identity and Nick was one of those individuals who expressed extreme anxiety about what he thought he was capable of in relation to harming others, particularly those who he was close to. The CTO for him was a way of externalising the control he did not feel able to exert over himself and therefore he accepted one particular ‘end’ of the CTO – risk management – as it related to the kind of individual he wanted to become. As such, Nick was also one of the individuals who did not want to be discharged from the CTO, and talked about it as being necessary for the safety of others as well as his continuing and relative autonomy in the community. James conversely, had taken on board the messages about responsibility inculcated in the CTO. He saw himself very much in relation to the broader mental health system and network of support he received from practitioners, family and

friends. In this sense he felt it his 'duty' and responsibility to use the CTO to recover and live what he viewed as a productive and independent life. James did not see the CTO as a permanent proposition, but trusted that the changes he was making in his life would demonstrate to practitioners that he was ready to move on from the CTO when ready.

Nick's compliance to the CTO and insistent dependence on its continuation can however also be seen as a form of resistance to practitioners' attempts to 'move people on' to independence. James, although he spoke in a particular way about authority, took some control from his treating team by making his own autonomous decision on how and where he should receive medication, and thus acted on his own volition to make the CTO process fit his perception of what it should be. In making this choice, James also reduced his treating team's ability to monitor his medication and consequently created some 'space' for himself within compulsion. Although Nick and James orientated themselves respectively to the risk and recovery aims of the CTO, they were therefore not entirely 'exemplars' of conduct. In this sense Nick and James encapsulated the tensions that can exist between differing policy ends.

Resistance to CTO means but acceptance of ends: Irene

Irene held much resentment about being under the CTO, related to a sense of what 'normality' should be for her and the anxiety the CTO caused as a framework for potential intervention at any time. However, much of her resentment was ironically yet strongly related to her acceptance of the potential ends of the CTO. By forcing her to engage, she felt the CTO had taken away her ability to engage on her own terms, which was very important to her. For Irene, the CTO reinforced barriers between her and professionals, blocking the ability for relational work and meaningful engagement whilst at the same time magnifying an adversarial focus on the negation of her rights. Irene wanted to be able to collaborate with professionals, a view which reflected her belief on what the service user-practitioner relationship should be. In this sense, Irene believed in the potential 'first-level' aim of the CTO – consistent engagement with services – whilst at the same time disliking the CTO as the means to get there.

Whilst the CTO ensured superficial compliance on Irene's part, it was only when it was lifted that she and her care coordinator felt she was able to fully engage with treatment and support. Consequently it can be argued that in cases like Irene's, where the 'norms' the CTO is supposed to be inculcating are accepted but the use of the CTO in itself is not, coming off the CTO might encourage the responsabilised response that its use is supposed to facilitate.

Resistance to CTO ends but acceptance of means: Simon

Resistance to CTO ends but acceptance of its means meant in Simon's case, 'playing the CTO game' for his own ends, which did not cohere with the CTO drivers of risk or recovery. Simon regularly attempted (and at least initially succeeded) in triggering recall by refusing his medication and avoiding contact with services. He explained this as a way for him to get admission to hospital, which he saw as a significant safety net when he needed respite, or was experiencing various pressures in the community that he wanted 'time out' from. Simon had developed a pattern over the years of seeking admission to a respite facility as a coping strategy, but with the closure of this service and increasingly limited access to beds in acute services, his coping strategy had been disrupted. In one sense placing Simon on the CTO had further removed his ability to decide when he needed additional help. However, by subverting the key component of the CTO, Simon had found a way of meeting his self-prescribed needs and retaining some kind of agency. Simon's care coordinator was sympathetic to Simon seeking to maintain his much-needed dependency on services in this way, understanding it as a protective factor, but at the same time his actions did not fit with the mandated use of recall, or the constraints on recall that existed within the service. Simon had effectively undermined the use of the CTO by making it difficult for practitioners to decide when *they* thought he 'needed' recall and consequently his CTO was eventually discharged.

Resistance to CTO ends and means: the contrasting cases of Andrew and Craig

At the furthest end of the spectrum were those individuals who rejected both the CTO and what it stood for. Resistance to CTO ends and means meant a

complete rejection of the ‘service user role’, and Andrew and Craig provide interesting insights into how this might play out. Neither Andrew nor Craig felt the CTO had any place in their lives – they resented both the compulsion it placed them under, and the sense that it was aimed at shaping their attitude and behaviour, when they wanted to be ‘left alone’ by services. They articulated this resistance in different ways however. Andrew would continue to have occasional meetings with his care coordinator, but avoided medication where possible and refused to meet his psychiatrist. Craig also avoided appointments, but would in addition resist recall by disappearing for days at a time when it was instigated, and regularly fight the CTO legally through the appeals system, thus in a way using the system against itself. A combination of Andrew’s forensic history and because of his tendency to acquiesce to recall - being one of the individuals where medication could be ensured through a monthly ‘recall cycle’ - meant that his treating team had decided the CTO on balance was worth maintaining even though it had a significant negative effect on him personally. In contrast, although it was felt unlikely Craig would consistently engage with services once the CTO was lifted, he was deemed to pose little risk. This, along with the additional problems the CTO was causing both practically and ethically meant that on balance the decision was made to stop his CTO.

These cases have illustrated both the non-binary forms conduct and counter-conduct can take to governmental programmes, as well as a different approach to the study of CTO ‘outcomes’. As I discussed in Chapter Two, conduct and counter-conduct are two sides of the same coin and mutually constitutive – neither involves ‘stepping outside’ of existing power structures, but instead responding to disciplinary power in different ways, as related to both individual and social means and ends. Removing this ‘either/or’ distinction from discussions of power and resistance means that such responses can be seen in a more variegated sense, which does not look ‘beyond government’ (Rose, 1999, 281) but at how individual action plays out *within* the strategies and techniques of government (Death, 2010). As Death (2010, 236, emphasis in original) comments, forms of conduct “have the potential to reinforce and bolster, as well as *and at the same time as*, undermining and challenging dominant forms of...governance”. With CTOs, it is possible to see where conduct and counter-

conduct contain continuity and movement between them: with Nick who although compliant in every sense to the CTO highlights the challenges practitioners might face when individuals resist the lifting of compulsion; Irene, whose personal ‘ends’ aligned with those of the CTO even if she resented the CTO in itself; Simon who took the means of the CTO to achieve his own ends; and even with Craig, who used the oversight system integral to the CTO as a form of resistance to the CTO.

Moving to how we might think about CTO outcomes, these six cases, along with examples I have given at other points in this chapter, also point to the way that complex responses can lead to complex and sometimes perverse consequences. Furthermore, I have highlighted how these consequences can be weighed up by practitioners in different ways dependent on the individual and their circumstances, thus leading to differentiated decisions on when the CTO might be continued or not. For example in Irene’s case it was recognised that the unintended consequence of the CTO was to further alienate her from the therapeutic relationship, and the consequence of removing it was to increase her sense of having some kind of responsibility for her treatment in partnership with practitioners, thus furthering her engagement with services. Or as in Simon’s case, his subversion of the recall function meant that the CTO was rendered useless and thus deemed pointless by practitioners to carry on. A similar story can be told, as noted earlier, about those individuals believed to be high risk, where the very presence of the CTO could further exacerbate ‘risky’ behaviour, inverting the intended purpose of the CTO as a way of managing risk in the community.

Hence, although the underlying premise of recall is to compel individuals to behave in a certain way, such compulsion can work least well for many of those who are deemed to need the CTO most. Mechanisms thus can help to explain a policy programme’s failure as well as its success, or indeed as with the persistent use of recall, potentially a mixture of both. During the fieldwork there was substantial variation in how different participants, across both practitioner and service user groups, perceived outcomes. However, CTOs were more often than not viewed in terms of success *and* failure by practitioners. For those individuals

like Andrew whose resistance to the CTO regularly triggered recall, practitioners might think of it as a ‘failed CTO’ because it has exacerbated rather than mitigated the ‘revolving door’ cycle, leaving individuals with less stability in the community, damaging the therapeutic relationship and costing time and resources. Certainly, although beyond the scope of this thesis, the regular use of recall raises questions about ‘knock-on’ effects on revocation of CTOs and therefore hospitalisation rates. An alternative view was if repeat recalls means service users are regularly taking medication and subsequently staying relatively well, then the CTO is working in lowering their risk to others and ensuring they are protected from the worst of relapse. By thinking about the implications of policy in this way, we are able to both elucidate the variety of outcomes that can occur through context-mechanism interactions, but also consider outcomes in more multifaceted and partial terms, taking into account the ethical balancing acts practitioners may face when weighing them up.

In a broader sense, the use of repeat recalls is in keeping with other ‘cycles’ highlighted in the thesis, such as the increased likelihood of further CTOs once used due to practitioner notions of causality, and the continuation of the CTO whether it is thought to be effective or not. Returning to the concept of the ‘revolving door patient’, whilst the CTO is supposed to be aimed at this group, it seems that a more wide-reaching consequence of its use than discussed thus far is that it may instead replace or supplement the revolving door with other forms of institutionalisation, potentially perpetuating what one practitioner called a *virtual asylum*. Such a theorisation moves beyond simply comparing hospitalisation to community compulsion, by complicating what may be considered the ‘least restrictive’ approach. It also highlights a second strand of practitioner decision-making considered in this thesis alongside ethical balancing acts, and that is how different kinds of knowledge are weighed up. In this sense, it is not just a case of practical-moral concerns about the consequences of the CTO, but also how practitioners consider and *think* about change, both internal and external, when making decisions about the CTO.

In Chapter Nine, I explored this in relation to both practitioners and appeal panel members. The appeals process is one that has rarely been explored in England,

certainly not in relation to CTOs thus far, and yet the significant difference between rates of discharge from inpatient care as compared to CTOs implies an interesting story. CTOs can be seen as ‘lobster pots’, in that they are easy to get into but difficult to get out of, and it is with appeals that we can see most clearly why that might be the case. As with practitioners a loose interpretation of insight seemed to underpin panel decisions. Similarly to Diesfeld and Sjostrom’s (2006, 93) study of Australian Tribunal decisions, it appeared that a lack of insight was perceived as a cause of non-compliance, and at the same time non-compliance was seen as evidence of lack of insight, making it difficult for the presence of insight to be ‘proven’. Insight therefore was the primary factor for such decision-making, being conflated with ideas of capacity and vulnerability in relation to ‘health and safety’, with risk a secondary concern.

Although I have argued in this chapter that a concern with risk to others is perhaps not necessarily the extensive framework for CTOs it has been presented as elsewhere (Glover-Thomas, 2011, Szumkler and Rose, 2013), the appeals process in particular highlighted the broad meaning that risk could carry, along with its ‘stickiness’ as a prevailing aspect of the stories told about service users by practitioners. As Glover-Thomas (2011) suggests – and similarly to insight - risk can be put to use as a fluid concept in argumentation, which makes it difficult to counter. Whilst insight and risk can be expected to be prominent in appeal decision-making, the influence of significant others and timing – in terms of both disruptive events in the service user’s life and the length of the CTO – also played important parts. This meant that even if arguments based on insight and risk were on metaphorically shaky ground, the decision could still be made to continue the CTO. The flexible use of these concepts, coupled with their cumulative effect, demonstrates the challenges inherent in reaching a discharge decision. It is with the review process that we see where discharge from the CTO can be made possible, as a more negotiated space for contestation. What I pick out here is the ways that practitioners and service users worked together to come to decisions. Practitioners took different approaches and had different comfort levels when managing uncertainty, but central to the decision to discharge was the evidence the service user presented – how convincing they were that ‘true’ change had been achieved – combined with the trust practitioners

held in them. As Ramsay (2009) states, the ability to reassure is necessary for individuals to move out from compulsory frameworks. In this sense, I turned from the more common way trust is considered – service users’ trust in practitioners and services – to the ways that trust plays out in practitioner decisions. Brown and Calnan (2012) in their study of trust in mental health services argue that a false dichotomy between rationality and irrationality underpins current thinking on decision-making, and that choosing to trust is a necessary and effective way of managing uncertainty. Trust is a difficult concept to pin down and Brown and Calnan (2012) separate it from notions of familiarity and confidence; describing the conditions in which it becomes relevant, such as where an individual is vulnerable amidst uncertainty, leading to an interaction of dependence with choice; and defining the process of trust formation as active and relational. For practitioners, being dependent on service users’ presented narratives meant to a certain extent taking a ‘leap of faith’. In this way I have illuminated how ‘formal’ logic and intuitive sense can become entwined in such decision-making, thus demonstrating how a decision in favour of CTO discharge might be reached. More broadly, having excavated the different ways CTO ‘ends’ can be thought about, I turn in the next chapter to a conclusion on CTO practice as a whole.

Conclusions for policy, practice, research and theory

In this concluding chapter, I sum up the implications of the discussion in the previous chapter for CTO policy, practice, research and theory. I start by giving an overview of current policy trends in relation to CTOs, before outlining the messages that the discussion in the previous chapter holds for CTO policy and practice. In the latter half of the chapter I consider the research agenda for CTOs, firstly by surveying the strengths and limitations of the methodological approach I have taken, before considering what such an agenda might look like. I end the chapter by reflecting on what can be said about the complementary relationship that I have developed between critical realism and governmentality, and what this relationship has brought to the conclusions I have come to on CTO practice.

Implications for policy and practice

It appears that CTOs are now an embedded and apparently durable feature of English mental health policy and practice. Despite the increased volume in calls for their dissolution that followed the publication of the OCTET study, which showed no difference in hospitalisation rates for CTO cases (Burns and Molodynski, 2014, Rugkasa, Dawson and Burns, 2014), and concerns raised in parliament about them (HC Health Committee, July 2013, HC 584), there has been no discernible downwards trend in the use of CTOs or any sign that their presence is being reconsidered at policy-level. Indeed, despite the initial projections of cost-savings expected through CTOs bringing lowered rates of hospitalisation (Department of Health, 2007), the figures continue to show a steady rise in both community and hospital based compulsion. The rate of people made subject to the Mental Health Act has increased from 34% per 100,000 population to 44 % since the introduction of CTOs in 2008, with CTOs making up 7% of the rise and compulsory detentions 3% (Health and Social Care Information Centre, 2014). Further, the agenda of both the previous Coalition and the current Conservative Government has moved on to broader and preventative mental health concerns, with little in the way of notable policy activity on CTOs. For example, the recently revised Mental Health Act Code of

Practice (Department of Health, 2015) contains only marginally different guidance on the use of CTOs as compared to the version it replaced (Department of Health, 2008). At the same time however, the continuing difficulties regarding bed shortages, the recent changes to commissioning and provision following the Health and Social Care Act 2012, and the ongoing disparity between health and mental health funding despite the pledge of ‘parity of esteem’ (Department of Health 2014), will continue to influence the use of CTOs and compulsion more broadly. In this sense, it is important to keep track of how CTOs are being used within the wider policy and practice context, as it can be imagined that further pressures on services are likely to make it harder for practitioners to use CTOs in the more individually tailored ways that I have highlighted as possible in this thesis. Nevertheless, we can still consider the messages the conclusions reached in the previous chapter hold for CTO policy and more significantly practice. In doing so, it is necessary to acknowledge that the approach I have taken makes it difficult to give a straightforward and indeed non-contradictory narrative on what can be said about CTO practice. Indeed, as Peattie (2001, 260) warns, “it is simply that the very value of the case study, the contextual and interpenetrating nature of forces, is lost when one tries to sum up in large and mutually exclusive concepts”. Consequently, these messages should be considered as starting points for discussion and debate rather than final proclamations on CTO practice, taking into account both the aforementioned constraints on practice I have explored in the thesis, alongside the diversity of situations, needs, perspectives and responses of practitioners and those individuals made subject to the CTO.

The interplay between (and within) policy, practitioner and service user ‘ends’

CTOs cannot be seen as premised on a single policy aim, but instead on the interplay of different goals – namely risk, recovery and resources - which can both support and be in tension with each other. These goals have been modified and mediated by practitioners in line with their own priorities, and also added to with protection/reciprocity appearing as drivers in practitioner accounts. In turn, service users hold their own purposes and anti-purposes for CTOs, which interact in various ways with policy/practitioner expectations, and disrupt the ‘thin’

theorisation of thought and behaviour that CTOs are based on. The challenges these different configurations bring for CTO ‘ends’ are many. From a policy perspective, the tensions present in policy formulations have been translated to practice, and although my findings suggest many practitioners tried to uphold recovery as an end result, there are strong constraining factors, including the very nature of the CTO framework which counteracts this agenda. I am not suggesting recovery as an aim is necessarily preferable to the other highlighted purposes in all circumstances. Indeed, all three goals of risk management, recovery and protection were important for different service users; the individualised version of recovery that dominates in policy/practice did not fit with many service users’ conceptions of what recovery is; and considerations of risk and protection had their place – albeit within their own sets of constraints – as part of the practice of CTOs, particularly considering the relational risk management that occurred. However, given the recent commentary following the OCTET study that suggests CTOs should be reconsidered because they have proven ineffective for ‘revolving door’ and recovery purposes, there is potentially a misalignment between policy/practice and the way that CTOs have been judged thus far from a research/commentary perspective, which may prove significant for future policy-level deliberations and justifications for CTOs. From the perspective of practitioners, the challenges are related to firstly balancing and prioritising competing goals for individuals service users at different points in the CTO and secondly demonstrating awareness and sensitivity towards the role service users see CTOs playing in their lives, so they can where possible, orientate CTOs to a shared purpose for service users’ treatment and support. In this way it seems more likely that outcomes will be reached that are acceptable and meaningful to both practitioners and service users.

The role of relationship in mediating coercion under the CTO

A large part of managing this challenge for practitioners is mediating the potentially coercive effects of CTOs for those service users who are not enamoured with their use. Spending time early on explaining and discussing the CTO with service users in a way that was relevant to them as an individual made

a significant difference to shifting the view of many service users and alleviating potential difficulties further down the line. In addition, practitioners talking about the aim of the CTO from the beginning, and developing with service users a clear idea of what success would look like for them instead of reinforcing a sense of being ‘in limbo’ on the CTO, could help mitigate feelings of hopelessness and uncertainty. Whilst the conditions of CTOs are automatically documented as part of the process, it may also be helpful, perhaps as part of the care plan, for practitioners to document what the CTO is being used *for* with that particular service user, which can be revisited as a guide throughout the process. Whilst these may seem obvious points, it appeared that this kind of practice was variable. It also should be acknowledged that with some service users, such an approach was not possible due to engrained mistrust in services and practitioners, which meant their view of the CTO would always be negative. In these cases however, ‘working round’ the CTO by adapting it to the service user, negotiating and arbitrating medication, and focusing on wider emotional, social and practical needs could support the continuation of helpful collaborative work. In addition, whilst service user beliefs about the CTO were more fixed and less amenable to external influence once it was in place and active, practitioners being honest and clear about how the CTO would work for individual service users at particular points could at times help to alleviate anxiety about its use. In a broader sense, it seems that an important ‘bridge’ that could be built is for practitioners to understand, accept and acknowledge this anxiety as connected to service users’ felt stigma and coercion, their sense of self and their hopes and fears, rather than invalidate it because there were no concrete adverse implications of the CTO.

The discussion also points to where the received wisdom on mitigating coercion may not always hold true. Using the CTO to protect from ‘harsher’ compulsion may have its place for some individuals, but simply comparing community compulsion favourably to hospitalisation is not always enough. For some service users, what feels like the unending presence of the CTO combined with not being able to make a choice on how they live in the community and ‘take a chance’ on being admitted, meant that this favourable comparison did not always stand. More specifically, attempts to circumvent or soften the functions of the CTO could have the effect of enhancing service users’ sense of coercion. There is no

easy answer to this, and as I pointed out in the discussion of ‘surface’ and ‘depth’ practice, practitioners might draw on approaches from both ‘types’ of practice in ways that are adapted to the individual service user they are working with, without assumptions being made about one approach necessarily being ‘better’ than the other. Further, it seemed important for care coordinators in particular to know when the CTO was a hindrance more than a help, and be given the opportunity by other professionals to ‘let go’ of control via rescinding the CTO in those cases in order to bring about a more sustainable relationship.

The role of institutional and cultural factors

The work practitioners carried out with service users cannot be seen in isolation - institutional and cultural factors were significant in shaping CTO processes and outcomes. There has been significant differences between rates and patterns of CTO use in different parts of the country (HC Health Committee, July 2013, HC 584), and whilst the institutional pressures in both field sites were relatively similar as connected to national policy and service trends, the team-level cultural influences appeared to contribute more to differences in use. Whilst I noted in Chapter Three that professional background did not seem to directly influence practitioner perspectives and practice on CTOs, organisational roles, such as that of care coordinator or AMHP, did make a difference. It was these professional roles that could lead to team-level tensions on CTO use, most evidently between psychiatrists and care coordinators, and psychiatrists and AMHPs. In addition, group decision-making on CTOs demonstrates that given the wide parameters of their criteria they can be difficult for practitioners to challenge, unless there was a team mandate to do so. As I have highlighted, it is ironic that the room for manoeuvre that practitioners have with CTOs means that they can feel that their options in decision-making are limited to agreement on the imposition and active use of CTOs. In their post-legislative scrutiny of the 2007 Mental Health Act, the Health Committee stated that they were “surprised by the extent of variation between clinicians” when using CTOs and that this should not “be permitted to continue without serious professional challenge” (HC Health Committee, July 2013, HC 584, para 92). In my view it should not be surprising given how CTOs have been set up to begin with that this variation has occurred. However, it is

difficult to say what ‘serious professional challenge’ might mean. It seems in the comparative team where CTOs were actively questioned and challenged there had been open discussion about them, which had meant the team coming to a general agreement on how they would be used irrespective of organisational role. Indeed, in the teams where I was embedded for the majority of the time, it was through the research process, particularly during my dissemination of findings, that practitioners began to talk together and reflectively about what they believed the CTO meant, and were sometimes surprised at the differing views that emerged on their use. Busy team environments are not always conducive to collective dialogue on the underpinning reasoning for interventions, but perhaps this says something about the potential usefulness of such forums for incubating a shared understanding of CTOs.

In a broader sense, inter-agency communication on the role and remit of the CTO is also of importance. As I described, criminal justice agencies such as the police and probation could see the CTO as almost akin or as a substitute to any involvement they might have with a service user, which could leave mental health practitioners sometimes feeling that they had been left without support and under pressure to ‘do something’ even if they justifiably did not regard it as entirely their responsibility in complex and high-risk cases. Although the pressures on inpatient services are qualitatively different, similar issues regards differing expectations of the CTO between inpatient and community services could adversely affect its functioning and the continuity of care within its bounds. These are long-standing issues in mental health, not only applicable to CTOs and unlikely to be resolved soon. However it seems important to acknowledge the significant role they play, particularly in contributing to the perverse outcomes that can result from CTOs.

Balancing the varying consequences of CTOs

Here is where we turn to those outcomes, specifically in this context in relation to how decisions on CTOs are reached, taking into account their consequences. The part intangible factors play in CTO decisions needs to be considered, in particular the roles that ideas and forms of knowledge take. I have explored the

theories that underpin CTO use at both policy and practice level. In particular I have noted the central place a consideration of insight takes in CTO decision-making and how it is put to use in a flexible way. It seems that practitioners who retained some critical distance from the concept of insight in mental health practice were able to come to an understanding of service user actions and motivations which meant they were more likely to demonstrate an adaptable and situational response to both the use of the CTO and when it should be discharged. Practitioners' consideration of insight can be seen to be working with, as well as against relational knowledge in decision-making however, specifically when deciding whether to trust service user accounts of change. More broadly, the connections between the ethical frameworks that practitioners espoused about the nature of practice and the way they responded to uncertainty and enacted risk-taking should also be highlighted. Practitioners beliefs about practice played out in terms of the parameters of control they were prepared to work within. In this sense, I have highlighted throughout the practical-ethical nature of practice and how practitioners navigate between what they think is ideal, what is possible, and indeed what is necessary when using CTOs. Indeed, taking account of the reactions of service users to the CTO and the subsequent effects that arose in terms of patterns of CTO active use, levels of engagement and behaviour more generally was a skilled endeavour which meant looking beyond what 'types' of service users CTOs 'should' be used for. Instead, it involved practitioners sorting through a constellation of factors, both evidential and ethical, and making decisions on that basis in relation to implications for the individual in question, as well as the community they live within. Emphasis is typically placed on the longevity of CTOs and the difficulty in bringing them to an end. Whilst my findings and discussion have supported this conclusion to a large extent, in illuminating *why* this might be the case, and more significantly when practitioners *do* feel able to discharge CTOs, it is possible to see a starting point for thinking and acting critically in relation to CTO cycles, specifically 'perpetual' CTOs and continuous re-imposition of CTOs.

Implications for research

I now consider what the conclusions reached about CTO policy and practice mean for CTO research, by sketching out a future research agenda. In order to give a full account of future directions for CTO research it is necessary first to outline what I see as the strengths and limitations of the approach I have taken. As I noted in Chapter Two, creating an account of causality from a realist perspective is essentially explanatory and based on generative power, but does not claim to be the final or full account of phenomena. Still, much can be learnt from honestly and critically reflecting on decisions made at different stages of the research and I explore here the elements of the research which contributed to the achievement of my research aims, and the shortcomings of the research process which have limited what I can say about CTOs.

Strengths and limitations of the research

Taking a case-based approach within an ethnographic framework meant I was able to gain sustained access to the field, which in turn enabled an analysis of CTOs over time and as key events occurred. Analysing CTOs at different 'levels', such as at an individual case level, within the team, within the Trust, and within policy context also gave depth to the data I gathered, which means I gained a good understanding of individual, interpersonal and contextual factors in the use of CTOs. Finally, drawing on different constituent groupings (practitioners, strategic leads, service users) and kinds of data (documents, interviews, observations) enabled a view of CTOs 'in the round', taking account of varying perspectives and sources to highlight different aspects of CTO use. If we take Hammersley's (1992) conceptualisation of truth in research, taken from his 'subtle realist' approach to ethnography, it is possible to see how both the depth and breadth of data elicited in the thesis may have developed a sense of plausibility. Hammersley equates truth with internal validity - as he points out, stating a knowledge claim is valid is more palatable in the social sciences than stating it may be true. From a critical realist perspective however, truth can be theorised in terms of corresponding to reality, and more specifically as a "selective representation rather than a reproduction of reality" (Hammersley,

1992, 69). As reality cannot reliably be known, judging research as being true depends on the evidence that the researcher supplies to support their claims. Through incorporating a range of methods in a longitudinal and intensive research design, and in being careful to present a variety of views and experiences, I hope to have created a sense of verisimilitude.

Hammersley (1992) suggests that alongside truth, an assessment of research in realist terms must also consider relevance. Taking relevance into account allows for an alternative perspective on generalisability, by foregrounding the transferability of research findings. As Shaw and Gould (2001, 195) suggest, in doing so, it is recognised that “all situations are different to some extent” and that logical comparison between contexts based on ‘thick description’ is consequently of more value for ‘real world’ practice settings. This perspective thus supposes that the application of theory is implicitly mid-range in nature (Merton, 1957), because it “makes no pretence of being able to explain all social phenomena, and is not founded upon any form of extreme reductionism” (Hestrom and Ylikoski, 2010, 61). As Flyvbjerg (2006) notes, there are inherent difficulties in the premise that predictive theory can exist in social science. Indeed, an argument I have made throughout this thesis is that the perceived generalisability of particular kinds of research findings for CTOs can be problematic, which in turn led to the approach I took to examining the generative process of CTO practice. Going further, Flyvbjerg (2006, 221) makes the argument that “context-dependent knowledge” allows for ‘deep’ experiential learning in a way that “rules-based” knowledge does not. Transferability of research findings can be seen as applying inside and across practice settings. In relation to the former, as I mentioned earlier, discussion of the research findings with practitioners in the field sites gave them an ‘external’ perspective on their work, which I was informed had supported reflection on how they went about CTO practice. Engaging practitioners in reflexive dialogue on research findings brings helpful understanding for the researcher, but also can lead practitioners to engage in a collaborative “hermeneutics of mutual curiosity” (Kjorstad, 2008, 157). Regarding transferability outside of the field sites, some of the ‘lessons learned’ through this thesis build on broader themes and theories in research for practice which can be applied across settings – for example about ways of working within

compulsion. At the same time, it should be acknowledged that research findings often have more of an indirect and cumulative influence than a direct impact on policy and practice (Cousins and Shulha, 2006). This calls for a modest and honest acknowledgment of what policy and practice-oriented research is capable of achieving, without taking a nihilistic view of such research (Shaw and Gould, 2001). Bloor's (1997) description of case studies where research has greater relevance for the micro-processes of practice than the macro development of policy fits well within this remit. He suggests that such research can both influence practitioner participants and practitioners who make up the audience for research. For interested practitioners external to the research, rich descriptions of case-based studies enable them to add to and make judgements on their own practice knowledge. As Flyvbjerg (2006, 238) argues, "The dense case study...is more useful for the practitioner and more interesting for social theory than...generalisations of theory [or findings]". Reaching "conceptual closure" (Flyvbjerg, 2006, 239) on research findings risks overly simplifying the 'messages' that can be taken from research, and denying the reader the possibility of interpreting and 'translating' such findings into their own world.

The same thinking can be applied to the process of doing research. Through reflecting on my findings, I have noted that whilst being able to contrast and synthesise different kinds of data and differing participant views has given a good reflection of CTO practice, I am also aware that I have not made as many references as I would have liked to about differences between the case study field sites, particularly between the two Trusts. I have also had to excise the contrasting findings that resulted from discussions with practitioners who used CTOs within the field of learning disability. This is partly due to the sheer volume of data I have generated through the study, but also because my analysis provided much more in the way of similarities across field sites than differences, which in turn seemed more significant to report on. As I have stated, my findings present significant variability and complexity in CTO practice and the responses of service users and practitioners to their use; however this variability was similar in range and nature across the field sites. This perhaps says something in itself about the operation of CTOs and the common issues that may arise in their use, which in turn suggests the potential for transferability of the

findings. With that in mind, it is my plan to revisit the data and carry out secondary analysis so as to pick out the contrasts between different areas of practice and different sites, which I can then report on elsewhere.

In a similar sense, the decisions made during the access and recruitment phase brought positives and negatives for what data could be included. A decision made early on was to find teams where I could gather a lot of rich data on CTOs, which meant Assertive Outreach Teams where they were used regularly. However, an alternative approach may have been to choose one of the teams as an example of where CTO usage was lower. Consequently, it is not known if the practices disclosed through the research would occur in teams with lower rates of CTO use; specifically I do not know how issues of expertise would play out in a lower use setting. I attempted to mitigate this through the inclusion of interviews with practitioners from other kinds of teams, but given more resources, it would have been helpful to include more variation within the field.

Turning to the methods deployed, one of the challenges of observational research is that the presence of the researcher may affect how participants act. Certainly, at the beginning of the fieldwork I was aware that practitioners and service users alike could be careful about what they did and did not share or allow me to see. However, I think this is where my identity as a social worker was helpful, in that having that professional background allowed me to 'fit in' with team life relatively quickly, and as the research went on access and participant behaviour became less of an issue. Achieving this status raised ensuing ethical questions about what I should include or exclude from the research, which has been a process of judgement on how significant 'sensitive' knowledge is to the research findings, particularly around team cultures. I think however that in being as honest and transparent as possible about my intentions, I was able to manage 'good enough' field relations. This, as far as I can be aware, seemed to enable most participants to reciprocate and be honest about their thoughts, feelings and experiences of CTOs. In turn, I have shared my findings with participants at various points of the study, thus enabling potential sensitivities to be accounted for.

The attitude of participants was not the only challenge in ensuring data collection. In addition it should be acknowledged that the ‘messy’ nature of ethnographic fieldwork meant that I did not always get access to data as planned. Although I did follow CTO cases over eight months, I would have spent longer in the field if I could. Not all the cases I followed were at the same stage, which although allowing for a breadth of experiences to be examined, meant that I did not get the same amount and kinds of data for each of the cases. This was especially so for those cases where the CTO was removed shortly after the individual was recruited, which meant I could not observe CTO related meetings. Conducting the fieldwork over eight months was a conscious choice however within the time constraints I was operating within, and was chosen as a time period as I knew it would encompass most of a six month CTO cycle. I also found that when examining decision-making processes at different points of the CTO that certain elements could not be accounted for. In particular, the more ‘informal’ aspects of decision-making were not always captured. Although I spent a great deal of unstructured time in both teams, I know that I missed key phone calls and ‘corridor conversations’. My partial response to this was to ask practitioners to retrospectively reflect on decisions in as much detail as they could, which helped fill in some of the missing pieces. More fundamentally, there were aspects of the CTO process which I was not able to consider in as much depth as I would like. In particular, whilst I learnt about recall ‘second hand’ through meetings, office discussions and interviews, I was not able to observe any recall procedures due to their time-critical nature, as well as their often difficult nature, which mean practitioners felt only those people who were necessary should attend. I was also not able to observe any decisions regarding converting recall to revocation of a CTO. Only one service user had their CTO revoked during the field work and I was not privy to that process. Following CTOs from the beginning through recall, revocation and then back into the community would have ‘closed the circle’ so to speak, and let me see what drove decisions at these later stages. More broadly, I would have liked to have had more access to the ‘hospital’ part of the CTO cycle, and in particular spoken to hospital-based practitioners about their perspectives on CTO use.

Finally, although not necessarily a strength or limitation of the research, I should acknowledge the specific way that I have approached outcomes. I have argued that taking a generative approach by following cases through within context can allow some sense of what can result in particular circumstances and constraints to particular people, and can also allow for unexpected and unwelcome consequences to be accounted for. Whilst I have highlighted what some of the possible ‘hard’ outcomes might be – for example in relation to risk - my focus on individual journeys and questions of identity has by its nature prioritised ‘soft’ outcomes generated by CTOs, related to service user self-perception, beliefs and engagement. In addition, I have taken an interest in both how consequences of the CTO relate to each other, and connectedly, how they are perceived by practitioners and service users. This has meant that I have taken account of consequences such as ‘recall cycles’ for example, which as an output rather than an outcome, would not be included in ‘typical’ outcome focused studies. It is my view however that it is important to include such consequences, firstly because they are demonstrably significant *as* consequences to practitioners and service users, secondly because they highlight what matters in outcome sequences (for example medication adherence being prioritised over ‘secondary’ outcomes), and thirdly because they provide a starting point to understand what further outcomes might arise (for example periods spent in the community versus in hospital). I believe I have argued consistently for the value of the approach I have taken. However, given more time and resources, and returning to the earlier discussion of generalisability, a mixed methods approach could have brought an additional ‘big picture’ dimension to the tracking of outcomes. On that note, I turn to ideas for a future CTO research agenda.

Future research

Taking into account the above overview on limitations, and the conclusions that were reached in the preceding chapter, a future research agenda on CTOs could consider the following:

- Given the range of purposes and associated outcomes that are possible from the CTO, it seems that research on CTOs, particularly within the

national context, could broaden its scope. In particular using CTOs for risk and protective related purposes could be further examined in a more focused way than has been possible within both the ‘whole-policy’ orientation and constraints of this thesis. I have highlighted a number of areas that would benefit from more research such as: defensive decision-making within the CTO criteria and group forums; practitioner conceptualisations of risk in relation to CTO use; an analysis of risk and protection-oriented outcomes, for example how well the CTO does or does not enable the management of various kinds of risk to others; and how reciprocity is understood and enacted in more or less ‘formal’ ways through the CTO and within the constraints present within the system.

- More in-depth research on the various ‘CTO cycles’ that I have brought attention to would also add to understandings of how CTOs are operationalised, how discharge is and is not made possible, and the phenomena of being placed on multiple CTOs. This would involve more longitudinal work, following CTOs through recall, revocation and beyond to see how such decision-making takes place, and to examine the effects of ‘long-term’ CTOs, both for those individuals who are kept on a CTO for a significant length of time and those who are placed on one CTO after another.
- Research on how CTOs are used in other populations and settings would also be a helpful addition to the field. I noted earlier that I had found some support that CTOs are used in learning disability services for example in a very different way to how they are used for ‘typical’ CTO cases, and this would merit further investigation. Analysing patterns and methods of CTO use in less high-intensity teams would also give a fuller picture of the use of CTOs in mental health services more broadly. The tensions between hospital and community have pointed to significant issues for the CTO process, and it would be helpful to have the view of hospital-based practitioners on the impact of CTOs on their work, and how they manage CTO cases, particularly during recall. Finally, the

influence of identity formation on CTOs would suggest that a study of the experiences of younger service users on CTOs would be helpful. CTOs do not have an age limit and very little if anything is known about their use with young people under the age of 18.

- As far as I am aware, this thesis is the first study that has explored the appeals system and process as applied to CTOs in this country. Again, the wide scope of the thesis in looking at the CTO as a whole meant that this aspect of the findings was one part of a larger picture. In light of the conclusions drawn related to CTO decision-making, a national and more systematic study of decision-making - perhaps comparing practitioner reasoning and decisions to appeal panel members as Jaworowski and Guneva (2002) did in Victoria, Australia - and a more in-depth analysis on how appeal panels understand and apply CTO criteria, would provide valuable evidence for when, how and why CTOs are discharged.
- Given the part that team-level cultures and associated tensions between different organisational roles – for example between care coordinators, AMHPS and psychiatrists – play in CTO practice, a more in-depth study of the influence of such roles on ‘street-level’ CTO policy-making would be of merit. As I have noted, the emphasis in research on mental health social work in particular has been on delineating the role of the social worker from other professional actors, particular regarding value positions for professional practice. It may be that an emphasis on *role* rather than *profession* in future research would yield interesting and useful findings in how and why CTO practice evolves as it does in localised settings.
- Finally, an analysis of CTOs as they reside within the broader policy and practice landscape would benefit from further attention. I briefly outlined some of the changes in mental health policy that have occurred over recent years, and as I mentioned in the findings, the relationship between CTOs, care clustering and payment by results may demonstrate evolution

in where CTOs are being used and for what reasons, especially given the additional financial component that comes with such policy innovations. Looking beyond mental health services, the use of CTOs as related to other agencies, and particularly in relation to multi-agency working on complex cases might also shed some light on how CTOs are perceived by non-mental health professionals who are involved in their use, and how they see CTOs adhering with their mandate.

Conclusion

In this thesis I have drawn out both how CTOs act on individuals through coercive, disciplinary and reflexive forms of power, and why they might or might not work in particular circumstances and ways. In doing so I highlighted how governmental and causal analyses do not necessarily contradict each other, but instead may helpfully complement each other. A governmental analysis of how practitioners and service users think and act in response to differential forms of power has implications for why CTOs follow particular pathways, and in introducing an ethical dimension to policy-practice evaluation also moves causal analysis beyond asking what factors make CTOs 'effective' or not. Conversely, exploring why CTOs play out as they do through context-mechanism configurations has highlighted the ways that a governmental analysis, which can emphasise the 'strategic games' (Foucault, 2000) individuals play out in response to reformatory forces, may be complicated by accounts of agency and interaction which situate such responses as also co-constructed and "embedded in broader practices of self-making and personhood" (Barnett et al, 2008, 644). As Sayer (2005, 51) explains, interpreting this normative dimension of everyday life is necessary to avoid a representation of "bloodless figures who seemingly drift through life, behaving in ways which bear the marks of their social position and relations of wider discourses, disciplining themselves only because it is required of them, but as if nothing mattered to them". Dawson et al (2003, 253) suggest that research on CTOs "cannot resolve the fundamental ethical and political conflicts this form of treatment delivery presents. Only through evaluative judgements can we determine the priority to give different criteria of success in compulsory community care...". What I hope to have demonstrated is that

research on CTOs may not settle such conflicts, but it *can* shed light on ethical dilemmas and the ensuing evaluative judgements that occur in practice in relation to CTO ‘success’, in a way that refers to both the multiple and overlapping implications of CTOs and what matters to practitioners and service users in their use.

In this way, synthesising governmentality within a critical realist framework has also allowed some movement beyond the dichotomous perspectives that have emerged on CTOs over the years of their existence, consequently engendering different kinds of knowledge which have addressed some ‘gaps’ in what we know about CTO practice.. Taking a view of the operation of power in micro-political and generative, causal terms has instead enabled CTOs to be understood as a complex, diversely realised intervention positioned within the social and ethical world of service users and practitioners. Consequently, whilst I have discussed the evaluative judgements made as part of CTO practice, I have been careful to not place myself as a researcher within a strong value position on CTOs, without at the same time being ‘value-free’. In this, I am with Dean (2010, 46) that “we need to adopt a stance that is neither enamoured with the ‘will to govern’ nor utterly opposed to the practice of governing”. Indeed in my view, exploring the variety of ways CTOs are interpreted, experienced and responded to by practitioners and service users precludes such a judgement. The connections that can be made between forms of conduct and counter-conduct in the face of CTO means and ends particularly demonstrates that the operation of power in this light does not neatly fit into categories of “power and powerlessness, consent and constraint, subjectivity and subjection” (Dean, 2010, 84). This excavation of CTO practice suggests that CTOs cannot be aligned simply or only with the more authoritarian arguments for their use made by government and critiqued by opponents. It seems therefore that the criticisms CTOs engender have perhaps overshadowed those elements of the policy that may result in positive practice and outcomes. At the same time, CTOs cannot be said to always or only reach the more ‘Utopian’ goals (Dean, 2010) also put forward by policy-makers and by advocates of their use; the perverse consequences I have highlighted suggest the ways that CTOs are not always without adverse implications, particularly in the way of coercive effects. In this

sense, 'taking a side' on CTOs does not allow for the contradictions that lie within such rationalities to begin with, nor with how there are continuities and breaks between these rationalities and practice which appear in sometimes unexpected ways. Holding such a view does not imply relativism however. As Sayer (2009) argues, a critical approach involves exploring what it is that may cause avoidable suffering as well as flourishing in society, and I have tried to impart the relationship of CTOs to both states of being, and consequently distil what messages can be carried forward into CTO policy and practice.

Appendices

Appendix One: Consent forms

Community Treatment Orders: Their Implications for Mental Health Practice in England

CONSENT FORM FOR PRACTITIONERS WHO PARTICIPATE (1)

Please initial each box

Yes No

1. I have read and understood the information sheet for this project. I have had time to think about the information and to ask any questions.

2. I understand that taking part is voluntary and that I am free to change my mind and withdraw at any time, without having to give a reason.

3. I agree to take part in interviews with the researcher and for them to be recorded.
I understand that I can refuse to answer a question if I don't want to.

4. I agree to take part in a focus group with my colleagues and the researcher and for it to be recorded. I understand that I can leave the group at any point if I need to.

5. I agree for the researcher to attend relevant meetings and for them to take notes on what is said and done in the meetings. I understand that I can request for the researcher to leave at any point.

6. I agree for a one to one meeting between myself and a service user to be recorded.
I understand that I may not be asked to do this. I understand that if I do take part in this, I can stop the recording at any point.

7. I understand that any information I give will only be used for the study. I agree that the researcher can use this (anonymous) information in reports and presentations

8. I agree that the researcher can keep this information for up to three years in a secure place.

9. I agree that if I choose to withdraw from the study, the researcher can still use information collected about me up to that point.

10. I understand and am happy with how the researcher will protect my rights to confidentiality and anonymity.

Name of participant

Signature

Date

Name of researcher

Signature

Date

1 copy for participant, 1 copy for researcher

Community Treatment Orders: Their Implications for Mental Health Practice in England

CONSENT FORM FOR PRACTITIONERS WHO PARTICIPATE (2)

Please initial box

Yes No

1. I have read and understood the information sheet for this project. I have had time to think about the information and to ask any questions.
2. I understand that taking part is voluntary and that I am free to change my mind and withdraw at any time, without having to give a reason.
3. I agree to take part in a focus group with my colleagues and the researcher and for it to be recorded. I understand that I can leave the group at any point if I need to.
4. I agree for the researcher to attend relevant meetings and for them to take notes on what is said and done in the meetings. I understand that I can request for the researcher to leave at any point.
5. I understand that any information I give will only be used for the study. I agree that the researcher can use this (anonymous) information in reports and presentations
6. I agree that the researcher can keep this information for up to three years in a secure place.
7. I agree that if I choose to withdraw from the study, the researcher can still use information collected about me up to that point.
8. I understand and am happy with how the researcher will protect my rights to confidentiality and anonymity.

Name of participant

Signature

Date

Name of researcher

Signature

Date

1 copy for participant, 1 copy for researcher

Community Treatment Orders: Their Implications for Mental Health Practice in England

CONSENT FORM FOR SERVICE USERS WHO PARTICIPATE

Please initial box

Yes No

1. I have read and understood the information sheet for this project. I have had time to think about the information and to ask any questions.

2. I understand that taking part is voluntary and that I am free to change my mind and withdraw at any time, without having to give a reason and without the services I receive being affected.

3. I agree to take part in interviews with the researcher and for them to be recorded. I understand that I can take a break or stop the interview if I need to, and can refuse to answer a question if I don't want to.

4. I agree for the researcher to sit in on meetings held about me and for them to take notes on what is said and done in the meeting. I understand that I can request for the researcher to leave at any point.

5. I agree for the researcher to have access to my case records and to take notes of any information that is relevant to the project..

6. I understand that any information I give, or that is gathered about me, will only be used for the study. I agree that the researcher can use this (anonymous) information in reports and presentations

7. I agree that the researcher can keep this information for up to three years in a secure place.

8. I agree that if I choose to withdraw from the study or can't carry on with it, the researcher can still use information collected about me up to that point.

9. I understand and am happy with how the researcher will protect my rights to confidentiality and anonymity.

Name of participant

Signature

Date

Name of researcher

Signature

Date

1 copy for participant, 1 copy for researcher



Community Treatment Orders: Their Implications for Mental Health Policy and Practice in England

INFORMATION SHEET FOR PRACTITIONERS WHO PARTICIPATE

My name is Hannah Jobling and I am a PhD student at the University of York. I would like to invite you to take part in my research project looking at how Community Treatment Orders (CTOs) are being used in community mental health services. Before you decide whether to take part, it is important you understand why the research is taking place and what it would involve for you. This information sheet will help you make your decision by answering common questions you might have. You will also be given the opportunity to talk with me individually to discuss your involvement and ask any questions before deciding if you want to take part. You may want to ask:

'Why are you doing this study?'

CTOs generated considerable debate when they were introduced in 2008 and nationally relevant research is necessary to determine their impact on mental health services. The majority of research on CTOs has tended to ask the question, 'Do they work?' We know far less about *how* they are being used and experienced 'on the ground' by the various people who have been affected by their implementation. The study therefore aims to find out how CTOs are being practiced and with what implications for the experiences of service users, carers and practitioners. The study also has an educational purpose in that I will submit a piece of academic work based on the findings for my PhD.

‘Why have I been invited to take part?’

I got in touch with the senior management team to see if they thought there would be interest within the Trust in participating in my research project. Your team was identified by them as being a potential site for the study, as it holds a number of CTO cases. The study aims to involve practitioners from across a range of professional backgrounds, and consequently all practitioners in your team will be approached to participate.

‘What will the study involve for me?’

I will be spending time within the team from April to November, following the progress of a small number (approx. five) CTO cases. During this time, I will be interviewing practitioners, service users and carers (with their permission), as well as observing a range of meetings and reading documents relating to the cases. As a practitioner, the level of your involvement in the study will depend on your relationship to the cases that are being followed. If you are a key practitioner for one of these cases, at the most you may be asked to participate in:

- One interview near the start and one near the end of the research period, which are aimed at understanding how you think about and use CTOs. These will last about an hour and would be at a time and place of your choosing. You won't have to do anything to prepare for the interviews.
- Observations of two meetings in relation to the case (i.e. care reviews) which will allow me to find out how CTOs are talked about and how decisions about them are made. I will not intervene in the meeting or ask you to do anything beyond normal practice.
- One audio-recording of an interaction between you and a service user (with their permission), in order to understand how you make sense of the CTO together. A recording device will be given to you prior to the meeting and it will be collected from you after the meeting. You will not be expected to do anything different from normal practice aside from ensuring the recording device is turned on.

Alongside these activities, I will invite all practitioners in the team to participate in:

- A focus group roughly an hour long near the beginning of the research period, in order to gauge how the team talk about CTOs together and gain an overall idea of the teams' views on CTOs.
- Observations of some team meetings by me throughout the research period. It is likely that I will be spending time in the team office during the research period and if events relevant to CTOs occur, I will also draw on them for the study.

If you are a practitioner who is not directly involved in one of the chosen cases, then your involvement in the research will be limited to the two activities above.

The interviews, focus group and interaction with a service user will be audio-recorded, transcribed and kept as computer files. In the meetings I will take notes, writing down what is said and done, by whom and when. If during interviews, you don't want to answer a question or want the interview stopped, this will be respected. When recording an interaction with a service user, you or the service user will both have equal say over how it is used and can stop recording at any time. If during observation of a meeting you or any other attendees do not feel it is appropriate for me to be there, I will leave the meeting.

'Do I have to take part?'

Taking part in the study is entirely up to you. I will arrange to talk with you before the research starts in order to explain the study and answer any questions. You will then be asked to sign a consent form. At this point or at any time in the research period you can choose not to take part, without having to give a reason. Deciding not to participate will not affect your work in any way.

'Will the information you collect about me be kept confidential?'

All information collected about you will be kept confidential and will be accessible only to me. Transcripts, audio files and field notes will be kept in locked cabinets and/or on a password protected university computer. Personal details about you such as signed consent forms will be stored separately, but in a similarly secure way. Any information that identifies you

will be removed from the transcripts and field notes, and you will be given a false name. Whilst you may be quoted in the final reports, care will be taken to ensure you cannot be identified from what you say. This will include not identifying *** Trust in the final report. All data will be kept for three years following the end of the project in accordance with the University of York's data protection procedures.

Anything you say to me will not be shared with anyone else. The study is not aiming to 'judge' your work and any information you give will not affect your position. I am independent of the Trust, and management will not be told of what you say and do during the research. However, if you tell me something that indicates someone may be at risk of serious harm, I may have to share that information as appropriate, in line with the 'whistle-blowing' policy of the Trust.

'What will happen to the information I give if I change my mind about participating?'

If you say something during an interview which you consequently do not want included, this will be removed from the transcript on request. You will also be given an opportunity at the end of the interview to generally review your remarks. If you request it, I will be happy to give you a copy of the interview transcript for you to comment on accuracy.

If you change your mind about being involved in the study after you have taken part in research activities, information collected up to that point may still be used, but will still be kept confidential and anonymous.

'What are the risks and benefits for me in taking part?'

The study presents minimal risk to practitioner participants and I have been careful to design the study to avoid inconvenience or excessive obligation on the part of practitioners. However, although every effort will be made to keep information anonymous, the relatively small-scale nature of the research means there is a small risk that your contribution may be identifiable. I am confident that the steps I plan to take to ensure anonymity will mitigate this risk.

In other studies of practice in health and social care, some practitioner participants have commented that being able to discuss and reflect on their work has been a positive experience. More generally, the research aims to provide a good picture of how CTOs work, which could benefit future practice.

‘What will happen to the results of the study?’

I will write a report for the Trust, along with a shorter summary of the findings which will be made available to all participants. If the team wishes, I will return to give a presentation of the study findings and discuss them with you. I will also submit the findings of the study as a piece of academic work for my PhD. Aspects of the study will be used in articles published in academic journals and for academic conference presentations.

‘Who is organising, approving and funding the research?’

I am working on this study alone, supported by two experienced supervisors from the University of York’s Social Policy and Social Work Department. The study has been funded by the University of York. Before the research starts, it will be approved by the Social Care Research Ethics Committee and by the *** Research and Development Department.

‘Who can I contact if there is a problem?’

This is very unlikely. But if you do feel unhappy about anything that happens during the research, I will be happy to talk about it with you at any time. If you don’t feel comfortable talking to me about any complaints or concerns you may have, then you can contact my supervisory team, Professor Ian Shaw and Dr Mark Hardy at: The Department of Social Policy and Social Work, University of York, Heslington, York, YO10 5DD. Tel: 01904 32 1231

‘Who can I contact for more information about the study?’

I will be in touch with you soon to gain your consent to take part in the research. However, If you would like to discuss anything, please don't hesitate to contact me at:

Department of Social Policy and Social Work, Postgraduate Unit, Alcuin Research Resource Centre, University of York, YO10 5DD. Tel: 01904 321261, Email: hjls500@york.ac.uk

Community Treatment Orders: What they Mean for Mental Health Practice in England

INFORMATION SHEET FOR SERVICE USERS WHO PARTICIPATE

My name is Hannah Jobling and I am a research student at the University of York. I would like to invite you to take part in my research project looking at how Community Treatment Orders (CTOs) are being used in community mental health services.

I have asked your care coordinator to give you this information sheet to so you can decide whether you want to be involved in the research project. Before you decide whether to take part, it is important you understand why the research is taking place and what it would involve for you.

This information sheet will help you make your decision by answering common questions you might have. I will also go through this information sheet with you before the project starts. Please feel free to get in touch with me at any time, or talk to others about the project. You may want to ask:

'Why are you doing this study?'

The study's main aim is to find out how CTOs are being used and how they have affected you, and anyone who might care for you, or work with you. I am hoping that the study will give us a better understanding of CTOs, which could benefit how they are used in the future.

‘Why have I been invited to take part?’

I asked all the care coordinators in the *** team to approach service users like yourself, who are on a CTO and who they thought would be happy to take part in the research. It is important to include the views of people like yourself who are on CTOs so that the research gives a fair picture of their use. I am hoping to involve about five service users from these teams.

‘What will the study involve for me?’

I am going to be doing the study from April to November and will be asking you to take part in four different kinds of activities during this time.

1. I would like to meet with you a couple of times, to talk with you in complete confidence about your experiences of CTOs. I’m happy to meet you wherever is most convenient for you. These interviews can be as long or as short as you want and we can take breaks if you need to. On average, I would expect them to last about an hour. You can invite someone supportive to sit in on the interview if you want. If at any point you want to stop or don’t want to answer a particular question, that will be fine with me.

If it’s OK with you, I’d like to record the interviews, so that I can write up exactly what you say for the research. You will be given a £15 voucher for each interview as a thank you for taking part. If you need to travel to meet with me, I will give you money to cover this.

2. I would like to sit in on a meeting such as your care plan review, so that I can get an idea of how the CTO is talked about with you by the people who work with you. I wouldn’t take an active part in the meeting, but I would take notes on what is said and done during the meeting. If at any point you don’t want me in the meeting, I’d be happy to leave.

3. I would like to take an audio recording of a one to one meeting between you and someone from the team who you work with. I won't be there personally, but would ask you and the worker to take the recording for me. You will be able to control how the recorder is used and stop the recording at any point.

4. Although it does not involve you directly, I would like to ask your permission to read and take notes on your case file. This is so I can get a good idea of how CTOs are written about. I will only make notes on things relevant to the study.

'Do I have to take part?'

Taking part in the study is entirely up to you. Your care coordinator will ask you if it's OK for me to get in touch with you. If you agree, I will contact you to arrange to meet before the research starts so that I can explain the study and answer any questions. You can ask someone to come along to support you when we meet if you like. If you're happy to take part, I will ask you to sign a consent form. At any time you can choose not to take part, without having to give a reason. Deciding not to participate will not affect the services you receive in any way.

'Will the information you collect about me be kept confidential?'

Anything you say to me will not be shared with anyone else. I am independent of the *** team, and they will not be told of what you say and do during the research. The only time I will speak to another appropriate person about you is if I am really concerned for your safety or the safety of other people. If possible, I will tell you my concerns and let you know what I plan to do, before I speak to anyone else.

Any audio recordings and notes that are about you will be stored securely on a password protected computer. I will keep audio recordings and notes for three years after the study is finished, in a

safe place at the University of York. I will make sure your name and any other personal details are stored separately. Only I will have access to any information about you.

Often when researchers write up their work, they like to include quotes to show what people have told them. If I want to include something you have said to me in any reports, no one will know it is you because I will refer to you using a false name and will remove any other identifying details about you. I will refer to the teams and the *** Trust by a false name as well.

‘What will happen to the information I give if I can’t carry on with the study, or don’t want to carry on with the study?’

If you say something to me which you regret during an interview, I will make sure it is not included in any information I use about you. You will also be given an opportunity at the end of the interview to generally review what you have said. If you request it, I will be happy to give you a copy of the interview for you to comment on.

If you change your mind about being involved in the study after you have taken part in research activities, or have to stop taking part for whatever reason, information collected up to that point may still be used, but still in complete confidence and anonymously.

‘Is there anything for me to be worried about if I take part?’

When I talk with you I am not going to be looking for ‘right’ or ‘wrong’ answers and I hope that the interviews will feel relaxed. However there is a chance we might get talking about things which are difficult for you, and could make you feel upset. If this happens, I would ask you whether you would like to end the interview, have a break or talk about something else. I would not expect you to carry on with the interview if you don’t feel up to it. It is not a problem, however, if you

do get upset while we are together, and it will not embarrass me or make me feel uncomfortable.

‘What benefits will there be for me in taking part?’

Some research participants have said they have enjoyed taking part in research and that being able to express their views and be listened to has been positive for them. You would also be contributing to a better understanding of CTOs, which might improve how they are used in the future.

‘What will happen to the results of the study?’

I will write a report for the *** Trust, along with a shorter summary of what I have found out about CTOs, which will be made available to all participants. If you would like, I could return to talk about the findings with you and answer any questions about them. I will also submit the research as a piece of academic work for my PhD. Some parts of the research will be published in academic journals and presented at conferences

‘Who is organising, approving and funding the study?’

I am working on this study alone, supported by two experienced supervisors from the University of York’s Social Policy and Social Work Department. The study has been funded by the University of York. Before the research starts, it will be approved by the Social Care Research Ethics Committee. A Research Ethics Committee is an independent group of people who check that research protects the dignity, rights and safety of participants.

‘Who can I contact if there is a problem?’

This is very unlikely. But if you do feel unhappy about anything that happens during the research, I will be happy to talk about it with you at any time. If you don't feel comfortable talking to me about any complaints or concerns you may have, then you can contact my supervisory team, Professor Ian Shaw and Dr Mark Hardy at: The Department of Social Policy and Social Work, University of York, Heslington, York, YO10 5DD. Tel: 01904 32 1231

‘Who can I contact for more information about the study?’

If you would like to discuss anything, please don't hesitate to contact me at:

Department of Social Policy and Social Work, Postgraduate Unit,
Alcuin Research Resource Centre, University of York, YO10 5DD. Tel:
01904 321261, Email: hjls500@york.ac.uk

Appendix Three: Topic Guides

Service users

Introduction

- Introduce myself
- Housekeeping (expenses, voucher)
- Purpose of research
- Purpose of interview
- To understand what their experience of the CTO has been
- To gain their views on CTOs
- Describe interview format – length, relaxed and loosely structured
- Reiterate that driven by them - can take breaks/stop/not answer a question
- Check OK to be recorded
- Explain will be taking notes and why
- Any questions

Significance of CTO

1. How would you describe your feelings about being on a CTO?
 - Follow-up: Does the CTO help you and if so in what way does it help you?
 - Follow-up: Does the CTO harm you, and if so in what way does it harm you?
2. What difference, if any, does it make to you being on a CTO?

If it does make a difference:
Why do you think the CTO has caused this change in your life?

If it doesn't make a difference:
Why do you think the CTO hasn't changed much for you?
3. Do you care whether you are on a CTO or not?

- Follow-up: Can you explain why you feel this way?
4. Do you think the CTO is for your benefit or for the benefit of others?
 5. Overall would you describe the experience of being on a CTO as positive or negative?
 6. What do you think would happen if you were not on a CTO?

Effect on relationships

7. Who do you receive the most help or support from?

If not mentioned, ask specifically about the following people:

- Your worker/support person you see most often?
 - Your psychiatrist?
 - Your family?
 - The people you live with?
8. How, if at all, does being on a CTO affect your relationship with these people?
 - Prompts: Does being on a CTO help or harm your relationship with these people?
 - Why does it help or harm your relationships?

Relationship with services

9. How often do you see your workers?
 - Follow-up: Has the amount you see them changed since being on a CTO?
10. Have there been any changes to the support and treatment you receive since being on a CTO?

- Follow-up: Do you think being on a CTO should change the support and treatment you receive?

11. Would you describe the contact you have with services as helpful or not?

Involvement with process at time of discharge

12. Can you remember what happened when it was decided you were going to be discharged onto a CTO?

- Prompt: What were your initial thoughts about the CTO?

13. Lots of different things could have happened, for example you could have stayed in hospital or been discharged. What do you think were the reasons you were given a CTO?

- Follow-up: What do you think of these reasons?

14. How much were you involved in decision-making about your CTO when it was made?

- Follow-ups:
- Who do you think had influence in the making of the CTO?
- How was the CTO presented to you as an option?
- What involvement did you or your carer have in the CTO conditions?
 - Were there any disagreements between you and the professionals working with you about the CTO?
 - Were there any disagreements between your carers and the professionals working with you about the CTO?

15. What information were you given about your CTO at the time of discharge?

- Follow-ups:
- In what ways were you given information?
- How helpful has this information been?

- Are you still talked to about the CTO by workers?

Compliance with the CTO

16. What does being on a CTO require you to do?

- Follow-up –what conditions do you think you have to keep to?
- Prompt – if mention substance use, ask: has the CTO had an effect on your use of alcohol or other drugs?

17. Do you think you have to do what the doctors and nurses tell you, because you are on a CTO?

- Follow-up: Why do you think that?

18. If you were not required to by the CTO, do you think you would still see your worker?

- Follow-up: Why would that be?

19. If you were not required to by the CTO, do you think you would still take your medication?

- Follow-up: Why would that be?

20. What do you think would happen if you refused to take your medication?

- Follow-up: Has that ever happened to you?

21. If you take your medication regularly, what are your reasons for doing so?

22. Overall, is it a good or a bad thing you are required to take medication?

Recall, Renewal and Discharge

23. What do you think would have to happen for you to be recalled to hospital?

- NB If they have already mentioned medication noncompliance earlier, ask about other reasons.
- Follow-up: How do you feel about returning to hospital?

24. If they have been recalled before:

- Prompt: What has your experience been of being returned to hospital because of the CTO?

25. If their CTO has been renewed: What involvement have you had in the process of renewing your CTO?

- Follow-up: What involvement has your carer or family had in the process of renewing your CTO?

26. Has there been a Tribunal or Manager's Hearing since being on your CTO?

- Follow-up: If no: Would you go to the meeting when it happens?
- What would be your reasons for deciding to go/not go?
- Follow-up: If yes: Did you go to the meeting?
- If yes: what was that experience like?
- Prompt: How much were you involved in the meeting?
- If no: what were your reasons for deciding not to attend?

27. What do you think would have to happen for you to be discharged from the CTO?

- Prompt: When do you think you will be discharged from the CTO?
- Prompt: How do you feel about discharge from the CTO?

Looking Ahead

28. How do you think the use of CTOs could be improved, if at all?

- If you could change one thing about the CTO, what would it be?

- What advice would you give to professionals about how CTOs are used?

29. What do you see happening for you in the future?

- What hopes do you have for the future?
- What worries do you have for the future?

Ending

- Would you like to add anything else?
- Do you have any questions?
- Is there anything you've said today that you would rather I didn't include in the research?
- Would you like a copy of your transcript to read?
- Thank you for giving me your time today. Either I or your care coordinator will be in touch soon about next steps.
- If you want to contact me in the mean time you can on...

Practitioners

Note: Questions will make specific reference to the particular case practitioners are linked to in the research where relevant.

Introduction

- Describe the aims of interview
 - To talk with them about their experiences and views of using CTOs, drawing particularly on the case under research
 - To explore how they practice CTOs
- Describe format of interview
 - Relaxed and loosely structured
- Check length of interview OK (about an hour)
- Check OK to be recorded
- Explain will be taking notes and why
- Any questions

Background

1. Can you tell me a bit about your role within the team?
2. How does your role interact with the use of CTOs?
3. In what ways have you been involved with CTOs?

Practice Experiences

4. What has been your experience of using CTOs?
 - Follow-up: Can you tell me about the CTO cases you've been involved with?
 - What has gone well?
 - What has gone not so well?
 - What practical issues, if any, do CTOs raise for you?

- What ethical issues, if any, have CTOs raised for you?
5. Looking at CTOs more broadly,
- How have they impacted on your practice and the practice of the team?
 - If we think about your particular team model (i.e. AOT, EIP, CMHT), how do you think CTOs fit within that?
 - How do you think service users feel about them?
6. How has the use of CTOs affected the therapeutic relationship between you and service users?
- NB: Most practitioners tend to automatically answer this question in negative terms, so prompt them to think about how CTOs have affected relationships in positive ways as well.

Decision-making

7. Can you describe how decisions have been made on the CTO in relation to your cases?
- Follow-up: At each of the following stages:
 - Discharge from hospital
 - Renewal or discharge from CTO
 - Recall
8. What do you think influenced the decisions on each case?
- Risk
 - Best interests
 - Resources
9. Who do you think had most influence on decisions?
- What was the balance of influence with other practitioners?

- How were service users and carers involved?
 - *For AMHPs:* Are you given enough time to complete your enquiries?
10. *For AMHPs:* In your view, should AMHPs be independent of the team and the case in question, or is it better to have prior involvement?
11. Can you tell me about any particular issues that deciding whether to discharge a CTO or not has raised for you?
12. In your experience, what kinds of conditions have been placed on CTOs?
- What tends to happen when these are breached?
 - Have you come across any cases where conditions have been a particular issue? (i.e. been varied, or debate at what to put on at discharge)
 - Do CTOs make any difference to how much service users can negotiate medication choices?
13. Can you tell me about the role of other professionals in CTOs?
- SOADs
 - IMHAPs
14. What has been your experience of Manager's Hearings and Tribunals?
- How do you think service users experience these meetings?
 - What do you think could be done to encourage their attendance?

Influences on practice

15. Why do you think CTOs were introduced by the government at the time?
- Follow-up if experienced: How do they compare to section 25 and section 17 long leash leave?

16. What purposes do you think CTOs have?
 - Do CTOs meet these purposes?

17. What are your views on CTOs more generally?
 - Professional identity and ethics

18. How do you think these views compare with other people's views?
 - In your team

19. How do you think the practice of CTOs could be improved?

Ending

20. Is there anything you want to add?
21. Do you have any questions?
22. Check anything they don't want included and if want copy of transcript
23. Thank for time and thoughts.

Consultants

Introduction

- Describe the aims of interview
 - To talk with them about their experiences and views of using CTOs, drawing particularly on the case under research
 - To explore how they practice CTOs
- Describe format of interview
 - Relaxed and loosely structured
- Check length of interview OK (about an hour)
- Check OK to be recorded
- Explain will be taking notes and why
- Any questions

Practice Experiences

- What role do you think CTOs play in the work of the Assertive Outreach Team?
- Have you any view on whether they have impacted on services more generally?
- How do you think they have affected clients (both on and off CTOs)?
 - What is the difference when someone is on or off a CTO?
 - What do you think are the benefits of CTOs?
 - What are the drawbacks of CTOs?
- How have they impacted on your practice?
 - What has gone well?
 - What has gone not so well?
 - What practical issues do CTOs raise for you? (paperwork, communication, understanding guidelines)

- What ethical issues have CTOs raised for you? (medication, user rights)
- What kinds of persuasion do you use with service users?
 - How have conflicts been resolved?
 - How much ‘teeth’ do CTOs have?
 - How coercive do you think CTOs are?
- Have you any view on whether CTOs affect the therapeutic relationship between practitioners and service users?

Decision-making

- Can you describe to me how decisions are made at different stages of the CTO?
 - Discharge from hospital
 - Recall
 - Revocation
 - Discharge/extension of the CTO.
- Who tends to be involved, in what way and at what stage?
 - Does the inpatient/outpatient divide cause any issues?
- If we look at all the CTOs you’ve dealt with, do any stand out in your mind for the way decisions were made?
 - If so what happened?
- What are the reasons when you have/have not kept someone on a CTO?
- What significant factors do you think influence your decisions on CTOs?
 - Risk
 - Best interests

- Resources
- Bureaucracy
- Who do you think influences decisions on CTOs?
 - What is the balance of power with other practitioners?
 - How are service users and carers involved?
- Can you tell me about any particular dilemmas CTOs have raised for you?
 - For example when discharging from a CTO?
 - How were these dilemmas resolved?
 - Can you tell me a bit about the role of Manager's Hearings/Tribunals?

Influences on practice

- Why do you think CTOs were introduced by the government at the time?
- Do you think that the reality of practice of CTOs reflects these concerns?
- What difference, if any, do you think there is between CTOs and s.25 or s.17?
- What problems do you think CTOs solve?
- What about alternative solutions to CTOs?
- Do you think your view as a psychiatrist is different to what may be that of social workers and CPNs?
- How do you think your views on CTOs compare with other people's views in your team?

- How could the practice of CTOs be improved?

Ending

- Is there anything you want to add?
- Do you have any questions?
- Check anything they don't want included and if want copy of transcript
- Thank for time and thoughts.

AMHPs

Background

- Can you tell me a bit about your role?
- How does your role interact with the use of CTOs?
- In what ways have you been involved with CTOs?

Practice Experiences

- What has been your experience of the use of CTOs?
 - What has gone well?
 - What has gone not so well?
 - What practical issues do CTOs raise for you? (paperwork, communication, understanding guidelines)
 - What ethical issues have CTOs raised for you? (medication, user rights)
- Looking at CTOs as a policy more broadly,
 - How have they impacted on your practice?
 - How do you think they have impacted on services more generally?
 - How do you think they have affected service users?
 - What do you think are the benefits of CTOs?
 - What are the drawbacks of CTOs?
 - How could the practice of CTOs be improved?
- How do you think the use of CTOs affects the therapeutic relationship?

Decision-making

- If we look at all the CTOs you've dealt with, do any stand out in your mind for the way decisions were made?
 - In terms of starting out, revocation, renewal

- What factors do you think influence decisions?
 - Risk
 - Best interests
 - Resources
 - Bureaucracy

- What is the balance of power with other practitioners?
 - How much do consultants involve you?
 - Are you given enough time to complete your enquiries?

- How are service users and carers involved?
 - How are CTOs communicated to them?

- What has been your experience of the kinds of conditions put on CTOs?
 - What issues have conditions caused in terms of compliance and when to recall and revoke for example?
 - Note: ask about residency

- Have you ever been told that the service user won't be discharged unless a CTO is agreed to?

- In your view, should AMHPs be independent of the team and the case in question, or is it better to have prior involvement?

Influences on practice

- Why do you think CTOs were introduced by the government at the time?

- How do they compare with s17 leave and the old s25?
- What purposes do you think CTOs have?
- What are your views on CTOs more generally?
 - Professional identity and ethics
- How do you think these views compare with other people's views?
 - In your team
 - With service users (Particularly the service user in the case under research)
- How do you think your views affect your practice?

Ending

- Is there anything you want to add?
- Do you have any questions?
- Check anything they don't want included and if want copy of transcript
- Thank for time and thoughts.

Managers' Hearing Chairs

Can you tell me about your experiences of CTO renewal hearings?

What problems have arisen in the running of hearings?

- Role of IMHA
- Role of solicitor
- Service user involvement
- NR involvement

What kinds of reasons do RCs and care coordinators give for wanting to extend the CTO?

What factors are you looking for in deciding whether a CTO should be extended or not?

Have there been any cases you can think of where you have decided not to uphold the CTO?

- Have there been any cases you can think of where there has been debate with the panel about whether to extend or not?

How have CTOs changed the work of Manager Hearings?

What support did you receive from the Trust in ensuring you were prepared for their introduction?

Do you have any general views on how they are being used in the Trust?

From your perspective, how do you think the use of CTOs could be improved?

Appendix Four: Practitioner Interview Framework

A. *What purposes the CTO holds*

Immediate purposes

- 1. Maintenance** (Wellness, safety, stability, small gains (not necessarily about change))
Links to conditions - CTO and depot (C2d), recall - reasoning behind use of recall (C3b), discharge - view on risk-taking (C5b), discharge – CTO cycles (C5f), CTO interaction with AOT model (D3), CTOs and broader practice context (D6), how the CTO works – insurance policy (E8b), the nature of proof and causality (F1), the temporal nature of outcomes (F2)
- 2. Protection** (Paternalism, managing vulnerability, ethics of care, making compulsion kinder, alleviating distress; but also professional comfort/safety net as below)
Links to risk (B6) and recall - reasoning behind use of recall (C3b), personal vs. state responsibility (E3)
- 3. Surveillance/risk management** (Safety of others, professional comfort/safety net, control, monitoring of medication)
Links to risk (B6), levels of relational knowledge (B7), recall - reasoning behind use of recall (C3b), recall - certainty and uncertainty (C3d), discharge - view on risk-taking in discharge (C5b), personal vs. state responsibility (E3), trust and distrust (E5), depth and surface work (E6), how the CTO works – insurance policy (E8b), explanatory tool (E8e), the kinds of outcomes practitioners referred to (F4)
- 4. Knowledge/relationship management** (Kick-start for relationship; managing lack of knowledge with new service users).
Links to levels of relational knowledge (B7), discharge - proof for discharge (C5e), how CTOs work – contract (E8a), relationship builder (E8c)

Longer lasting purposes

- 5. Positive liberty** (Compulsion leading to less coercion in future, medication adherence basis for psychosocial work; CTO length and consolidation; managing ethical discomfort)
Links to perceptions of discretion (B2) and balancing act (B3), discharge - the nature of individual change (C5d), discharge – service user attitude (C5c), response of service users (E2), personal vs. state responsibility (E3), developing a relationship within compulsion (E7), how CTOs work - relationship builder (E8c), all of F (except F5)

- 6. Individual change** (Stimulating reflection, developing insight, developing responsibility, becoming self-managing; external compulsion vs. internal change; rates of change; evidence of change; direct vs. indirect causal relationship to CTO).

Links to insight and beliefs (B4), recall – reasoning behind use (C3b), discharge – service user attitude (C5c), discharge – the nature of individual change (C5d), discharge – proof (C5e), personal vs. state responsibility (E3), depth and surface work (E6), how CTOs work – bargaining tool (E8d), all of F except 5

- 7. Policy purposes comparison** (As contrast: social control, risk management scepticism, resources, revolving door management, limiting discretion)

Links to view on the CTO (B1), Conditions – limits to compulsion (C2a), Oversight – system centred or person centred (C4c), the AOT ethos (D1), CTOs and resources (D2), broader practice context (D6)

- B. *What influences practitioners' judgements on appropriateness of use of CTOs*

First three are interrelated frameworks for how practitioners approach CTOs based on personal/professional understandings and beliefs

- 1. View on the CTO** (Ambivalence (across a spectrum); Concerns about – unnecessary coercion – least restrictive principle, narrowing of choices, impact on practice, not bringing anything new)
Links to policy purposes comparison (A7), recall – how recall happens (C3a), recall – continuity and discontinuity (C3c), discharge – ethical concerns (C5a), CTOs and resources (D2), CTO interaction with AOT (D3), CTOs and practice remit (D4), CTOs and broader practice context (D6), the relationship between CTOs and other legislation (D7), tension between discourses (E4), the nature of proof and causality (F1)
- 2. Perceptions of discretion** (Views on level of discretion in CTO process; Necessary vs. helpful; moral/ethical justification; Influences include – perception of power of CTO, perceived impact on service users, efficacy of local policy/practice mechanisms, beliefs on: autonomy and personhood, the medical model, the power of relationship and how change occurs)
Links to positive liberty (A7), decision-making (C1), conditions – boundaries to compulsion and areas of choice (C2a and b), recall – blurring boundaries of compulsion (C3e), discharge –ethical concerns (C5a), What 'good' CTO practice looks like (D5), CTOs and practice remit (D4), CTOs and broader practice context (D6), response of service users

(E2), personal vs. state responsibility (E3), the nature of proof and causality (F1), balancing outcomes (F3), the kinds of outcomes referred to (F4)

3. **Balancing act** (A bioethical endeavour – harms vs. benefits; influenced by conception of professional identity and aims).
Links to positive liberty (A7), decision-making (C1), conditions (C2), recall – certainty and uncertainty (C3d), recall – blurring boundaries of compulsion (C3e), oversight – networks of power/knowledge (C4b), discharge – ethical concerns (C5a), service user attitude (C5c), responses of service users (E2), personal vs. state responsibility (E3), tension between discourses (E4), trust and distrust (E5), depth and surface work (E6), how CTOs work – contract (E8a), balancing outcomes (F3)

Insight as an overarching factor which influences views on risk and capacity/consent

4. **Insight and beliefs** (Differing conceptions of what insight means, problematising insight, views on beliefs held by service users, insight as connected to autonomy and competence, **Manager Hearings – help-seeking**)
Links to individual change (A6), conditions - CTOs and depots (C2d), discharge - the nature of individual change (C5d), response of service users (E2), personal vs. state responsibility (E3), the temporal nature of outcomes (F2), the kinds of outcomes that practitioners referred to (F4)
5. **Capacity and consent** ('Grey area' for practitioners; capacity and variable role in decision-making; capacity and insight; different kinds of capacity; capacity and 'best practice'; relationship between capacity and consent; consent and 'best practice'; judging 'true' consent)
Links to decision-making – involvement of service users (C1c), conditions – CTO and depots. (C2d), recall - blurring boundaries of compulsion (C3e), what 'good' practice looks like (D5), perceived levels of understanding (E1), personal vs. state responsibility (E3), depth and surface work (E6)
6. **Risk** (Risk and insight, perceived vulnerability, socially problematic behaviour, risk of stigma, risk to others, predicting or proven risk, presence of alternative strategies, ability to monitor/measure risk; view of other agencies (police)).
Linked to protection (A2), surveillance/risk management (A3), recall – certainty and uncertainty (C3d), discharge- view on risk-taking (C5b), discharge – proof (C5e), How CTOs work – insurance policy (E8b), explanatory tool (E8e), the kinds of outcomes practitioners referred to (F4)
7. **Levels of relational knowledge** (If people are 'known' or not; perceptions of individual characteristics – categorisation and expected

individual response; relapse profile – speed, intensity, pre-existing coping strategies, presentation to professionals, obviousness, consequences; timing and history)

Links to surveillance/risk management (A3), knowledge/relationship management (A4), recall – reasoning behind use (C3b), certainty and uncertainty (C3d), discharge – service user attitude (C5c), discharge – CTO cycles (C5f), how CTOs work – relationship builder (E8c)

- 8. Contextual factors** (Accommodation type, social network, involvement of family, reassuring family, other ‘checks and balances’, kinds of medication able to be used, drug/alcohol use)

Links to Conditions – CTOs and depots (C2d), discharge – proof (C5e), CTOs and broader practice context (D6), the kinds of outcomes practitioners referred to (F4)

C. *How key mechanisms work (Decision-making, Conditions, recall, oversight, discharge)*

1. Decision-making

- a. AMHPs – negotiation of safeguards, rubber stamping and routinisation, unilateral vs. joint decision-making, practice dilemmas, knowledge/power, inevitability, working within the CTO;
Links to perceptions of discretion (B2), balancing act (B3), CTO interaction with AOT model (D3), what ‘good’ CTO practice looks like (D5), CTOs and broader practice context (D6), the relationship between CTOs and other legislation (D7), the nature of proof/causality (F1), corroboration by others (F5)
- b. Care coordinators and responsible clinicians – style of the RC, shared responsibility and risk, care coordinator as advocate and ‘middle man’;
Links to perceptions of discretion (B2), balancing act (B3), CTO and practice remit (D4), perceived levels of understanding (E1), developing a relationship within compulsion (E7), corroboration by others (F5)
- c. Involvement of service users – being told, explained to, persuasion and bargaining, choice over choices and the nature of consent, getting under the surface; negotiating within the CTO framework
Links to perceptions of discretion (B2), balancing act (B3), capacity and consent (B5), AOT ethos (D1), what good practice looks like (D5), perceived levels of understanding (E1), depth and surface work (E6), developing a relationship within compulsion (E7), how CTOs work – bargaining tool (E8a), explanatory tool (E8e)

2. Conditions

- a. (Limits to compulsion/discretion – self-administered limitations, how conditions are negotiated, informal criteria (law, ethics, feasibility); *Links to policy purposes comparison (A7), perceptions of discretion (B2), balancing act (B3), AOT ethos (D1), CTO interaction with AOT model (D3), perceived levels of understanding (E1), response of service user (E2), tension between discourses (E4), developing a relationship within compulsion (E7), levels/layers of compulsion (E8f), psychological leverage (E8g)*
- b. Areas of choice – autonomy, rights and social norms; moral justification (lifestyle choices vs. medication, kinds of ‘treatment’); *Links to perceptions of discretion (B2), balancing act (B3), what good CTO practice looks like (D5), personal vs. state responsibility (E3)*
- c. Certainty and uncertainty – the level of certainty of predication in operation of conditions, how practitioners construct what would happen if and when conditions are breached; relationship to ethical stance; hard and soft conditions
Links to balancing act (B3), CTO interaction with AOT model (D3), trust and distrust (E5), developing a relationship within compulsion (E7), how CTOs work – contract (E8a), levels of compulsion (E8f)
- d. ⁴¹CTOs and depots – symbiotic relationship, relationship to purpose of CTO, relationship to how the CTO is perceived to work, questions of choice and autonomy)
Links to maintenance (A1) (this specifically but also A more generally as the foundation for the CTO), perceptions of discretion (B2), insight and beliefs (B4), capacity and consent (B5), contextual factors (B8), CTO interaction with AOT model (D3), CTOs and practice remit (D4), response of service users (E2), the kinds of outcomes practitioners referred to (F4)

3. Recall

- a. (How recall happens - Guidance vs. challenges of practice (time-consuming, bureaucratic, complex, confusing), working round the legislation, changing of care coordinators role, variable circumstances of recall, communication with other agencies, inpatient-community relationship, ⁴²imaginative vs. mechanistic use, recall cycles; *Links to view on the CTO (B1), CTOs and resources (D2), CTOs and AOT model (D3), CTOs and practice remit (D4), CTOs and broader practice context (D6), perceived levels of understanding (E1), response of service users (E2), developing a relationship within compulsion (E7), levels/layers of compulsion (E8f), psychological leverage (E8g)*

⁴¹ How depots and CTOs relate is the key example of the above three sub-categories of boundaries to compulsion, areas of choice and certainty and uncertainty.

⁴² This ties in with both Continuity and discontinuity, and certainty and uncertainty.

- b. Reasoning behind use – ensuring medication compliance, behaviour modification, preventative intervention, quick response to risk, legislative short-cut;
Links to maintenance (A1), protection (A2), surveillance/risk management (A3), individual change (A6), levels of relational knowledge (B7), CTOs and resources (D2), CTOs and the broader practice context (D6), the relationship between CTOs and other legislation/systems (D7), response of service users (E2)
 - c. Continuity and discontinuity – dislocation for service users, discontinuity of care and knowledge, mediation of the nature of practice, service centred vs person centred;
Links to view of the CTO (B1), what good CTO practice looks like (D5), CTOs and broader practice context (D6), depth and surface work (E6), the kinds of outcomes practitioners referred to (F4)
 - d. Certainty and uncertainty – uncertainty about the recall process, levels of certainty of response to service user behaviour, recall as managing uncertainty, catch-22 and defensive decision-making; recall and complex cases, impossible cases;
Links to surveillance/risk management (A3), risk (B6), levels of relational knowledge (B7), CTO interaction with AOT model (D3), perceived levels of understanding (E1), response of service users (E2), tension between discourses (E4), depth and surface work (E6), how CTOs work – contract (E8a), levels of compulsion (E8f), balancing outcomes (F3), corroboration by others (F5)
 - e. Blurring boundaries of compulsion – psychological leverage, the nature of consent, porous boundary between community and hospital)
Links to perceptions of discretion (B2), balancing act (B3), capacity and consent (B5), CTO interaction with AOT model (D3), CTOs and practice remit (D4), response of service users (E2), personal vs. state responsibility (E3), tension between discourses (E4), depth and surface work (E6), how CTOs work – psychological leverage (E8g), balancing outcomes (F3)
- 4. Oversight**
- a. (Enforcing rights) – real or abstract rights, automated nature of CTOs, paradox of safeguards; tribunal view on their role; procedural justice
Links to what good practice looks like (D5), response of service users (E2), depth and surface work (E6), how CTOs work – contract (E8a)
 - b. Networks of power/knowledge – professional knowledge and expert truths, presence or absence of conflicting accounts (patients), professional identity (legal vs care), disenfranchisement, distancing; identity and stigma;

Links to balancing act (B3), CTOs and practice remit (D4), tension between discourses (E4), trust and distrust (E5), how CTOs work – explanatory tool (E8e), balancing outcomes (F3), corroboration by others (F5)

- c. System centred or person centred – who the CTO is for, inflexibility of SOADs, nature and protocol of Tribunals, what service users perceive to be part of the system (supportive or disciplinary).

Links to Policy purposes comparison (A7), AOT ethos (D1), what good CTO practice looks like (D5), CTO and broader practice context (D6), developing a relationship within compulsion (D7), perceived levels of understanding (E1), balancing outcomes (F3)

5. Discharge (also how it works – lapsing, discharge)

- a. Ethical concerns – differing conceptions of justice and fairness, institutionalisation and dependency; looking beyond legislative requirements

Links to view on the CTO (B1), balancing act (B3), what good CTO practice looks like (D5), personal vs. state responsibility (E3), trust and distrust (E5), developing a relationship within compulsion (E7), the kinds of outcomes practitioners referred to (F4)

- b. View on risk-taking – positive risk-taking, practitioners providing hope, practitioners proving trustworthiness, defensive thinking (insurance policy) note: unexpected alignments – i.e. psychiatrists who think care coordinators are too risk averse. The medical model not aligned with risk (because about wellness or not), whereas the social model can be more so

Links to maintenance (A1), surveillance/risk management (A3), risk (B6), CTO interaction with AOT model (D3), what good CTO practice looks like (D5), personal vs. state responsibility (E3), trust and distrust (E5), developing a relationship within compulsion (E7), how CTOs work – insurance policy (E8b), bargaining tool (E8d), the nature of proof and causality (F1), the temporal nature of outcomes (F2)

- c. Service user attitude – persuasion and reverse compulsion, defuse conflict, shifting the nature of interactions, shifting responsibility, emphasising interdependence;

Links to positive liberty (A5), individual change (A6), balancing act (B3), levels of relational knowledge (B7), response of service users (E2), personal vs. state responsibility (E3), developing a relationship within compulsion (E7), balancing outcomes (F3)

- d. The nature of individual change – the length of the CTO, how change relates to the CTO framework, weightings given to past/present/future, beliefs on possibility of change, measuring and predicting the depth and

nature of change, what counts as change, difficulty and uncertainty, 'right' and 'wrong' kinds of change; discharge as symbolising wellness
Links to positive liberty (A5), individual change (A6), insight and beliefs (B4), CTO interaction with the AOT practice model (D3), trust and distrust (E5), surface and depth work (E6), all of F (apart from 5)

- e. Proof – 'testing out' service users, environmental change/stability – strategies that professionals use to keep the CTO on in oversight settings, the paradox of proving active compliance under compulsion; paradoxical use of recall

Links to Knowledge/relationship management (A4), individual change (A6), risk (B6), contextual factors (B8), response of service users (E2), trust and distrust (E5), developing a relationship within compulsion (E7), how the CTO works – bargaining tool (E8d), the nature of proof and causality (F1), the temporal nature of outcomes (F2)

- f. CTO cycles – evidence and assumptions of causality, becoming drawn in to long-lasting compulsion, last resort and last chances).

Links to maintenance (A1), levels of relational knowledge (B7), the nature and proof of causality (F1), the temporal nature of outcomes (F2), corroboration by others (F5)

D. *Perceived interaction of CTOs with practice*

CTOs and team practice

- 1. Assertive Outreach Team ethos/culture** (Skilful work, resource intensive; assertive vs. coercive, service change vs. individual change; role – being a resource, finding out what will work, mutual ground).
Links to policy purposes comparison (A7), decision-making – involvement of service users (C1c), conditions – limits to compulsion (C2a), oversight - system centred or person centred (C4c), response of service users (E2), personal vs. state responsibility (E3), tension between discourses (E4), trust and distrust (E5), how CTOs work – levels of compulsion (E8f), corroboration by others (F5)
- 2. CTOs and resources** (less referrals, less manpower, less use of sections; bureaucracy, recall difficulties, paperwork; impact on face time, whether resulted in better quality care).
Links to policy purposes comparison (A7), view on the CTO (B1), recall – how recall happens (C3a), recall - reasoning behind use (C3b), response of service users (E2)
- 3. CTO interaction with AOT model** (AOT as natural home of CTOs; compulsion and clarity (for both); routinisation; contrast of 'skilled')

practice ('quality', incremental, acceptance of relapse, acceptance of uncertainty, understanding behaviour, creativity, social focus, depth/relational work) with deskilled CTO practice ('black and white' work, immediate change, no need for understanding, medical focus, maintenance, surface/mechanised work).

Links to maintenance (A1), view on the CTO (B1), decision-making – AMHPs (C1a), conditions – limits to compulsion (C2a), conditions – certainty and uncertainty (C2c), conditions – CTOs and depot (C2d), recall – how recall happens (C3a), recall – certainty and uncertainty (C3d), recall – blurring boundaries of compulsion (C2e), discharge – view on risk-taking (C5b), discharge – the nature of individual change (C5d), tension between discourses (E4), depth and surface work (E6), developing a relationship within compulsion (E7), how CTOs work – contract (E8a), relationship builder (E8c)

CTOs and individual practice

- 4. CTOs and practice remit** (CTOs and reformation of practice; discretion paradox; narrowing choices; medical model; social police)
Links to view on the CTO (B1), perceptions of discretion (B2), decision-making – CCs and RCs (C1b), Conditions – CTOs and depots (C2d), recall – how recall happens (C3a), recall - blurring boundaries of compulsion (C3e), oversight – networks of power/knowledge (C4b), response of service users (E2), tension between discourses (E4), trust and distrust (E5), depth and surface work (E6), how CTOs work – levels of compulsion (E8f)
- 5. What 'good CTO practice' looks like** (critical thinking – taking the CTO seriously, not taking it for granted, considering alternatives first, using it selectively; encouraging service users to take up their rights; trying to gain 'proper' consent – agreement/partnership/exchange; being clear and accountable; doing it for the good of the service user, not the service; treating it as a process not an event – increasing service user understanding of it over time, making clear what needs to happen for discharge to occur; following practice guidelines; planning carefully and early; mitigating coercion with reciprocity; continuity of care).
Links to perceptions of discretion (B2), capacity and consent (B5), decision-making – AMHPs (C1a), involvement of service users (C1c), conditions - areas of choice (C2b), recall – continuity and discontinuity (C3c), oversight – enforcing rights (C4a), system centred or person centred (C4c), discharge – ethical concerns (C5a), views on risk-taking (C5b), perceived levels of understanding (E1), developing a relationship within compulsion (E7), how CTOs work – contract (E8a), relationship-builder (E8c), bargaining tool (E8d)

CTOs and practice context

- 6. CTOs and broader practice context** ('Payment by results' – categorisation and impact on care plans – maintenance vs. recovery; resource cuts; shrinking number of beds and lack of respite/crisis care (impact on family of having to cope but also on pre-existing coping strategies of service users) (interesting also that challenges assumptions that CTOs are being used to free up beds by discharging early – instead it is easier just to discharge so might not be in interests of inpatient team to decide on CTO); inpatient/community services separation. Note – it's interesting how much defensiveness in interviews there was about this). *Links to maintenance (A1), policy purposes comparison (A7), view on the CTO (B1), perceptions of discretion (B2), contextual factors (B8), Decision-making (C1), recall – how recall happens (C3a), recall – reasoning behind use (C3b), recall – continuity and discontinuity (C3c), oversight – system centred or person centred (C4c), response of service users (E2)*
- 7. The relationship between CTOs and other legislation/systems** (The uniqueness of the CTO; Section 17 – psychological separation, resource management, discretion and restriction; section 25 – lacking 'teeth', intrinsic power vs. psychological power; Guardianship – welfare orientated vs. treatment orientated, 'greyness' and interpretation; Sections – trauma and difficulty, hot vs. cold; Criminal justice – influence of CTO on CJ outcomes, language and understanding, protection and diversion, surveillance and proof of 'wellness'; Benefits – persuasive shorthand). *Links to view on the CTO (B1), decision-making – AMHPs (C1a), recall – reasoning for use (C3b), perceived levels of understanding (E1), response of service users (E2), personal vs. state responsibility (E3), how CTOs work – contract (E8a)*

E. CTOs and the practitioner-service user relationship

How practitioners viewed and dealt with service users' responses to the CTO

- 1. Perceived levels of understanding** (Service user perceptions of purpose and power of CTO; clarification, challenging 'black and white' thinking; 'helpful' misunderstandings; CTO as on-going, interactive). *Links to capacity and consent (B5), decision-making (C1), conditions – limits to compulsion (C2a), recall – how recall happens (C3a) and certainty and uncertainty (C3d), oversight – system centred or person centred (C4c), what good CTO practice looks like (D5), the relationship between CTOs and other legislation/systems (D7)*

- 2. Response of service users** (How practitioners interpreted service user responses; Typology (response to authority/legal power, values and means) – active/passive, resistance/acceptance (reluctant compliance), ambivalence, subversion (subversive obedience/disobedience), relationship to how and if the CTO works (agreement-based only?), CTO as point of conflict, community care as battle; disruption of coping strategies – closing down of alternatives, disruption of choices - ‘forced to be well’)

Links to positive liberty (A5), perceptions of discretion (B2), balancing act (B3), insight and beliefs (B4), conditions – limits to compulsion (C2a), conditions – CTOs and depots (C2d), recall – how recall happens (C3a), recall – reasoning behind use (C3b), recall – blurring boundaries of compulsion (E3e), discharge – service user attitude (C5c), discharge – proof (C5e), AOT ethos (D1), CTOs and resources (D2), CTOs and practice remit (D4), CTOs and broader practice context (D6), the relationship between CTOs and other legislation (D7), balancing outcomes (F3), the kinds of outcomes referred to (F4)

- 3. Personal vs. state responsibility** (Getting the balance right – compliance and dependence/passivity, conditioning and institutionalisation, limiting emotions/behaviours; limiting service responsibility; exacerbating service user irresponsibility; compulsion as structurally or individually driven; ‘right’ kinds of autonomy, choosing to do the right thing).

Links to protection (A2), surveillance/risk management (A3), positive liberty (A5), individual change (A6), balancing act (B3), insight and beliefs (B4), capacity and consent (B5), conditions – areas of choice (C2b), recall – blurring boundaries of compulsion (C3e), discharge – ethical concerns (C5a), view on risk-taking (C5b), service user attitude (C5c), AOT ethos (D1), the relationship between CTOs and legislation (D7), balancing outcomes (F3), the kinds of outcomes referred to (F4)

The relationship and the CTO

- 4. Tension between discourses** (Contrast between work doing and work wanting to do, partnership, responsibility/independence, creativity, needs, recovery; damage to the therapeutic relationship; differences in professional values)

Links to view on the CTO (B1), balancing act (B3), conditions – limits to compulsion (C2a), recall – certainty and uncertainty (C3d), blurring boundaries of compulsion (C3e), oversight – networks of power/knowledge (C4b), AOT ethos (D1), CTO interaction with AOT model (D3), CTOs and practice remit (D4)

- 5. Trust and distrust** (Honesty – being upfront, difficult conversations (enables practitioner but may disenable service user); persuasive conversations – justification to service user and to self (integrity); obfuscatory ‘soft’ language; uncertainty – not knowing/believing (both ways); role of hope and promised change; lack of trust – fear, hiding (figuratively and literally), disengagement, reinforcing barriers).
Links to surveillance/risk management (A3), balancing act (B3), conditions – certainty and uncertainty (C2c), oversight – networks of power/knowledge (C4b), discharge (C5), AOT ethos (D1), CTOs and practice remit (D4), balancing outcomes (F3), the kinds of outcomes referred to (F4)
- 6. Depth and surface work** (contrast – depth and surface ways of working; mutual reinforcement - ‘good’ CTOs’ involve exchange, difficulties with reading and working with ‘surface’ compliance - doubt, ‘impossible’ relationships and on-going struggles, personality disorder).
Links to balancing act (B3), capacity and consent (B5), recall – continuity and discontinuity (C3c), recall – certainty and uncertainty (C3d), recall – blurring boundaries of compulsion (C3e), oversight – enforcing rights (c4a), discharge – the nature of individual change (C5d), CTO interaction with AOT model (D3), CTOs and practice remit (D4), the temporal nature of outcomes (F2), the kinds of outcomes practitioners refer to (F4)
- 7. Developing a relationship within compulsion** ((Perceived power of relationship; empathy, mediation, advocacy; small meeting points – mutuality of purpose/common ground (focusing on aims, not means); keeping the CTO positive – reciprocity mitigating coercion; providing hope and being optimistic that the situation will change; attempting to work in a person-centred way in a service centred context; use of professional identity in strategies for engagement (distancing from the CTO and medical model); negotiating within boundaries (medication, where to meet, ‘testing out’). Note: although if testing out (e.g. giving service user the opportunity to take medication orally of own accord) it can be viewed as a ‘last chance’ as if it doesn’t work with the CTO it can be deemed not able to work at all).
Links to positive liberty (A5), decision-making (C1b and C1c, conditions – limits to compulsion (C2a), conditions – certainty and uncertainty (C2c), recall – how recall happens (C3a), oversight – system centred or person centred (C4c), discharge – ethical concerns (C5a), discharge – risk-taking (C3b), service user attitude (C5c), proof (C5e), CTO interaction with AOT (D3), what good CTO practice looks like (D5), balancing outcomes (F3)

The general characteristics of CTOs in practice as mediated by the interaction between practitioner and service user (inclusive of positive influence on relationship)

8. How CTOs work

- a. Contract (clear guidelines for both practitioner and service user to operate within and know what they can and can't do; the CTO as clarifying and therefore protecting service user rights; reciprocity as mitigating coercion)

Links to knowledge/relationship management (A4), balancing act (B3), conditions – certainty and uncertainty (C3c), recall – certainty and uncertainty (C3d), oversight – enforcing rights (C4a), CTOs interaction with AOT model (D3), what good CTO practice looks like (D5), the relationship between CTOs and other legislation (D7)

- b. 'Insurance policy' (CTOs as an insurance policy "kept in the background" and used when necessary. This is a point relevant to the issues around discharge).

Links to maintenance (A1), surveillance/risk management (A3), risk (B6), discharge – views on risk-taking (C5b), the temporal nature of outcomes (F2)

- c. Relationship builder (The CTO could be used as a framework to see individuals regularly who had previously avoided services and try and build some kind of a working alliance with them; provides structure to build up interaction; enables calmer, goal-orientated work with less fire-fighting).

Links to knowledge/relationship management (A4), positive liberty (A5), levels of relational knowledge (B7), CTO interaction with AOT (D3), what good CTO practice looks like (D5), the temporal nature of outcomes (F2)

- d. Bargaining tool (setting out what someone needs to do to come off the CTO as an encouragement for change; pointing out what the CTO has done for them so far). Note: this could also apply (although not in the same sense of power) for service users – e.g. 'I'll agree to this if...'

Links to individual change (A6), decision-making – involvement of service users (C1c), discharge – perception of risk-taking (C5b), discharge – proof (C5e), what good CTO practice looks like (D5)

- e. Explanatory tool (Enabling the practitioner to talk to the service user about difficult topics, particularly how the practitioner perceives the service users' level of risk)

Links to surveillance/risk management (A3), risk (B6), decision-making – involvement of service users (C1c), oversight – networks of power/knowledge (C4b)

f. Levels/layers of compulsion (the different strategies used before the final level of recall – reminders, ‘threats’, persuasion).

Links to conditions – limits to compulsion (C2a), certainty and uncertainty (C2c), recall – how recall happens (C3a), certainty and uncertainty (C3d), AOT ethos (D1), CTOs and practice remit (D4)

g. Psychological leverage (Setting out the consequences of noncompliance in a way that is understandable to the individual service user and effective in maintaining compliance)

Links to conditions – limits to compulsion (C2a), recall – how recall happens (C3a), recall – blurring boundaries of compulsion (C3e)

Note: in regards to the above all the practitioners believed that nevertheless for a specified minority, the CTO had to be used in a straightforwardly coercive way

F. *When CTOs judged to work or not (how practitioners talk about CTO outcomes and what they judge to be good or bad outcomes)*

1. The nature of proof and causality (what does ‘working’ mean; evaluation of CTOs as change agent; proximal and distal effects – present and future outcomes, chains of causality)

Links to maintenance (A1), positive liberty (A5), individual change (A6), view on the CTO (B1), perceptions of discretion (B2), Decision-making – AMHPs (C1a), discharge – view on risk-taking (c5b), the nature of individual change (C5d), proof (C5e), CTO cycles (C5f)

2. The temporal nature of outcomes (Outcomes when CTO is still active, outcomes post-discharge; view on ‘internalisation’ of CTO (connected to view on indefinite use or not).

Links to maintenance (A1), positive liberty (A5), individual change (A6), insight/beliefs (B4), discharge – perceptions of risk-taking (C5b), the nature of individual change (C5d), proof (C5e), CTO cycles (C5f), depth and surface work (E6), how CTOs work – insurance policy (E8b), relationship builder (E8c)

3. Balancing outcomes (How practitioners managed ethical discomfort, ‘sacrifice’, working in some ways and not working (or worsening) in others; the tangibility of effects the CTO might bring and how they might be qualified – ability to ‘prove’, ‘hard’ positive outcomes vs. ‘soft’ negative outcomes; who the CTO is supposed to be ‘good’ for – service user views about meaning of success weighted against practitioner views)

Links to positive liberty (A6), individual change (A7), perceptions of discretion (B2), balancing act (B3), recall – certainty and uncertainty (C3d), oversight – networks of power/knowledge (C4b), system centred or person centred (C4c), discharge – service user attitude (C5c), the nature of individual change (C5d), response of service users (E2), personal vs. state responsibility (E3), trust and distrust (E5), developing a relationship within compulsion (C7)

- 4. The kinds of outcomes practitioners referred to** (ensuring treatment – primary outcome and foundation; behavioural change – lessening problematic behaviour, bringing about positive changes in engagement, broader social as well as clinical change, short term ‘forced’ change and long-term ‘internalised’ change; Lowering levels of restriction – ‘lesser of two evils’, length community compulsion vs. shorter hospital compulsion – kinds of freedom; lowering levels of risk – monitoring and supervision, fixing holes in the safety net; negative outcomes – exacerbation of revolving door, reinforcement of negative behaviour, creation of dependency/passivity, negative psychological repercussions, disengagement from services/practitioner; ambivalence over what CTOs can change - insight)

Links to surveillance/risk management (A2), positive liberty (A5), individual change (A6), perceptions of discretion (B2), insight and beliefs (B4), risk (B6), contextual factors (B8), CTOs and depots (C1d), recall – continuity and discontinuity (C3c), discharge – ethical concerns (C5a), the nature of individual change (C5d), response of service users (E2), personal vs. state responsibility (E3), trust and distrust (E5), depth and surface work (E6),

- 5. Corroboration by others** (the role of multi-disciplinary teams and manager’s hearings/tribunals, group reinforcement, managing doubt)
Links to decision-making (C1a, C1b), recall – certainty and uncertainty (C3d), oversight – networks of power/knowledge (C4b), discharge - CTO cycles (C5f), CTO ethos (D1)

Appendix Five: Access Letter

THE UNIVERSITY *of York*

DEPARTMENT OF
SOCIAL POLICY AND
SOCIAL WORK

Heslington, York YO10 5DD

Telephone (01904) 430000

Direct telephone (01904) 321260

Dear

I am writing in order that you may consider the possibility of my gaining access to a Community Mental Health or Assertive Outreach Team in your Trust, for a research project I am currently undertaking. I am a social work qualified, full-time PhD student in the Department of Social Policy and Social Work at the University of York. The research project concerns the use of Community Treatment Orders within Community Mental Health Services. The title of the research is:

‘Community Treatment Orders: Their Implications for Mental Health Policy and Practice in England’

Community Treatment Orders are complex policy interventions. The majority of research on the use of CTOs has tended to ask the question ‘Do they work?’ We know far less about *how* they are being used and experienced ‘on the ground’ by the various people who have been affected by their implementation. This represents a notable gap in our knowledge of CTOs. By carrying out research which asks ‘How do they work?’ my aim is to make a significant contribution both to our understanding and the future development of best practice in the use of CTOs.

The research will involve service users, carers and practitioners from across disciplines as research participants, and provisionally will utilise a range of qualitative methods, including:

- A focus group with practitioners
- In-depth interviews with practitioners, service users and carers

- Observations of a selection of team meetings, case reviews, and meetings between Approved Mental Health Professionals and Responsible Clinicians.
- Tape recordings of interactions between an agreed number of service users and practitioners.
- Case file analysis.

I envisage starting the fieldwork phase of the research in April 2012, and that this will last no more than eight months.

My academic supervisors are Professor Ian Shaw and Dr Mark Hardy, who respectively hold expertise in qualitative research and the study of mental health policy and practice. They will oversee all aspects of the project. The research will also be scrutinised by the University of York, a NHS Research Ethics Committee and by the Research and Development Team of your Trust.

My intention is to carry out fieldwork in more than one Trust, and as part of this I have also written to nine other Trusts in the region. I will make contact with you in the next ten days to explore further the potential involvement of your Trust in the research. I would be happy to meet with you and/or appropriate members of your management team, to give a more detailed overview of the project. In the meantime, if you have any questions or would like further information, please don't hesitate to contact me.

Yours sincerely,

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Appendix Six: Ethics Procedures and Safeguards

Informed consent

For all participants, care was taken to ensure that they had full understanding of the research prior to taking part, especially in regards to its voluntary nature and that they could withdraw at any time. All information given to participants was developed in consultation with the Trusts' respective service user and carer forums, and presented clearly and written using non-technical, lay language. Information sheets given to participants was appropriate to their status and covered topics such as; the main aims and objectives of the research, what their involvement entailed, what would happen to the data and how research findings would be disseminated. A signed declaration of consent was obtained from each participant before the research commenced verifying that they had read and understood the information sheet, understood their rights and were happy to take part in the research. The consent form included separate statements for each research activity that participants were asked to agree to (e.g. for service users, this would be for interviews, researcher presence at meetings and access to their files). In addition, a process approach was taken to consent, whereby ongoing information-giving, assessment of understanding and evaluation of participant willingness to be involved occurred at each research activity (Keogh and Daly, 2009).

Anonymity and Data Protection

All electronic information was stored solely on a University computer. Audio files were given a unique identification number. Transcripts were given a corresponding identification number to their audio file and were also anonymised with pseudonyms used, as were written up field notes of observations. Audio files and transcripts will be held for up to three years following the end of the study, as per Principle Five of the Data Protection Act (1998) which allows data to be held indefinitely for research purposes. This will initially be by me and following the end of the study, in the University of York archives. This will allow the audio files to be used for on-going research purposes. Personal information such as name and contact details were coded with the corresponding identification number and pseudonym, but kept in a separate password protected file and a hard copy backup was kept in a locked filing cabinet in a locked office. Hard copies of signed consent forms were also kept in the same way. All personal data will be destroyed after the study has finished. Any quotations used in

the thesis, publications or reports, were anonymised with local identifiers removed, and participants were made aware of this on the information sheet. Case file analysis took place in the Team office, and no documents relating to the case were taken out of this environment. Service users were asked for their consent for access to files as part of the consent process. I made notes from case files only pertaining to areas of interest in the research.

Confidentiality and Disclosure

All participants were informed on the information sheet and consent form that information they shared would not be reported to anyone else. Specifically, practitioners were assured that management would not be told of what they say or do and the same was stated to service users in regards to services. It was stressed that whether the service user takes part or not, the services they received would not be affected. Alongside the more general reassurances in regards to confidentiality and anonymity, my independence from services was made clear. The usual caveat to confidentiality regarding serious harm to the participant or others was also explained on information sheets and verbally prior to interviews. If I felt information given by the participant necessitated further action, it was decided that where possible the participant would be informed of this at the time, and what the action will be. However it was recognised that circumstances may not always allow for this. A protocol was clarified with the team manager in the event that a participant did disclose something of this nature. If a service user disclosed poor practice it was planned that they would be informed of the complaints procedure of the Trust, unless it was of a level of seriousness that it met the harm criteria. In addition, I made myself familiar with the whistle-blowing policy of the Trust, in order that I could use it if necessary.

Researcher and Participant Safety

I consulted with the teams before meeting alone with service user and carer participants to ascertain whether there are any risks involved. A judgement was made on this basis whether to go ahead with the research contact or to ensure it is in a setting where support is available. It was agreed with the team manager that the interview would be immediately terminated if I felt at risk of harm. When visiting participants in their homes, I used the teams' lone worker procedures and checked in and out with the duty worker. In regards to participant safety, service user and carer participants were met in a place that was comfortable for them and I carried identification to the first meeting. As

per Trust requirements, I completed an enhanced CRB check. When using team office space, it was ensured that the room used protected participant privacy and confidentiality.

Distress and Providing Support

I was aware that discussing their experiences of CTOs may be at times difficult for some service user participants. As highlighted in the research overview, previous qualitative research has demonstrated that some service users can feel angry and frustrated at what they perceive to be the restrictions placed on them by CTOs. The following strategies were employed in the event that a service user displayed signs of distress during interviews:

- The consent procedures were on-going and it was emphasised to participants that the interview could be stopped either for a break or altogether at any time if involvement became overly upsetting.
- Participants' rights to not disclose information or answer questions they deemed to be too sensitive were respected. If it was judged that a particular topic was causing distress, I moved on to another area of discussion.
- It was made clear to participants that they could bring a supportive person to the interview if they wished.
- If held at home, I would be sensitive to the wishes of the participant in regards to whether they would like me to leave straightaway or remain with them for a period of time to debrief. If held in the community or treatment setting, I supported the participant to make their way home.
- When necessary I would check out whether the participant had someone they were able to talk with once I had left, be it a carer, family member, friend, support worker, or a voluntary organisation. I carried details of local organisations that may be able to provide support, and these were made available to participants prior to the interview starting.
- In regards to observation of meetings, I would leave the meeting if any of the participants feel my presence was not appropriate.

Incentives

Travel expenses were paid to service user participants, along with a small voucher payment (£15) of their choice for each interview. A record of vouchers given was kept. Whilst I was aware of the views that offering payment can sometimes undermine participants' ability to take part in research of their own free will, the amount of £15 was believed sufficiently low for this not to be a concern. Furthermore, taking account of service user perspectives on research (Faulkner, 2004), it is understandable that participants' may wish to be offered some recompense for their time. A thank you card was also sent to participants at the end of the fieldwork period and refreshments were provided during interviews.

Risks and benefits

Given the nature of the research, the risk of harm to participants was small, and evidence suggests that in non-clinical research such as this, participants' feel that the benefits to them outweigh potential harm (NRES, 2011). As stated earlier, the risk to service user participants' primarily related to the triggering of an emotional response. However, this risk cannot be said to universally apply, or that the potential to feel distressed is significantly greater than it would be in a clinical encounter. The strategies outlined earlier to deal with distress helped to manage this risk. Moreover, the fieldwork took account of the view that it can be ethically questionable to exclude participants from social and healthcare research on the basis of assumptions around vulnerability, as it does not allow them the right to make their own choice (Liamputtong, 2007, Ulivi, Reilly and Atkinson, 2009).

In regards to practitioners, there was a risk that they would find taking part in the research burdensome. However I was very careful to ensure that the research was as unobtrusive as possible, by acting on practitioner views on the appropriateness of some fieldwork activities, and by drawing on my own experience of working in a busy multidisciplinary team.

More generally, I was aware that all participants' may feel there could be a risk of their confidentiality being breached, either through the mishandling of data, or through me telling others about what they had said. In the first instance, I made participants' aware that a clear protocol for data storage, handling and anonymisation had been developed

which would minimise the risk of a data leak. In the second instance, I made clear to participants what confidentiality meant, the boundaries in place and my independence from services.

In terms of benefits, although again not assumed to be universal, involvement in the research may have been a positive experience for participants, in being able to express their views, have their story heard and feel they are contributing to a better awareness of CTO practice. Indeed this view was expressed by a number of participants, who refused the offer of a voucher because they wanted to make it clear they were taking part solely in order to be listened to, and to help the development of services. For practitioners in particular, the opportunity to reflect on aspects of their work may have been a helpful experience. Both potential risks and benefits were described on the information sheet.

List of Acronyms

AMHP – Approved Mental Health Professional

AOT – Assertive Outreach Team

CMHT – Community Mental Health Team

CPS – Crown Prosecution Service

CQC – Care Quality Commission

CTO – Community Treatment Order

EIP – Early Intervention in Psychosis

IMHA – Independent Mental Health Advocate

MHA – Mental Health Act

SOAD – Second Opinion Appointed Doctor

SCT – Supervised Community Treatment

SD – Supervised Discharge

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